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

MINISTRY OF SOCIAL AFFAIRS AND HEALTH

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MINISTRY OF SOCIAL AFFAIRS AND HEALTH
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TO THE MINISTRY OF SOCIAL AFFAIRS AND HEALTH

The Ministry of Social Affairs and Health appointed a working group to prepare a national plan for mental health and substance abuse work, with the working group's term covering the period from 1 April 2007 until 30 December 2008.

The working group was assigned with the task of:

1. drafting a plan for mental health and substance abuse work for the Ministry of Social Affairs and Health in accordance with the Ministry's Strategy 2015;
2. submitting proposals for the dissemination of good practices in social welfare and health care;
3. where necessary, submitting proposals for the development of steering tools.

The working group was chaired by Marja-Liisa Partanen, Deputy Director-General, Ministry of Social Affairs and Health, with Kari Paaso, Director, Ministry of Social Affairs and Health serving as the deputy chair. Other members and their personal deputy members appointed to the working group were Kari Haavisto, Senior Officer, Ministry of Social Affairs and Health (deputy member Veli-Matti Risku, Senior Officer), Kristian Wahlbeck, Research Professor, National Research Centre for Welfare and Health (deputy member Maijaliisa Junnila, Director of Division), Jouko Lönnqvist, National Public Health Institute (deputy members Jaana Suvisaari, Academy Research Fellow), Jari Korhonen, Provincial Medical Officer, State Provincial Office of Eastern Finland (deputy member Helena Kemppinen, Provincial Medical Officer), Liisa-Maria Voipio-Pulkki, Chief Administrative Physician, Association of Finnish Local and Regional Authorities (deputy member Soile Hellstén, Special Advisor), Teija Honkonen, Chief Physician, Finnish Institute of Occupational Health 1 April 2007–8 January 2008, replaced by Matti Ylikoski, Director, Finnish Institute of Occupational Health from 9 January 2008 (deputy member Martti Kuokkanen, Chief Physician 1 April 2007–8 January 2008, replaced by Leena Hirvonen, Project Manager, Finnish Institute of Occupational Health, from 9 January 2008), Antero Lassila, Chairman of the Steering Group of the Ostrobothnia Project, Vaasa Hospital District (deputy member Matti Kaivosoja, Chief Physician), Jorma Posio, Project Manager, Lapland Project, City of Rovaniemi (deputy member Timo Peisa, Medical Director), Maria Vuorilehto, Project Manager, Umbrella Project, City of Vantaa (deputy member Timo Aronkytö, Director of Health

Services 1 April2007–25 August 2008, replaced by Lauri Kuosmanen, Project Coordinator, from 25 August 2008), Lasse Murto, Managing Director, A-Clinic Foundation (deputy member Pekka Heinälä), Marita Ruohonen, Executive Director, Finnish Association for Mental Health (deputy member Liisa Saaristo, Head of Development). Teija Honkonen continued as an expert of the working group as a representative of the Ministry of Social Affairs and Health from 9 January 2008. The working group's expert secretaries were Timo Tuori, Senior Medical Officer, and Airi Partanen, Development Manager, National Research and Development Centre for Welfare and Health.

From August 2008 the working group was assisted by Terhi Hermanson, Ministerial Counsellor for Health Affairs, Ministry of Social Affairs and Health. The working group's technical secretaries were Hanna Vihermäki, Departmental Secretary, Ministry of Social Affairs and Health, and Hanna Kääriä, Project Secretary, National Research and Development Centre for Welfare and Health.

The working group met 14 times and held two internal seminars, 28–29 August 2008 and 12–13 November 2008. Policies for the future of mental health and substance abuse work were outlined in spring 2008 at five regional consultation events, an NGO consultation event and a seminar at Parliament. A consultation event regarding the working group's preliminary proposals took place on 4 November 2008. The Ministry of Social Affairs and Health concluded an agreement with Jussi Suojasalmi, Managing Director, for an assignment from 1 October 2008 until 31 December 2008 under which he participated in the planning work regarding the drafting of proposals related to the service system. He also drafted a separate proposal regarding the development of the substance abuse service system and related emergency on-call services in particular.

Having completed its task, the working group hereby respectfully submits its memorandum to the Ministry of Social Affairs and Health.

Helsinki, 10 February 2009

Marja-Liisa Partanen

Kari Paaso — Kari Haavisto
Kristian Wahlbeck — Jouko Lönnqvist
Jari Korhonen — Liisa-Maria Voipio-Pulkki
Matti Ylikoski — Maria Vuorilehto
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Lasse Murto — Marita Ruohonen
Timo Tuori — Airi Partanen

SUMMARY

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

■ The national plan for mental health and substance abuse work outlines the core principles and priorities for the future of mental health and substance abuse work until 2015. The plan starts from the premise that mental health problems and substance abuse play a major role in public health. For the first time in Finland, the plan sets joint objectives for mental health and substance abuse work at the national level.

The plan emphasises the strengthening of service user status, promotion of mental health and freedom from substance abuse, prevention and treatment of problems and adverse effects and provision of mental health and substance abuse services for all age groups with a focus on primary and community care. New key policy definitions for service system development include the principle of low-threshold single entry points for access to treatment at social and health centres and the introduction of integrated community care for mental health and substance abuse services. The plan is concluded with a presentation of the steering tools necessary for the implementation of the plan.

Key words:
community care, lifecycle, mental health, primary services, promotion and prevention, service system, service user, substance

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INTRODUCTION

■ Following a motion introduced by 106 Members of Parliament in 2005, the Ministry of Social Affairs and Health (MSAH) launched the preparation of a plan for mental health and substance abuse work in 2007. The major role that mental health problems and substance abuse play in public health is receiving increasing attention. Although there has been no change in the prevalence of mental disorders, there has been a major increase in related incapacity for work. One in four days on sickness allowance and one in three new disability pensions are granted on mental health grounds. The direct treatment, control and social insurance-related costs arising from mental disorders and substance abuse are high, and indirect costs, such as those arising from lost labour input and cuts in productivity, are manifold compared to the direct costs. The most common cause of death among the Finnish working age population is alcohol, with total consumption tripled since the late 1960s. The most recent period of steep rise in alcohol consumption began in 2004 following a decrease in alcohol taxation. At the same time there has been a clear increase in alcohol-related mortality and morbidity. Drug abuse became more common after the mid-1990s. There has also been a clear increase in the co-occurrence of mental health problems and substance abuse.

Mental health and substance abuse services are currently provided separately from each other in a scattered service system. Mental health services are mainly provided under health care services, while specialised services for substance abusers are organised under social welfare services. Such a scattered service system affects access to services by those who need them and contributes to dropping out of services despite the personnel in the different units being competent and strongly committed to their work. Some services are provided by the municipalities themselves, while others are provided by NGOs and private providers. The development of community care has played a secondary role, and there is a disproportionate focus on institutional treatment in mental health care and substance abuse care costs. It is important to develop work that promotes mental health and substance-free lifestyles and prevents related problems alongside the delivery of mental health and substance abuse services. Investments in mental health and substance abuse work are investments in functional capacity and productivity.

When preparing the plan for mental health and substance abuse work, the working group took into consideration the restructuring of municipalities and services currently underway as well as the extensive bill drafting programme to develop social welfare and health care services as broader regional entities. The plan is also in compliance with the international poli-

ces adopted by the European Union, the Council of Europe and the World Health Organization (WHO). This is the first time in Finland that mental health and substance abuse issues have been consolidated at the level of a national plan. The plan for mental health and substance abuse work already attracted attention at the drafting stage, which could be seen as active participation in the spring 2008 consultation events and public debate.

The main themes selected for the mental health and substance abuse plan are strengthening the status of service users, promotion and prevention as well as organisation of mental health and substance abuse services as a functional whole with a focus on primary and community care services and closely integrated mental health and substance abuse work. The steering tools needed to implement the plan are also presented.

When mental health and substance abuse services are organised primarily through community care, they serve users better and support their own resources. Intensification of early-stage community care with a focus on primary services can help avoid the aggravation and prolongation of conditions and reduce the need for institutional beds. The priority is on the development and diversification of community care, and only after this is achieved can reductions be made in institutional treatment. The plan proposes that mental health and substance abuse work competence in primary services be ensured through social welfare and health care professionals specialised in these fields.

