

**First Line
Therapies**

First-Line Therapies model



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To the reader

The *First-Line Therapies model* has a long-shared history with the Finnish social and health care reform and the therapy guarantee. When the project was founded in 2020, the reform had already been under preparation for a long time. From the beginning, its key aims included strengthening basic services, improving access to care, streamlining care pathways through the integration of services, and increasing equity and effectiveness. The therapy guarantee citizens' initiative sought to ensure through legislation that mental health services would not be overlooked in the reform, and that access to treatment would genuinely improve.

At the same time, these goals were neither unique to Finland nor relevant only here. For example, the WHO had long emphasized the central role of mental health as part of public health and encouraged the development of mental health services to be more comprehensive, more strongly based in primary services, and inclusive of the entire population. The same goals are reflected in Finland's national Mental Health Strategy, which the *First-Line Therapies model* helps to implement. Internationally, the development, research and implementation of stepped-care models, primary-level therapy methods, and digitally supported mental health services have been major areas of research interest.

In 2020, it was clear that legislating a therapy guarantee on a fast schedule without adequate preparation would lead to difficulties. At the very least, it would have resulted in uncontrolled use of outsourced services. Now, in 2026, the conditions for reforming mental health services are significantly better: wellbeing services counties have been established and stabilized, professionals in effective therapy methods have been trained across all counties, the principles of a stepped-care model suited to Finland have been agreed upon, and multiple digital and support services benefiting the wellbeing services counties have been completed through national collaboration. Strengthening primary-level mental health services, accelerating access to effective psychosocial treatments, and systematically implementing a stepped-care approach are now widely recognized as essential goals for the service system.

The purpose of this handbook is to describe the core principles and services of the *First-Line Therapies model*, which has been developed since 2020. It is the result of a historically large national investment and long-term project aimed at developing primary-level mental health and substance-use services in collaboration across all wellbeing services counties. The work has involved mental health experts from across Finland, therapy and intervention coordinators who have driven development at the county level, project staff, and professionals carrying out client work amid heavy workloads and organizational changes. It is unequivocally the largest mental health service system reform project undertaken in Finland in this century.

We hope this handbook clarifies what the *First-Line Therapies model* aims to achieve, the principles and evidence on which it is built, the services it includes, and how wellbeing services counties and other service providers can use it to organize mental health services that are as effective and equitable as possible. Mental health problems have become a major public health concern in Finland—one that we can no longer afford, neither humanly nor economically.

The *First Line Therapies model* and its service suite have been built through close national collaboration; cooperation and co-development have been essential to its success. Maintaining this strong collaboration is undoubtedly the most important factor to safeguard also beyond 2026. The mental health service system is an extremely complex entity, and lasting cooperation between counties and service providers is invaluable for its development. In a small country, developing high-quality digital mental health services is cost-effective only through national collaboration.

First-Line Therapies is both a model and a service package. It does not solve all issues in the mental health service system, nor does it address, for example, specialized care or rehabilitation. However, it provides a clear vision for a better-functioning service system and a practical roadmap for getting there. If national collaboration continues as strong as it was between 2020 and 2025, Finland has the potential to become an international leader in mental health services—rather than a country defined by a mental health crisis.

This handbook is the second edition describing the overall model. It is intended both to provide an overview and to serve as a practical handbook for those responsible for developing and organizing mental health services. It complements the more detailed descriptions of the model and its services found at www.terapiatetulinjaan.fi. The handbook and website will continue to be updated regularly as the model and services evolve.

The *First-Line Therapies model* continues to expand, and the handbook will be updated accordingly. In this updated edition, new content includes, for example, the service package built to support occupational health care (chapter 9), methods suited to social services (chapter 8.2), Mentalhub.fi materials designed for students, teachers and workplace instructors (chapter 20.2), and a stepped-care model for neurodevelopmental disorders (chapter 5.2). This version undoubtedly still contains areas for improvement, so all feedback and suggestions for enhancement are warmly welcomed!

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adolescents during the pandemic in most countries⁵. Among working-age adults, on the other hand, this increase appears to have stabilised according to 2024 figures yet remains at an exceptionally high level⁶.

1.2. The service system cannot meet the demand

The Finnish mental health service system is congested at multiple levels: primary care services, specialised healthcare, and Kela-funded rehabilitative psychotherapy all face long delays. Explosive growth in demand during the 2010s, fragmented funding, and overlapping work highlight key areas for growth within the service system, which currently over-relies on long, intensive treatments and rehabilitation due to insufficiently effective primary care services.

Improving access to treatment has been identified as one of the key strategies for reducing the burden of disease caused by depression and anxiety disorders. However, depression and anxiety disorders have become so common that the resources of traditional treatment models and specialised healthcare-driven systems are not sufficient. Therefore, the focus of treating depression and anxiety disorders must shift from specialised healthcare to primary healthcare. This also enables improved access to treatment — but only if the need for treatment is correctly recognised in primary care services and effective treatments are available.

For psychosocial treatments to be effective in practice, the service system must function well as a whole. A stepped care model appears to be the most effective approach, improving outcomes for depression and anxiety disorders.

Access to treatment and delays between the different stages of care are often long. In traditional clinical practice, even the assessment of the need for treatment alone may take several weeks. In the worst case, the help-seeker is referred to another unit for yet another assessment. After this lengthy process, they are then placed on a waiting list for treatment, which can again take months to begin. With this delay, treatment effectiveness decreases and risk of disorders becoming chronic increases. This in turn increases sickness absence and the demand for specialised healthcare.

Although many effective psychosocial interventions exist for common mental health disorders, their availability within mental health services has not met the demand. In addition, there have been no jointly agreed models for organising treatment, resulting in large variations between regions and professionals. From the perspective of the help-seeking client, this means it is entirely a matter of chance — and dependent on the services of their wellbeing services county — what treatment they will receive. In the short term, medication and psychotherapy are equally effective in treating depression and anxiety, but in the long-term psychotherapy appears to reduce recurrence more effectively than medication.

⁵ Kauhanen, L., Wan Mohd Yunus, WMA., Lempinen, L., Peltonen, K., Gyllenberg, D., Mishina, K., Gilbert, S., Bastola, K., Brown, J. S. L., & Sourander, A. A Systematic review of the mental health changes of children and young people before and during the COVID-19 pandemic. *Eur J Child and Adol Psych* 2022 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9373888/pdf/787_2022_Article_2060.pdf (Accessed on 14.3.2025)

⁶ Kela press release, 28 January 2025: The increase in sickness absences due to mental health conditions came to a halt in 2024: <https://www.sttinfo.fi/tiedote/70847590/mielenterveysperusteisten-sairauspoissaolojen-kasvu-pysahtyi-vuonna-2024?publisherId=69820426&lang=fi> (Accessed on 14.3.2025)

The Finnish mental health care system has traditionally placed an internationally unique emphasis on long-term psychotherapy, due to Kela's rehabilitation funding system and the limited availability of shorter treatment models. Since 2010, the number of people receiving rehabilitative psychotherapy has quadrupled—from 15,000 to more than 64,000. At the same time, Kela's psychotherapy reimbursements have risen from 23 million to 105 million euros, not including client co-payments⁷.

On the other hand, measuring how well the service system functions is challenging. Monitoring is based mainly on the number of referrals and length of waiting lists. Electronic patient information systems have not supported the needs of knowledge-based management. In addition, the culture of mental health services in Finland has not promoted setting treatment goals or conducting systematic monitoring of effectiveness. There is no guidance for whom rehabilitative psychotherapy is suitable, nor is their individual-level effectiveness monitored systematically as part of the overall public healthcare system. This means that no systematic, group-level comparable data accumulate on the benefits or harms of different treatments and interventions—data that would enable service development and ensure that patients and rehabilitees receive better and more cost-effective care.

1.3. The Act on Therapy Guarantee for Children and Young People is not a sufficient solution

Although the Act on Therapy Guarantee for Children and Young People is a step in the right direction, the Act itself does not solve the problems of the service system. If it did, access to psychosocial treatments should already have been ensured on the basis of the Primary Healthcare Treatment Guarantee and the Specialised Healthcare Treatment Guarantee. The reasons are more complex than legislation and cannot be resolved through legislation alone.

In a municipality-based, decentralised system, it has been impossible to form a comprehensive understanding of mental health services for children and adolescents, and prevention and treatment methods have not been developed through national cooperation. As a result, many gaps have emerged in the system, through which children and adolescents with difficulties may fall.

The Act can serve the best interests of children and adolescents only as part of a functioning whole: Low-threshold treatments must be available before those that fall under the Act are offered and more intensive treatments after it. Children and adolescents also face complex problems, for example related to difficult family situations, and treatments provided under the Act alone are not sufficient to address them.

The First-Line Therapies model is based on the principle that timely and effective psychosocial treatment should be equally available to people of all ages in line with Finnish legislation, healthcare ethics, and the need to address the sustainability gap. Differentiating the care people receive based on age or employment status is not sustainable.

The Ministry of Social Affairs and Health (STM) has prepared guidance on the implementation of the Act on Therapy Guarantee for Children and Young People, focusing on the application of the legislation. In addition, the university-level wellbeing services counties have produced

⁷ Kela's Rehabilitation Statistics 2024. <https://tietotarjotin.fi/uutinen/991217/kuntoutuspsykoterapiaa-saavia-toistaiseksi-ennatysmaara-kustannusten-kasvu-on-tasaantunut-viime-vuosina?q=terapia> (Accessed on 14.3.2025)

joint guidance that focuses on the selection and organisation of treatment modalities suitable for implementing the legislation.

1.4. What can be done to resolve the mental health crisis?

Fixing the mental health crisis is not difficult because the challenges or solutions are not recognised, but because implementing large-scale changes in a complex system is difficult. Even after the health and social services reform, the system remains structurally complex, with multi-channel financing and multiple service providers. When resources are increased in one part of the system, bottlenecks and challenges are easily shifted elsewhere.

The starting point of the First-Line Therapies model is that repairing the Finnish mental health service system requires both long-term strategic support and measures that can be implemented immediately.

This means, among other things, the following:

- Mental health services must be organized more systematically than at present according to the principles of stepped care, which increases the effectiveness of the system and improves the use of resources.
- Emphasis must be placed on the broad implementation of treatments that start quickly, are effective, and digitally supported, in order to secure access to care.
- Effective and timely treatments must be equally available to all people in Finland, regardless of their place of residence. Citizens must be provided with tools that support their participation and understanding of treatments.
- All social and healthcare professionals must receive support and guidance for the mental health work they do.
- Regional care pathways and treatment processes must be monitored systematically. The accumulation of regional data and comparing data between regions form the foundation for developing the service system.
- National digital support services and co-development are needed because the problems are complex and shared by all wellbeing services counties. Co-development saves resources especially in the development of the increasingly complex digital mental health services.

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2. The idea and objectives of the First-Line Therapies model

The First-Line Therapies model offers practical solutions to the mental health crisis and a structured approach to developing psychosocial treatments. It aims to equip every frontline social and healthcare professional with methods to support clients' mental health, so people can receive help quickly wherever they seek it.

At the core of the First-Line Therapies model are

- national co-development
- stepped care of psychosocial treatments and services
- digital solutions that support professionals' work
- knowledge-based management and monitoring of effectiveness.

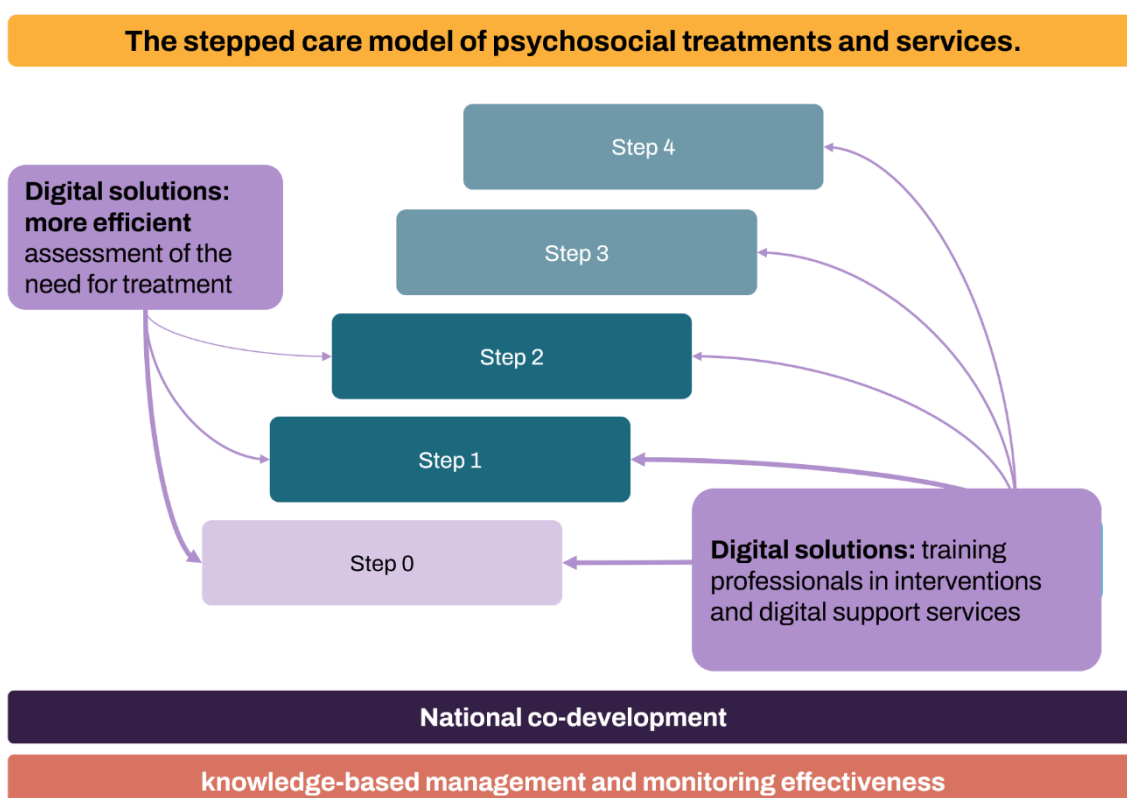


Figure 1: The solutions of the First-Line Therapies model: national co-development, stepped care of psychosocial treatments and services, digital solutions, knowledge-based management, and monitoring of effectiveness

2.1. National co-development

Mental health disorders have become Finland's key public health issue and a crisis that can only be resolved through national cooperation. By developing shared practices, care pathways, digital services and training, the system can be improved far more effectively than if each wellbeing services county worked independently. Co-development saves resources while simultaneously enabling more equal and equitable services.

In the First-Line Therapies model, the centralised services team, and the wellbeing services counties work in close collaboration to identify the best possible solutions and to make use of knowledge and lessons learned from other regions.

Co-development between professionals in the field, supervisors, leadership, and those developing the model is at the core of everything. Each stakeholder must have the means to adopt the solutions, participate in their further development, and communicate about them.

Improving access to psychosocial treatments is not only about introducing new methods or digital tools—although these are important parts of the solution. Ultimately, it is about changing ways of working: ensuring that professionals make use of the new solutions, so their work becomes easier, more effective, and more meaningful.

Co-development is described in more detail in Chapter 4 of the handbook.

2.2. Stepped care of psychosocial treatments and services

The basic idea behind stepped care of psychosocial treatments and services is that services are organised as a continuum: the higher the step, the more severe the situation and the more intensive the treatment provided. A person in need of help is offered evidence-based treatment that places as little burden as possible on both them and the service system.

The benefits of a stepped care service system have been demonstrated in international studies. For a large proportion of those seeking help, a short intervention that begins quickly is sufficient. This ensures that resources remain available for those who need more intensive and longer treatments.

How stepped care is implemented depends on the operational environment. The stepped care models for children, adolescents and adults may differ, but the underlying principle remains the same. Although the content of the steps may vary by region, every step must be covered—from low-threshold interventions to specialised healthcare and rehabilitative psychotherapy.

The low-threshold support, treatment methods and digital solutions included in the First-Line Therapies model help wellbeing services counties implement stepped care.

You can read more about organising treatments and services in accordance with stepped care in Chapter 5 of this handbook. The stepped care for adult mental health services is described in Chapter 13, and the stepped support and treatment for children and adolescents in Chapter 19.

2.3. Digital solutions that support the work of professionals

Digital solutions improve the availability of services for clients regardless of where they live. Numerous studies have shown that digitally supported treatments have a significant impact in treating mild, moderate, and severe mental health disorders. In addition, digitally supported solutions can make professionals' work easier and more efficient.

The key digital solutions in the First-Line Therapies model are the open-access Mentalhub online service, the Finnish Therapy Navigators for adults (FTN), children (FTN-C), and adolescents (FTN-A), which support guidance to treatment, as well as the training services and the Mentalhub professional section.

The Mentalhub is an open online public service that supports citizens' mental health regardless of time and place. The service includes, for example, information pages, self-help programs, and symptom scales. Mentalhub also includes a professional section with information and tools for social and healthcare professionals.

The Mentalhub online service is described in more detail in Chapter 6 of this handbook.

The Finnish Therapy Navigators are digital questionnaires designed to support guidance to treatment. They are completed either before meeting a professional or together during the appointment. The purpose of the navigators is to assess the help-seeker's current situation and symptoms comprehensively and efficiently. When the assessment of treatment needs can be completed in a single appointment, the client can access a suitable treatment more quickly, and professionals also have more time available for implementing interventions.

The Finnish Therapy Navigators for adults, children, and adolescents and the First Assessment are described in general terms in Chapter 7 of the handbook. In addition, the Finnish Therapy Navigator for adults is described in Chapter 15, the Finnish Therapy Navigator for children in Chapter 21 and the Finnish Therapy Navigator for adolescents in Chapter 22.

The training services provide professionals with a flexible way to learn psychosocial methods. Online pedagogy is used to ensure low training costs and maintenance of competence as well as equal standards of training quality and regional flexibility. A wide range of interventions is offered to different target groups.

The training services are described in more detail in Chapter 8. In addition, the methods of the First-Line Therapies model for adults are described in Chapter 16, the methods for children in Chapter 23 and the methods for adolescents in Chapter 24.

2.4. Knowledge-based management and evaluation of effectiveness

Knowledge-based management and evaluation of effectiveness are at the core of the First-Line Therapies model. This means that available resources are used in an equal, sustainable, and transparent way so that everyone seeking help can benefit from better treatment outcomes and experiences.

Effectiveness data are collected and used to help embed organisational changes and support continuous development. Without effectiveness data, it is impossible to assess whether services create value for clients and patients.

Collecting and using effectiveness data also requires a cultural shift, making service effectiveness a core value that guides operations. For this change to succeed, everyone in the organisation must commit to using outcome data. These data support all levels of the organisation, from everyday clinical decisions to leadership's strategic planning.

National development, shared understanding of the indicators and measures of effectiveness and co-development are the key requirements for developing effective services.

In the First-Line Therapies model, the collection of effectiveness data has been central from the beginning. The aim is to evaluate the effectiveness of the model's solutions comprehensively and to develop practical approaches to knowledge-based management together with the regions. These practical approaches are intended to support management. Knowledge-based management requires continuous development at all organisational levels. The First-Line Therapies model maintains recommendations for effectiveness indicators and measures in mental health and substance use services.

The overall concept of knowledge-based management is described in Chapter 11 of this handbook.

3. Implementation of the First-Line Therapies model and the therapy guarantee

One of the central objectives of the First line therapies- model has been to create solutions for the practical implementation of the therapy guarantee legislative initiated in 2020.

Although the Act on Therapy Guarantee currently applies only to children and adolescents, the First-Line Therapies model is based on the principle that timely, effective psychosocial treatment should be equally available to people of all ages. With this model, it is also possible to achieve this in practice. Differentiating the care people receive based on age or employment status is not sustainable.

3.1. The Act on Therapy Guarantee for Children and Adolescents

The aim of the Therapy Guarantee legislation for Children and Adolescents is, in accordance with the Government Program, to ensure equal access to psychotherapy and other effective psychosocial treatments in primary care services. The goal is to improve the availability of prevention, treatment, and support for mental health disorders in both health and social care.

The Act on Therapy Guarantee for Children and Adolescents has been in force since 1 May 2025 and applies to those under 23 years of age. The legislation introduces provisions on the Therapy Guarantee to the Health Care Act (§53 and §55), the Social Welfare Act (§25 and §45) and the Act on Student Health Care for Higher Education Students (§10). In addition, the decree on the content and preparation of cooperation agreements between wellbeing services counties now requires an agreement at the cooperation area (YTA) level on implementing the Act.

Since 2017, the centralisation decree under the Health Care Act (Government Decree 582/2017) has included a similar provision requiring the university-level wellbeing services counties and the HUS group to evaluate and maintain psychotherapeutic and psychosocial treatment methods in their areas.

3.2. National recommendations to support the implementation of the Act on Therapy Guarantee

The Ministry of Social Affairs and Health has prepared a guide for the implementation of the Therapy Guarantee legislation, describing in more detail interpretations of the law and the principles for organising services. The Ministry does not define the treatments.

Responsibility for treatment methods lies with the wellbeing services counties. To support this responsibility, the university-level wellbeing services counties have, under the centralisation decree, prepared national recommendations for implementing the Act on Therapy Guarantee for Children and Adolescents, including guidance on treatment method selection. The recommendations apply to mental health services for people under 23 years of age and provide concrete guidelines for implementation. They include principles for, among other things, building

a regional stepped care model and conducting an assessment of the need for treatment, as well as recommendations on key psychosocial methods to be maintained.

Separate recommendations have been prepared for those under 18 years of age and those aged 18–22, as the methods available differ slightly.

The recommendations have been drawn up jointly by experts from the university-level wellbeing services counties in accordance with the centralisation decree, and all wellbeing services counties have been consulted in their preparation.

The recommendations are based on nationally coordinated projects launched in 2020 to support the implementation of psychosocial methods, applying the principles of the First-Line Therapies model in ways that reflect regional circumstances and needs. The recommendations are aligned with the principles of the First-Line Therapies model presented in this handbook.

Links to the recommendations (in Finnish):

[Principles for implementing the therapy guarantee for those under 18 in health care](#)

[Principles for implementing the therapy guarantee for those over 18 in health care](#)

[Guidance from the Ministry of Social Affairs and Health: Provisions on access for children and young people under 23 to basic-level brief psychotherapy and to standardised short interventions in Social and healthcare.](#)

CENTRALISED SERVICES OF THE FIRST-LINE THERAPIES MODEL

This chapter describes the networks, services and methods that enable the implementation of the First-Line Therapies model.

The chapter includes the following:

- National co-development and coordination
- Stepped care of psychosocial interventions and treatments
- The Mentalhub service for citizens and professionals
- The Finnish Therapy Navigators for adults, children, and adolescents and the First Assessment
- Training services
- Brief psychotherapy on a service voucher and the psychotherapy quality registry
- Knowledge-based management and real-world effectiveness

4. National co-development and coordination

Mental health disorders have become Finland's key public health issue and a crisis that can only be solved through national cooperation. By developing shared practices, care pathways, digital services and training, the system can be improved far more effectively than if each well-being services county worked independently. Co-development saves resources while also enabling more equal and equitable services.