A switch from the current institution-focused system to a system with a focus on community care will result in a temporary increase in mental health and substance abuse service costs because extra resources will be needed in primary-level mental health and substance abuse work to implement the changes. The development of community care will render some institutional beds unnecessary. The resources freed up from institutional treatment must be reallocated to secure primary-level mental health and substance abuse work in the future too.

Mental disorders and substance abuse have major health and economic impacts and considerable social significance. The plan proposes that the Government take a decision-in-principle regarding the development of mental health and substance abuse work, specifying the main mental health and substance abuse work policies and methods covering the various fields of social policy in order to secure the development of and necessary resource allocation for comprehensive, promotional, preventive and curative mental health and substance abuse work.

WORKING GROUP'S PROPOSALS

Proposal 1. Individuals with mental health problems and substance abuse should be ensured access to services and, while receiving services, be treated equally to all other service users. This should take place through training aimed to achieve a change in attitudes, service supervision and guaranteed access to treatment and services.

Proposal 2. Flexible access should be provided to mental health and substance abuse services through a low-threshold single entry point primarily via a social and health centre and, in the absence of one, via a primary health care unit.

Proposal 3. User experts and peers should be included in the planning, implementation and evaluation of mental health and substance abuse work.

Proposal 4. The Ministry of Social Affairs and Health should produce a draft for a Government proposal concerning a common framework act containing provisions regarding limitation of the right of self-determination and submit a proposal for a statute concerning second opinions by external experts regarding admission to involuntary treatment in a psychiatric hospital. A national programme to reduce the use of coercive measures in psychiatric hospital treatment should also be implemented.

Proposal 5. The types of income security available for periods of treatment and rehabilitation should be developed so that they will promote substance abuse and mental health service users' self-initiated entry into and commitment to treatment and promote their return to employment once progress has been made in rehabilitation.

Proposal 6. To prevent mental health and substance abuse problems, there should be a focus on three priority areas:

1. Alcohol taxation should be increased considerably from the 2009 level.

2. Communities that support wellbeing should be strengthened and people's opportunities to influence decisions affecting themselves should be increased.

3. The intergenerational transmission of mental health and substance abuse problems should be identified and prevented.

Proposal 7. Municipalities should include a mental health and substance abuse work strategy in their health and wellbeing promotion plan as part of the municipal strategy. The status of preventive and promotional mental health and substance abuse work should also be strengthened by the appointment of at least one permanent full-time coordinator of this work in areas with a large population base.

Proposal 8. The municipality responsible for service organisation and funding must coordinate public, third-sector and private sector services more efficiently into a well-functioning set of services.

Proposal 9. Municipalities should increase the efficiency of primary and community care for those with mental health and substance abuse problems by increasing and diversifying services such as emergency, mobile and consultation services. This will create the prerequisites for reducing the need for institutional beds. Specialised community care units for psychiatric care and for substance abusers should be integrated. Psychiatric hospital treatment should, as a rule, be provided in conjunction with general hospitals.

Proposal 10. Mental health and substance abuse work organised by municipalities for children and young persons should primarily take place in their everyday environments, such as the home, day care or school. Primary services should be diversely supported by specialised services.

Proposal 11. Prevention and early intervention in mental disorders and substance abuse should be promoted through the provision of continuing education for occupational health personnel and the development of reimbursement practices of the Social Insurance Institution of Finland (Kela). Job retention and return to work among those with mental health problems and substance abuse should be promoted by strengthening the coordination role of occupational health care between the workplace and other health care and rehabilitation providers.

Proposal 12. Factors threatening the work capacity of unemployed persons with mental health problems or substance abuse should be addressed early enough through measures such as the development of health checks and rehabilitating work for unemployed persons. The employability of mental health rehabilitees receiving disability pension or cash rehabilitation benefit and seeking access to employment should be improved.

Proposal 13. The prevention of mental disorders and substance abuse among the ageing population should be invested in and their treatment

should be made earlier and more efficient through measures such as the development of treatment methods that are suitable for the ageing.

Proposal 14. A joint working group of the Ministry of Social Affairs and Health and the Ministry of Education (MoE) should determine the minimum curriculum of mental health work education and training. These, together with the minimum curriculum of substance abuse work education and training, should be included in the basic education and training programmes in the fields of social welfare and health care.

Proposal 15. The National Institute for Health and Welfare (THL) should compile mental health and substance abuse work recommendations under a single social welfare and health care database and take care of updates to key recommendations and monitoring of their implementation. A programme supporting the implementation of good practices should be executed.

Proposal 16. All levels of administration from the municipal level to the central government level must consider the impacts of their actions and decisions on citizens' mental health and substance use. At the central government level, the Advisory Committee on Intoxicant and Temperance Affairs should be expanded and become the Advisory Committee on Mental Health and Substance Abuse Affairs. The national coordination of preventive and promotional mental health and substance abuse work should be centralised under the National Institute for Health and Welfare. The Substance Abuse Prevention Forum maintained by the Finnish Centre for Health Promotion should be expanded and become a forum for preventive mental health and substance abuse work.

Proposal 17. The amount of central government transfers to local government for social welfare and health care to develop primary-level mental health and substance abuse services should be increased. In addition to this, part of the discretionary government transfers for social welfare and health care development should be allocated for the development of the mental health and substance abuse service system. The use of other funding opportunities available for service system development should be made more efficient by compiling information on funding in a centralised manner.

Proposal 18. The Ministry of Social Affairs and Health should update the Mental Health Act, the Act on Welfare for Substance Abusers and the Temperance Work Act and look into the possibility of consolidating the Mental Health Act and the Act on Welfare for Substance Abusers.

PROPOSALS WITH JUSTIFICATIONS

The working group has adopted the following priorities and principles for the development of mental health and substance abuse work: (1) strengthening the status of service users, (2) emphasising prevention and promotion, (3) integrating services into a functional whole and taking the needs of different age groups into consideration and (4) increasing the efficiency of steering tools.

> The working group proposes that the Government take a decision-in-principal regarding mental health and substance abuse work in 2009. This decision-in-principle should secure the sustained development of mental health and substance abuse work towards an increased focus on community care and primary services and ensure access to the resources needed for this.

1 STRENGTHENING THE STATUS OF SERVICE USERS

To strengthen the status of service users, there should be a focus on equality, the principle of low-threshold single entry points, the status of user experts and peer support, the introduction of second opinions by external experts, regulations regarding limitations of the right of self-determination, and income security.

Proposal 1. Equal treatment and access to services

Individuals with mental health problems and substance abuse should be ensured equal access to services and, while receiving services, be treated equally to all other service users. This should take place through training aimed to achieve a change in attitudes, service supervision and guaranteed access to treatment and services.

Organisations responsible:	MSAH, Kela, MoE, Finnish National Board of Education (FNBE), municipalities, joint municipal boards
Implementing organisations:	MSAH, Kela, THL, National Supervisory Authority for Welfare and Health (Valvira), municipalities, joint municipal boards, NGOs, private service providers
Schedule:	2009–

Stigma and discrimination experienced by people with mental health problems and substance abuse should be reduced at the various levels of society. Equal access to services and equal treatment in the service system require that the entire social welfare and health care service system adopts an attitude towards these problems that is as serious as towards other health problems. The need to effect change in discriminatory attitudes must be taken into consideration as early as in basic education and training. Social welfare and health care decision-makers, management and personnel must, as appropriate, be provided with continuing education to change their attitudes.

In addition, the equal status of individuals with mental health problems and substance abuse to other service users must be strengthened through steering tools related to the statutory principle of guaranteed access to treatment and services. Guaranteed access to treatment emphasises access to

treatment within specific periods of time regarding non-urgent treatment. Guaranteed access to services contains the time limits set by the Child Welfare Act and the Social Assistance Act for assessments of the need for child protection measures, appointments with social workers and decisions on social assistance. The criteria for non-urgent and urgent treatment in mental and substance abuse disorders in particular must be made more specific.

Treatment provided must be in line with the Current Care Guidelines. Access to effective and necessary psychotherapy as specified in the Current Care Guidelines must be provided in accordance with the criteria set for non-urgent care within six months.

Under-23-year-olds in need of treatment must have access to specialised psychiatric care and substance abuse treatment within three months of the date on which their need for treatment was established, regardless of their place of residence. The working group proposes that a legal provision be introduced regarding the uniform age limit of under-23-year-olds.

Legislation pertaining to service user fees must be amended to ensure harmonised user fees for mental health and substance abuse services provided by social welfare and health care services regardless of administrative branch.

Service users' language and cultural background must be taken into consideration in mental health and substance abuse service delivery. In addition to service provision in Finnish and Swedish, access to and development of services in the Sámi language must also be ensured. Training and use of interpreters' services should be employed to strengthen consideration for the language and cultural background of different immigrant groups.

In working life, those with mental health and substance abuse problems must be treated the same as others who are partially capable of work. The benefits laid down in rehabilitation and disabilities legislation for those with mental health and substance abuse problems must be the same as those received by other persons with disabilities.

Prerequisites: Training that addresses discriminatory attitudes. Application and further specification of existing legislation. Implementation of good practices. Increased resource allocation for psychotherapy training and for equal geographical access to psychotherapy.

Monitoring: Implementation of legislation. Realisation of guaranteed access to treatment and services. Access to psychotherapy services. Continuing education. Overall economic impact on municipalities and central government.

Proposal 2. The single entry point principle

Flexible access should be provided to mental health and substance abuse services through a low-threshold single entry point primarily via a social and health centre and, in the absence of one, via a primary health care unit.

Organisations responsible:	MSAH, municipalities, joint municipal boards
Implementing organisations:	THL, municipalities, joint municipal boards, NGOs, private service providers
Schedule:	2009–

A fifth of the Finnish population have mental health and substance abuse problems, and these problems are highly significant in terms of public health. There must be capacity to treat most of these at the primary level.

The integration of mental health and substance abuse services is connected with the extensive restructuring of the Finnish social welfare and health care service system. The development of a well-functioning set of social welfare and health care services includes the establishment of social and health centres that provide access to local services through a low-threshold single entry point.

So far there are only few combined social and health centres in the country. Currently the most natural low-threshold unit through which those with mental health problems and substance abuse can access treatment is the primary health care system, which covers the entire country and operates around the clock. Occupational health care and school and student health care units also act as entry points alongside health centres. Municipalities responsible for service organisation and funding can, as appropriate, approve the use of other service units, such as integrated community care units for mental health and substance abuse services operating on the low-threshold principle as primary points of entry for mental health and substance abuse service users. The treatment system is tasked with ensuring that the services needed by users forms an appropriate and flexible whole.

To implement the single entry point principle, health centres must have a nurse's or social worker's reception, which operates on the low-threshold principle, for assessing the need for treatment in consultation with service users and possibly also their relatives, friends or legal representatives. Based on the assessment and a preliminary plan, service users should then be referred to services that meet their needs, to which they must have flexible access.

Prerequisites:	Targeting primary service resources at low-threshold reception activity.

Monitoring:	Increase in the number of low-threshold single entry points at social and health centres or in primary health care.

Proposal 3. User experts and peers

User experts and peers should be included in the planning, implementation and evaluation of mental health and substance abuse work.

Organisations responsible:	THL, municipalities, joint municipal boards, NGOs
Implementing organisations:	THL, municipalities, joint municipal boards, NGOs
Schedule:	2009–2012

Participation of user experts and peers in the planning, implementation and evaluation of mental health and substance abuse services must be increased for the service system to better take user needs into consideration.

Peers are persons who, based on their own experience, are voluntarily involved in activity such as support for service users' long-term treatment in the service system or who act in peer groups or as peer supporters. Alcoholics Anonymous (AA) is an example of peer involvement.

User experts are individuals with personal experience of mental health problems or substance abuse, either as someone who has them, has recovered from them or has used related services or as a relative or friend. User experts must be used in contexts such as municipal strategy formulation, service evaluations and rehabilitation working groups. They can also be invited as experts to administrative bodies of treatment units. Their expertise must also be increasingly utilised in housing services for mental health and substance abuse rehabilitees, the work to reduce involuntary treatment and coercive measures and when obtaining second opinions by external experts. The involvement of user experts and the related renumeration system must be developed in cooperation between NGOs and municipalities. The experiences of minors must also be taken into consideration when developing user expert involvement.

Prerequisites:	Development of user expert and peer involvement through means such as funding from Finland's Slot Machine Association (RAY)
Monitoring:	Development of user expert models and increase in the use of user experts and peer support.

Proposal 4. Involuntary treatment

The Ministry of Social Affairs and Health should produce a draft for a Government proposal for a common framework act containing provisions regarding limitation of the right of self-determination and submit a proposal for a statute concerning second opinions by external experts regarding admission to involuntary treatment in a psychiatric hospital. A national programme to reduce the use of coercive measures in psychiatric hospital treatment should also be implemented.

Organisation responsible:	MSAH
Implementing organisations:	THL, Valvira, regional state administration, joint municipal boards
Schedule:	2009–2012

The provisions and procedures regarding involuntary treatment laid down in the Mental Health Act and the Act on Welfare for Substance Abusers differ a great deal from each other and must be harmonised in order to ensure equal treatment. The reformed provisions on involuntary treatment and coercive measures are suitable for incorporation into the common framework act containing limitations of the right of self-determination and covering the entire social welfare and health care system that is being planned. In addition, special provisions must be enacted for special social welfare and health care legislation to provide further specifications to the framework act. The patient's own opinion must be taken into consideration in coercive measures. An agreement on a psychiatric advance directive should be concluded with patients who repeatedly need to be subjected to consideration of involuntary treatment or coercive measures. This should take place when their condition is at a better stage. A provision regarding psychiatric advance directives needs to be incorporated into the Mental Health Act.

Provisions regarding compulsory community treatment of forensic patients must be incorporated into the Mental Health Act in accordance with the proposal of the working group appointed to examine and consider the matter by the Ministry of Social Affairs and Health. This would ensure the necessary community-based treatment and in many cases enable early access to treatment. The suitability of compulsory community treatment for the treatment of others with severe mental health problems should also be assessed.

A policy of obtaining a second opinion from an external expert should be established in psychiatric hospital treatment on the basis of the comments of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). This aims to increase the reliability, openness and transparency of decision-making and the legal protection of those in involuntary treatment. External experts are psychiatrists who

are independent of the treatment organisation and who can also utilise user experts in their assessment. Hospitals must help the patient find an external expert for a second opinion if the patient so wishes having been subjected to involuntary psychiatric treatment. In the future the use of second opinions should also be considered in cases of prolonged psychiatric hospital treatment lasting more than three months.

The programme to reduce the use of coercive measures in psychiatric hospital treatment should contain good practices that reduce involuntary treatment and coercive measures and result in a change in attitudes through measures such as training and benchmarking between hospitals. In Finland the use of coercive measures is high in international comparison; the programme aims to reduce it by around 40 percent.

Prerequisites: Drafting of a framework act and special provisions regarding limitations of the right of self-determination. The incorporation of a provision regarding second opinions by external experts into the Mental Health Act. Allocation of resources for second opinions by external experts. The incorporation of a provision regarding second opinions by external experts into the psychiatric patient's dataset in the National Hospital Discharge Register (Hilmo). Resources for the national programme to reduce the use of coercive measures.

Monitoring: Implementation of amendments to legislation. Monitoring of second opinions by external experts on the basis of the psychiatric patient's dataset in the Hilmo Register or electronic patient records. Monitoring of the financial impacts of amendments to provisions regarding involuntary treatment, use of second opinions by external experts and the programme to reduce the use of coercive measures. Service user satisfaction.

Proposal 5. Income security

The types of income security available for periods of treatment and rehabilitation should be developed so that they will promote substance abuse and mental health service users' self-initiated entry into and commitment to treatment and promote their return to employment once progress has been made in rehabilitation.

Organisations responsible: MSAH, Ministry of Employment and the Economy (MEE)

Implementing organisations: Kela, municipalities, NGOs

Schedule: 2009–

Mental health and substance abuse rehabilitees often live on low incomes. Their income security should be improved to increase their capacities for independent housing and employment.

Combined sources of income that encourage and support efforts to access independent housing and employment should be created for service users seeking long-term rehabilitation and those receiving rehabilitation and housing services. The basic income of mental health and substance abuse rehabilitees must be organised in a way that it is not endangered when rehabilitees enter or return to employment through for instance social enterprises, supported employment, transitional employment, work try-outs or with the support of a work coach.