National cooperation has been built as part of the *First-Line Therapies model* since 2020 in the South Finland cooperation area, and nationally since 2022 when the coordination projects for psychosocial methods funded by the Ministry of Social Affairs and Health began. In practice, nationwide co-development only became possible with the establishment of the well-being services counties in 2023. HUS has coordinated this national cooperation.

4.1. Structures of national cooperation

With project funding, a network of national and collaborative area specific centres of expertise was established as the core structure of the First-Line Therapies model. Its task is to promote the nationwide availability of effective psychosocial methods and digital mental health services. This structure, aligned with the centralisation decree, has proven essential for supporting and strengthening national cooperation.

During the coordination projects, collaborative area project managers were responsible for leading the project in their own cooperation area and served as an important link between national development and their regional operations. After the projects ended, funding for development and coordination in the university hospital-led collaborative areas was no longer available. As a result, the structures, and practices of cooperation at the collaborative area-level currently vary considerably.

At present, the national cooperation structures include:

- the First-Line Therapies model project office, which serves all wellbeing services counties
- the therapy and intervention coordinator networks of the wellbeing services counties
- cooperation groups for leaders of psychiatry and primary mental health services in university-level wellbeing services counties, separately for adult and child and adolescent services
- the national leadership network for mental health and substance use services for children, adolescents, and adults, which includes all wellbeing services counties

4.2. Practical implementation of national cooperation

The principles of national cooperation are based on a clear division of responsibilities between the experts at the First-Line Therapies model and the wellbeing services counties.

The experts at the *First-Line Therapies model* and HUS Psychiatry hold primary responsibility for the content development and implementation support of digital services—such as The Finnish Therapy Navigators and the digital training services—as well as for convening and coordinating national networks. DigiFinland Oy (owned jointly by the wellbeing services counties) will maintain the MDR-certified Therapy Navigator services from 2026 onwards.

Project developers and managers—for example the stepped care model, training services, therapy and intervention coordination, The Finnish Therapy Navigators, and knowledge-based management—are responsible for their own networks and communications.

Coordinators in the wellbeing services counties play a key role in implementing the services and new methods of the *First-Line Therapies model*, as well as in national and collaborative area cooperation. Method, therapy, and intervention coordinators have acted as links between professionals, supervisors, service managers, regional projects, and the *First Line Therapies- model* national project office.

Coordinators are specialists in their own regional services with connections both locally and nationally. Their task is to help professionals use new methods and support regions in developing and embedding the stepped care model in ways that reflect regional needs. They also help align regional development and provide method-specific supervision. Their responsibilities vary across adult, child and adolescent services and between regions.

In the cooperation groups of university-level wellbeing services counties, the aim is to identify shared guidelines and topics that need national coordination, and to agree on how to take them forward, for example through separate working groups. The leadership of university hospitals has also been invited to help develop the model's content and to appoint representatives who have participated actively.

The leadership of mental health and substance use services in the wellbeing services counties plays a key role in advancing the First-Line Therapies model in each region by setting strategic direction and operational goals. National cooperation is considered highly important in leadership, as challenges in mental health services are shared across all wellbeing services counties. Common challenges and solutions are discussed, for example, in national seminars for leaders of mental health and substance use services.

Process	National support services	Collaborative area- level support services
Digital self-help services 24/7	Mentalhub: technical development and content development	Integration of digital self-help services into regional service platforms and support for implementation; experts for content development
Digital Professional services 24/7	Mentalhub professional section: maintenance of the professional service platform and content development; networks	As above
Assessment of need for treatment and guidance to treatment	Content development, technical development, and maintenance of The Finnish Therapy Navigators; integration into regional and national systems	Experts for content development; integration of assessment of need for treatment systems into the regional service system and maintenance
Development and support of treatment processes and stepped care model	National support and training for therapy and intervention coordinators (coordinator academy); model evaluation and development; service voucher handbook etc.	Therapy and intervention coordinators in each wellbeing services county; co-development of care pathways at the collaborative area- and regional level; maintenance and development of competence
Therapy training and competence maintenance	Content development, maintenance, and technical development of the national therapy training system; national coordination and delivery of trainings	Experts for content development; collaborative area training and monitoring of competence needs; organisation of supervision and mentoring
Effectiveness, quality and availability, and knowledge-based management	Shared principles, measures, goals, and analysis models; national benchmarking and regional support	Collaborative area- level effectiveness monitoring, benchmarking, peer learning and improvement, support for knowledge-based management

Table 1: National and collaborative area-level support services in the First-Line Therapies model

4.3. Continuity of national co-operation

The core idea of the *First-Line Therapies model* has been to establish national cooperation structures, practices and services that continue sustainably after the project ends. All services and structures have been designed so that national cooperation and co-development are more cost-effective and efficient than each wellbeing services county developing solutions independently.

Between 2020 and 2022, these services could not be permanently integrated into line organisations because the wellbeing services counties did not yet exist. Organisational structures

began to stabilise only in autumn 2023, just as the finances of the wellbeing services counties started to deteriorate significantly.

The financial difficulties facing the wellbeing services counties and current legislation do not support the sustained national cooperation needed to reform mental health services. This handbook explains why close national and collaborative area-level co-development is essential to delivering effective services for citizens.

5. Stepped care of psychosocial interventions and treatments

Stepped care aims to improve both treatment outcomes and cost-effectiveness of the service system by making better use of available resources. According to several meta-analyses, a well-implemented stepped care model significantly improves treatment results.

Stepped care refers to organising interventions and treatments developed for mental health disorders—such as evidence-based brief therapeutic interventions and psychotherapies—by level of intensity.

In the First-Line Therapies model, stepped care focuses mainly on organising treatments for the most common mental health disorders, such as anxiety and depression, within wellbeing services counties. The same basic structure can also be applied to stepped care of less common treatments. The stepped care model does not define the division of responsibilities between different services (primary care, specialised healthcare, social welfare, student health care); instead, it aims to describe an ideal model for organising treatments, which can be implemented in several ways.

In the First-Line Therapies model, people are first offered intervention or treatment that is likely to be sufficient for their individual situation. If the intervention is not sufficient, higher-step treatment is offered. It is also important that treatment can begin quickly so that symptoms do not get worse while waiting.

How stepped care is implemented depends on the operational environment. The stepped care models for children, adolescents and adults may differ, but the underlying principle remains the same.

In the Finnish stepped care model, regions typically use 3–4 steps and a step 0. The model's basic structure should remain consistent across wellbeing services counties, even though the content may vary by region. A shared basic structure is necessary for national development and cooperation in service processes and their support services.

Step 0: open access services. A person with mild to moderate mental health symptoms—or someone close to them—uses self-help materials independently, for example through the Mentalhub online service. No contact with healthcare is required.

Step 1: promptly initiated psychoeducation, guidance, and brief interventions (1–5 sessions)

Step 2: brief symptom-focused interventions or structured psychological treatments (5–10 sessions)

Step 3: brief psychotherapy or targeted psychological intervention (10–20 sessions)

Step 4: referral to specialised healthcare or long-term psychotherapy (e.g. Kela-supported rehabilitative psychotherapy)

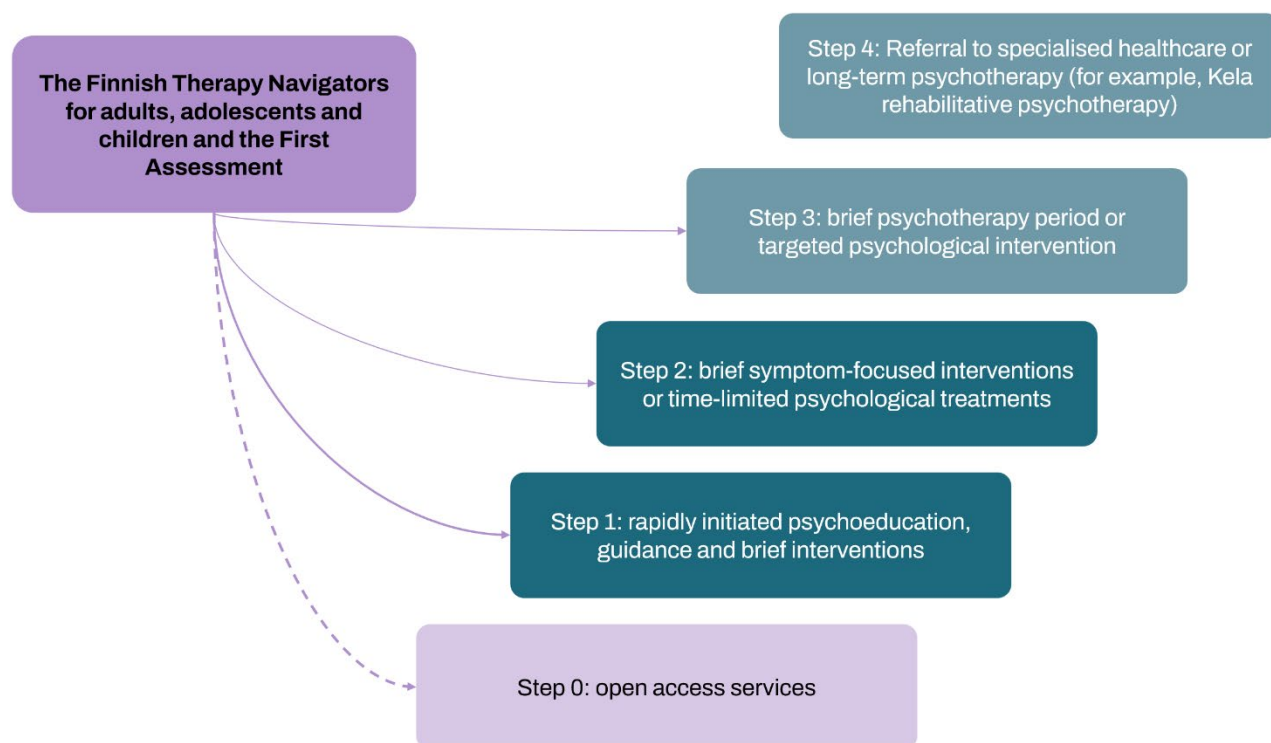


Figure 2 The basic structure of the stepped care model

Although the content of the steps may vary by region, every step must be covered—from low-threshold interventions to specialised healthcare and rehabilitative psychotherapy. The range of treatments must include interventions in line with the *Current Care* guidelines or other consensus recommendations. In the stepped care model, the effectiveness of treatment is also monitored using validated symptom scales.

Process	National support services	Collaborative area-level support services
Development and support of treatment processes and the stepped care model	National support and training for therapy and intervention coordinators (coordinator academy), evaluation and development of the model, service voucher handbook, etc.	Therapy and intervention coordinators in each wellbeing services county, co-development of care pathways at the collaborative area- and regional-level, maintenance, and development of competence.

5.1. The role of third sector organisations in the stepped care model

Social welfare and health organisations play a significant role in the mental health service system. Many third sector organisations provide preventive services such as information, counselling, and conversational support. They therefore act, alongside social and healthcare services, as one of the first-line services for clients seeking mental health support. It is important that third-sector organisations know the available services and referral pathways. This helps them guide clients, for example, to complete The Finnish Therapy Navigator and to contact healthcare when needed.

Third sector organisations also offer various individual, couple, and group interventions, which may be positioned at steps 1 and 2 in the stepped care model. When third sector services are included in the regional stepped care model and services, clients can be directed more accurately during the First Assessment to the right level of treatment or support. Regional third sector services may also be trained in the methods of the First-Line Therapies model.

Third sector organisations also play an important role when a client's treatment ends. They help clients stay connected to everyday life by offering community-based activities that support daily routines, as well as service guidance, advice, and peer support. Close relatives of people with mental health disorders often receive little or no support from the service system, and third sector organisations play a central role in supporting and advocating for them.

5.2. Development of the stepped care model of psychosocial support and treatment for neurodevelopmental disorders

The need for treatment for neurodevelopmental disorders has increased in recent years, and available forms of support and treatment have developed significantly. This highlights the need for systematic stepped care that balances access to effective individualised support and treatment with available resources.

The stepped care model of psychosocial support and treatment for neurodevelopmental disorders has been developed through national, multidisciplinary cooperation since 2024. The model covers services for all ages and follows the most recent Current Care Guidelines, including the extensively updated ADHD Guidelines published in 2025.

Co-development networks for developing care pathways

National networks have been established to support the development of care pathways for people with neurodevelopmental disorders: one for children and adolescents, and one for adult services. The networks support the development, implementation and embedding of the stepped care model of psychosocial support and treatment for neurodevelopmental disorders within the wellbeing services counties.

The goals of the networks are to:

- strengthen collaboration and expertise in national development related to neurodevelopmental disorders
- support the implementation and consolidation of the stepped care model
- share practical solutions and lessons learnt from the wellbeing services counties
- enable co-development between regions

Stepped care model of psychosocial support and treatment for neurodevelopmental disorders

Example of a stepped care model of psychosocial support and treatment for neurodevelopmental disorders

Step 0 – Open access services (no diagnostic assessment or diagnosis required)

- Self-help (Mentalhub)
- Other online services
- Materials and activities provided by associations and member organisations

Step 1 – Psychoeducational and guidance support services (no diagnostic assessment or diagnosis required)

- Guided self-help (individual and group)
- Group intervention for adults with concentration difficulties
- Group for parents of children with neurodevelopmental traits
- Short psychoeducational and coaching courses

Step 2 – Support services that strengthen day-to-day functioning (some may require a diagnosis)

- Neurodevelopmental coaching
- Support groups for day-to-day functioning
- Guided internet cognitive behavioural therapy (guided iCBT)
- Strategy parent training program

Step 3 – Rehabilitative and therapeutic services (diagnosis required)

- LAKU family rehabilitation (Kela)
- Oma Väylä rehabilitation (Kela)
- Therapeutic interventions
- Group-based rehabilitation programs

Step 4

- Demanding medical/ discretionary rehabilitation (Kela)
- Specialised healthcare

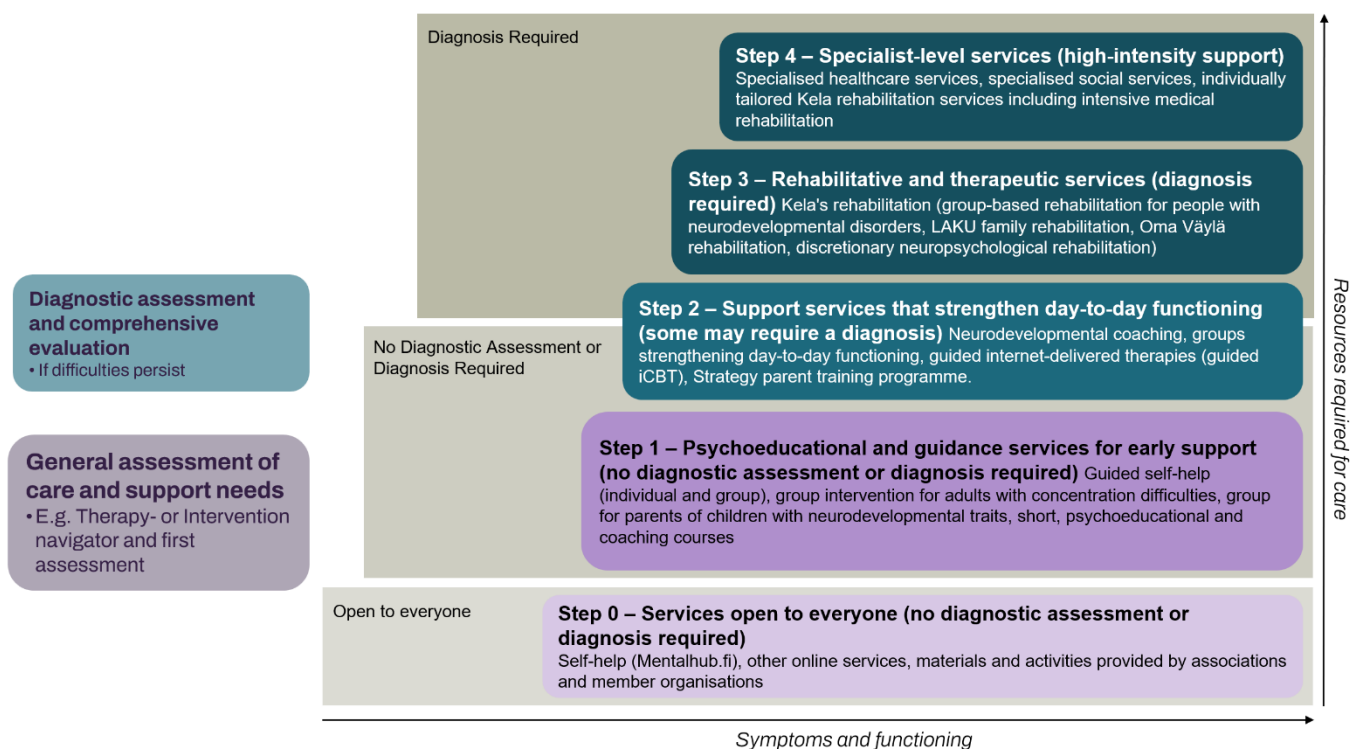


Figure 3 Stepped care model of psychosocial support and treatment for neurodevelopmental disorders

Training

Increasing competence in recognising neurodevelopmental disorders – the training provides basic knowledge of the most common neurodevelopmental disorders, especially ADHD and autism spectrum disorders, as well as recognising and addressing them in clinical practice. The aim is to increase professionals' ability to work with adult clients in social and healthcare services, taking individual needs into account.

Neurodevelopmental difficulties in clinical practice – the training provides information and practical tools for taking neurodevelopmental difficulties into account in treatment. The aim is to help professionals understand the client's experience and adapt treatment to individual needs. The module covers difficulties in attention, language, and perception as well as autism spectrum and the most common learning difficulties.

Group-based treatment models are being developed and piloted

The Concentration Difficulties Toolkit group model has been developed in collaboration with the wellbeing services counties of Southwest Finland and Vantaa and Kerava. The group is an early-support method for adults and is particularly suitable in situations where ADHD-related assessments have not yet been started or no diagnosis has been made.

The group model for parents of children with neurodevelopmental traits is designed to support parents with day-to-day challenges and parenting. This early-support group is aimed at parents of children aged 5–8 with neurodevelopmental traits but no diagnosis. The model has been co-developed in collaboration with the City of Helsinki and the wellbeing services county of North Savo.

6. The Mentalhub online service for citizens and social and healthcare professionals

The Mentalhub is an online service that provides information related to mental health for both citizens and social and healthcare professionals. The service is also useful for close relatives of someone experiencing symptoms, as well as students in social and healthcare fields.

HUS is responsible for maintaining the Mentalhub service. The service is continuously developed based on needs and feedback. Continuous development enables smooth production of new content. Contents are also created in collaboration with different organisations.

Because Mentalhub is an open access service, its significance for public health promotion is substantial. Its contents are widely used throughout Finland and also internationally. The Mentalhub service has been translated into several languages. The entire site is available in Swedish, and in addition, selected information pages and self-help programs have been translated into, for example, English and Sámi.

6.1. Contents of the Mentalhub online service for citizens

For citizens, the Mentalhub online service does not require registration or signing in. It provides immediate help and support for a wide range of mental health related questions. The content is organised by theme and is available free of charge.

When used independently, the contents of the Mentalhub service fall under step 0 of the stepped care model—that is, services that can be used independently and accessed before any contact with social and healthcare services. In 2024, Mentalhub received 4.52 million visits.

The Mentalhub service includes information on mental health and mental health promotion. The pages also provide symptom scales to assess personal wellbeing. The service offers a wide range of different self-help programs to alleviate symptoms or support personal wellbeing and different life situations.

Self-help programs and information pages

Self-help programs in Mentalhub provide reliable help and support for a wide range of life situations and symptoms. They are high-quality programs created by professionals and can be used for both individual and group psychoeducation, as their content provides information, helps ease symptoms, and guides the user forward. They are suitable for both people experiencing symptoms and their close relatives. For professionals, Mentalhub content is a useful resource for clinical work.

Mentalhub contains more than 50 self-help programs for adults, adolescents, children, and families. The programs for children are designed to be used together with a parent or guardian.

Self-help programs increase understanding of symptoms and offer ways to help. For many, the psychoeducation offered by these programs is sufficient support. Mentalhub's self-help programs also provide help and support while waiting for other treatment and after a completed treatment or intervention.

Mentalhub's **information pages** offer extensive content on various life situations as well as on mental health and well-being. The content is organised by theme and age group, for example materials for older adults, making them easy to browse. Mentalhub also includes dedicated information pages for school and work communities.

Examples of self-help programs and theme pages for adults can be found in section 14 of this handbook.

Examples of self-help programs and theme pages for children and adolescents can be found in section 20.

6.2. Contents of the Mentalhub service for social and healthcare professionals

The Mentalhub professional section is intended for all Finnish social and healthcare professionals and students. The service is accessed with a social welfare and healthcare professional's ID card, organisational or online banking credentials.

The professional section includes:

- over 100 digital symptom scales
- training, for example in the use of symptom scales
- recordings of training
- a wide range of guides, for example for implementing group interventions and engaging patients

Professionals can also use the contents of Mentalhub when providing guided self-help for adults in accordance with the First-Line Therapies model. Further information on guided self-help can be found in the method sections of this handbook.

6.3. Communicating about the Mentalhub service

Communicating about the Mentalhub online service is designed to be as effortless as possible. The service can be found at www.mielenterveystalo.fi, and links to the service can be shared in appointment letters and text messages, patient instructions, patient records and on websites. A link to the website can be added directly, for example, to the wellbeing services county's webpages or other materials, making it easy to access Mentalhub's content.

The following resources can be used when promoting the service:

- **Material bank**
At Mielenterveystalo.fi/materiaalipankki, you can find printable materials, printed products, digital banners for websites and presentation slides for digital information displays.
- **Informing and training**
Professionals in the First line therapies- model and in the national collaboration network of the Mentalhub understand the service and its purpose. Coordinators in each wellbeing services county are happy to present the service. Their contact details can be found at www.mielenterveystalo.fi/yhteystiedot.
- **Social media channels**
Mentalhub is available on Instagram and Facebook. A wide range of content is

produced for social media, offering information and tips for different situations and symptoms. Wellbeing services counties can easily share Mentalhub content in their own channels.

Process	National support services	Collaboration area-level support services
Digital self-help services 24/7	Mentalhub: technical development and content development	Integration of digital self-help services into regional service platforms and support for implementation, and experts for content development
Digital Professional services 24/7	MentalHub professional section maintenance and content development, and networks	As above

7. The Finnish Therapy Navigator for adults, children, and adolescents and the First Assessment

Timely and appropriately targeted guidance to treatment is essential for the effective management of mental health disorders. Investing in this early stage ensures a smoother overall treatment pathway.

However, the early phase of the treatment process involves significant challenges from the perspective of the service provider. Too few or, in some cases, disproportionately many resources may be allocated to assessing the need for support and treatment. Assessment practices may be unclear or inconsistent between professionals. This often results in overlapping work and inconsistent processes.

For an adult, adolescent or family with children seeking help, problems related to the assessment may cause delays in starting treatment or lead to inappropriate treatment. The assessment process can involve long waiting times and require several consecutive appointments. In the worst case, the client does not receive any support during the waiting period and their situation gets worse.