The opportunity to leave the disability pension in abeyance currently only applies to recipients of national pension. A review of relevant provisions to extend coverage to all disability pension recipients will remove obstacles to employment faced by pension recipients. A legislative amendment to this effect is being drafted. The financial prerequisites of access to employment of those who are partially capable of work can be improved by developing opportunities for vocational rehabilitation, including rehabilitation allowance, and the use of pay subsidy and support for workplace arrangements.

Sorting out benefits can be supported by municipal patient ombudsmen and social ombudsmen as well as national mental health and substance abuse ombudsmen. There is a need for consistent and clear guidelines as to which issues attention should be paid when applying for different benefits in order to be granted them.

Rehabilitation, active participation and employability can be promoted through more flexible use of benefits granted by municipal social welfare services departments, including preventive social assistance and assistance granted on the basis of participation in specific work in accordance with the Social Welfare Act.

Prerequisites: Amendments to legislation regarding basic income and the development of rehabilitation. Measures by the MEE to improve the employability of recipients of cash rehabilitation benefit or disability pension granted until further notice. Making rehabilitation legislation more specific to ensure income flexibility. More flexible use of benefits provided by municipal social welfare services departments.

Monitoring: Basic income level of those with mental and substance abuse problems. Opportunity to access employment among recipients of benefits granted on the basis of incapacity for work.

2 PREVENTION AND PROMOTION

There should be a focus on reducing overall alcohol consumption, increasing communality and inclusion and identifying and reducing intergenerational transmission of problems in the promotion of mental health and freedom from substance abuse and the prevention of mental health and substance abuse problems. In addition, a prevention and promotion strategy should be included in the municipal strategy and be implemented broadly throughout the service system.

Proposal 6. Priorities in preventive mental health and substance abuse work

To prevent mental health and substance abuse problems, there should be a focus on three priority areas:

1. Alcohol taxation should be increased considerably from the 2009 level.
2. *Communities that support wellbeing should be strengthened and people's opportunities to influence decisions affecting themselves should be increased.*
3. *The intergenerational transmission of mental health and substance abuse problems should be identified and prevented.*

Organisations responsible: MSAH, MoE, MoF, THL, FNBE

Implementing organisations: MSAH, MoF, MoE, THL, Valvira, regional state administrative authorities, municipalities and joint municipal boards, NGOs and private service providers, Alko and other alcohol businesses

Schedule: 2009–

The promotion of mental health and freedom from substance abuse and the prevention of problems aim to strengthen resources and other protective factors and to reduce risk factors. The strengthening of communality and inclusion both protects against problems and enables early intervention. A reduction in overall alcohol consumption helps prevent and reduce adverse mental, somatic and social effects. Mental health and substance abuse problems can also be transmitted intergenerationally. Awareness and identification of problems transmitted intergenerationally from parents to children can help support children, young people and families at risk and reduce their morbidity.

1. The most efficient ways to reduce overall alcohol consumption are to increase the price of alcoholic beverages, restrict access to alcohol and regulate image advertising. The level of alcohol taxation must be increased until a decrease in overall alcohol consumption is reached. Supervisory authorities must be guaranteed sufficient supervision resources for the implementation of the Alcohol Act, and their cooperation with the police and alcohol businesses must be increased for measures such as restricting access to alcohol among minors. The portrayal of positive images related to alcohol consumption in advertising should also be addressed.

2. Communality, promotion of inclusion and the functioning of democracy are closely interrelated. The promotion of communality belongs to all levels of society, including state administration, working life and local actors. It is important to ensure the functioning of grassroots democracy when introducing broader regional structures in conjunction with the restructuring of municipalities and services. Many NGOs play a major role in the promotion of inclusion and communality, for instance by coordinating peer support and leisure activities and offering opportunities that strengthen inclusion, including for people who are socially excluded and live in vulnerable conditions. The capacities of such NGOs should be strengthened.

For children, communality is constructed in the home but also in day care, the school environment, leisure activities and the local neighbourhood. Communality should be promoted through measures such as the closer integration of special needs education into other teaching and its provision in mainstream classrooms through cooperation between teachers. Student welfare services should develop work targeted at both the individual and the school community.

For adults, communality is linked with their access to influence in their workplace. Good management and opportunities to influence one's own work promote wellbeing at work. To promote communality, both working life and the education system should be developed in accordance with the principles of integration and inclusion. This means a switch from requirements set for the individual towards requirements set for the community. The main focus in the participation of people who have health conditions or disabilities should be on resources and rights and support provided by experts. Care should be taken not to use expertise to reduce the individual's rights to participate.

Communality also arises from access to influence in the local neighbourhood. Access can be improved by implementing projects that promote residents' active participation, increasing cooperation between schools and residential activity, developing premises for and support to residential activity and increasing social housing management. These perspectives should be taken into consideration in urban planning. For projects to increase communality, they must produce genuine and permanent opportunities to exercise influence. Good models that strengthen communality need to be different for rural and urban areas as appropriate to address their respective needs.

3. Mental health and substance abuse problems are commonly transmitted intergenerationally. There must be awareness of this intergenerationality, and children and young people at risk because of their parents' mental health problems or substance abuse must be identified and their balanced growth supported. Staff must always assess children's possible need for treatment and support when providing treatment for adults with mental health problems or substance abuse. This helps prevent and reduce children's and young people's susceptibility to mental disorders or substance abuse. Methods developed to support children's and young people's balanced growth must be used more extensively. Intervention models suitable for day care centres must also be developed. Particular attention should be paid to the identification of children and young people at risk during transition stages from day care to school, from the lower level of comprehensive school to the upper level, general upper secondary school or vocational institution, other secondary and tertiary education and further to employment.

In addition to the priority areas of prevention and promotion presented in this plan, work should continue in the fields of prevention of intimate partner and domestic violence and suicide prevention, and these should also be included in the prevention of mental disorders and substance abuse. Finnish suicide figures are high in international comparison. Suicides are almost always connected with mental disorders, usually depression and/or alcohol dependence but also with poverty, unemployment and loneliness. The most effective ways to prevent suicides are suicide risk identification, restriction of access to means used to commit suicide, multifaceted mental health services and after-care for suicide attempters.

Prerequisites: Increase in alcohol taxation and provision of more resources for alcohol supervision. Use of work methods that strengthen communality and people's access to influence. Provision of added resources for student welfare and school health care.

Monitoring: Level of excise duty of alcoholic beverages and level of overall alcohol consumption. Implementation of school health care quality recommendations. Monitoring of changes in special needs education. Development of grassroots democracy and monitoring of indicators of inclusion: residents' activity in local elections, participation in local NGOs. Extent of use of working models targeted at risk groups. Implementation of the policy programme for the well-being of children, youth and families, the policy programme for employment, entrepreneurship and worklife and the policy programme for health promotion adopted by the Government with regard to the above-mentioned measures.

Proposal 7. Mental health and substance abuse work strategy

Municipalities should include a mental health and substance abuse work strategy in their health and wellbeing promotion plan as part of the municipal strategy. The status of preventive and promotional mental health and substance abuse work should also be strengthened by the appointment of at least one permanent full-time coordinator of this work in areas with a large population base.

Organisations responsible:	MSAH, THL, municipalities, joint municipal boards
Implementing organisations:	MSAH, THL, municipalities, joint municipal boards, NGOs, church social work, alcohol and other businesses
Schedule:	2009–2011

The mental health and substance abuse work strategy should bring together a broad spectrum of players from different sectors for action towards jointly-defined mental health and substance abuse work goals. Networking and the development of prevention and promotion should be supported by the coordination of prevention and promotion at the organisational level of areas with a large population base.

The mental health and substance abuse work strategy must cover work that promotes mental health and substance-free lifestyles and prevents related problems as well as policies regarding treatment. High-quality preventive and promotional mental health and substance abuse work calls for a multidisciplinary approach, clear management system and sufficient resources. The mental health and substance abuse work strategy should be included in the health and wellbeing promotion plan of the municipality or cooperation area. In addition to the municipal social welfare and health care sector, it is important to achieve the commitment to prevention strategy work of players such as education, youth and cultural departments and urban planning, supervision and control authorities as well as third-sector representatives operating in the municipality. As part of municipal operational and financial planning, the leadership, resources, division of tasks and monitoring within preventive mental health and substance abuse work should be defined. Mental health and substance abuse services included in municipal service provision responsibilities should be described on the basis of the organisation of mental health and substance abuse services delineated in Proposal 9. Strategy implementation should be evaluated every year, and the strategy should be updated at least once in four years.