A particular challenge is the variation in assessments of need for treatment and support and guidance to treatment practices between social welfare and health care services as well as public and private service providers. Assessment practices and available services vary depending on the point of contact rather than the client's needs. Ideally, regardless of the service, professional or organisation, the client should be immediately directed to effective treatment or support suited to their needs.

Unnecessary variation in the early phase assessment of the need for treatment and guidance to treatment causes not only harm to the help-seeker but also significant waste of resources. If a treatment or service pathway begins with the wrong focus, it may later be difficult or even impossible to correct its direction. For this reason, clarifying and streamlining the early part of the care pathway is particularly important.

7.1. Principles of the navigator services

To streamline guidance to treatment and support both professionals and clients, The Finnish Therapy Navigator for adults, The Finnish Therapy Navigator for adolescents aged 13–19, and The Finnish Therapy Navigator for children and families have been developed. The content development has been conducted in collaboration with the wellbeing services counties. The navigators gather the most essential information about the client's situation for directing them to treatment or support—ideally already before the first appointment with a professional. When the assessment of the need for support and treatment is completed comprehensively and efficiently, the treatment can begin immediately or soon after the First Assessment – that is the interview the professional conducts with the client based on the results of the navigator, gaining further information relevant to the client's situation. This process helps shorten service queues and ensures clients receive appropriate and timely support or treatment before their situation worsens.

The navigators include questions on the most common factors affecting health and functioning. The Finnish Therapy Navigator for adults and The Finnish Therapy Navigator for adolescents also use nationally recommended symptom scales to assess common mental health problems. The navigators do not make automated conclusions, provide health advice, or create profiles, nor do they recommend specific treatments based on responses. The professional is responsible for the assessment and decides on treatment or support during the First Assessment, taking the client's wishes into account.

To increase transparency, all users of the navigators receive a summary of their responses. The responses are compiled into a summary report showing symptom scale scores and symptom severity levels. The respondent can also view each answer via an extended report. Using a personal code provided after completion, the respondent can view their responses for one month.

Use of the navigators is anonymous and free of charge for both clients and professionals working in wellbeing services counties or other social and healthcare settings. The navigators do not require new integrations or technical development, as they operate as independent websites. Information can be transferred without integration: the client shares the response code with the professional, who is then able to access the client's navigator responses. The navigators include a built-in feature that allows easy copying of the summary report into electronic patient or client information systems.

Navigator services are continuously developed. The Finnish Therapy Navigator for adults has been in use the longest and is already well established. The navigators for adolescents and children are in the implementation phase.

From 2026 onwards, DigiFinland Oy will be responsible for the technical implementation of the navigator services and compliance with medical device certification requirements. HUS Psychiatry remains responsible for developing the clinical content of the navigators, for the First Assessment training, and for supporting implementations in the wellbeing services counties.

7.2. Principles of the First Assessment and training for the First Assessment

The first appointment with a client and the discussion about their need for treatment or support is a significant event. The assessment discussion is not merely a neutral information gathering situation; it is also a meaningful clinical intervention that influences both the

relationship between the client and the professional and the treatment itself. In the context of the navigators, the first appointment is called the First Assessment. During the First Assessment, the professional reviews the navigator results, gains necessary further information on the responses and determines whether issues not covered by the navigator’s questions are relevant to the client’s situation. At the same time, the foundation for the client-professional relationship is established and treatment suitability and motivation are explored.

The navigators and the First Assessment help identify clients who can be directed to low-threshold, rapidly initiated, intensive brief psychosocial treatments, and those whose situation requires a more detailed assessment or more intensive treatment, such as psychotherapy. Moving clients forward appropriately requires that the regional stepped care model of psychosocial treatments is established and the treatments on each step are clearly defined so that the client can be guided directly to the intervention assessed as appropriate.

The First-Line Therapies model provides the First Assessment training for professionals working with children, adolescents, and adults. The training is arranged with the organisation providing the services. They are intended for professionals who assess and guide clients with mental health symptoms or disorders to psychosocial treatment or support. The training consists of online studies, skills practice and a final test. In the First Assessment training, professionals learn to use and apply the information gained from the navigators in a way that supports selecting the appropriate level of treatment or support. Training in their region’s stepped care model of psychosocial interventions and available support and treatment options is also required in using the navigators and the First Assessment.

More detailed information on the practical use of the different navigators and the First Assessment can be found in the age-specific service chapters 15, 21 and 22 of this handbook.

Process	National support services	Collaborative area- level support services
Assessment of need for treatment and support and guidance to treatment	Content development and maintenance of the Therapy navigators, integration into regional and national systems	Experts for content development, integration of guidance-to-treatment systems into the regional service system and maintenance

8. Training services

The goal of the First-Line Therapies model training services is to maintain a training structure that is appropriate in content, pedagogically high-quality and emphasises regional ownership.

The training services are based on:

- online learning
- feedback-informed delivery of training interventions
- method-specific supervision

The aim is that all wellbeing services counties can effectively and at low cost maintain and develop the competence of their staff and thereby ensure equal access to services and treatments in line with recommendations. Modern online pedagogy enables low training costs, maintenance of competence and regional flexibility.

The training services of the First Line Therapies- model can be found in the Mentalhub online education section, which requires a personal user account. Training takes place in regional groups or at unit level.

The training services are not intended to be exhaustive; they do not include all possible evidence-based treatments that might be appropriate to offer to citizens. The goal is to provide training in the best-documented evidence-based treatments for the most common disorders, enabling competence to be maintained sustainably and at a reasonable cost.

Since 2021, more than 16,000 professionals have completed or are currently completing a training included in the First-Line Therapies model's training services. As a continuous structure, the training services' online platform enables flexible annual training of 1,000–2,000 professionals in evidence-based methods.

Responsibility for organising the training is shared between the First-Line Therapies model and the method experts, who work together to develop the content, structures, and graduate certification. The training provider, such as a wellbeing services county, is responsible for the practical implementation of the training, including organising method-specific supervision, monitoring progress, and ensuring regional embedding of the method.

Each training group has a designated person responsible for monitoring study progress and organising or coordinating regional structures for skills practice.

Process	National support services	Collaborative area-level support services
Training and competence maintenance	National development, maintenance, and technical development of the training services, as well as national coordination and delivery of training	Experts for content development, area-specific training, and monitoring of competence needs, and organising method-specific supervision and mentoring

8.1. Online pedagogy as the foundation of the training services

All First-Line Therapies model trainings make broad use of online pedagogy and digital learning solutions. The digital learning environment ensures consistent, high-quality training, continuous updates to training content and integration of user feedback.

The training platform is comprehensive. In addition, online training enables:

- self-paced, flexible participation, fitting the training in with daily clinical practice as opposed to whole training days
- long-term access to the platform after the training, contributing to continuous professional development
- more time for skills practice in training and supervision

Each training course is built hierarchically and modularly, which guides the learner, helps them understand each part of the whole and supports revision of key content. Online training uses multiple content formats, for example text, images, videos and various learning activities such as questionnaires and reflective assignments—which the user can complete directly on the training platform.

8.2. Training services for social welfare in the First-Line Therapies model

In early 2025, development began on evidence-based methods for social welfare as part of the First Line Therapies-model's training services. The goal is to make broad use of the widely adopted training services and to support multidisciplinary competence development.

The development is focused on services for children and families and early support practices that can be applied within social welfare and was initiated by the City of Helsinki's family services. Experts from several wellbeing services counties are participating, including the City of Helsinki, as well as the wellbeing services counties of Central Ostrobothnia, North Ostrobothnia and Western and Central Uusimaa. The development draws on the expertise of the social welfare sector and its experience in supporting day-to-day family life.

Trainings suitable for social welfare and early support of children and families

In the first phase of the development, three interventions focusing on parenting, family interaction and day-to-day functioning have been completed. They are clearly structured and suitable for use in family counselling, family centres, and home-based services.

- **NaP-MIDI (Nurture and Play-Midi)**
A six-session early interaction intervention supporting the relationship between a parent and a young child. It is based on the *Nurture and Play* intervention, which has a strong evidence-base. NaP-MIDI is designed especially for home visits and social welfare clients.
- **Emotionally Focused Family intervention**
A brief intervention derived from the Emotionally Focused Therapy for Couples, focusing on family relationships. The intervention provides a concrete framework for supporting the parental relationship and family interaction. It is designed primarily for professionals in family counselling and related services.
- **Group interventions for families with children**
Group-based early-support interventions for families with children experiencing

challenges with concentration, executive functioning, or daily routines. The interventions support parenting and the day-to-day life.

The trainings have been developed in multidisciplinary working groups involving both method developers and professionals working in social welfare services.

The trainings include:

- training materials, principles, and guidance for delivering training interventions and method-specific supervision practices
- self-assessment and monitoring tools
- principles for evaluating effectiveness

Piloting of the interventions began in summer and autumn 2025 in selected regions. After the piloting phase, they will be available nationwide for all wellbeing services counties on the Mentalhub education section as part of the First-Line Therapies model's training services.

8.3. Training portfolio

The First-Line Therapies model training portfolio includes interventions of varying lengths for use in services for children, adolescents, and adults. The duration of trainings ranges from a few hours to one year. The full training portfolio is presented in Figure 3. Age-specific training content is described in more detail in the chapters of this handbook for each age group. In addition to the trainings described in the portfolio, trainings can also be tailored to the needs of a specific unit with separate agreement.

Training materials are available in both Finnish and Swedish, and parts of the training content—such as materials distributed to clients—have also been translated into English.

The training portfolio is developed according to scientific evidence and the needs of primary care services across all age groups. National co-development structures ensure that new training can be added to the portfolio in approximately six months when there is an evidence base, a clear need, well-defined content, and support from key experts in the field.

Guided self-help	 	  			step 1
Cognitive behavioural intervention for child and adolescent anxiety	 		 	MO	step 2
Cognitive behavioural therapy	 	  	MO	ESH	step 2-3
IPC		 	MO		step 1-2
IPT		 	MO	ESH	step 2-3
Emotionally Focused Couple intervention					step 1-2
Emotionally Focused Family intervention		  	MO		step 3
NaP MIDI				MO	step 2
The Concentration Difficulties Toolkit group model		 			step 1
The group model for parents of children with neurodevelopmental traits					step1
+other complementary trainings such as trauma-informed practice and recognising and taking neurodevelopmental disorders into account.					



MO Includes method-specific supervisor training and induction

ESH Can be applied to specialised healthcare

Figure 1: The training portfolio of the First-Line Therapies model

In addition to the trainings included in the training portfolio, open online courses are available to professionals in training. These courses complement the content of the main training modules.

Support trainings	• Brief therapies in specialised healthcare • Brief therapies with older adults • Brief therapies with adolescents • Neurodevelopmental difficulties in clinical practice • General practice module in the <i>guided self-help (adults)</i> training • Maternity clinic module in the <i>guided self-help (adults)</i> training • Training for supervisors on implementing change and real-world knowledge-based management • Avoidant/Restrictive Food Intake Disorder (ARFID)
Open trainings	• Trauma-informed practice • Trauma-informed interaction • User perspectives on mental health services • Strengthening skills in recognising neurodevelopmental difficulties

Table 2 Open online courses available to professionals in the First-Line Therapies model training system

8.4. Feedback informed implementation of training interventions

Trainings are primarily targeted at units where the methods will be actively used. Training interventions are delivered as part of clinical practice, and clients are directed to these interventions according to regional guidelines. Total number of completed interventions and hours of training interventions are defined in each training.

A feedback-informed approach means systematic monitoring of treatment outcome throughout the entire treatment. The professional collects feedback on the client's symptoms and changes in them, as well as on how the client experiences the treatment. Through a feedback-informed approach, the therapist continuously receives information on the effectiveness and progress of the treatment they are delivering. The information collected is used during the treatment and planning any future treatment.

Systematic monitoring of treatment effectiveness is also important for the unit and the organisation providing the treatment, as monitoring allows them to identify factors that are known to reduce effectiveness, for example, long waiting times or too infrequent treatment sessions. It is important to note that even in this context, the focus is not on effectiveness of a treatment delivered by a single professional, but on ensuring that patient care is organised appropriately, effectively and is of high quality.

8.5. Method-specific supervision and method-specific supervision training

The purpose of the method-specific supervision included in the trainings is to enable trainees to safely practise and establish new ways of working. The method-specific supervisor supports and teaches professionals in using the new method. Therefore, the method-specific supervisor must have deep knowledge of the method and understand the key principles of its underlying framework.

Typically, in the First-Line Therapies model's training services, regional therapy coordinators, staff members of the line organisation, or externally contracted resources act as method-

specific supervisors. The training services also include training for new supervisors, which is described in more detail in the following subsections.

The criteria for applying to become a method-specific supervisor depend on the method being guided. The more demanding the method and client group, the stronger the expertise required. Method-specific supervisor criteria are compiled in tables found in Appendices 1 and 2. Criteria for trainers of method-specific supervisors are provided in Appendix 3.

Content and organisation of method-specific supervision training

Method-specific supervision training includes online studies, group-based supervision and supervising at least one group in training. Training takes from six months to a year depending on the method. A method-specific supervisor certificate can be granted once the first supervised group has completed its training.

Key method-specific supervision skills practised in the training include:

- supporting trainees learning
- creating a safe learning environment and addressing potential problems
- Supervising skills practice in a group
- supporting feedback-informed practice

Method-specific supervision trainings are organised in collaboration between the First-Line Therapies model and the wellbeing services county or collaborative area. The First-Line Therapies model is nationally responsible for training materials for the induction phase, as well as for delivering the introductory session and skills workshops.

The aim is that, at the collaborative area-level, small-group supervision can be arranged for trainees during their first supervision groups.

It is important to support the competence of certified method-specific supervisors also after the training. For maintaining competence, internal mentoring within the region or organisation is recommended, as well as participation in the national network meetings organised by the First-Line Therapies model. Building collaborative area-level, method-specific support structures may also be valuable.

8.6. Post-training mentoring

Post-training mentoring is a support structure within the stepped care model of support and treatment, aimed at strengthening the professional's competence and skills and supporting the active, high-quality, and effective use of the method. Mentoring combines educational elements, supporting clinical work and the broader development of the regional service system. Post-training mentoring helps ensure the regional embedding and functioning of the stepped care model and its methods.

Mentoring plays an important role in building collaboration between different units and aligning care pathways. For this reason, mentoring is best organised as part of the service system, as it requires an understanding of the responsibilities within the wellbeing services county. This ensures effective collaboration between different professionals and services from the client's perspective.

The impact of mentoring extends from the individual intervention to the entire stepped care services. Without mentoring, there is a risk that the quality, equity, effectiveness, and cost-effectiveness of services will decrease and that service provision will become random.

Group mentoring is highly recommended. It is important to note that mentoring does not replace individual or group supervision for professionals.

The mentor's areas of responsibility

In the First-Line Therapies model, mentoring is a natural part of the role of a wellbeing services county's therapy, method, or intervention coordinator, as they understand regional needs and characteristics and can support problem solving at the level of service processes. Coordinators have direct connections across the service system—from professionals to supervisors and service managers, which facilitates development.

Mentor's responsibilities related to service processes:

- know the role and significance of the method within their wellbeing services county's services
- identify development needs and promote solutions within their networks
- understand the method's limitations, communicate them clearly and view them in relation to the range of services offered within the stepped care model

Mentor's responsibilities related to treatment delivery, usability, and effectiveness:

- support the resolution of common challenges related to delivering the method
- know the method's key active components and monitor real-world effectiveness
- activate skills practice and feedback-informed practice to support the professional's competence development

9. First Line Therapies in occupational health care

The role of occupational health care in the Finnish healthcare system is significant. Therefore, it is important that occupational health care is also able to support mental wellbeing and mental health treatment. At the same time, it is essential that mental health and substance use services of the wellbeing services counties consider work ability and working life as part of an individual's treatment.

In 2025, a co-development project *First Line Therapies supporting occupational health care and promoting cooperation with wellbeing services counties* was launched. The goals were to a) strengthen the assessment of treatment need process from the perspective of occupational health and work ability, b) increase the competence of occupational health care professionals in delivering effective, low-threshold psychosocial methods, c) support cooperation and alignment of service pathways between mental health and substance use services, wellbeing services counties and occupational health care.

9.1. Services tailored for occupational health care

First Line Therapies services have been tailored to better meet the needs of occupational health care.

- A new Work theme page has been added to the Mentalhub website, described in more detail in section 14.1 of this handbook.
- A work ability module has been developed for The Finnish Therapy Navigator, allowing assessment of a help-seeker's work ability and the impact of work-related factors on their wellbeing. The First Assessment training has been updated to suit the needs of occupational health care. More detailed information about the work ability module of the Therapy navigator can be found in section 15.1.
- The guided self-help (adults) training has been supplemented so that it is also suitable for occupational health care. In addition, Guided internet cognitive behavioural therapy (guided iCBT) is well suited to occupational health care.

9.2. Smoother guidance to services between occupational health care and the wellbeing services counties

Integration of occupational health care and mental health services of the wellbeing services counties is important, as occupational health care serves more than two million people in Finland. Occupational health care does not provide a uniform service for all employees; instead, services depend on employer-specific agreements and the treatment options offered by the service provider. This makes it difficult to standardise and align care pathways between occupational health care and the wellbeing services counties.

At the same time, wellbeing services counties typically do not have direct contact with workplaces, nor detailed information about working conditions or the health relevance of work. For this reason, wellbeing services counties cannot impact on work ability or work-related issues as effectively as occupational health care can.

The aim of coordination is to improve cooperation between wellbeing services counties and occupational health care so that the service pathways of primary mental health services become clearer. This facilitates clients' transition between services and supports timely and appropriate access to support.

As a result of the coordination, a process description is created. It covers the main occupational health care providers in the region and includes clear consultation and referral criteria from occupational health care to the wellbeing services county and vice versa.

First Line Therapies services can support the alignment of occupational health care and wellbeing services counties in several ways. The Therapy navigator and the stepped care model provide a shared basis for assessment of need for treatment and guidance to treatment. Shared methods, for example guided self-help, can reduce overlapping work. First Line Therapies services have also been aligned with models supported by the Finnish Institute of Occupational Health, such as the Työote model.

9.3. First Line Therapies services in occupational health care 2026–

For effective alignment of activities, it is essential that occupational health care providers can sustain their own competence even after the project ends.

From the beginning of 2026, responsibility for continuing training, planning, and implementing training processes, maintaining them, and providing the necessary support structures lies with the occupational health care providers.

Training can be started flexibly according to the provider's own training plan and staff needs. We recommend that each occupational health care provider appoint a coordinator who oversees the training process and its stages. This ensures that competence remains available in the long term.

The support offered by the First-Line Therapies model to occupational health care providers is like the services intended for wellbeing services counties but in a lighter form, meaning companies carry a larger share of responsibility.

Using the support material for occupational health care supervisors helps ensure the new ways of working become a routine in the organisation. The support materials found on the Mentalhub education section are intended for occupational health care supervisors, leadership, and other developers.

To secure and maintain competence, providers are encouraged to train their own trainers. A dedicated **trainer support package** has been created for them, focusing especially on implementing the Therapy navigator and the First Assessment and organising guided self-help (adults) training (particularly skills workshops).

Occupational health care providers who were not part of the First Line Therapies as support for occupational health care project may also participate in the trainer training.

10. Outsourced psychotherapy with a service voucher and the psychotherapy quality registry

The outsourced psychotherapy with a service voucher and the psychotherapy quality registry belong to step 3 of the stepped care model in the First-Line Therapies model. The service fills the gap between low-threshold brief interventions and long-term psychotherapy or specialised healthcare. The HUS service voucher system⁸ has been modelled, and the service voucher handbook is freely available for the wellbeing services counties to use.

A promptly initiated, 20-session brief psychotherapy would be sufficient and effective for many clients, making specialised healthcare or long-term psychotherapy unnecessary. Regionally, brief psychotherapy's availability, however, varies and in many areas the option is entirely missing from primary care. Brief psychotherapy initiated at the primary care level would speed up access to treatment, expand the range of treatments available in primary care, and reduce the need for specialised healthcare.

In the HUS area, most brief psychotherapy is organised as outsourced psychotherapy, using a service voucher system and a psychotherapy quality registry. This system and the service voucher handbook have been developed and refined for more than five years, and more than

⁸ <https://palse.fi/portaalin kuvaus HUS palvelusetelijärjestelmästä: https://palse.fi/?page=svc&inst=50000000&orgpalv=9> (Accessed on 14.3.2025)

5,000 service vouchers have been granted. In practice, this system has proven to be a highly functional way of organising brief psychotherapy. The waiting time for treatment has reduced: approximately 50% begin brief psychotherapy within six weeks. In addition, feedback from both clients and psychotherapists has been very positive.

The service voucher model is a significantly more agile way to organise outsourced psychotherapy compared to tendering, provided the service voucher handbook has been carefully created. Since the most labour-intensive part—the service voucher handbook—is already in place, implementing the system requires only minimal effort from wellbeing services counties. The First-Line Therapies model, together with the HUS PALSE working group, provides a ready-to-use model for wellbeing services counties to organise their step 3 services and brief psychotherapy. By using the existing materials and processes, a wellbeing services county can adopt a service voucher system and handbook that have already been refined through extensive development and practical experience to organise early-phase, 20-session brief psychotherapy.

Benefits of the service voucher system for the wellbeing services county:

- a ready-made system, processes and materials that can be adapted by regional experts to meet local needs
- significantly increases regional availability of psychotherapy
- more affordable than specialised healthcare, supports reducing waiting lists and thereby negative impacts of treatment delays
- enables delivering brief psychotherapy remotely, giving access to all psychotherapists nationwide who provide brief psychotherapy within the service.

In addition, the psychotherapy quality registry makes it possible to monitor the purchased treatments and their effectiveness.

10.1. The quality registry helps monitor the effectiveness of treatments

The psychotherapy quality registry enables wide-scale, standardised monitoring of the effectiveness and availability of psychotherapy. It allows treatment decisions to be based on data collected at the level of the individual patient, diagnosis, service provider, or treatment method. When the quality registry is used alongside the service voucher system, treatment can begin earlier and be more precisely targeted, including patient groups that are not covered by public services. The psychotherapy quality registry and service voucher system are already in use or being prepared for use in several wellbeing services counties across Finland.

The psychotherapy quality registry has been developed by the health information system company BCB Medical, which has a framework agreement with public social and healthcare operators. Implementing the registry requires a separate agreement between the wellbeing services county and the company.

For an individual patient, the psychotherapy quality registry enables higher quality care. It allows continuous monitoring of treatment progress and identification of potential adverse effects. A typical adverse effect in psychotherapy—treatment stagnation—can be detected and the treatment plan adjusted quickly. Psychotherapists can also use the collected data to develop their own competence. Through the registry, the therapist can monitor the patient's wellbeing and collect feedback, for example, on the quality of the therapeutic relationship and the delivery of treatment regularly, even weekly. This supports feedback-informed treatment and enables tailoring treatment to the patient's changing needs.

The quality registry also enables group-level process monitoring and knowledge-based service development. For example, the initiation of treatments and treatment delays are monitored continuously, which has helped identify bottlenecks such as congestion in certain types of services. Based on this information, training or recruitment can be targeted to improve access to treatment.

The quality registry makes it possible to identify significant delays in treatment initiation. For example, at the beginning of 2021, among adults starting brief psychotherapy in primary care, only around 20% began treatment within six weeks. Through the development of various components of the service voucher system, this has improved substantially: in 2024, about 45% of patients began brief psychotherapy within six weeks of receiving a service voucher.

Combining the psychotherapy quality registry with the service voucher system enables treatment to start increasingly faster and in a more targeted way. At HUS, approximately 2,000–3,000 patients are directed to psychotherapy annually through a service voucher. Of these, more than half are referred directly from primary care. The service voucher system also enables psychotherapy each year for more than 1,000 specialised healthcare patients who are not eligible for Kela-supported psychotherapy but for whom psychotherapy is clinically well justified.

Literature

Saarni, S. E., Rosenström, T., Stenberg, J. H., Plattonen, A., Holi, M., Ekelund, J., ... Saarni, S. I. (2022). Finnish Psychotherapy Quality Register: rationale, development, and baseline results. *Nordic Journal of Psychiatry*, 77(5), 455–466.
<https://doi.org/10.1080/08039488.2022.2150788>

11. Knowledge-based management and real-world effectiveness

Collecting and making use of effectiveness data is a way to improve the individual-level effectiveness of psychosocial interventions as well as the overall effectiveness of services. It should be made a permanent part of mental health services.

Collecting and using effectiveness data also requires a cultural shift, making service effectiveness a core value that guides operations. For this change to succeed, everyone in the organisation must commit to the generation and utilisation of outcome data. Outcome data supports all levels of the organisation, from everyday clinical decisions to leadership's strategic planning.

- Outcome data helps **professionals** to work in a feedback-informed way, that is, to tailor the delivery of interventions more precisely on an individual basis and to assess their sufficiency based on the changes achieved during the intervention.
- **Supervisors** are responsible for operational activities and can use accumulated data to optimise stepped care, the use of available resources, short-term changes, and staff competence management.
- **Leaders** are responsible for strategic decision making, steering strategy and long-term change management. In their decision making, leaders use not only data accumulated within the organisation but also insights gained from peers.

In addition to using effectiveness data in their own clinical work, professionals, supervisors, and leaders must discuss how it is used. Professionals delivering interventions should be involved in setting and monitoring organisational goals. Everyone should share the understanding that the purpose of collecting and using data is to improve support for people seeking help.

11.1. Real-world effectiveness is developed through benchmarking

In the literature, effectiveness is divided into experimental effectiveness and real-world effectiveness. Experimental effectiveness refers to knowledge obtained through randomised controlled trials, where the aim is to isolate the impact of an intervention on a specific problem or illness under standardised conditions. Real-world effectiveness, in turn, refers to the benefit achieved under routine clinical conditions, that is, the value an intervention is observed to have in day-to-day work⁹. The evaluation and development of First Line Therapies-model's services and methods are based on real-world effectiveness. In this handbook and in the First-Line Therapies model, effectiveness refers to real-world effectiveness unless otherwise stated.

Developing real-world effectiveness requires commensurability and benchmarking.

- **Commensurability** means that organisations responsible for the same services use the same measures and indicators to define and develop effectiveness. If these differ between regions, the data accumulated in a region cannot be compared. If the measures and indicators are not aligned, it is impossible to identify the most effective and cost-effective solutions and methods.
- **Benchmarking** is the primary way to define and improve effectiveness and to assess system-level changes. Benchmarking requires close cooperation, with those responsible for the same services comparing clients' and patients' baseline situations, the interventions provided and the outcomes.

11.2. National support services for regional development

To support the operationalisation and development of real-world effectiveness in mental health and substance use services, a shared national measurement framework is maintained as part of the First-Line Therapies model. In addition, a network is maintained to further develop this framework and to support its implementation.

The recommended measures and procedure codes for assessing the effectiveness of treatments and services are compatible with the recommendations of the Finnish Institute for Health and Welfare (THL). In defining the measures and, for example, when introducing procedure codes, current recommendations are monitored and cooperation is carried out with THL.

⁹ Malmivaara, A. Kohti lääketieteen arkivaikuttavuutta. *Duodecim*. 2012; 128:445-6.

A shared national measurement framework for assessing and developing the effectiveness of psychosocial interventions

In national co-development, shared measures and indicators have been defined—based on both national and international recommendations—for assessing the real-world effectiveness of services delivered in primary mental health and substance use services^{10 11 12 13}(Table 3). The list of shared indicators and measures is an ongoing project that is continuously refined according to the needs of the service system, scientific evidence and recommendations derived from these.

Measures for adults are presented in Chapter 17, and measures for children and adolescents in Chapter 26.

Operational goal of social and healthcare services	Indicator
Availability	• Delay from first contact to assessment of need for treatment (days) • Delay from assessment of need for treatment to intervention (days) • Number of people waiting for services (from first contact to assessment of need for treatment & from assessment of need for treatment to intervention)
Accessibility, equity	• Target symptom/problem descriptor • Previous psychosocial treatment/support sought for the same target symptom/problem within the past year
Quality, cost-effectiveness	• Service delivered (procedure code) • Compliance with <i>Current Care</i> / PALKO recommendations • Duration of interventions (days & number of sessions)
Real-world effectiveness, safety	• Change in symptoms¹ • Change in functioning² • Need for follow-up treatment/support • Client experience³

Table 3 Nationally shared core measures and indicators for real-world effectiveness in primary mental health and substance use services.

¹ Age-specific symptom scales are presented in Chapters 17 and 26.

² In addition to symptom scales, routine monitoring and data collection should also focus on measuring the client's or patient's functioning or their perceived ability to work or study, and changes in these over time. At present, there is no clearly established recommendation for the most suitable measure of functioning. The recommendations for measures and indicators will be supplemented based on further review and consensus work, involving relevant expert groups.

³ At minimum, the Net Promoter Score (NPS) in line with THL's recommendation.

¹⁰ Wahlbeck, K., Hietala, O., Kuosmanen, L., McDaid, D., Mikkonen, J., Parkkonen, J., ... & Tourunen, J. (2018). Toimivat mielenterveys- ja päihdepalvelut. <https://julkaisut.valtioneuvosto.fi/handle/10024/160554> (Accessed on 14.3.2025)

¹¹ World Health Organization. (2024). Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services. (Accessed on 14.3.2025)

¹² Kelley, T. A. (2015). International consortium for health outcomes measurement (ICHOM). *Trials*, 16(Suppl 3), O4.

¹³ Saarni, S. E., Rosenström, T., Stenberg, J. H., Plattonen, A., Holli, M., Ekelund, J., ... & Saarni, S. I. (2023). Finnish Psychotherapy Quality Register: rationale, development, and baseline results. *Nordic Journal of Psychiatry*, 77(5), 455–466.

11.3. National network for co-developing effectiveness

A national network of leaders, supervisors, and coordinators responsible for services for children, adolescents and adults is maintained to support national cooperation. The network meets 2–3 times in both spring and autumn. Its task is to support the implementation of the national measurement framework described above and to guide its further development.

The goals of the network are to:

1. Justify the need for service-system-oriented national data operationalisations and benchmarking.
2. Produce a shared list of the data (measures and indicators) needed to define and develop real-world effectiveness
3. Produce data specifications for regional system developers on how and at what intervals data should be made available for review (considering both routine clinical practice and organisational management needs)
4. Define and maintain a plan for the national structure of benchmarking and knowledge-based service improvement

In addition, the network promotes themes it has identified as important. These include, for example, clarifying the use of procedure codes, harmonising documentation practices and advancing research collaboration.

Other centralised services of the First-Line Therapies model to support knowledge-based management

- **Analytics and benchmarking services:** we compile data accumulated both regionally and nationally. This includes, for example, evaluating the effectiveness of interventions during trainings, reporting feedback collected on different solutions, regional/national aggregation of data collected by the Therapy navigator services, and comparative analyses of routinely collected outcome data between wellbeing services counties/organisations according to regional needs.
- **Regional projects to promote the collection and use of data:** we work on site in the regions, in co-development with leaders, supervisors, coordinators and professionals, to improve how consistently defined data can be collected in routine clinical practice and how it can be used in delivering and managing services.
- **Synthesising research literature:** we respond to questions raised by partner organisations by compiling international literature and identifying best practices from other countries.
- **Support for research projects:** support structures for regionally implemented scientific research related to the First-Line Therapies model.

Process	National support services	Collaborative area-level support service
Knowledge-based management and evaluation of effectiveness	Facilitation of national cooperation and formulation of shared principles. Recommendations on indicators, targets, and analysis models in line with national data definitions. Implementation of national benchmarking. Support for scientific research.	Collaborative area-level effectiveness monitoring and promotion of benchmarking and improvement between wellbeing services counties, with close regional support for knowledge-based management.

THE FIRST LINE THERAPIES-MODEL IN ADULT MENTAL HEALTH AND SUBSTANCE USE SERVICES

Ensuring timely and appropriate access to mental health services requires continuous effort. Implementing and sustaining new work methods, service structures, and the required cultural change is a challenging task. Especially due to high staff turnover in social and health care services, a system is needed to help new employees adopt these new ways of working.

This section describes the services of the First-Line Therapies model in adult services. It includes the following subsections:

- Regional structures for implementing and maintaining the model
- Regional stepped care model
- Mentalhub content for adults
- The Finnish Therapy Navigator for adults and the First Assessment
- Methods in adult services
- Data collection, knowledge-based management, and real-world effectiveness

12. Regional structures for implementing and maintaining the model

Therapy coordination plays a central role in implementing and embedding the stepped care model into the wellbeing services county's services. This chapter describes the role of a therapy coordinator and how the wellbeing services county benefits from therapy coordination. In some wellbeing services counties, the therapy coordinator is called a method coordinator. The chapter also describes the role of supervisors and the services of the First-Line Therapies model available to supervisors.

Subsections:

- The role of therapy coordinator
- Supervisor training and national network

12.1. The role of a therapy coordinator

Building and maintaining the stepped care model requires advancing several things simultaneously across service areas. This requires shared commitment to the same goals and the ability to work across organisational boundaries. High-quality therapy coordination, combined with the stepped care model, improves the quality and efficiency of services in the wellbeing services county and reduces overlapping work and costs.

The therapy coordinator serves the entire wellbeing services county, from professionals working with patients and frontline supervisors to middle and senior management. As an expert in both the First-Line Therapies model and their own region, the therapy coordinator is able to identify the most suitable regional solutions and practices for implementing and sustaining the stepped care model.

The therapy coordinator ensures the overall management of the whole service system. This reduces the risk of sub-optimisation within service pathways—that is, ensuring that individual services do not develop in isolation but support one another and form a coherent whole. Leadership and organising services become clearer with therapy coordinators ensuring that all parties are aware of shared goals and practices.

Therapy coordinators support and guide professionals in adopting new methods and help units in their region implement, maintain, and further develop the stepped care model. Therapy coordinators also play an important linking role across professional groups, promoting multidisciplinary collaboration and communication.

Therapy coordination requires clear responsibilities, collaboration structures, and networking within the wellbeing services county. Therapy coordinators make use of nationally accumulated experience and best practices and participate actively in the national coordinator networks of the First-Line Therapies model.

Kay tasks of the therapy coordinator

Tasks related to building and maintaining the stepped care model:

- planning the implementation and maintenance of the stepped care model together with the whole organisation
 - participating in the development and alignment of care pathways
 - training staff in the principles of the stepped care model and regional practices
 - promoting the embedding and integration of new practices into daily clinical work
 - planning and implementing support structures for the stepped care model, e.g. regular mentoring and development days
- More information on mentoring is provided in Chapter 8.5.

Tasks related to implementing trainings:

- training planning and monitoring the implementation of trainings in the wellbeing services county
- coordinating the practical arrangements of trainings
- delivering trainings on The Finnish Therapy Navigator for adults, the First Assessment and guided self-help (adults)
- providing method-specific supervision during brief therapy trainings (e.g. CBT, IPC, and IPT)
- mentoring after trainings to increase professional competence and support method delivery

Tasks related to real-world effectiveness and knowledge-based management:

- promoting practices for collecting effectiveness data (e.g. separate monitoring or extracting data from client information systems) together with the actors in the wellbeing services county
- using effectiveness data as part of routine clinical work in collaboration with supervisors and professionals

Tasks related to national co-development:

- participating in national co-development networks for therapy coordinators
- participating in the national peer learning and improvement network for effectiveness data
- participating in the network of cognitive behavioural therapy (CBT) method-specific supervisors

12.2. Training for supervisors and the national network

Supervisors play a key role in implementing and embedding new ways of working. Concrete support is offered to supervisors in adult services, for example through meetings, coaching sessions, and peer support.

The training for supervisors in the stepped care model addresses the most common questions and challenges by providing structure and practical tools for implementing and embedding new practices. The training is suitable for supervisors with any level of experience of the stepped care model.

The training can be completed on the First Line Therapies-model's digital training platform along with the other training services. The training is built on scientific evidence, best practices, and nationally accumulated experience. It has been developed in national collaboration together with supervisors.

Topics covered in the training include the principles and practical application of the stepped care model, supporting teams during change, managing key risks and tools for implementing knowledge-based management. After completing the training, supervisors understand the principles of the stepped care model and real-world effectiveness, can communicate goals and phases of change, and can apply best practices in their own work.

A national network has been established for supervisors in mental health and substance use services, where experiences of challenges and best practices can be shared. The network meets four times a year, each session has a predefined topic and an introduction from a well-being services county.

13. Regional stepped care model

Briefly, stepped care refers to organising psychosocial interventions and treatments as a continuum. The goal is to offer timely and appropriate treatment for patients with mental health concerns. The development of the stepped care model is described in more detail elsewhere in this handbook.

For the stepped care model to work, assessment of the need for treatment and guidance to treatment must be systematic. In addition, sufficient competence in and availability of short-term and digitally supported psychosocial methods is required. It is important to monitor the individual-level effectiveness of treatments to evaluate how well they work and to ensure continuity.

In the First-Line Therapies model, the stepped care model is always viewed as a whole, consisting of:

- digitally supported assessment of the need for treatment and guidance to treatment
- expanding the range of treatments through method-specific trainings
- developing service processes to ensure timely treatment initiation and continuity of care
- monitoring service effectiveness and using this information in daily clinical practice

For the purposes of national cooperation, peer co-development, and various support services, it is essential that the stepped care models in all wellbeing services counties share the same basic 0–4 step structure. The selection of specific treatments, their placement on the steps and the service providers naturally vary between regions. With a shared structure, regions can best learn from one another and collaborate, gradually improving the service system through peer co-development.

The centralisation decree and the collaborative area agreement decree encourage joint development at the collaborative area-level. The aim is to define a coherent service offering of psychosocial treatments, supported by method-specific competence across regional boundaries.

13.1. Stepped care model in adult services

Building a comprehensive picture of the methods available in regional services is essential in developing a stepped care model. This chapter describes an example of a stepped care model in adult services (also Figure 4). The methods in the example are commonly used interventions in Finland. Interventions trained within the First-Line Therapies model are marked with an asterisk (*). These methods, as well as guided internet cognitive behavioural therapy (guided iCBT), are described in more detail in Chapter 16.

Step 0 includes preventive and other services that a client may access before contacting healthcare. These include, for example, the self-help programs in the open-access Mentalhub online service. Third sector organisations also provide preventive services.

Step 1 treatments should start with minimal delay and be suitable for most people seeking help. In practice, this means that they are aimed at common mental health disorders that begin as mild or moderate, such as anxiety disorders, depression, or acute crises. Step 1 treatments are usually semi-structured, brief treatments that help clients make sense of their situation and find suitable ways to improve their wellbeing.

Step 1 treatments are often called low-threshold treatments because they are brief, easily accessible, and simple to deliver in social and healthcare services. They also do not require psychotherapeutic expertise or long training from the professional. The First-Line Therapies model offers training in guided self-help (adults), interpersonal counselling (IPC), and the emotionally focused couple intervention for professionals in public healthcare.

Examples of step 1 treatments include:

- *guided self-help (adults) (1–5 sessions)
- brief crisis intervention (1–3 sessions)
- *interpersonal counselling (IPC) (3–6 sessions)
- *emotionally focused couple intervention (5 sessions)
- guided internet cognitive behavioural therapy (guided iCBT)
- structured and targeted group therapy programs
- *) Interventions trained within the First-Line Therapies model

Step 2 consists of evidence-based time-limited therapeutic interventions, delivered weekly for 5–10 sessions. They are suitable if step 1 treatments have not been sufficient, or they are considered the appropriate treatment in the First Assessment. The First-Line Therapies model offers training in cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) for professionals in public healthcare. These year-long trainings include theoretical studies, method-specific supervision, training treatments, and post-training mentoring.

Examples of step 2 treatments include:

- *cognitive behavioural therapy (CBT)
- *interpersonal therapy (IPT)
- acceptance & commitment therapy (ACT)
- cognitive analytic therapy (CAT)
- guided internet cognitive behavioural therapy (guided iCBT)
- *) Interventions trained within the First-Line Therapies model

Steps 1 and 2 are usually offered in primary health care, meaning they are provided in social and health care centres and primary mental health and substance use services. Step 1 and step 2 treatments should be suitable and safe for most people seeking help. Generally, these treatments require a good ability to function, the ability to engage in a collaborative relationship and motivation to work on psychological tasks independently as part of the treatment.

At higher levels, **steps 3–4**, patients need the capacity to engage in psychotherapy, and professionals must have more advanced psychotherapeutic training and competence. Step 3 treatments are referred to as brief psychotherapy and usually last 10–20 sessions. Step 4 treatments typically last one to three years and are most often provided as Kela-supported rehabilitative psychotherapy supporting work or study ability.

To improve access to step 3 brief psychotherapy, the service-voucher system is recommended, as it enables the organisation of psychotherapy across different theoretical orientations throughout the country. For example, analytic brief psychotherapies are most naturally delivered at step 3, as equivalent step 2 interventions do not generally exist. Group, couples and family psychotherapy are also available and should be considered. The service voucher system for psychotherapy is described in more detail in Chapter 10.

Examples of step 3 treatments include:

- brief psychotherapies with a service-voucher or in-house provision
- group treatments (e.g. dialectical behaviour therapy, DBT) or individual treatments (e.g. mentalization-based therapy, MBT for personality disorders)
- CBASP for chronic or recurrent depression
- structured interventions based on psychological case formulation

Examples of step 4 treatments include:

- long-term psychotherapy, e.g. rehabilitative psychotherapy or service-voucher psychotherapy

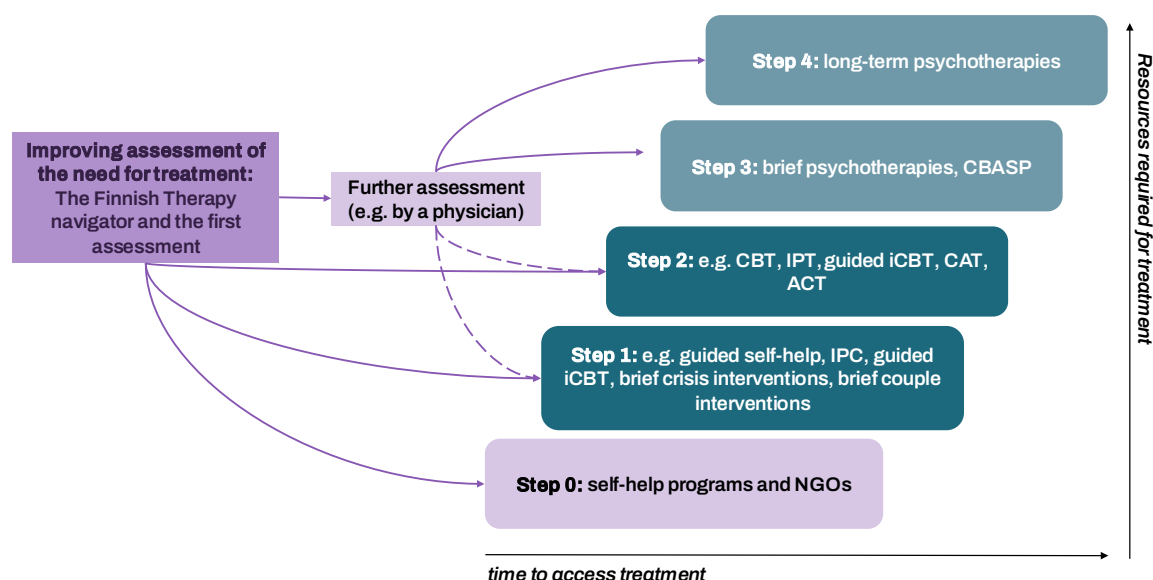


Figure 2: Example of the stepped care model of psychosocial treatments and psychotherapies. The abbreviations are explained in the text above.

13.2. Maintaining the stepped care model in the wellbeing services county

Implementing new services requires active maintenance to prevent losing previously achieved progress. It is therefore crucial to consider how the wellbeing services county will sustain the stepped care model. The primary way to maintain and further develop the stepped care model is to ensure the continuity of therapy coordination within the wellbeing services counties. Therapy coordination is a cost-effective and agile way to develop the service system as a whole, making systematic use of experiences and lessons learned from national co-development networks. Some wellbeing services counties have already established therapy coordination as part of their line operations, and most are currently preparing to do so.

Best practices and risk management for the maintenance phase are described in more detail in Chapter 28.4 of this handbook.

14. Mentalhub contents for adults

Mentalhub is an online service that provides information and self-help related to mental health for both citizens and social and healthcare professionals. The service is also useful for close relatives of someone experiencing symptoms, as well as students in social and healthcare fields.

The Mentalhub service is described in more detail in Chapter 6 of this handbook.

The education theme pages designed for upper secondary school students, teachers and workplace instructors are described in Chapter 20.2.

Below is a table with examples of Mentalhub contents for adults:

Theme/symptom	Self-help programs	Information pages
Anxiety, social anxiety, panic	• self-help program for anxiety • self-help program for social anxiety • self-help program for panic	• Basic information about anxiety • Physical symptoms of anxiety and depression • Basic information about panic • Social anxiety
Depression and burnout	• self-help program for depression • self-help program for burnout • self-help program for preventing study-related burnout • self-help program for insomnia	• Basic information about depression • How can I help someone who is depressed? • Basic information about burnout • Symptoms of burnout
Relationships	• self-help program for couples • self-help program for separation crisis • self-help program for loneliness • self-help program for jealousy	• Separation, emotions, mood • Crisis and relationships • Children and parental separation • Information about jealousy
Sexuality and gender	• self-help program for sexuality • self-help program for gender identity exploration • self-help program for recovering from sexual violence • self-help program for sexual interest in children • Redirection – self-help program for users of illegal imagery	• Sexuality and mental wellbeing • How do mental health problems affect sex? • How to recognise sexual harassment and sexual violence? • Consequences of sexual harassment and violence
Neurodevelopmental difficulties	• self-help program for concentration difficulties • self-help program for the autism spectrum	• Autism spectrum disorders • Basic information about ADHD • Tics and Tourette syndrome
For family and loved ones	• For family and loved ones of someone with an eating disorder • For parents of a child with mental health difficulties • For family and loved ones of a young person using drugs	• Wellbeing and mental health of a family member or loved one • How can I cope with a loved one's mental illness? • A child and a loved one's illness

Table 4 examples of Mentalhub contents for adults

14.1. Mentalhub's Work theme page

The Mentalhub Work theme pages are intended for employees, supervisors, employers, work communities, entrepreneurs, and occupational health care. The site also provides useful information, for example, for the unemployed and furloughed. The theme pages include information, for example on promoting one's own wellbeing at work and developing the work community, as well as self-help programs for issues such as work wellbeing and burnout. The site also provides materials for preventing and addressing problems at both the individual and work community level. The Work theme pages have been compiled as part of the First Line Therapies as support for occupational health care- project, and its contents have been developed in cooperation with the Finnish pension agency Keva and the Finnish Institute of Occupational Health.