To support preventive mental health and substance abuse strategy work within municipalities and cooperation areas, there is also a need for efficient

coordination that takes place in areas with a large population base, thus supporting strategic cooperation between municipalities and cooperation areas and strengthening the prevention knowledge base. There must be at least one permanent full-time coordinator in areas with a large population base for the coordination of prevention and promotion in mental health and substance abuse work.

Prerequisites: Municipal strategic planning. Resource allocation for coordinators in areas with a large population base. Implementation of legislation.

Monitoring: Mental health and substance abuse work strategies of municipalities, cooperation areas and other corresponding areas and their implementation. Number of area coordinators for preventive mental health and substance abuse work.

3 ORGANISATION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

There should be a focus in the development of mental health and substance abuse services on municipal responsibility for the coordination of a diverse set of services, and on increasing the efficiency of primary and community care services and on taking the needs of different age groups into consideration.

Proposal 8. Coordination of the set of services

The municipality responsible for service organisation and funding should coordinate public, third-sector and private sector services more efficiently into a well-functioning set of services.

Organisations responsible: Municipalities

Implementing organisations: THL, municipalities, joint municipal boards

Schedule: 2009–

Improved management of municipal mental health and substance abuse services, service coordination and smooth exchange of information will clarify the service system and make it a well-functioning whole. The appropriate use of the mental health and substance abuse service system also calls for efficient information provision targeted at the population, particularly in the context of changes being made to the service system.

Municipalities have the statutory responsibility to organise and fund social welfare and health care services. They should assume a considerably clearer responsibility for the organisation, management and coordination of mental health and substance abuse services. The use of the negotiated procedure and direct award provided for in the Act of Public Contracts in the procurement of contracted-out services should also be promoted as alternatives to competitive bidding for service contracts.

Service organisation must take place on the basis of population and service user needs in a manner that is efficient and effective. In addition to service users, any need for support experienced by their family and others close to them must also be taken into consideration in mental health and substance abuse services. Children's situation and need for support must always be taken into consideration in mental health and substance abuse service delivery for adults. Municipalities are responsible for 1) determining the service network and the organisation responsible for it, 2) planning the provision methods, 3) controlling quality and 4) monitoring the population's need

for social and health services. Services should be coordinated and borders between them removed. Administrative and operational structures should also be harmonised as far as possible. Where services are not provided by the municipality, the municipality can procure them within the limits set by public contracts legislation on the basis of contracts based on competitive bidding, supplement its service provision by entering into contracts based on strategic partnership regarding services provided by the third sector or establish a cooperation organisation with other municipalities, the hospital district and third- and private-sector organisations.

Improved coordination of diverse municipal mental health and substance abuse services will clarify the service system, reduce any overlaps and prevent non-access to services. Efficient coordination calls for the smooth exchange of information relevant to treatment between service providers. This can be promoted by harmonising information systems and developing shared access to social welfare and health care data files.

Following the introduction of electronic patient data registers shared by the various data file controllers in health care, the long-term objective should be to harmonise these with the electronic information systems of social welfare services regardless of the service provider. Hospital district-specific patient data registers and social service user registers should be jointly accessible by social welfare and health care services, either subject to the service user's separate consent or, primarily, with provisions regarding shared use being laid down in legislation. An exception to these basic principles regarding the electronic information system are services targeted at special groups that emphasise a low entry threshold, such as health advice points for drug abusers based on service user anonymity.

Prerequisites: Development of electronic information systems. Drafting of legislation on the electronic processing of social welfare and health care service user data.

Monitoring: Monitoring of service user paths by utilising social welfare and health care data files. Service user satisfaction.

Proposal 9. Increasing the efficiency of primary and community care

Municipalities should increase the efficiency of primary and community care for those with mental health and substance abuse problems by increasing and developing varied services such as emergency, mobile and consultation services. This will create the prerequisites for reducing the need for institutional beds. Specialised community care units for psychiatric care and for substance abusers should be integrated. Psychiatric hospital treatment should, as a rule, be provided in conjunction with general hospitals.

Organisations responsible:	Municipalities, joint municipal boards
Implementing organisations:	THL, Association of Finnish Local and Regional Authorities, municipalities, joint municipal boards, NGOs, private service providers, church social work, trade organisations
Schedule:	2009–

Service users receive the best help from mental health and substance abuse services when the service system is an integrated functional whole that covers a varied range of community care and institutional services, primary and specialised services and mental health and substance abuse services. Although the service selection covers many different administrative branches and levels and there are several different service providers, the service user must have easy access to services. It is the duty of the system to tailor an individual set of services for each user.

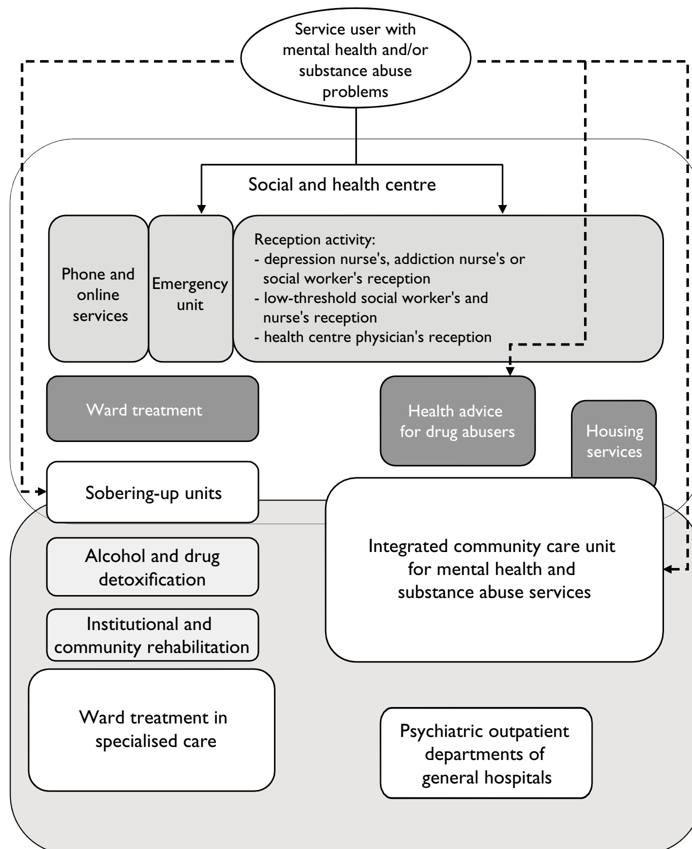

Figure 1. Organisation of mental health and substance abuse services

Community care in primary services

Outpatient care at social and health centres, school and student health care and occupational health care should form the core of the mental and substance abuse service system in primary services. The service user should enter the system through a single entry point, as a rule at the social and health centre (Figure 1) or other primary point of entry as decided by the municipality. Following the first contact, attendance to the service user's problem can begin at the low-threshold nurse's or social worker's reception referred to in Proposal 2. Outside office hours, the emergency units of health and social welfare services should be used, from where the service user should, if necessary, be referred directly to hospital or other institutional treatment.

In large municipalities sobering-up and emergency care for intoxicated persons should be provided at separate sobering-up units where service users' situation is examined and their need for other treatment assessed. Alternatively, the sobering-up unit can be provided in cooperation between a health centre emergency room and the substance abuse services or in conjunction with a police prison. Under social welfare and health care services the unit can operate either in conjunction with an emergency health care unit or with a detoxification unit operated by the substance abuse services, depending on which is better functionally, financially and in terms of location and resources.

Health advice points for drug abusers that are free and operate on the basis of user anonymity should be part of the low-threshold services of the primary health care system.

Social and health centres and corresponding primary services must take care of the identification of mental disorders and substance abuse problems, provision of early support and treatment of most depression and anxiety disorders and substance abuse problems as well as basic detoxification treatment and long-term further treatment of substance abusers, such as opiate replacement therapy. The treatment of part of those with chronic schizophrenia also belongs under primary health care.