The Work theme pages provide information and tools on the following topics:

- Work promotes health
- Trust in the work community
- Recovery from work
- Raising concerns at the workplace
- Grief in the work community
- Workplace atmosphere
- Work ability management
- Workplace bullying
- Work stress and burnout
- Occupational health negotiations
- Returning to work after sick leave

In addition, the site includes an information package for supervisors on how to use Mentalhub content in promoting work wellbeing.

The site also includes self-help programs related to working life:

- self-help program for anxiety
- self-help program for depression
- self-help program for work wellbeing
- self-help program for returning to work
- self-help program for burnout
- self-help program for insomnia
- self-help program for reducing alcohol use
- self-help program for concentration difficulties
- self-help program for panic
- self-help program for social anxiety
- self-help program for problematic gaming
- self-help program for reducing social media use
- self-help program for people left unemployed

At least one additional self-help program will be published on the site during 2026, offering help for pain related to musculoskeletal disorders and their impact on mental health.

15. The Finnish Therapy Navigator and the First Assessment

This chapter describes the guidance-to-treatment process using the Finnish Therapy Navigator and the First Assessment. The subsections are:

- What is the Finnish Therapy Navigator?
- What is the First Assessment?
- How is the First Assessment organised in practice?

15.1. What is the Therapy Navigator?

The Finnish Therapy Navigator is a digital tool created to support early-stage assessment. It compiles essential information about the help-seeker's situation, symptoms, and problems, as well as their work ability and the impact of work-related factors. The help-seeker completes the Therapy Navigator independently and anonymously, and the results are reviewed together with a healthcare professional during the First Assessment interview.

The Therapy Navigator is designed to support and simplify decision-making for healthcare professionals during initial non-urgent assessment. It collects information about the most common mental health difficulties. The aim of the Therapy Navigator is to ensure timely and appropriate treatment or support for the patient.

The Therapy Navigator streamlines and standardises information collection for guidance to treatment. It functions as a digital questionnaire covering the most common background and symptom information and compiles the collected data into a report. More detailed information on the content and functioning of the Therapy Navigator is available at <http://www.terapiatutkimus.fi/aikuiset/terapianavigaattori> and you can explore the Therapy Navigator at www.terapianavigaattori.fi.

The Therapy Navigator does not include automation or provide recommendations to either the professional or the patient based on responses; instead, the professional always assesses the patient's situation individually during the First Assessment, using the summary report as supporting background information.

The help-seeker is encouraged to complete the Therapy Navigator before an appointment with a professional, except in situations requiring immediate care. The most common ways to guide clients to the Therapy Navigator are:

- 1. Website guidance**
The website includes instructions on who to contact after completing the Therapy Navigator.
- 2. Guidance by a professional**
Patients may be directed to the Therapy Navigator, for example, through appointments at a health centre or mental health services, maternity and child health clinics, social services, or upper secondary student welfare services.
- 3. Electronic communication**
The client receives a secure personal message requesting them to complete the Therapy Navigator before meeting a professional.
- 4. During registration or while waiting for an appointment in non-urgent situations**
The Therapy Navigator is not designed for use in emergency situations or when planning treatment for more severe psychiatric or neurodevelopmental disorders, such as bipolar disorders, psychotic disorders, eating disorders, personality disorders,

attention-related problems, or autism spectrum disorders. For these conditions, the information collected by the Therapy Navigator may be used as part of a broader assessment, but it is not sufficient on its own.

Completing the Therapy Navigator is never compulsory for accessing services; it is always voluntary for the help-seeker.

The Therapy Navigator in occupational health care

Mental disorders pose a significant threat to work ability, and timely identification of these issues is increasingly important in occupational health care. Identifying mental health disorders is challenging due to overlapping, diverse and co-occurring symptoms. Assessment practices also vary between service providers, which may lead to difficulties going unrecognised.

A new work-ability module for the Finnish Therapy Navigator was launched in May 2025. Its purpose is to help professionals identify:

- mental health symptoms, difficulties and challenges of varying severity and their impact on work ability
- risk factors and signs of reduced work ability
- effects of work-related factors on mental health and functioning
- appropriate support or treatment

The questions in the occupational health module were developed in collaboration with occupational health professionals and experts from the Finnish Institute of Occupational Health. The questions assess how symptoms affect work ability and coping at work, as well as how work-related factors influence wellbeing. The aim is to understand how mental health problems are connected to work-related factors and to identify ways to support continued work ability.

The Therapy Navigator and the First Assessment support existing best practices and core duties in occupational health care. The new module allows work ability challenges and contributing factors to be structured more clearly and comprehensively. The quality and consistency of assessments improve, time is saved in information gathering and documentation, and interventions can be targeted more precisely. The Therapy Navigator and clear documentation of the First Assessment also facilitate smoother cooperation between occupational health care and the public sector, as the assessments are standardised.

15.2. What is the First Assessment?

Reviewing the information collected by the Finnish Therapy Navigator together with the client is called **the First Assessment**. In the First Assessment, the professional identifies the most appropriate intervention for the client in line with the stepped care model for psychosocial treatments and psychotherapies. In a stepped care model, treatment based on the professional's assessment and tailored to the individual's need can begin at any step.

Most commonly, the First Assessment is carried out immediately when the client contacts primary care services for mental health reasons, or at the latest after the assessment of the need for treatment has been completed. The First Assessment can be completed on paper forms and by interviewing if the client cannot or does not want to use the Therapy Navigator.

During the First Assessment, the professional's task is to:

- identify clients who are suitable for and likely to benefit from low-threshold psychosocial treatments (step 1)
- identify clients who require further assessment and/or higher-step treatments
- lay the foundation for a trusting, client-centred and goal-oriented therapeutic relationship

Guidance-to-treatment based on the First Assessment focuses on assessing:

- symptoms and their severity
- level of functioning and psychological wellbeing
- work ability and the impact of work-related factors (from 1 May 2025)
- the primary focus of treatment when clearly identifiable
- the need for collaboration with social services, occupational health care, or student health care
- previous psychosocial treatments and treatment experiences
- the client's interest and motivation regarding the available step 1 treatments

Step 1 treatments are generally recommended, beneficial and sufficient for most clients when the client's symptoms are no more than moderate, their ability to function is reasonable or better, they do not have an acute severe substance use problem, and they have not recently received effective treatment for the same target symptoms.

When the client's symptoms are severe, ability to function clearly reduced, they have a severe substance use disorder or significant previous treatment history, further assessment, for example, by a physician or a psychologist, is recommended.

If the First Assessment reveals that work ability and work-related factors affect the client's situation and wellbeing, it is important to consider the suitability of occupational health care services or to encourage the client to contact their occupational health care provider if they are primarily using wellbeing-services-county services.

Using the Therapy Navigator and the First Assessment as part of the assessment of the need for treatment and guidance-to-treatment process offers the following advantages:

- The Therapy Navigator and the First Assessment support the professional's decision-making.
- They save time in the mechanical aspects of assessment, such as completing and documenting symptom scales, allowing more time for meaningful discussion and client engagement.
- Professionals report improved quality of assessments and documentation, and clearer workflow after implementing the Therapy Navigator.
- There is shared understanding among professionals about the principles of early-stage mental health assessment.
- Clients' understanding of their own difficulties increases in the early stages of the process.

15.3. How is the First Assessment organised in practice?

When the Finnish Therapy Navigator and the First Assessment are adopted as part of a unit's early-stage assessment, a regional stepped care model of treatments must be in use and the process for using the Therapy Navigator and the First Assessment must be described clearly from both the professional's and the client's perspective. Regional coordinators, most often therapy coordinators, support the implementation of the Therapy Navigator and the First Assessment.

The First Assessment can be carried out by a healthcare professional who has completed the First Assessment training. The training is delivered as online studies on the Mentalhub education section of the First-Line Therapies model and includes a final test. Trained professionals receive the Therapy Navigator First assessment manual, which is updated regularly.

The therapy coordinator or, if agreed, the unit's supervisor ensures that new professionals are trained in the First Assessment and oriented to the unit's practices (e.g., documentation and current regional treatments).

The First Assessment is an early-stage assessment, which—based on national implementation experience—takes on average 20 minutes. It can be conducted by phone, via remote connection or face-to-face and can typically be completed during a 30–45-minute appointment including documentation time. In practice, face-to-face First assessments understandably take longer than those conducted by phone.

Where possible, and if the client wishes, the First Assessment may also be conducted via chat. In this case, it is important that the professional has solid experience in the assessment of the need for treatment with clients with mental health difficulties and in conducting the First Assessment by phone or face-to-face.

Chat-based assessment must still reach a sufficiently clear and reliable conclusion. It is essential that the assessment can be continued flexibly via video connection or an in-person if necessary. Whenever possible, the same professional should conduct both the First Assessment and any subsequent further assessment. Following these recommendations improves patient safety and protects the professional from undue workload.

From the perspective of timely guidance to treatment and sustainable use of resources, it is important that the First Assessment does not expand into a multi-session assessment without justification. If the First Assessment requires more than one appointment, it is already considered further assessment, which is appropriate only for a subset of clients. National data show that 25–35% of clients are referred for further assessment as the outcome of the First Assessment¹⁴.

¹⁴ Saarni, S.I., Nurminen, S., Mikkonen, K., Service, H., Karolaakso, T., Stenberg, JH., Ekelund, J., Saarni, S.E. The Finnish Therapy navigator – digital support system for introducing stepped care in Finland. *Psychiatria Fennica* 2022 (vol.53) https://www.psykiatriantutkimussaatio.fi/wp-content/uploads/2022/11/Psychiatria_Fennica-2022-Saarni.pdf (Accessed on 14.3.2025)

Important – do not misuse the Therapy Navigator

One of the most important principles of The First Assessment is client-centred practice. To streamline guidance to treatment, no actions should be taken that are not in the client's best interest, for example:

- **Guidance to treatment must not be based solely on the Therapy Navigator report:** The Therapy Navigator is designed to streamline information gathering. The First Assessment always includes an interview conducted by a healthcare professional, and the actual guidance to treatment is based on the professional's assessment following the interview.
- **Guidance to treatment must not focus only on the symptoms and disorders included in the Therapy Navigator:** Treatment decisions must not be limited to the information provided by the Therapy Navigator. The professional must also assess other issues relevant to the client's situation.
- **Using the Therapy Navigator must not be made compulsory for clients:** Not everyone seeking help can or wants to use digital tools. The client has the right to decline completing the Therapy Navigator, in which case the professional gathers all necessary information through an interview. However, the use of the Therapy Navigator is recommended because it significantly reduces the time required for assessment and guidance to treatment.

16. Methods in adult services

In this chapter, we describe the interventions and treatments included in the adult training portfolio. At present, these consist of guided self-help (adults), motivational interviewing (MI), brief cognitive behavioural therapy (CBT), emotionally focused couple intervention, interpersonal counselling (IPC), and interpersonal therapy (IPT). In addition, we train already qualified professionals to provide method-specific supervision for new trainees.

In addition to the trainings included in the training portfolio, open online courses are available to professionals in training: User perspectives on mental health services, trauma-informed interaction, trauma-informed practice, and strengthening skills in recognising neurodevelopmental difficulties.

The training portfolio includes the key methods recommended in the Current Care Guidelines for the most common mental health disorders in adults. It is therefore designed to meet the requirements for the Act on Therapy Guarantee for young people aged 18–22.

In addition to the methods included in the First Line Therapies' training services, there are several other effective and recommended treatment methods for common mental health disorders. Maintaining new methods permanently without wider cooperation can be difficult or expensive. Psychosocial methods for less common disorders should also be made available whenever possible, in line with regional care pathways. Appendix 4 describes the evidence reviews of psychotherapy frameworks included in the Current Care Guidelines for adult services. The following sections provide a concise description of the methods. Each method has a procedure code used in healthcare information systems to monitor the implementation of the method.

16.1. Guided self-help (adults)

Primary target group: Adults with mild to moderate mental health disorders and mental distress (including anxiety, depression, panic disorder, social anxiety, insomnia, addictions)

Level: Step 1

Duration of treatment: 1–5 sessions, on average 3 sessions

Provider: Public social and healthcare professionals and units where the client seeks help

Procedure code: IZH19 (Self-help, mental health or substance use disorder)

Guided self-help (IZH19) is a 1–5 session intervention for mild to moderate mental health disorders and difficulties. In guided self-help the patient independently progresses through the self-help programs available in the Mentalhub online service with support from a professional. The method is suitable for use in health centres, mental health units, and social services. In the stepped care model for adults, guided self-help is positioned at the first step.

Guided self-help is based on the well-established methods of CBT which according to current knowledge and research evidence are effective and central to the treatment of mental health problems. These methods recur across various time-limited, evidence-based interventions and treatment programs. In guided self-help, observed positive changes are also thought to be explained by common factors shared by all therapeutic approaches, including the client's expectations, jointly agreed goals and working methods, the collaborative relationship between the client and the professional, the characteristics of the client and the therapist, and situational factors.

Guided self-help is included in the Finnish *Models for Outpatient Primary Care in the social and healthcare system*, a *Good Practice* consensus recommendation¹. In addition, its use is supported by the following evidence reviews included in the *Current Care* (Käypä hoito) recommendations:

- *Self-help interventions based on information technology–assisted cognitive behavioural therapies, with or without guidance from a healthcare professional, are beneficial in the treatment of depressive symptoms.* Level of evidence: A².
- *Guided self-help for adolescents and adults reduces symptoms of binge eating disorders compared to a waiting list.* Level of evidence: A³.
- *Internet-delivered therapies (self-guided or assisted) based on CBT or ERP are effective in reducing symptoms of obsessive-compulsive disorder (OCD) in adults.* Level of evidence: A⁴.

In addition, the maintenance of guided self-help as part of the stepped care model is based on the method's low structural burden from both training and implementation perspectives. Furthermore, the method is suitable for the treatment of several common mental health problems, symptoms, and disorders⁵. By including goal-oriented methods that are less resource-intensive as part of the service offering, it is possible to initiate interventions with minimal delay. Internationally, low-intensity cognitive behavioural psychosocial interventions such as guided self-help are widely recommended, and at the group level their effectiveness in the treatment of anxiety and depression is comparable to face-to-face psychotherapy.^{6 7}

The effectiveness of guided self-help can be explored in the outcome report related to the method⁸.

Implementation of guided self-help

Guided self-help is particularly suitable for mild to moderate mental health disorders, but it can also be offered as a starting point in more severe presentations when the waiting time for other treatments is long. Self-help programs are available for a wide range of symptoms, life situations, and mental well-being. The most popular are the self-help programs for depression and anxiety.

Guided self-help is intended to be implemented in primary care units where people seek help. The method is suitable for use in health centres, mental health units, and social services. It is positioned at the first step of the stepped care model for adults, and guided self-help should be initiated without delay as soon as the help-seeker expresses challenges related to mental health—physician’s assessment is not required.

Guided self-help typically consists of three sessions and the patient working independently between them. The sessions include an initial session (on average 30–45 minutes), a guidance session (15–45 minutes), and a closing session (15–45 minutes), with session lengths varying on average between 15 and 60 minutes. In between sessions, clients can use the online materials of the self-help program at their convenience. If necessary extra guidance sessions can be added with a maximum of five sessions. Weekly sessions are recommended, face-to-face or remotely.

Training in guided self-help

The training in the method is intended for all social and healthcare professionals who work in mental health and does not require prior knowledge of mental health disorders or psychosocial interventions. Professionals trained in the method include, for example, nurses, psychologists, physicians, social workers, and other social services professionals. The training is suitable for professionals with any level of experience.

Training in guided self-help consists of a short 5–10-hour online course. The online training includes an induction to the guided self-help process and the objectives of each session, as well as the exercises used in the self-help programs for anxiety, depression, and insomnia. In addition to the online training, two training interventions are completed, for which reports are produced. Implementation of the method can be further supported through skills practice and active monitoring of method delivery and treatment outcomes. The number and duration of support sessions, as well as group size, are determined by the unit in training.

A “context module” can be added to the guided self-help training to support implementation in maternity clinics, general outpatient services, and services for older adults.

¹ Perusterveydenhuollon avovastaanotto toiminnan mallit sote-järjestelmässä. *Good Practice* consensus recommendation by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 23 November 2022. <https://www.terveysportti.fi/apps/dtk/ltk/article/hsu00024> (accessed 14 March 2025)

² Tietotekniikka-avusteiset kognitiivis-behavioraalisiin terapioihin pohjautuvat omahoidot. Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak09360> (accessed 14 March 2025)

³ Syömishäiriön itsehoito ammattilaisen tukemana. Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 18 September 2024. <https://www.kaypahoito.fi/nak09934> (accessed 14 March 2025)

⁴ Internet delivered therapies and other technology assisted (self-guided or assisted) therapies in the treatment of OCD. Duodecimin näytönastekatsaus. Suomalainen lääkäriseura Duodecim, Helsinki. Julkaistu 24.1.2023. <https://www.kaypahoito.fi/nak09774> (viitattu 14.3.2025)

⁵ Mikkonen, K., Bombino, A., Villa, A., Nurminen, S., Roiha, R. M., Roslund, P., ... & Saarni, S. (2024). Guided Self-help in the Treatment of Common Mental Health Disorders: The development of the Finnish guided self-help (F-GSH) model. *Psychiatria Fennica*, 55, 30–47.

⁶ Cuijpers, P., Donker, T., van Straten, A., Li, J., & Andersson, G. (2010). Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies. *Psychological medicine*, 40(12), 1943-1957.

⁷ Bennett-Levy, J., Richards, D., Farrand, P., Christensen, H., Griffiths, K., Kavanagh, D., ... & Williams, C. (Eds.). (2010). *Oxford guide to low intensity CBT interventions*. OUP Oxford.

⁸ Report on the effectiveness of guided self-help. HUS, First-Line Therapies model: <https://terapiatulinjaan.fi/wp-content/uploads/2025/02/Ohjattu-omahoito-seurantatulokset-2024.pdf> (accessed 14 March 2025)

16.2. Guided internet cognitive behavioural therapy (guided iCBT) for adults

Primary target group: People aged 16 and over with mild to moderate mental health disorders, and a program to support adjustment to cancer

Level: Step 2

Duration of treatment: 3–4 months

Provider: Internet therapists who are employees of the HUS Group

Procedure code: IDY03 (Cognitive behavioral therapy (CBT), individual treatment)

Guided internet cognitive behavioural therapies (guided iCBT; IDY03) are effective low-threshold treatments for mild to moderate mental health disorders. Guided iCBT is positioned at the second step of the stepped care model and typically lasts 2–4 months.

The use and maintenance of guided iCBT as part of the stepped care model are based on the following evidence reviews included in the Current Care (Käypä hoito) recommendations:

- *Technology-assisted internet-delivered therapies (guided internet therapies) are as effective as face-to-face psychotherapy in alleviating the symptoms of mild to moderate depression.* Level of evidence: A¹.
- *Self-help interventions based on information technology-assisted cognitive behavioural therapies, with or without guidance from a professional, are beneficial in the treatment of depressive symptoms.* Level of evidence: A².
- *Internet-delivered cognitive behavioural therapy is apparently as effective but more cost-effective than face-to-face group-based cognitive behavioural therapy in the treatment of social anxiety disorder in working-age adults.* Level of evidence: B³.
- *Internet-delivered cognitive behavioural therapy is apparently as effective as face-to-face cognitive behavioural therapy in the treatment of panic disorder in working-age adults.* Level of evidence: B⁴.
- *Guided self-help for adolescents and adults reduces symptoms of binge-eating disorders compared to a waiting list.* Level of evidence: A⁵.
- *Internet delivered therapies (self-guided or assisted) based on CBT or ERP are effective in reducing symptoms of obsessive-compulsive disorder (OCD) in adults.* Level of evidence: A⁶.

Target group for guided internet cognitive behavioural therapy (guided iCBT)

Guided iCBT is intended for mild to moderate mental health disorders and problems. The patient must be willing to participate in guided iCBT and be prepared to work independently on various tasks and contents for approximately two hours per week over a period of several months. Guided iCBT for social anxiety in adolescents is targeted at 13–17-year-olds. Other guided iCBT programs provided by HUS are suitable for individuals aged 16 and over.

HUS offers guided iCBT for the following mental health disorders:

- depression
- generalised anxiety disorder
- insomnia

- social anxiety disorder
- panic disorder
- obsessive-compulsive disorder
- bulimia
- persistent physical symptoms
- bipolar disorder
- alcohol misuse
- social anxiety in adolescents (ages 13–17)
- ADHD
- cancer diagnosis
- burnout

Referral instructions⁷ for guided iCBT are available in the Mentalhub online service.

Implementation of guided internet cognitive behavioural therapy (guided iCBT)

Using guided iCBT as part of the service offering can speed up access to treatment and reduce queues by making flexible, needs-based use of an external resource. A patient can be referred to guided iCBT by a physician anywhere in Finland without a separate agreement. Because guided iCBT is intended for mild to moderate mental health disorders, referral processes should be kept simple. Guided iCBT usually begins approximately one week after the referral is made.

After the patient is accepted into HUS guided iCBT, the referrer remains responsible for care management. When necessary, the referrer must monitor the patient's overall situation and medication.

Guided iCBT is based on the patient independently progressing through the program at their convenience. The therapy lasts 3–4 months, during which the patient is supported by a psychologist or a nurse specialising in the patient's symptoms. The professional monitors the patient's progress and responds to their questions via messaging throughout the guided iCBT. At the start of the therapy, the patient and therapist also have one telephone conversation. When the patient's guided iCBT ends, the referrer receives a final summary from HUS.

During guided iCBT, the patient is under the supervision of their internet therapist. If the patient does not start guided iCBT or does not progress as expected, the therapist contacts the patient and informs the referring physician.

Effectiveness and theoretical framework of guided iCBT

Guided self-help is based on the well-established methods of CBT which according to current knowledge and research evidence are effective and central to the treatment of mental health problems. These methods recur across various time-limited, evidence-based interventions and treatment programs.

More information about guided iCBT and, for example, effectiveness research is available in the Mentalhub service: <https://www.mielenterveystalo.fi/fi/ammattilaiselle-tietoa-nettitera-piasta>

¹ Technology-assisted internet-delivered therapies (guided internet therapies) help alleviate depressive symptoms in mild to moderate depression to a similar extent as face-to-face psychotherapy (Tietotekniikka-avusteiset terapiat depressioiden hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak06935> (accessed 14 March 2025)

² Self-help interventions based on information technology-assisted cognitive behavioural therapies, guided either by the patient themselves or by a healthcare professional, are beneficial in the treatment of depressive symptoms (Tietotekniikka-avusteiset kognitiivis-behavioraalisiin terapioihin pohjautuvat omahoidot). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak09360> (accessed 14 March 2025)

³ Internet-delivered cognitive behavioural therapy is apparently as effective but more cost-effective than face-to-face group-based cognitive behavioural therapy in the treatment of social anxiety disorder in working-age adults (Internetin välityksellä toteutettu kognitiivinen käyttäytymisterapia työikäisten sosiaalisten tilanteiden pelon hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09153> (accessed 14 March 2025)

⁴ Internet-delivered cognitive behavioural therapy is apparently as effective as face-to-face cognitive behavioural therapy in the treatment of panic disorder in working-age adults (Internetin välityksellä toteutettu kognitiivinen käyttäytymisterapia työikäisten paniikkihäiriön hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09155> (accessed 14 March 2025)

⁵ Guided self-help for adolescents and adults reduces symptoms of binge eating disorders compared with waiting on a treatment queue (Syömishäiriön itsehoito ammattilaisen tukemana). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 18 September 2024. <https://www.kaypahoito.fi/nak09934> (accessed 14 March 2025)

⁶ Internet delivered therapies and other technology assisted (self-guided or assisted) therapies in the treatment of OCD. Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 24 January 2023. <https://www.kaypahoito.fi/nak09774> (accessed 14 March 2025)

⁷ Guided internet cognitive behavioural therapies and referral instructions. HUS, MentalHub online service: <https://www.mielenterveystalo.fi/fi/ammattilaiselle-nettiterapian-laheteohjeet> (accessed 14 March 2025)

16.3. Interpersonal counselling (IPC) for adults

Primary target group: Adults with mood symptoms and mild depression

Level: Step 1

Duration of treatment: 3–6 sessions

Provider: Public social and healthcare professionals and units responsible for the treatment and prevention of mental health disorders

Procedure code: IDY27 (Interpersonal counselling, IPC)

Interpersonal counselling, or IPC (IDY27), is a 3–6 session intervention for the prevention and treatment of mood symptoms and mild depression. IPC is a suitable method for all social and healthcare professionals whose role includes the treatment and prevention of mental health disorders. In the stepped care model for adults, IPC is positioned at the first step, complementing guided self-help in the treatment of depression.

IPC is not included in the Current Care (Käypä hoito) recommendations. The use and maintenance of IPC as part of the stepped care model are based on positive experiences gained in Finland in the treatment of mood symptoms and mild depression.

The effectiveness of IPC can be explored in the outcome report related to the method¹.

Implementation of IPC

IPC is primarily suitable for the prevention of mild depression and mood symptoms in situations where the mood-related symptoms can be linked to an interpersonal focus area.

IPC is derived from the more intensive interpersonal therapy (IPT). In IPC, the professional and the patient work in an equal collaborative relationship, guided by the selected focus area, towards a jointly defined goal. Interpersonal counselling is based on the idea that depression is connected to a person's interpersonal relationships. During the treatment, interpersonal relationships and significant life events are addressed, as well as the interconnections between these factors and depressive symptoms.

Weekly sessions lasting 45 minutes are recommended, and they can be delivered both face-to-face and remotely.

IPC training

IPC can be delivered by trained social and healthcare professionals whose role includes the prevention and treatment of mental health disorders, for example, nurses and psychologists. The training is suitable for professionals with any level of experience.

IPC training lasts six months. The training includes approximately 15 hours of online studies, 15 hours of method-specific supervision, and the delivery of three training interventions. The online training provides an evidence-based treatment model for alleviating depressive symptoms across four different focus areas: role transitions, role disputes, grief, and social isolation / social withdrawal. In addition, the professional acquires general skills that support the formation of a therapeutic alliance and the delivery of therapeutic interaction.

IPC method-specific supervision

Method-specific supervision is a combination of supervision and teaching, in which the core skills and delivery of the intervention are practiced. Method-specific supervision is required in order to develop method-related skills and to ensure successful delivery of the method. In IPC, method-specific supervision is arranged in groups of 3–5 participants in sessions lasting several hours at a time (e.g. 5 × 3 hours) at intervals of approximately 4–5 weeks. A professional committing to the supervision training must complete an orientation module on method-specific supervision. The supervisor must have:

- IPC training
- IPC method-specific supervisor training or other supervisor training (or other relevant background training)
- at least six completed IPC treatments

Effectiveness and theoretical framework of IPC

The method is based on the framework of interpersonal therapy, the core assumption of which is that depressive symptoms are linked to the patient's interpersonal relationships and related difficulties.

According to preliminary results obtained during the training, 50% of those who completed the intervention did not require further treatment after the intervention. Among those who had disorder-level symptoms at the start of treatment, 30% recovered reliably.

¹ Follow-up results of the IPC intervention for adults. HUS, First-Line Therapies model. 2024. <https://terapiatetulinjaan.fi/wp-content/uploads/2025/02/IPC-aikuiset-seurantatulokset-2024.pdf> (accessed 14 March 2025)

16.4. Interpersonal therapy (IPT) for adults

Primary target group: Adults with mild and moderate depression/mood symptoms and, under certain conditions, also severe depression

Level: Step 2

Duration of treatment: 12–16 sessions

Provider: Public social and healthcare professionals and units responsible for the treatment of mental health disorders

Procedure code: IDY05 (Interpersonal therapy, IPT, individual treatment)

Interpersonal therapy, or IPT (IDY05), is a 12–16 session intervention for the treatment of mild and moderate depression/mood symptoms and, under certain conditions, also severe depression. IPT is suitable for social and healthcare professionals working in units where mental health disorders are treated. In the stepped care model for adults, IPT is positioned at the second step and complements depression treatment alongside, for example, brief cognitive behavioural therapy. IPT is also suitable for delivery in specialised healthcare.

The use and maintenance of IPT in the treatment of depression and mood symptoms are based on the following evidence reviews included in the Current Care (Käypä hoito) recommendations:

- *Cognitive behavioural and interpersonal brief therapies are effective treatments for the acute phase of depressive disorders.* Level of evidence: A¹.

Implementation of IPT

IPT is a treatment model for depression and mood symptoms. In particular, IPT is well suited to situations where mood symptoms can be linked to an interpersonal focus area. Interpersonal therapy is based on the idea that depression is connected to a person's interpersonal relationships. IPT emphasises the significance of current close relationships both in the development of depressive symptoms and in recovery from depression. In addition to alleviating symptoms, the aim is to improve social functioning.

Patients may be referred directly through care coordination or after first-step treatments (such as guided self-help or IPC). IPT can be delivered by trained social and healthcare professionals whose role includes the prevention and treatment of mental health disorders.

Weekly sessions lasting 45 minutes are recommended, and they can be delivered both face-to-face and remotely.

IPT training

For example, nurses and psychologists can train in the IPT method. The training lasts approximately one year and includes around 25 hours of online studies, 21 hours of method-specific supervision, and the delivery of three training interventions.

The online training provides an evidence-based treatment model for alleviating depressive symptoms across four different focus areas: role transitions, role disputes, grief, and social

isolation / social withdrawal. In addition, the professional acquires general skills that support the formation of a therapeutic alliance and the delivery of therapeutic interaction.

IPT method-specific supervision

Method-specific supervision is a combination of supervision and teaching, in which the core skills and delivery of the intervention are practised. Method-specific supervision is required in order to develop method-related skills and to ensure successful delivery of the method. In IPT, method-specific supervision is arranged in groups of 3–5 participants in sessions lasting several hours at a time (e.g. 7 × 3 hours) at intervals of approximately 4–5 weeks. A professional committing to the supervision training must complete an orientation module on method-specific supervision.

The method supervisor must have:

- IPT training
- IPC method-specific supervisor training or other supervisor training (or other relevant background training)
- The orientation component of the First-Line Therapies model's method-specific supervisor training completed
- At least six completed IPT treatments

Effectiveness and theoretical framework of IPT

IPT is based on the framework of interpersonal therapy, whose core assumption is that depression is connected to the client's interpersonal relationships. The positive changes observed in IPT are also thought to be explained by factors common to all forms of therapeutic work, including the client's expectations, the collaborative relationship between the client and the professional, the characteristics of the client and the therapist, and situational factors.

¹ Cognitive behavioural and interpersonal therapy in the acute phase treatment of depressive disorders (Kognitiivis-behavioraalinen ja interpersonaalinen terapia depressioiden akuuttivaiheen hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak04361> (accessed 14 March 2025)

16.5. Emotionally focused couple intervention

Primary target group: Adults/couples with relationship difficulties

Level: Step 1

Duration of treatment: 5 sessions

Provider: Primary social and healthcare professionals working with couples and relationship difficulties

Procedure code: IDP10 (Couple therapy)

The emotionally focused couple intervention (IDP10) is a five-session intervention for addressing relationship problems. The intervention is positioned at step 1 of the stepped care model. The emotionally focused couple intervention can be delivered by a social and healthcare professional trained in the method.

Including the emotionally focused couple intervention in the stepped care model is supported by research on its theoretical framework for treating relationship problems, as well as on the availability of a brief intervention suitable for primary care services in Finland. In addition, its use is supported by the following evidence review included in the *Current Care* (Käypä hoito) recommendation on depression:

- *Couple and family therapy can apparently alleviate depressive symptoms and improve couple and family problems. Its use may be justified when depression is associated with significant relationship or family problems. Level of evidence: B¹.*

Implementation of the emotionally focused couple intervention

The emotionally focused couple intervention is suitable for situations where relationship difficulties place a burden on the individual or the family. It can be offered, for example, in child and family counselling centres as well as in mental health and substance use units. However, the intervention is not intended for the treatment of an individual mental health disorder, such as depression.

The aim of the intervention is to help couples identify and change the negative interaction patterns in their relationship. In addition, the goal is for couples to learn to build safer interaction during the five sessions.

Weekly sessions lasting 90 minutes are recommended, and they can be delivered both face-to-face and remotely.

The intervention is based on attachment theory, and its central concept is the negative cycle, which helps to integrate both partners' behaviour, thoughts, and feelings into a structured whole.

Training in the emotionally focused couple intervention

Training in the emotionally focused couple intervention is primarily designed for primary social and healthcare professionals who work with couples and relationship difficulties, for example,

nurses, social workers, psychologists, and social service professionals. The training is suitable for professionals with any level of experience.

Training in the emotionally focused couple intervention lasts approximately six months. The training includes 10–15 hours of online studies and the delivery and reporting of one training intervention per trainee. In addition, two regionally provided mentoring meetings during the training are strongly recommended (2 × 90-minute sessions). Professionals either familiar with the method or with emotionally focused work more generally can act as mentors. The online studies include, in addition to the five-session intervention model, an introduction to attachment theory and the concept of the negative cycle.

Effectiveness and theoretical framework of the emotionally focused couple intervention

The method is based on emotionally focused couple psychotherapy developed by the Canadian psychologist Susan Johnson and adapted into a brief intervention. This brief intervention is not couple psychotherapy, but it provides a safe and clear framework for working with couples in primary care. The positive changes observed in the emotionally focused couple intervention are also thought to be explained by factors common to all forms of therapeutic work, including the clients' expectations, the collaborative relationship between the client and the professional, the characteristics of the client and the therapist, and situational factors.

¹ Couple and family therapies in the treatment of depressive disorders (Pari- ja perheterapiat depressioiden hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak06941> (accessed 14 March 2025)

16.6. Cognitive behavioural therapy (CBT) for adults

Primary target group: Adults with moderate mental health disorders (including generalised anxiety disorder, depression, social anxiety disorder, panic disorder, insomnia, addictions)

Level: Step 2

Duration of treatment: 5–10 sessions, on average 7

Provider: Public healthcare professionals and units responsible for the treatment of mental health disorders

Procedure code: IDZ02 (Cognitive behavioural therapy (CBT), individual treatment)

Cognitive behavioural therapy (CBT; IDZ02) is a treatment consisting of 5–10 sessions, on average seven sessions, intended for the treatment of moderate mental health disorders. Symptoms may include, for example, generalised anxiety, depression, insomnia, addictions, social anxiety, or panic disorder. CBT is a suitable method for public healthcare professionals working in units that treat mental health disorders. In the stepped care model for adults, the method is positioned at step 2. Cognitive behavioural therapy can also be delivered in a group format (IDR17).

The use and maintenance of the treatment models included under cognitive behavioural therapy in the treatment of mental health disorders as part of the stepped care model are based on the following evidence reviews included in the *Current Care* (Käypä hoito) recommendations:

Anxiety disorder:

- *Cognitive behavioural psychotherapy is more effective in the treatment of generalised anxiety disorder than standard psychiatric care, psychological placebo, or a waiting list. Level of evidence: A¹.*
- *New cognitive behavioural psychotherapies effectively reduce excessive worry associated with generalised anxiety disorder. Level of evidence: A².*
- *Psychotherapy that combines cognitive restructuring and exposure is effective in treating anxiety and comorbid depression in generalised anxiety disorder. Level of evidence: A³.*
- *Cognitive behavioural psychotherapy effectively reduces both anxiety and comorbid depression in generalised anxiety disorder. Level of evidence: A⁴.*
- *Treatment outcomes achieved with cognitive behavioural psychotherapy in reducing excessive worry are likely to be maintained for 12 months after the end of treatment. Level of evidence: A⁵.*
- *Cognitive behavioural psychotherapy is apparently effective in the treatment of generalised anxiety disorder in people aged 55 and over compared with a waiting list and standard care, but there is apparently no difference compared with active treatment. Level of evidence: B⁶.*
- *Cognitive behavioural psychotherapy reduces the frequency of panic attacks and associated avoidance behaviour. Level of evidence: A⁷.*

- *Treatment outcomes achieved with cognitive behavioural psychotherapy are apparently maintained for at least six months after the end of treatment. Level of evidence: B⁸.*
- *Cognitive behavioural psychotherapy is effective in the treatment of social anxiety disorder. Level of evidence: A⁹.*
- *Cognitive behavioural psychotherapy that includes in vivo exposure (i.e. exposure in real-life situations) is apparently effective in the treatment of agoraphobia. Level of evidence: B¹⁰.*

Depression:

- *Cognitive behavioural and interpersonal brief therapies are effective treatments for the acute phase of depressive disorders. Level of evidence: A¹¹.*
- *Behavioural interventions that activate positive experiences and social functioning are beneficial in reducing depressive symptoms. Level of evidence: A¹².*
- *Short problem-solving therapy and cognitive behavioural psychotherapies, mainly used in primary care, are effective in the treatment of depression. Level of evidence: A¹³.*

Addictions:

- *Cognitive behavioural therapy that is more extensive than motivational interviewing (MI) apparently improves treatment outcomes in moderate to severe alcohol use disorder. Level of evidence: B¹⁴.*
- *Both cognitive behavioural therapy and motivational enhancement therapy appear to be effective treatments for cannabis dependence when the patient does not have a severe mental health disorder. Level of evidence: B¹⁵.*
- *The therapeutic community model, contingency management, cognitive behavioural therapy, and combinations of these apparently reduce opioid use and increase abstinence among people who misuse opioids, have successfully withdrawn from opioids, and are not in opioid substitution treatment. Level of evidence: B¹⁶.*

Insomnia:

- *Cognitive behavioural treatment programs are suitable for use in primary care. Level of evidence: A¹⁷.*
- *Cognitive treatment programs are effective in the treatment of insomnia, and the results appear to be long-lasting. Level of evidence: A¹⁸.*
- *Cognitive behavioural insomnia treatment programs (CBT-I) intended for use in primary care are apparently suitable for use also when the patient has a comorbid condition. Level of evidence: B¹⁹.*
- *Cognitive behavioural methods are apparently suitable for the treatment of insomnia in older adults. Level of evidence: B²⁰.*

The effectiveness of cognitive behavioural therapy can be explored in the outcome report related to the method²¹.

Delivery of cognitive behavioural therapy (CBT)

Cognitive behavioural therapy (CBT) is an appropriate and timely treatment for moderate mental health disorders and under certain conditions also for more severe symptoms, for example in situations where a longer, more intensive treatment is not immediately available.

In CBT, the professional and the patient work in an equal collaborative relationship on a selected problem or symptom using a structured treatment program, towards a jointly defined goal. Patients may be referred to CBT either directly through care coordination or after first-step treatments (such as guided self-help or interpersonal counselling, IPC).

Weekly sessions lasting 45 minutes are recommended, and treatment can be delivered both face-to-face and remotely. CBT can also be delivered in a group format (IDR17) with a recommended session length of 1 hour 45 minutes and two group facilitators.

Training in cognitive behavioural therapy

CBT can be delivered by a social and healthcare professional trained in the method. In primary mental health and substance use services, nurses, social workers, psychologists, and physicians are trained. The training is suitable for professionals with any level of experience.

Training in CBT lasts one year. It includes extensive online studies, 30 hours of method-specific supervision, and 70 hours of delivering training treatments. It also covers core therapeutic skills, for example building a collaborative relationship.

The training covers evidence-based treatment models for the following mental health problems: generalised anxiety, depression, insomnia, addictions, social anxiety, and panic disorder. In addition, the training provides professionals with tools for professional development and well-being at work.

A training tailored to specialised healthcare is also available. In specialised healthcare, the length of training interventions may be longer in duration (however, no more than 20 sessions). In addition, CBT training packages can be tailored to different contexts on request.

Method-specific supervision in cognitive behavioural therapy

Method-specific supervision is a combination of supervision and teaching, in which the core skills and delivery of the intervention are practiced. Method-specific supervision is required in order to develop method-related skills and to ensure successful delivery of the method. In CBT, method-specific supervision is delivered in groups of 3–5 participants in sessions lasting several hours at a time (e.g. 10 × 3 hours) at approximately monthly intervals. A new supervisor must complete an induction module on method-specific supervision.

A method-specific supervisor must be:

- a psychotherapist with cognitive orientation (CBT, cognitive)
- a psychotherapist of another orientation familiar with cognitive behavioural methods
- a social and healthcare professional undergoing cognitive (behavioural) psychotherapy training
- a psychologist familiar with cognitive behavioural methods
- a nurse with training in a cognitive behavioural approach and at least two years of experience in delivering interventions based on CBT framework
- a healthcare professional who has completed CBT training and has delivered at least 70 hours of treatment according to the model after training

Theoretical framework of cognitive behavioural therapy

According to current knowledge and research evidence CBT is effective and central to the treatment of mental health problems. The methods of CBT recur across various time-limited, evidence-based interventions and treatment programs.

The positive changes observed in CBT are also thought to be explained by factors common to all forms of therapeutic work, including the client's expectations, the collaborative relationship between the client and the Professional, the characteristics of the client and the therapist, and situational factors.

¹ Effectiveness of cognitive behavioural psychotherapy compared with usual psychiatric care in generalised anxiety disorder (Kognitiivis-behavioraalisen psykoterapian teho verrattuna tavanomaiseen psykiatriseen hoitoon yleistyneessä ahdistuneisuushäiriössä). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypa-hoito.fi/nak09121> (accessed 14 March 2025)

² Cognitive psychotherapy, excessive worry, and generalised anxiety disorder (Kognitiivinen psykoterapia, liiallinen huolestuneisuus ja yleistynyt ahdistuneisuushäiriö). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypa-hoito.fi/nak09124> (accessed 14 March 2025)

³ Effectiveness of cognitive restructuring and exposure in generalised anxiety disorder (Kognitiivisen restrukturoinnin ja altistamisen teho yleistyneeseen ahdistuneisuushäiriöön). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09122> (accessed 14 March 2025)

⁴ Effectiveness of cognitive behavioural psychotherapy in generalised anxiety disorder (Kognitiivis-behavioraalisen psykoterapian teho yleistyneeseen ahdistuneisuushäiriöön). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypa-hoito.fi/nak09120> (accessed 14 March 2025)

⁵ Cognitive behavioural psychotherapy, durability of treatment outcome, and generalised anxiety disorder (Kognitiivis-behavioraalinen psykoterapia, hoitotuloksen pysyvyys ja yleistynyt ahdistuneisuushäiriö). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09125> (accessed 14 March 2025)

⁶ Effectiveness of cognitive behavioural psychotherapy in the treatment of generalised anxiety disorder in people aged 55 years and older (Kognitiivis-behavioraalisen psykoterapian teho 55 vuotta täyttäneiden yleistyneen ahdistuneisuushäiriön hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09086> (accessed 14 March 2025)

⁷ Cognitive behavioural psychotherapy and panic attacks (Kognitiivis-behavioraalinen psykoterapia ja paniikkikohtaukset). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09115> (accessed 14 March 2025)

⁸ Cognitive behavioural psychotherapy and durability of treatment outcome (Kognitiivis-behavioraalinen psykoterapia ja hoitotuloksen pysyvyys). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09117> (accessed 14 March 2025)

⁹ Effectiveness of cognitive behavioural psychotherapy in social anxiety disorder (Kognitiivis-behavioraalisen psykoterapian teho sosiaalisten tilanteiden pelkoon). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypa-hoito.fi/nak09110> (accessed 14 March 2025)

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- ¹⁰ Cognitive behavioural psychotherapy, in vivo exposure, and fear of public places (Kognitiivis-behavioraalinen psykoterapia, in vivo -altistaminen ja julkisten paikkojen pelko). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09119> (accessed 14 March 2025)
- ¹¹ Cognitive behavioural and interpersonal therapy in the acute phase treatment of depressive disorders (Kognitiivis-behavioraalinen ja interpersonaalinen terapia depressioiden akuuttivaiheen hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak04361> (accessed 14 March 2025)
- ¹² Behavioural activation in the treatment of depressive disorders (Käyttäytymisen aktivointi depressioiden hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak08230> (accessed 14 March 2025)
- ¹³ Brief psychotherapies – mainly used in primary care – in the treatment of depression (Lyhyet – lähinnä perusterveydenhuollossa käytettävät – psykoterapiat depression hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak08237> (accessed 14 March 2025)
- ¹⁴ Cognitive behavioural therapy in the treatment of moderate or severe alcohol use disorder (Kognitiivinen käyttäytymisterapia kohtalaisen tai vaikean alkoholiongelman hoidossa). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 4 September 2015. <https://www.kaypahoito.fi/nak04630> (accessed 14 March 2025)
- ¹⁵ Psychosocial treatment of cannabis dependence (Kannabisriippuvuuden psykososiaalinen hoito). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 12 April 2018. <https://www.kaypahoito.fi/nak05105> (accessed 14 March 2025)
- ¹⁶ Psychosocial treatments for people who misuse opioids (Opioidien väärinkäyttäjien psykososiaaliset hoidot). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 12 April 2018. <https://www.kaypahoito.fi/nak05139> (accessed 14 March 2025)
- ¹⁷ Cognitive behavioural treatment programs intended for use in primary care (Perusterveydenhuollon käyttöön tarkoitetut kognitiivis-behavioraaliset hoito-ohjelmat). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 3 December 2015. <https://www.kaypahoito.fi/nak06356> (accessed 14 March 2025)
- ¹⁸ Cognitive treatment programs as treatment for chronic insomnia (Kognitiiviset hoito-ohjelmat kroonisen unettomuuden hoitona). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 3 December 2015. <https://www.kaypahoito.fi/nak06355> (accessed 14 March 2025)
- ¹⁹ Cognitive behavioural insomnia treatment programs (CBT-I) intended for use in primary care and patients' comorbid long-term conditions (perusterveydenhuollon käyttöön tarkoitetut kognitiivis-behavioraaliset unettomuuden hoito-ohjelmat (CBT-I) ja potilaan sairastamat samanaikaiset pitkäaikaissairaudet). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 3 December 2015. <https://www.kaypahoito.fi/nak08546> (accessed 14 March 2025)
- ²⁰ Non-pharmacological treatment of insomnia in older adults (Ikääntyneiden unettomuuden lääkkeetön hoito.) Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 3 December 2015. <https://www.kaypahoito.fi/nak06357> (accessed 14 March 2025)
- ²¹ Outcomes of cognitive behavioural therapy. HUS, First-Line Therapies model (2024): <https://terapiatulinjaan.fi/wp-content/uploads/2024/06/Kognitiivinen-lyhytterapia-seurantatulokset-2024.pdf> (accessed 14 March 2025)

16.7. Motivational interviewing (MI)

Primary target group: Adults with substance use disorders

Level: Step 1

Duration of treatment: 1–3 sessions

Provider: Public healthcare professionals and units responsible for the treatment and support of substance use disorders

Procedure code: IEY09 (motivational interviewing)

Motivational interviewing is an approach and a way of discussing change that explores and strengthens the patient's readiness and willingness for change. The central aim of motivational interviewing is to encourage the patient to reflect on their own patterns of behaviour and to make new kinds of choices. It is used to support change in voluntary behaviour, for example addressing problematic behaviours (including smoking, alcohol or other substance use, unhealthy diet), enhancing commitment to treatment programs, and supporting lifestyle changes.