The somatic illnesses, mouth conditions and injuries of people with substance abuse problems should also be treated in primary health care.

Because these disorders are common, it is vital that every health centre physician and nurse as well as social worker is able to identify and treat them to the same extent as other public health problems. For primary services to be capable of assuming treatment responsibility for the growing group of people with mental health and substance abuse problems, versatile and sufficient consultation, training and clinical supervision support deployed to the primary level must be provided by specialised psychiatric care and special substance abuse services. Each health centre must also employ a depression and addiction nurse's working model. A social work-oriented approach must be strengthened in primary health care. In primary services the service menu must be made more diverse, particularly through the provision of emergency services, services provided in homes, schools or children's and

young people's other development settings, and group-type services. The utilisation of information technology is important nationwide, and its role is further emphasised in remote and rural areas.

Integrated community care units for mental health and substance abuse services

Mental health and substance abuse problems are increasingly co-occuring and they should be treated as a whole. Therefore the working group proposes that the current specialised psychiatric out-patient care units and specialised outpatient care unit for substance abusers be integrated as shown in Figure 1. Child guidance and family counselling centres can also be brought under the same administrative and operational unit because mental health and substance abuse problems affect the entire family.

The units can operate either under municipal primary services or under joint municipal boards responsible for a large population base. They can be located at combined social and health centres, health centres or under social welfare services at the premises of units such as current A-Clinics, at general hospital clinics or as totally separate units. When integrating units, it must be ensured that all human and competence resources are preserved and efforts must be made to create a unit in which special expertise in mental health and substance abuse work is combined and where work pairs and teams for treatment can be created as appropriate. The integrated units should provide treatment for patients with psychoses and bipolar disorders, patients with a dual diagnosis, those at risk of suicide, mixed substance abusers with multiple problems and drug abusers, pregnant substance abusers and others with mental health and substance abuse problems in need of demanding specialised care. The integrated units should also provide diverse support to primary services.

Duties can be divided in large cities and areas with a population exceeding 100,000 and with several integrated units. In these settings each unit focuses on covering specific areas of the broad field of mental health and substance abuse work, such as rehabilitation of patients with schizophrenia, affective syndromes or substance addiction, acute mental health and substance abuse work that calls for special expertise, or patients with a dual or triple diagnosis.

Services supporting community care, and hospital and institutional services

Service users must have access to wide-ranging services that support community care provided not only by the public sector but also by the third and private sectors. These must be developed further. The third sector provides services including different types of peer support, such as A-Guilds and mental health associations, as well as sheltered workshop, clubhouse and other corresponding activity. Drop-in activity centres can be provided by public psychiatric clinics

and integrated mental health and substance abuse service units, but also by the third sector.

Health centre in-patient wards can be used for the treatment of different psychosocial crises and detoxification treatment for substance abusers. Alcohol-induced delirium, like other types of delirium, must be treated in somatic wards. Day hospitals are often part of public psychiatric hospital care. Patients with acute or recurrent psychosis, severe affective syndrome or at risk of suicide are typically admitted to psychiatric hospitals. Eating disorders may also require hospital admission, either to a somatic or psychiatric ward.

Today the third sector is a major provider of institutional treatment for people with substance abuse problems. This may comprise short periods of detoxification treatment of physical withdrawal symptoms or longer-term institutional rehabilitation that may take weeks. Long-term non-medicated treatments in therapeutic communities can last even longer. Co-morbidity of mental health and drug abuse disorders can be treated in institutions intended for substance abusers if their treatment does not require an involuntary treatment decision under the Mental Health Act and the patient does not have a serious psychiatric or somatic disorder or condition.

The development of psychiatric hospital treatment should be set the objective of gradually transferring all psychiatric hospital wards to general hospitals in order to provide less institutionalising and stigmatising treatment while also being better able to take the high somatic co-morbidity of people with mental health and substance abuse problems into consideration in examinations and treatment. The implementation of this change can, for example, be incorporated into measures to address the necessary refurbishment needs of hospital properties. This change is a continuation of the current trend.

Psychiatric hospital treatment and institutional substance abuse treatment must not result from housing problems. If the psychiatric hospitalisation of an adult exceeds six months without an interruption and the hospital in question no longer finds psychiatric hospitalisation necessary, the municipality must be obliged to provide the service user with access to community care and sheltered housing.

The working group estimates that the strengthening and diversification of community-based mental health services will reduce the need for psychiatric hospitalisation to the extent that in 2015 there will only be a need for around 3,000 psychiatric beds instead of the current figure of around 4,600.

Services produced by special responsibility areas (SRAs[1])

The examination and treatment of mental disorders and substance abuse problems that are rare or call for special expertise should be centralised. The largest of such groups is forensic psychiatric patients, whose examination and

1 *Finland is divided in five SRAs for centralised delivery of highly specialised health care. Each SRA encompasses one university hospital.

treatment is centralised at two state hospitals and usually at units of university hospitals. In addition, each special responsibility area based on a university hospital district agrees on regional division of duties with the joint municipal boards with a large population base operating in its area.

Rehabilitation and housing services

The rehabilitation of those with mental health problems and substance abuse must be diverse and part of the treatment process, starting from acute-stage early rehabilitation and continuing, if necessary, as tailored psychosocial and vocational rehabilitation.

A clear obligation for broad-based and multisectoral cooperation and the inclusion of service users and carers must be incorporated into the legal provisions to be drafted regarding treatment and rehabilitation plans. The main focus of rehabilitation development should be on community care. In substance abuse services, group-based community care programmes as well as related housing and work coaching services should be developed and increased. Institutional substance abuse rehabilitation should also be developed. The clubhouse network of mental health rehabilitees or corresponding activity should be expanded to cover the whole of Finland.

The continuation of the care of those who have participated in long-term substance abuse rehabilitation in prison should be ensured by obliging their home municipality to provide appropriately-supported community care or sheltered housing immediately on their release. The substance abuse rehabilitation of service users sentenced to community service and probationary liberty under supervision must be provided systematically in cooperation between the Criminal Sanctions Agency and the community care unit for mental disorders and substance abuse.

The development recommendations regarding mental health rehabilitees' housing services must be supplemented and introduced when housing services for mental health and substance abuse rehabilitees are ordered, procured, implemented and supervised.

Prerequisites: Resource allocation for primary services. Increased efficiency of basic and continuing education and training in mental health and substance abuse work.

Monitoring: Establishment of low-threshold reception points at social and health centres. Increased use of depression and addiction nurse models. Establishment of sobering-up units for intoxicated persons. Use of community care. Number of beds in psychiatric and substance abuse treatment institutions. Number of people with mental health and substance abuse problems receiving housing services.

Proposal 10. Mental health and substance abuse work for children and young people

Mental health and substance abuse work organised by municipalities for children and young persons should primarily take place in their everyday environments, such as the home, day care or school. Primary services should be comprehensively supported by specialised services.

Organisations responsible:	Municipalities and joint municipal boards
Implementing organisations:	THL, municipalities, joint municipal boards, NGOs
Schedule:	2009–

Service organisation and development should consider the fact that support for children and young people's development, mental health promotion, and prevention and treatment of disorders are indivisible. Children's and young people's development does not follow the service system division into mental health (health services), social (social welfare services) and educational (school student welfare services) development. In addition to these, services must simultaneously take into consideration the help needed by the rest of the family.

Mental health and substance abuse services for children and young people must focus on primary and neighbourhood services and community care, supported by specialised services. This promotes children's and young people's wellbeing better than if services were provided in a disorder-focused manner. Collaboration between specialised and primary services must be developed across sectoral borders in children's and young people's development settings. For example, the border between child guidance and family counselling centres and health care that supports psychological development must be eradicated. The threshold for seeking help must be kept low through means such as sufficient presence of the school psychologist and nurse and pupils and students being familiar with them.

Cooperation of child protection with mental health and substance abuse services and child and adolescent psychiatry must be developed, taking into consideration the prevalence of mental health and substance abuse problems among child protection service users. In addition, new types of methods in which responsible adults related to the life of the child or young person are included are needed to help child protection service users. Family rehabilitation must be increased and access to it improved.