The use and maintenance of motivational interviewing in the treatment of mental health disorders as part of the stepped care model are based on the following evidence review included in the *Current Care* (Käypä hoito) recommendations:

- *Motivational interviewing improves treatment outcomes (alcohol-related problems). Level of evidence: A¹.*

Implementation of motivational interviewing

Motivational interviewing can be delivered as a stand-alone intervention, but it is also suitable for use alongside other interventions.

Training in motivational interviewing

The motivational interviewing training module is included, for example, in the training for cognitive behavioural therapy for adults and adolescents. The training can also be delivered as an independent course consisting of online studies.

Theoretical framework of motivational interviewing

Motivational interviewing is based on the idea that every person has the capacity to change their own behaviour. Motivational interviewing draws on several psychological and behavioural theories (e.g. self-determination theory, the stages of change model).

¹ Motivational interviewing for people with alcohol problems (Alkoholiongelmaisen motivoiva haastattelu). Evidence summary by Duodecim. Finnish Medical Society Duodecim, Helsinki. Published 4 September 2015. <https://www.kaypahoito.fi/nak04628> (accessed 14 March 2025)

16.8. Outsourced psychotherapies for adults

Brief psychotherapy provided as an outsourced service fills the gap between lighter brief interventions and long-term psychotherapies or specialised healthcare. Outsourced psychotherapies are positioned at the third step of the stepped care model. A timely initiated 20-session brief psychotherapy is a sufficient and effective psychosocial treatment for many when specialised healthcare or rehabilitative psychotherapy is not indicated. Brief psychotherapy provided with a service voucher and the psychotherapy quality register, as well as their organisation within the wellbeing services county, are described in more detail in Chapter 10.

16.9. Other methods

In addition to full training programs, the Mentalhub education section offers various shorter training courses that enable professionals to deepen their expertise. This subsection briefly describes them.

User perspectives in mental health services training provides mental health professionals with a new perspective on mental health work through service-users' lived experience.

The Trauma-informed interaction training introduces an approach that takes into account the effects of trauma on a person's life and well-being. This approach is considered a universal way of engaging with people. The training provides a concise overview of trauma-informed interaction as a good and sensitive way to engage diverse individuals with mental health challenges.

The Trauma-informed practice training offers a good and sensitive way to engage all kinds of people in social and healthcare, regardless of their challenges or support needs. The training presents trauma-informed practice in greater depth than the trauma-informed interaction training.

The Strengthening skills in recognizing neurodevelopmental difficulties training provides information on some of the most common neurodevelopmental disorders and their assessment and treatment. The training focuses on ADHD and autism spectrum, as increasing number of people with these presentations are seeking help than ever before.

The training is designed for social and healthcare professionals who work with adult clients. Patients with neurodevelopmental disorders or difficulties are encountered across a wide range of social and healthcare services, where the competence provided by the training can be beneficial. The training does not require prior experience or knowledge of neurodevelopmental disorders.

16.10. Development of the training portfolio

The aim of the First-Line Therapies model's training services is to ensure adequate treatment of common mental health disorders directly at the primary care level.

The First Line Therapies training portfolio is continuously expanded in line with research literature and treatment guidelines as well as the needs of the service system. When developing the trainings, attention is given not only to the factors mentioned above, but also to how easily

the method can be adopted in primary care services and how the acquired competence can be maintained as part of the unit's routine practice.

At present, the training portfolio does not include all the methods used and recommended for the treatment of mental health disorders, although these methods are important from the perspective of the service system.

The most central methods missing from the training portfolio:

- *Psychotherapy frameworks with A- and B-level evidence recommended in the Current Care (Käypä hoito) Guidelines and interventions derived from them for adults:*
 - Depression: psychodynamic psychotherapy, couple, and family psychotherapy (excluding the emotionally focused couple intervention, which is included in the training portfolio)
 - Social anxiety disorder: psychodynamic psychotherapy
 - Alcohol use disorders: couple and family psychotherapy, AA groups
 - Borderline personality disorder: schema therapy, dialectical behaviour therapy, mentalization-based therapy, psychodynamic psychotherapy
 - Bipolar disorder: Family Focused Therapy for couples
 - Eating disorders: couple and family psychotherapy, psychodynamic psychotherapy, psychoanalytic psychotherapy
 - Post-traumatic stress disorder: trauma psychotherapy (exposure-based cognitive behavioural therapy)
 - Schizophrenia: cognitive behavioural psychotherapy, couple, and family psychotherapy
 - Obsessive-compulsive disorder: cognitive behavioural psychotherapy, the Bergen model

Methods not included in treatment recommendations (e.g. currently IPC) are trained in Finland based on accumulated positive experiences, trainability, and the needs of the service system.

Rarer, disorder-specific methods may be added to the training portfolio if this is justified by syndrome-specific care pathways, the overall service system, and the established division of responsibilities. An additional requirement is that the treatment method can be derived from the Current Care Guidelines or corresponding recommendations. In some cases, it is possible to proceed on the basis of a separate evaluation using otherwise well-justified methods.

Methods belonging to specialised healthcare can, for the time being, only be developed according to its identified needs.

17. Data collection, knowledge-based management and promoting real-world effectiveness

Information on how well services function as well as their quality and effectiveness is required for continuous improvement of services. Knowledge-based management refers to actions based on this information, the impact of which can be assessed by determining whether services improved in the desired way. Co-development between regions means that supervisors and leaders in wellbeing services counties can compare their services and make use of results from other counties in their own development. For this to succeed, information on how well services function is needed. Data must be collected reliably and in a sufficiently

consistent manner. Because the information must be up to date and allow further examination, county-specific electronic information systems are a key source of data.

Within the First Line Therapies model, all wellbeing services counties have jointly defined key process and outcome indicators for counties to monitor through their own systems. The collaborative network supports benchmarking and improvement—comparison of results and the factors influencing them, as well as mutual learning. The indicators are aligned with national and international recommendations.

17.1. Indicators and cutoff values used in adult services

The indicators and measures have been selected based on both national and international recommendations as well as domestic reviews. The selected indicators complement the national indicators compiled in Sotkanet with indicators suitable for concise, organisation-specific monitoring. For the measures (e.g., symptom scales), the recommendations of the Finnish Institute for Health and Welfare (THL) are followed and supplemented with the recommendations of the International Consortium for Health Outcomes Measurement (ICHOM). The aim in selecting these is to ensure specificity regarding the problem, symptom or disorder being treated.

The measures used in adult services and their threshold values are listed in Table 4. A referenced version of the table can be found in Appendix 5. In addition, the following shared indicators are used in outcome-informed management (Note: Together, the measures and indicators provide a functional basis for evaluating the implementation of the Act on Therapy Guarantee for Children and Young People under 23 years of age):

- delay from first contact to assessment of treatment need (days)
- delay from assessment of treatment need to intervention (days)
- number of people waiting for services (waiting for assessment of treatment need after first contact & waiting for intervention after assessment of treatment need)
- target symptom/problem of the intervention
- previous psychosocial treatment/support for the same symptom/problem within the past year
- service delivered (procedure code)
- adherence to Current Care / PALKO recommendations
- duration of interventions (days & number of sessions)
- change in symptoms
- change in functioning
- need for follow-up treatment/support
- client experience

Problem descriptor	Measure/scale	Cutoff for clinical significance/caseness	Threshold for clinically significant change
Depression	PHQ-9	10	≥ 5
Generalized anxiety	GAD-7	10	≥ 4
Social anxiety	SPIN-FIN	19	≥ 10
Panic	PDSS-SR	≥ 9	≥ 5
Insomnia	ISI	10	≥ 6
Addictions	Addiction-specific measure	According to the specific addiction e.g. AUDIT (men ≥ 8, women ≥ 6)	No clear cut off ¹
Concentration difficulties	ASRS	No clear cut-off ²	No clear cut-off ³

Table 5 Measures and threshold values used in adult services.

¹There are no clear threshold values for identifying significant change, and impact assessment should always be related to the target of the intervention (reducing/stopping substance use). Systematic monitoring of individual goals using standardised measures can be used to support impact assessment.

² The ASRS questionnaire consists of two parts. Part A functions as an ADHD screening tool. Items are scored on a scale from 0 to 4, and the score range for Part A is 0–24. If four or more of the respondent's answers fall within the instrument's shaded boxes, their symptoms correspond to the ADHD symptom profile, and further assessment is warranted.

³ Assessment of effectiveness using the ASRS should include both Parts A and B. In assessing clinical effectiveness, emphasis is placed on evaluating the impairment caused by the symptoms. Clear cut-off scores are not yet available.

17.2. Goals for access to treatment and effectiveness

The following goals are derived from international treatment models as well as domestic reviews. Current and upcoming legislation must also be considered. The goals describe what primary mental health services can realistically achieve: timely and effective support that helps meet people's needs while preserving the system's capacity.

- Step 1 treatment can be initiated for all suitable clients of any age within one week.
- Step 2 treatment can be initiated for all suitable clients of any age within one month (incl. the therapy guarantee for children and young people).
- At least 50% of those recovering reliably from the disorder, symptoms or problems achieve recovery after step 1 and step 2 treatments in primary care services.

FIRST LINE THERAPIES IN CHILD AND ADOLESCENT SERVICES

Developing mental health services for children and adolescents is particularly challenging because services are fragmented and delivered across different sectors under different legislation. Professionals in healthcare, social services and education all encounter children and adolescents with varying needs for psychosocial support and treatment.

From May 2025, the Act on Therapy Guarantee for Children and Adolescents has made wellbeing services counties responsible for organising statutory services. To succeed in this, co-operation across sectoral and regional boundaries is essential. Within the First-Line Therapies model, the development of psychosocial services for children and adolescents in line with the guarantee has been carried out in national collaboration since 2020. During this time, many wellbeing services counties have:

- trained thousands of professionals in psychosocial methods
- recruited intervention coordinators who promote changes in the mental health service system in their area in regional collaboration
- developed stepped care models aimed at clarifying regional services and their providers
- adopted The Finnish Therapy Navigators for adolescents and children to support the professionals' assessment and guidance to an appropriate level of support and treatment
- established knowledge-based management practices so developing services stays evidence-based, and results can be monitored in real time

As with adult services, the First-Line Therapies model covers only part of the overall mental health service needs of children and adolescents. The model focuses on supporting wellbeing services counties in improving the availability and effectiveness of promptly accessed primary mental health services. The model and national support services are continuously developed in collaboration with the wellbeing services counties.

This section of the handbook describes how the First-Line Therapies model is built and maintained in child and adolescent services. It also explains how the model's services meet the Act on Therapy Guarantee for Children and Adolescents. It includes the following subsections:

- Regional structures for implementation and maintenance of the model
- Regional stepped care model
- Mentalhub content for at children, adolescents, and families
- The Finnish Therapy Navigator for children and the First Assessment
- The Finnish Therapy Navigator for adolescents and the First Assessment
- Methods in child and adolescent services
- Data collection, knowledge-based management, and effectiveness in routine clinical practice

18. Regional structures for implementation and maintenance of the model

Implementing a stepped care model for support and treatment requires ongoing collaboration across all key services. It also calls for a major cultural shift, supported by both a shared vision and strong commitment. In developing child and adolescent services, two key roles that support regional co-development have been identified.

Seamless cooperation can be strengthened through effective coordination. **An intervention coordinator** working in the region is an expert with a broad overview of the wellbeing services county's service needs, existing support and treatment, and care pathways.

In addition to the intervention coordinator, it is important for the region to have **an implementation working group** consisting of representatives responsible for different services. The task of the implementation working group, led by the intervention coordinator, is to develop the region's services for children and adolescents in a way that ensures that all parties are heard. The aim of the working group is to define the region's shared stepped care structure for psychosocial support and treatment. This shared structure enables a common strategy for the wellbeing services county, supports training planning and the creation of symptom-specific care pathways, ensuring equal access to psychosocial support regardless of the child's or adolescent's place of residence.

This chapter describes how child and adolescent mental health services can be developed within a region with the support of an intervention coordinator and an implementation working group.

18.1. The role of the intervention coordinator

Intervention coordinators are experts in promoting and improving child and adolescent mental health services within their wellbeing services county.

Because child and adolescent mental health work is carried out widely and in different service sectors, forming and maintaining an up-to-date overall picture is challenging. Coordinators maintain a clear overview of their wellbeing services county's services for children and adolescents, including goals, staff training needs, and the regional distribution of trained professionals. Intervention coordinators develop and maintain the time- and place-based availability of interventions in their wellbeing services county and are therefore key actors in training planning and maintenance of professionals' competence in psychosocial interventions. They also develop and maintain regional stepped care and service pathways in collaboration with the county's networks.

Intervention coordinators act as knowledge-sharing links between the national support of the First-Line Therapies model, coordination at the collaborative area-level, and the wellbeing services counties. They network with key stakeholders, negotiate and plan piloting. National cooperation between coordinators helps ensure equal services for all children and adolescents regardless of where they live.

The role of intervention coordinator includes, among others, the following areas:

- 1. Coordinates and supports the implementation and maintenance of the wellbeing services county's stepped care model of psychosocial support and treatment for children and adolescents:**
 - is responsible for maintaining the county's stepped care model of psychosocial support and treatment for child and adolescent mental health services, ensuring equal access to support and treatment, and monitoring its implementation and effectiveness in cooperation with the implementation working group
 - has a broad understanding of the importance of processes, care pathways, and interfaces for implementing interventions, and develops the overall system across the entire service landscape for children and adolescents
 - is responsible for developing and introducing care pathways together with the implementation working group
 - is responsible for the implementation processes of new methods (assessment, preparation, delivery, maintenance) in cooperation with the implementation working group
 - supports supervisors and strengthens their role in implementing and maintaining psychosocial methods
- 2. Coordinates and delivers intervention and the First Assessment trainings:**
 - trains professionals in psychosocial methods and coordinates intervention trainings
 - trains professionals in the First Assessment with The Finnish Therapy Navigator for adolescents and coordinates piloting and implementation
 - supports professionals in training and monitors training progress
 - provides method-specific supervision for interventions they are qualified to supervise
 - coordinates method-specific supervision
- 3. Supports the maintenance of interventions:**
 - identifies and resolves factors that slow down or prevent the use of interventions in collaboration with services, and supports, strengthens, and disseminates factors that accelerate use
 - organises and facilitates peer mentoring meetings and method expert days
 - coordinates and/or organises refresher trainings
- 4. Supports knowledge-based management:**
 - monitors and develops the use and effectiveness of methods, and reports data to the management and supervisors of the operating unit/area
 - promotes the adoption and use of procedure codes
- 5. Participates in communication:**
 - gathers and shares current information with intervention experts, service management, and supervisors
 - communicates at the wellbeing services county level
 - participates in national communication between wellbeing services counties
- 6. Engages in network collaboration and participates in co-development at the collaborative area- and national levels.**

18.2. Implementation working group

Developing mental health services requires close cooperation across sectors. This work is carried out by a regional co-development group, referred to here as the implementation working group. The group is coordinated by an intervention coordinator or another person responsible for coordination. When establishing the implementation working group, it is important to include the key cross-sector actors needed for service development. In child and adolescent mental health services, these may include, for example:

- child health clinics
- family counselling centres
- social services
- student welfare services
- school and student health services
- primary mental health services
- specialised healthcare services organised by the wellbeing services county

Members of the group must be able to decide on and execute the necessary policies.

The main goal of the working group is to create and maintain a shared, evidence-based regional stepped care structure of psychosocial support and treatment. To ensure commitment, it is important to involve stakeholders from all sectors and service levels. This structure serves as a shared regional strategy and guides training planning and the development of symptom-specific care pathways. A carefully designed stepped care model ensures equal access to psychosocial support for children and adolescents across the region, regardless of their place of residence.

The implementation working group discusses and resolves questions such as:

Stepped care of support, treatments, and guidance to treatment

- What types of support and treatment should children and adolescents in the region receive to promote their mental health, and who provides them?
- Is the range of support and treatment sufficient?
- Is support and treatment equally accessible across the wellbeing services county?
- What practices are needed for guidance to support and treatment?

Training and maintenance of methods

- Are there enough professionals trained in the different methods?
- How is staff turnover considered in training planning?
- What kind of support do professionals need during training, delivery and in maintaining competence?

Outcome informed management

- How is knowledge-based management integrated into daily clinical practice?
- What data collection practices exist in the region?
- How is the data monitored, and what can be learned from it?

Maintaining the change

- How does the region sustain and develop the jointly agreed stepped care model and related structures in an evidence-based manner?

The phases of implementing and maintaining the First-Line Therapies model and the key questions involved are described in more detail in Section 26 of the handbook.

19. Regional stepped care model

Stepped care of psychosocial support and treatments requires ongoing strategic work carried out across sectors within the wellbeing services county. This work results in a regional stepped care model that clearly sets out what services are available to support the mental health of children and adolescents, and who provides them. In addition, the stepped care structure supports training planning and the creation of symptom-specific care pathways. Above all, it ensures equal access to psychosocial support for every child and adolescent, regardless of their place of residence.

Section 27 of the handbook describes the phases included in this development. Section 5 provides a general description of the stepped care model. This chapter explains in more detail the steps of support and treatment for children and adolescents, and the methods included in each step. The end of the chapter also includes a collection of best practices that can promote successful implementation.

Subsections:

- Stepped care model of psychosocial support and treatments for children and adolescents
- Maintaining the stepped care model in the region

19.1. Stepped care model of psychosocial support and treatments for children and adolescents

Stepped care of support and treatment refers to organising psychological interventions developed for mental health difficulties—such as evidence-based psychosocial methods, brief therapies, and psychotherapies—according to their level of intensity. The goal is to ensure that a child or adolescent in need receives timely and appropriately matched support without delay. If the support offered is not sufficient, a more intensive form of support or treatment is offered.

How stepped care is implemented depends on the operational environment. The support and treatments at each step may vary regionally but the underlying principle remains the same: Every step must be covered—from low-threshold interventions to specialised healthcare and long-term psychotherapy. A nationally coherent structure is a prerequisite for interregional collaboration and peer learning and improvement.

Organising stepped care of psychosocial support and interventions for children and adolescents is particularly challenging because, in addition to social and health care services, early childhood education, schools and other educational institutions also play key roles. The availability and placement of centralised mental health services vary considerably between wellbeing services counties. Practices can differ both regionally and between individual service units.

Systematic stepped care structure of support and treatment and intervention planning is, however, worthwhile. The aim is to respond to symptoms as early as possible to prevent escalation. In the early stages, support does not have to be provided by mental health

professionals, allowing all regional resources to be used effectively and reserving specialised services for those who most need them. Regional equity ensures that a child or adolescent in the same situation receives equally good care regardless of where they seek help.

19.2. Example of the stepped care model for children and adolescents

The forms of support, services and stepped care for children, adolescents, and families within the First-Line Therapies model are continuously being developed. This chapter presents an example of a stepped care model in child and adolescent services. The example methods are interventions commonly used in Finland. Methods trained within the First-Line Therapies model are marked with an asterisk (*). These methods are described in more detail in Chapters 23 - 25, and guided internet cognitive behavioural therapy (guided iCBT) in Chapter 16.2.

In the stepped care model used in the First-Line Therapies model (Figure 5), regions typically have 3–4 steps and a step 0.

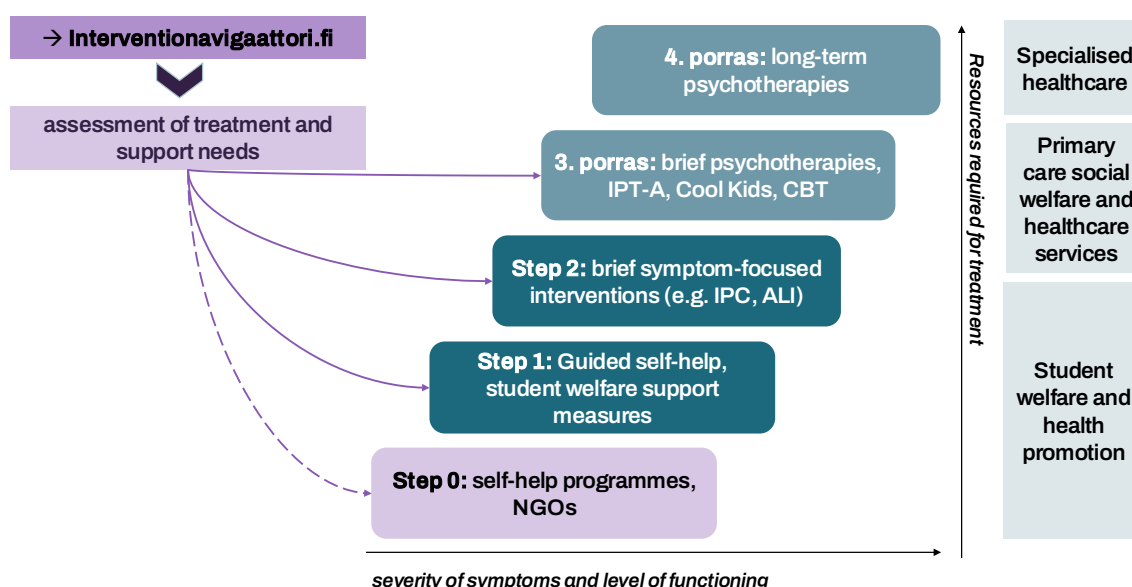


Figure 3: An example of stepped care model of support and treatment for children and adolescents.

Step 0 psychoeducational and self-help materials available to everyone, along with preventive support such as the self-help programs on the Mentalhub website. Mentalhub has developed many materials over the past year that parents can use with their child in daily life.

In addition, school-based support measures, such as the KiVa Antibullying Program, are part of step 0 support.

Step 1 treatments should be suitable for the majority of children, adolescents and families seeking help. Step 1 includes psychoeducational and guided services delivered by a professional, who also supports the family or the young person during independent work. At this step, the ability to function is good and symptoms are mild.