Parents and other important adults must be included in the concrete implementation of children's treatment in psychiatric hospitals. Units providing treatment for under-12-year-olds must allow a parent or other guardian to participate daily in the child's treatment. The opportunity to add a provision to the Act on the Status and Rights of Patients setting the maximum

period for which minors can be kept away from their family in hospital treatment should be explored. A uniform practice regarding the daily allowance for parents during the period of their child's treatment should be created.

Important interpersonal relations with family, other close people and networks significant to the age group must be strengthened in the treatment of mental disorders and substance abuse problems. Peer groups must also be used to translate manifestations of problems into resources through self-knowledge and self-respect.

The development and diversification of community care will help reduce the need for 24-hour ward treatment in child and adolescent psychiatry.

Prerequisites:	Funding for the KASTE Programme.
Monitoring:	Development of services for children and young people as part of the programme for under-21s implemented under the KASTE Programme.

Proposal 11. Role of occupational health care in mental health and substance abuse problems of the working age population

Prevention and early intervention in mental disorders and substance abuse should be promoted through the provision of continuing education for occupational health personnel and the development of Kela's reimbursement practices. Job retention and return to work among those with mental health and substance abuse problems should be promoted by strengthening the coordination role of occupational health care between the workplace and other health care and rehabilitation providers.

Organisations responsible:	MSAH, Kela, advisory committees on occupational safety and health, labour market organisations, municipalities, joint municipal boards, employment administration
Implementing organisations:	FIOH, employers, municipalities, private service providers
Schedule:	2009–

Sick leaves due to mental and substance abuse disorders and their unnecessary prolongation as well as the amount of disability pensions granted on the basis of such disorders can be reduced by increasing the efficiency of occupational health care and its cooperation with the workplace, other health care and the social insurance system.

Heavy consumption of alcohol is an important background factor for several problems with health and work capacity and the most important cause

of death among the working age population. The prevention of alcohol-related problems should be strengthened in occupational health care through measures including brief interventions as well as education and advice provision at workplaces. Workplaces should adopt a substance abuse programme to promote the prevention of adverse effects, early detection of problems and appropriate referral to treatment.

Occupational health care staff has an excellent opportunity to identify employees' need for treatment and rehabilitation of mental health and substance abuse problems at an early stage as well as to instigate timely treatment and refer employees to rehabilitation in time. Attention should be also paid to supporting the mental health and work capacity of those in various types of atypical employment – fixed-term, temporary or temporary agency work – by developing occupational health care and health checks.

The objective of occupational health care is to ensure employees' good capacity to continue work and return to work in all circumstances – including following periods of cash rehabilitation benefit and disability pension. Employees' health and functional capacity should be supported during sick leaves and they should be activated during the recovery period; the need for workplace and task arrangements and the opportunity to utilise a period of partial capability for work should be assessed well in time before their return to work.

Policies and models agreed in cooperation regarding early support for work capacity, monitoring of sick leaves, and return to work create the prerequisites for job retention and a successful return to work of employees with mental health and substance abuse problems.

Prerequisites: Proposals for legislative amendments regarding the development of occupational health care. Development of Kela's reimbursement practices. Development of the content of continuing education.

Monitoring: Changes in the amount of sick leaves and disability pensions related to mental health and substance abuse problems and in alcohol-related mortality rates.

Proposal 12. Employability of persons with mental health and substance abuse problems

Factors threatening the work capacity of unemployed persons with mental health problems or substance abuse should be addressed early enough through measures such as the development of health checks and rehabilitating work for unemployed persons. The employability of mental health rehabilitees receiving disability pension or cash rehabilitation benefit and seeking access to employment should be improved.

Organisations responsible:	MSAH, MEE, Kela, labour market organisations, municipalities, joint municipal boards, employment administration, authorised pension providers
Implementing organisations:	Municipalities, employment offices, NGOs, private service providers, adult education institutions
Schedule:	2009–

Mental and substance abuse disorders are common conditions threatening the work capacity of the long-term unemployed. Health checks targeted at them should be coordinated by employment authorities and labour force service centres (health check units) where the need for treatment and rehabilitation can be identified and factors threatening work capacity addressed. Unemployed persons' capacities for work can also be promoted by developing rehabilitating work and taking the individual needs of these special groups into consideration in it.

The assessment of the employability of mental health rehabilitees seeking access to employment while on disability pension granted until further notice or on cash rehabilitation benefit (disability pension awarded for a specific period of time) should be developed. Mental health rehabilitees' opportunities to return to employment can be supported by appropriately utilising work try-outs, entry into employment supported by a work coach, job coaching and vocational rehabilitation, vocational training and preparatory training services. The return to employment can also be supported by transitional employment and social enterprises.

Prerequisites:	Compliance with policies regarding rehabilitation and the elimination of obstacles to access to employment faced by those who are partially capable of work. Measures by the MEE to improve access to employment among recipients of disability pension and cash rehabilitation benefit. Resource allocation for the development of working methods for entry into employment supported by a work coach. Resource allocation needed to expand health checks for the unemployed.
Monitoring:	Increase in cases of entry into employment supported by a work coach. Health checks for the unemployed.

Proposal 13. Mental health and substance abuse services for the ageing population

The prevention of mental disorders and substance abuse among the ageing population should be invested in and their treatment should be made earlier and more efficient through measures such as the development of treatment methods that are suitable for the ageing.

Organisations responsible: MSAH, THL, municipalities

Implementing organisations: THL, municipalities, joint municipal boards, NGOs, private service providers, church social work, adult education institutions

Schedule: 2009–

The quality of life and functional capacities of the ageing can be improved by paying attention to the risk factors of depression and substance abuse related to this stage in life, such as somatic conditions and loss of spouse. Interventions to prevent depression and substance abuse problems among the ageing must be developed.

Physical health and independent coping in one's home are promoted by the early detection and efficient treatment of problems. For example, preventive home visits can address mental health and substance abuse issues and assess the need for support. Types of treatment for mental disorders and substance abuse problems targeted specifically at the ageing must be developed. The deployment of specialised services in mental health and substance abuse and support for relatives is necessary so that the ageing can be primarily cared for in their own environment.

Competence regarding the mental health and substance abuse problems of the ageing must be strengthened though basic and continuing education and training of staff. Coordinated cooperation between primary health care, social welfare services, specialised geriatric psychiatric care, NGOs and the church is also needed. Relatives must be taken into consideration as active partners in cooperation.

Prerequisites: Attention to the special issues of the ageing in the minimum curriculum of mental health and substance abuse work education and training. Continuing education. Development of primary and specialised services.

Monitoring: Prevalence of substance abuse and mental health problems among the ageing. Development of mental health and substance abuse services targeted at the ageing. Use of mental health and substance abuse services among the ageing.

4 DEVELOPMENT OF STEERING TOOLS

The focus of steering tools for the development of mental health and substance abuse work should be on the development of education and training, compilation of and updates to various recommendations on mental health and substance abuse work and the monitoring of their application, clearer national coordination of mental health and substance abuse work, strengthening of resources allocated for mental health and substance abuse work, and development of legislation regarding mental health and substance abuse work.

Proposal 14. Development of education and training in mental health and substance abuse work

A joint working group of the Ministry of Social Affairs and Health and the Ministry of Education should determine the minimum curriculum of mental health work education and training. These, together with the minimum curriculum of substance abuse work education and training, should be included in the basic programmes in the fields of social welfare and health care education and training.

Organisations responsible:	MSAH, MoE, FNBE
Implementing organisations:	Educational institutions in the field of social welfare and health care
Schedule:	2009–2012

The basic education and training of social welfare and health care professionals does not currently reflect the public health significance of mental disorders and substance abuse or the needs of working life. Teaching in mental health and substance abuse work must be increased for basic qualifications and degrees in both medicine and other social welfare and health care professions.

Staff in all fields of social welfare and health care must have the basic capacities to identify and bring up mental health and substance abuse problems. Minimum curriculum contents have been specified for teaching in substance abuse work, and these must be included in basic qualification and degree courses in the fields of social welfare and health care. Correspondingly, minimum curriculum must also be specified for teaching in mental health work and include these in education and training programmes. Diverse and multiprofessional continuing education in mental health and substance abu-

se work is also needed. Shared continuing education is particularly necessary for the harmonisation of mental health and substance abuse services.

The further vocational qualification in substance abuse welfare work currently taken as a competence-based qualification must be expanded to create a further vocational qualification in mental health and substance abuse work. This would support aspects such as the participation of mental health and substance abuse rehabilitees as user experts in service design, evaluation and implementation.

Prerequisites:	Cooperation between MSAH, MoE and FNBE. Appointment of a joint MoE and MSAH working group on the creation of minimum curriculum contents for mental health education and training.
Monitoring:	Extent of application of minimum substance abuse work curriculum recommendations. Creation and application of minimum curriculum for mental health work. Introduction of a further vocational qualification in mental health and substance abuse work.

Proposal 15. Mental health and substance abuse work recommendations

The National Institute for Health and Welfare (THL) should compile mental health and substance abuse work recommendations under a single social welfare and health care database and take care of updates to key recommendations and monitoring of their implementation. A programme supporting the implementation of good practices should be implemented.

Organisation responsible:	THL
Implementing organisations:	THL, FIOH, Association of Finnish Local and Regional Authorities, Duodecim
Schedule:	2009–2012

Mental health and substance abuse work is steered using a variety of guidelines and recommendations. These include the national criteria for non-urgent treatment, the Current Care Guidelines, quality and development recommendations and good practice descriptions. Non-binding guidelines and recommendations vary in quality and do not always contain implementation plans.

Recommendations are more effective if based on researched or evaluated data and actively updated, while use and compliance are facilitated if recommendations are easy to access, understand and implement.

The key recommendations in the field of mental health and substance abuse work that have been evaluated as good must be collated in a single electronic database and their dissemination, the monitoring of their implementation and regular updates must be agreed upon. The database can be created for instance by THL. Updates to the mental health and substance abuse service quality recommendations should take place as part of a more extensive quality recommendation development project.

Activities to promote good practice in the field of social welfare and health care should be continued at the THL, developing and maintaining elements such as tutoring, learning networks and the Good Practice online service and database that support the identification and description of good practices in the field of mental health and substance abuse work. The development of the THL's good practice work is linked with the Good Practice innovation project, which in turn is part of the broader Service Innovation Project.

Prerequisites: Compilation of and updates to recommendations and monitoring of their application.

Monitoring: Uptodateness of recommendations and extent of their use. Extent of the adoption of good practices.

Proposal 16. Coordination of mental health and substance abuse work

All levels of administration from the municipal level to the central government level should consider the impact of their actions and decisions on citizens' mental health and substance use. At the central government level, the Advisory Committee on Intoxicant and Temperance Affairs should be expanded and become the Advisory Committee on Mental Health and Substance Abuse Affairs. The national coordination of preventive mental health and substance abuse work should be centralised under the National Institute for Health and Welfare. The Substance Abuse Prevention Forum maintained by the Finnish Centre for Health Promotion should be expanded and become a forum for preventive mental health and substance abuse work.

Organisations responsible: MSAH, other ministries, THL, municipalities, Finnish Centre for Health Promotion (FCHP)

Implementing organisations: MSAH, THL, other ministries and agencies operating under them, municipalities, NGOs

Schedule: 2009–2011

The joint national coordination of mental health and substance abuse work increases the efficiency of preventive and curative work in the field of mental health and substance abuse broadly across the different sectors of society.

Along co-morbidity, mental health problems and substance abuse are commonly associated with social disadvantage. Socioeconomic health inequality can be addressed through social policy measures including: 1) improving social status through education, training, income and employment measures, 2) improving the working, housing and living conditions of the most disadvantaged groups, 3) supporting vulnerable individuals, reducing their risks and preventing ill health, 4) repairing existing damage and securing people's livelihoods and living conditions regardless of their health problems.

At the central government level, the Advisory Committee on Intoxicant and Temperance Affairs must be expanded and become the Advisory Committee on Mental Health and Substance Abuse Affairs. The national coordination of preventive mental health and substance abuse work must be centralised under the THL. The Substance Abuse Prevention Forum must be expanded and become a forum for preventive mental health and substance abuse work that brings NGOs together to plan activity related to mental health and substance abuse work.

Prerequisites: Legislative amendment.

Monitoring: Changes in coordination.

Proposal 17. Strengthening of mental health and substance abuse work resources

The amount of central government transfers to local government for social welfare and health to develop primary-level mental health and substance abuse services should be increased. In addition to this, part of the discretionary government transfers for social welfare and health care development should be allocated for the development of the mental health and substance abuse service system. The use of other funding opportunities available for service system development should be made more efficient by compiling related data in a centralised manner.

Organisations responsible: MSAH, MoF, MEE, MoE, regional state administrative authorities, joint municipal boards, municipalities, NGOs

Implementing organisations: MSAH, regional state administrative authorities, THL, municipalities and joint municipal boards, NGOs

Schedule: 2009–2015

Service development in the manner described in this plan calls for increased resource allocation, which should be targeted particularly at primary and community care in order to increase the efficiency of the prevention of mental disorders and substance abuse as well as that of early support and treatment. Elements such as low-threshold nurse's and social worker's receptions, prevention coordinators and a comprehensive network of depression and addiction nurses as well as the provision of need-adapted psychotherapy call for the reallocation of existing resources and the allocation of further resources.

The need for further resources applies to the next few years, after which the need will be balanced by the staff that become available from institutional treatment and by other savings in institutional treatment costs. The working group proposes that funding for the interim period could consist of larger central government transfers to local government, municipal funding, development project appropriations and other sources intended for the development of mental health and substance abuse work. If four new nurses or social workers were hired for each area with a population base of around 20,000, this would result in an annual expenditure of around 37 million.

The situation in mental health and substance abuse services has been taken into account in instruments such as the National Development Programme for Social Welfare and Health Care (KASTE Programme) adopted by the Government for 2008–2011. In addition to the discretionary government transfers partially targeted at the development of mental health and substance abuse work through social welfare and health care development activity, a separate appropriation must also be allocated for basic-level development work in mental health and substance abuse services in 2010–2015.

Resources intended for the development of mental health and substance abuse work should also be available from the Ministry of Employment and the Economy, the Ministry of Education, regional state administrative authorities, RAY, the Finnish Innovation Fund (SITRA) and Finnish Funding Agency for Technology and Innovation (TEKES). Some of the appropriations targeted at health promotion should also cover the development of mental health and substance abuse work. Provision of information about the use of these funding sources, including application processes and allocation principles, should be intensified by centralising it under the THL for dissemination via the THL online portal. Of the above sources of funding, the THL should coordinate the use of the health promotion appropriation and it should also steer the development work.

Prerequisites: Further central government and municipal budget resources allocated for mental health and substance abuse work.

Monitoring: Development of mental health and substance abuse services.

Proposal 18. Updating of the Mental Health Act, the Act on Welfare for Substance Abusers and the Temperance Work Act

The Ministry of Social Affairs and Health should update the Mental Health Act, the Act on Welfare for Substance Abusers and the Temperance Work Act and look into the possibility of consolidating the Mental Health Act and the Act on Welfare for Substance Abusers.

Organisation responsible: MSAH

Implementing organisation: MSAH

Schedule: 2009–2012

The Ministry of Social Affairs and Health should launch the process to update the Mental Health Act, the Act on Welfare for Substance Abusers and the Temperance Work Act to bring them in line with the current situation in issues including the restructuring of municipalities and services. In this context the possibility to consolidate the Mental Health Act and the Act on Welfare for Substance Abusers should also be examined.

Prerequisites: Assessment of legislation.

Monitoring: Performance of legislative reform.

ABBREVIATIONS AND DEFINITIONS

FCHP	Finnish Centre for Health Promotion
FIOH	Finnish Institute of Occupational Health
FNBE	Finnish National Board of Education
KASTE Programme	National Development Programme for Social Welfare and Health Care
Kela	Social Insurance Institution of Finland
MEE	Ministry of Employment and the Economy
MoE	Ministry of Education
MoF	Ministry of Finance
MSAH	Ministry of Social Affairs and Health
RAY	Finland's Slot Machine Association
Sitra	Finnish Innovation Fund
Tekes	Finnish Funding Agency for Technology and Innovation
THL	National Institute for Health and Welfare
Valvira	National Supervisory Authority for Welfare and Health

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