Step 1 treatments include, for example:

- *Guided self-help for parents of infant to preschool children
- Voimaperheet - Finnish Strongest Families parent training program
- *) Interventions trained within the First-Line Therapies model

Step 2 includes brief, evidence-based interventions for mild to moderate symptoms when ability to function remains fairly good. At this step, the child or adolescent clearly benefits from structured, symptom-focused interventions.

Step 2 treatments include, for example:

- *cognitive behavioural intervention for child and adolescent anxiety
- *interpersonal counselling (IPC)
- The Incredible Years parenting program
- Aggression Replacement Training (ART)
- guided internet cognitive behavioural therapy (guided iCBT) for adolescents
- *) Interventions trained within the First-Line Therapies model

Step 1 and step 2 treatments are designed to start quickly and to meet the needs of most clients seeking help. When designing the stepped care model, it is important to consider whether the range of services/interventions is sufficient and whether the region has trained enough professionals in the methods so that most clients can be supported.

At step 3, symptoms are already moderate and ability to function is somewhat impaired. Treatment often requires a multidisciplinary team or consultation.

Step 3 treatments include, for example:

- *cognitive behavioural therapy (CBT)
- *interpersonal therapy for adolescents (IPT-A)
- Cool Kids
- brief psychotherapy
- trauma focused cognitive behavioural therapy (TF-CBT)
- multidimensional family therapy (MDFT)
- dialectical behaviour therapy (DBT)
- Theraplay
- Oppi parenting skills program
- other effective individual treatments (time-limited and measured)
- *) Interventions trained within the First-Line Therapies model

At step 4, symptoms are severe and complex and ability to function is significantly impaired. Specialised healthcare services or long-term psychotherapies are needed.

Step 4 treatments and services include, for example:

- specialised psychiatric healthcare
- long-term psychotherapy, e.g. as rehabilitative psychotherapy or psychotherapy with a service voucher
- Eye Movement Desensitization and Reprocessing (EMDR)

20. Mentalhub.fi content for children, adolescents, and families

The Mentalhub.fi online service provides support for children, adolescents and families in different life situations, promotes mental health, and helps manage mental health symptoms. The service is intended for both citizens and social and healthcare professionals. It is also beneficial for close relatives of people experiencing symptoms, as well as students in social and healthcare fields.

The Mentalhub.fi online service is described in more detail in Section 6 of this handbook.

The table below presents examples of Mentalhub content for children and adolescents:

Theme / symptom	Self-help programs	Information pages
Anxiety, depression	• Self-help program for child anxiety • Self-help program for adolescent anxiety • Self-help program for adolescent depression • Self-help program for children's speech anxiety	• Child anxiety and fears • Supporting an anxious pupil • Child depression • Adolescent depression • Supporting a depressed pupil • Selective mutism in children
Relationships	• Self-help program for challenges in peer relationships • Self-help program for children's friendship skills • Self-help program for parent-child interaction	• Bullying, bullying in adolescence • Problems in parent-child interaction • Information on adolescent social withdrawal
Eating problems	• Self-help program for eating problems • Self-help program for children's eating problems	• Eating problems in young children • Addressing eating-related difficulties at school
Crisis and trauma	• Self-help program for adolescent crises • Self-help program for self-harm (cutting)	• Child self-harm • Adolescent self-harm • Child and adolescent crisis following the death of a loved one
Sleep	• Self-help program for insomnia • Self-help program for adolescent sleep difficulties • Self-help program for child sleep difficulties	• Basic information on insomnia • Child sleep disorders • Information on adolescent sleep problems

Table 6 examples of Mentalhub content for children and adolescents

20.1. School community pages

The school community pages of the Mentalhub.fi online service are specifically intended for teachers, student welfare services, and other adults working in schools. The pages provide support when learning is at risk and various symptoms restrict study progress. The school community pages compile information, for example, for situations where there is concern about a pupil, and describe how the Mentalhub.fi service can be used in schools.

In addition, the school community pages include dedicated information pages for the following situations or symptoms:

- Supporting an anxious pupil
- Supporting a sensory-sensitive pupil
- Supporting a shy pupil
- Supporting a pupil who is easily overwhelmed
- Supporting a pupil with inflexible behaviour
- Supporting a nervous pupil
- Supporting a pupil with concentration difficulties
- Supporting a behaviourally reactive pupil
- Supporting a depressed pupil
- Supporting a pupil going through puberty
- Neurodevelopmental traits in the school environment
- Supporting a pupil who behaves differently to others
- Supporting a pupil with speech anxiety
- Supporting social skills at school
- Taking gender diversity into account at school
- Addressing eating-related difficulties at school
- Supporting emotional regulation skills at school
- Supporting an active and impulsive pupil
- Supporting a tired pupil

20.2. Theme pages for students, teachers, and workplace instructors

New content has been produced for the Mentalhub.fi online service for upper secondary students as well as for teaching staff and workplace instructors in educational institutions.

The theme page for students compiles information and self-help programs that support students' mental well-being. It aims to promote the completion of studies and the transition into working life. The site provides information related to the following areas:

- Have you lost motivation?
- How to take care of your well-being as a student?
- Does becoming independent feel difficult?
- How to succeed in on-the-job learning?
- What does professional identity mean?
- Do you feel anxious in social situations?
- Are you feeling anxious?
- Are your studies overwhelming you?
- Are you burnt out?

- Do absences hinder your studies?
- Do neurodevelopmental traits make studying difficult?
- Have you experienced bullying or harassment?
- Is it difficult to feel part of the community?
- Is diversity taken into account at your educational institution?
- Do you need support to complete your studies?

In addition, the page includes self-help programs specifically designed for students.

The theme page for teachers and workplace instructors offers information and practical tips for supporting students' mental well-being. Information is available on the following themes:

- What to do if you are worried about a student?
- A teacher with good well-being supporting a student
- Becoming independent as a phase in a student's life

The site also includes an information package on how the Mentalhub.fi service can be used in educational institutions.

Content for teachers and other educational institution staff:

- Strengthening student motivation
- Supporting study well-being
- Supporting a student during on-the-job learning
- Strengthening a student's professional identity
- Supporting a socially anxious student
- Supporting an anxious student
- Supporting an overwhelmed student
- Supporting a burnt-out student
- Absences are accumulating – how to support a student?
- Supporting a student with neurodevelopmental traits
- Bullying and harassment in educational institutions
- Supporting a student's sense of belonging
- Taking diversity into account in educational institutions
- Supporting a student in completing their studies

Content for workplace instructors and work communities:

- Strengthening student motivation during on-the-job learning
- Supporting student well-being during on-the-job learning
- How to ensure successful on-the-job learning
- Strengthening student professional identity during on-the-job learning
- Supporting a socially anxious student during on-the-job learning
- Supporting an anxious student during on-the-job learning
- Supporting an overwhelmed student during on-the-job learning
- Supporting a burnt-out student during on-the-job learning
- Absences are accumulating – how to support a student during on-the-job learning
- Supporting a student with neurodevelopmental traits during on-the-job learning
- Bullying and harassment during on-the-job learning
- Supporting a student's sense of belonging during on-the-job learning

- Taking diversity into account during on-the-job learning

The new content has been produced as part of the Mielihyvin duunissa 2.0 project. The project is coordinated by Silta-Valmennusyhdistys ry. Other co-implementers include Kuntoutussäätiö, Mielenterveyden keskusliitto, Valo-Valmennusyhdistys ry, and the wellbeing services counties of Central Finland, North Savo, and North Karelia.

The project is funded by the Ministry of Social Affairs and Health through the European Union Recovery and Resilience Facility as part of Finland's Sustainable Growth Programme. Funding for the Sustainable Growth Programme comes from the EU's one-off recovery instrument (Next Generation EU).

21. The Finnish Therapy navigator for children and the First Assessment

This chapter describes how to determine the right support for children aged 7–12 using the Finnish Therapy Navigator for children and the First Assessment. The subchapters are:

- What is the Finnish Therapy Navigator for children?
- What is the First Assessment with children?
- How to organise the First Assessment in children's services?

21.1. What is the Finnish Therapy Navigator for children?

The Finnish Therapy Navigator for children was completed in March 2025, and the first pilots were conducted during 2025. At the time of writing, the Finnish Therapy Navigator for children is still in the pilot phase, and continuous development is being carried out based on feedback from the piloting. This section describes the basic principles of the Finnish Therapy Navigator for children.

The Finnish Therapy Navigator for children, also referred to as the Child Navigator, is a digital tool designed to support social and healthcare professionals in the assessment of a child's need for psychosocial support and treatment. It can be used with children aged 7–12, their guardians, and teachers.

The Child Navigator gathers current information about the child's situation and presents it in the form of a report, allowing responses from different respondents to be compared with one another. The final number of respondents depends on the child's situation and symptoms. The responses provide comprehensive information that is used in the interview conducted with the child and the guardian(s).

With younger primary school children, the navigator is generally completed with the support of either a guardian or a professional. With older primary school children (approximately 10-12-year-olds), the navigator can be completed independently, depending on the child's individual developmental level. However, it is generally recommended that the Finnish Therapy Navigator for children is completed in the presence of an adult, who can assist with reading and answering the questions if necessary. If the child has neurodevelopmental difficulties or, for example, difficulties with reading, it is recommended that the navigator is completed with an adult—either a guardian or a professional.

The Child Navigator does not include symptom scales, automation, or guidance for the professional or the parent based on the responses. Instead, the professional assesses the situation of the child and family using the summary report to support their assessment and clinical judgement.

Using the Child Navigator offers, among other things, the following benefits:

- saving time in collecting and transferring information, for example from a teacher or a non-resident parent to the professional conducting the First Assessment
- ensuring that the child's perspective is considered from the very beginning of the assessment processing
- allowing appointment time to focus on issues that are most relevant for the child and family
- standardising the assessment process by collecting information in a consistent manner
- efficient data collection and low costs
- standardising documentation practices when transferring information into electronic client and patient records
- early identification of risks and symptoms through systematic and comprehensive data collection
- supporting decision-making: determining where support and help should be directed as information about the child's environments is also gathered (family and school)

The Child Navigator supports professionals in the initial assessment when concern about a child's situation or symptoms is not urgent. Although the Finnish Therapy Navigator for children is not intended for use in diagnostic assessment, a more thorough assessment may be indicated by the navigator responses and the First Assessment. The aim is to identify, in particular, the children and families who are likely to benefit from interventions in primary care services, thereby enabling early access to support.

21.2. What is the First Assessment conducted with children?

The First Assessment refers to the process in which a professional assessing a child's need for support and treatment gains further information on the responses gathered by the Finnish Therapy Navigator for children by interviewing the child and their guardian(s) or other parental caregiver. During the First Assessment, the overall picture of the child's situation becomes more complete, helping the professional to evaluate what kind of support or treatment can be recommended and where it should be targeted. The First Assessment is also designed for situations in which the need for support and treatment has already been identified as non-urgent and an initial assessment is required when concern about a child has arisen.

If the responses highlight parental or family difficulties, it is advisable to include a separate meeting for the guardian as part of the First Assessment. Collaboration with guardians without the child being present is particularly important in situations where the guardians' responses are strongly contradictory or where there appear to be difficulties between the guardians. In addition to assessing the child's situation, it is important to explore the guardians' need for support and services.

In the First Assessment, the professional's tasks are to:

- identify children who may benefit from early intervention (steps 1 and 2)
 - an appropriate treatment can be selected in line with the regional stepped care model
- identify children and families who require further assessment and/or more intensive support
- consider the wishes of the child and family regarding support and treatment

When guiding to treatment, particular attention is paid to:

- symptoms and their severity in different environments
- level of functioning (child, family) in different environments
- the primary focus of support or treatment when clearly identifiable
- previous psychosocial support or treatments and experiences of these
- previously diagnosed illnesses or disorders
- family- and behaviour-related risk factors

When assessing the child's situation, the professional must evaluate the child's decision-making capacity. If the child is assessed as capable of making decisions about their treatment, their opinion must be considered when planning care. In such cases, the child may also decide on the disclosure of their information to parents, other guardians, or other legal representatives.¹⁵

21.3. How to organise the First Assessment in children's services?

The First Assessment may be conducted by a social or healthcare professional who has completed First assessment training and whose role includes assessing children's need for psychosocial support and treatment. Interpreting the results of the Finnish Therapy Navigator for children requires a clinical assessment conducted by a professional and meeting with the child and their guardians. It is necessary to become familiar with the principles of the First Assessment before using the navigator. When planning implementation, it is important to ensure appropriate training for professionals. In addition, it is advisable to decide how the code received by each respondent will be delivered to the professional so that they can review and compare the responses of different respondents simultaneously.

The results can be reviewed during the First Assessment or prior to it. If both social and healthcare professionals familiar with the navigator work within the service, information can be transferred by submitting the code to another professional within a set time limit (within 30 days of completion). In addition, it is important to plan how the information produced by the navigator is entered into the client or patient information system and how information is transferred when the child and family are referred to other services. In this way, the information generated by the navigator and the First Assessment will also be available for use by other professionals who may later be involved in the care of the child and family.

¹⁵ Laki potilaan asemasta ja oikeuksista, 2 luku, 7 § Alaikäisen potilaan asema: <https://finlex.fi/fi/laki/ajantasa/1992/19920785 - L2P7> ja Laki sosiaali- ja terveydenhuollon asiakastietojen käsittelystä, 8 luku, 51 § Alaikäisen oikeus kieltää tietojensa luovuttaminen huoltajalle: <https://www.finlex.fi/fi/laki/alkup/2023/20230703#Pidm46434450661440> (Accessed on 14.3.2025)

22. The Finnish Therapy navigator for adolescents and the First Assessment

This chapter describes how to determine the right support for adolescents aged 13–19 using the Finnish Therapy Navigator for adolescents and the First Assessment. The subchapters are:

- What is the Finnish Therapy Navigator for adolescents?
- What is the First Assessment?
- How to organise the First Assessment in youth services?

22.1. What is the Finnish Therapy Navigator for adolescents?

The Finnish Therapy Navigator for adolescents, also referred to as the Youth Navigator, is a digital tool designed for adolescents aged 13–19. It can be used by all social and healthcare professionals who work with adolescents experiencing mental health difficulties and whose responsibilities include assessing the need for support and treatment. The Youth Navigator screens for the most common mental health disorders but does not include questionnaires related to more severe psychiatric disorders or neurodevelopmental traits. It can be used, for example, in student welfare services and in centralised mental health services for adolescents.

The Youth Navigator streamlines and standardises the assessment of an adolescent's need for support and treatment by collecting sufficient information about the adolescent's situation at once, by all professionals. It compiles the adolescent's responses into a report that can be easily transferred to client and patient information systems, reducing the mechanical work for the professional. The Youth Navigator supports the professional in planning the appropriate level of support and treatment for the adolescent.

Guardians can also be involved in the assessment process as needed. The Youth Navigator includes a section for guardians with questions about the adolescent's situation for the guardian. Guardians' responses and interviews are an important source of information when assessing the adolescent's overall situation. However, the Youth Navigator can also be used without guardian responses.

The Youth Navigator does not function independently but always requires a professional. The professional guides the adolescent to complete the navigator and then gains further information on the responses during an appointment together with the adolescent and, where appropriate, the guardians. This process is referred to as the First Assessment. The Youth Navigator does not include automation or response-based guidance for the professional or the adolescent.

The Youth Navigator is beneficial for professionals conducting assessments, for adolescents, and for other actors within the wellbeing services county in the following ways:

- The Finnish Therapy Navigator for adolescents facilitates collaboration between adolescents, guardians, and professionals.
- The Finnish Therapy Navigator for adolescents and the First Assessment help involve guardians in discussions about the adolescent's situation and enable a structured assessment of the need for support or treatment.

- The Finnish Therapy Navigator for adolescents and the First Assessment encourage adolescents to talk about difficult topics.

The Youth Navigator can be accessed at www.interventionnavigaattori.fi or www.nuorten-navi.fi.

22.2. What is the First Assessment?

The First Assessment refers to an appointment in which a professional assessing an adolescent's need for support and treatment gains further information on the responses of the Finnish Therapy Navigator for adolescents together with the adolescent. During the First Assessment, the overall picture of the adolescent's situation becomes more complete, which helps the professional to determine what kind of support or treatment can be recommended for the adolescent.

If guardians have also completed the Finnish Therapy Navigator for adolescent, they can be invited to participate in the First Assessment, as necessary. Collaboration with guardians is particularly important in situations where there is significant concern about the adolescent's wellbeing or where the adolescent's and guardians' responses are contradictory. In addition, guardians' support may be significant in the treatment. Alongside assessing the adolescent's situation, it is also important to explore the guardians' need for support and services.

The professional's aim in the First Assessment is to:

- identify whether early intervention is sufficient for the adolescent (steps 1 and 2)
- identify whether the adolescent's situation requires further assessment or more intensive support (steps 3–4)

Factors influencing the choice of support and treatment include:

- symptoms and their severity
- level of functioning
- the primary focus of support or treatment when clearly identifiable
- the adolescent's readiness to engage and to change
- study-related difficulties
- crisis- or trauma-related factors in the adolescent's growth environment and current life situation
- substance use
- previous psychosocial support and treatment

22.3. How to organise the First Assessment in youth services?

The First Assessment may only be carried out by a social or healthcare professional who is familiar with the Finnish Therapy Navigator for adolescents and the principles of the First Assessment. When planning implementation, it is therefore essential to ensure appropriate training for professionals.

Before training professionals, it is necessary to carefully plan how the use of the Finnish Therapy Navigator for adolescents and the First Assessment will be implemented in the unit.

Planning may involve individuals responsible for coordinating services and training in the area, as well as supervisors. It is also advisable to involve professionals in the planning process.

The starting point for planning is the regional stepped care model of support and treatment. Professionals must have sufficient intervention competence and the opportunity to deliver early-stage interventions if such a need is identified for the adolescent.

Before introducing the navigator, the unit's navigator process is defined and clarified in terms of how the Finnish Therapy Navigator for adolescents and the First Assessment fit into the existing processes of the unit. In addition, shared documentation and data collection practices are agreed upon. Consultation pathways and referral practices are also clarified at the planning stage. To avoid multiple assessment processes, the responses from the Finnish Therapy Navigator for adolescents and the documentation from the First Assessment should also be available to other professionals involved in the adolescent's care.

Best practices

One of the most important principles of the First Assessment is a client-centred approach. To streamline guidance to support and treatment for adolescents, actions that are not in the adolescent's best interest should be avoided, for example:

- **Guidance to support or treatment should not be based solely on the report generated by the Finnish Therapy Navigator for adolescents:** The Finnish Therapy Navigator for adolescents is designed to streamline information gathering. Assessing the need for support and treatment always requires a First assessment interview with the adolescent conducted by a trained professional and the actual guidance to treatment is based on the professional's assessment following the interview.
- **Guidance to support or treatment should not focus solely on mental health symptoms.** The assessment of an adolescent's need for support and treatment must also consider other issues relevant to the adolescent's situation and the need for support provided by other services, such as school or educational institution, substance use services, child protection, and social services.
- **Use of the Finnish Therapy Navigator for adolescents must not be made compulsory:** Some adolescents do not want to or are not able to complete The Finnish Therapy Navigator for adolescents. In such cases, the assessment is carried out by interviewing the adolescent. The Finnish Therapy Navigator for adolescents can also be completed together with a professional during an appointment. However, it should never be a requirement for accessing services.

23. Methods in children's services

The trainings aimed at child and adolescent services currently include the following methods: guided self-help for parents of infant to preschool children and guided self-help for parents of primary school children; cognitive behavioural intervention for child anxiety; cognitive behavioural therapy (CBT) for both children and adolescents; and Cool Kids. The following sections provide a concise description of the methods. Each method has a procedure code used in healthcare information systems to monitor the implementation of the method. Appendix 6 describes the evidence reviews on psychotherapy frameworks included in the Current Care Guidelines for child and adolescent services.

23.1. Guided self-help for parents of infant to preschool children

Primary target group: Parents of children under 6 years of age

Level: Step 1

Length of treatment: 1–5 sessions, on average 3 sessions

Provider: Social and healthcare professionals in primary child health clinics and family services

Procedure code: IHZ19 (Self-help, mental health or substance use disorder)

Guided self-help for parents of infant to preschool children is a brief psychosocial intervention lasting 1–5 sessions aimed at parents of children under 6 years of age. It includes face-to-face guidance as well as the parent independently progressing through the materials available on the Mentalhub website. The method is intended for the treatment of relatively mild symptoms and for early-stage preventive parental guidance. In the stepped care model, guided self-help for parents of infant to preschool children is positioned at Step 1 and is designed for use by social and healthcare professionals working in primary care child health clinics and family services.

Guided self-help for parents of infant to preschool children is not mentioned in the Current Care Guidelines. The use and maintenance of the method as part of the stepped care model are based on positive experiences gained in Finland and on the lack of low-intensity methods in primary care child health clinics and family services. The evidence base for guided self-help for parents of infant to preschool children has been assessed in a separate literature review (in Finnish): [Kirjallisuuskatsaus lasten ja pienten lasten ohjatusta omahoidosta](#).¹

The effectiveness of guided self-help for parents of infant to preschool children can be explored in the results report related to the method².

Implementation of guided self-help for parents of infant to preschool children

Guided self-help for parents of infant to preschool children has a preventive focus, which means that the intervention can be delivered even if the child does not have any actual symptoms. As the intervention focuses on guiding the parent, it is sufficient that the parent wishes to work on their parenting skills. Guided self-help for parents of infant to preschool children can also be provided while the family is waiting to access more intensive support or for a longer intervention to begin.

Guided self-help for parents of infant to preschool children typically consists of three sessions: an initial session (on average 30–45 minutes), a guidance session (15–45 minutes), and a concluding session (15–45 minutes). Weekly sessions are recommended and they can be partly delivered remotely and/or as phone calls. The number of sessions can be increased if necessary. The balance between face-to-face guidance and independent work can also be adapted to the client's preferences.

Strengthening parent-child interaction is central to guided self-help for parents of infant to preschool children. Regardless of the self-help program used, the guidance focuses on the parent's sensitivity to the child's signals and their ability to respond to them consistently. An

increase in the parent's sense of competence and self-compassion, in turn, strengthens their ability to notice and better understand the child.

Training in guided self-help for parents of infant to preschool children

The method is intended particularly for use by social and healthcare professionals working in primary care child health clinics and family services and does not require prior knowledge of mental health disorders or psychosocial interventions. Professionals trained in the method include, for example, nurses, psychologists, physicians, social workers, and other social services professionals. The training is suitable for professionals with any level of experience.

Training in guided self-help for parents of infant to preschool children is a short online course lasting 5–10 hours. The online training includes induction to the guided self-help process and session-specific goals, as well as a concise in-depth exploration of parenting and interaction themes. In addition, the training includes self-help programs for children's sleep problems, eating problems, and behavioural challenges. The self-help programs designed for parents of young children are based on up-to-date knowledge on early childhood development and well-being.

In addition to the online training, two training interventions are completed, for which reports are produced. The delivery of the intervention can be further supported through skills practice and active monitoring of method delivery and treatment outcomes. The number and duration of support sessions and, for example, group size are determined by the unit being trained.

A "context module" can be added to the guided self-help training to support the implementation in maternity clinics.

Theoretical framework of guided self-help for parents of infant to preschool children

The key background theories underpinning the training and the self-help programs are attachment theory, parental mentalization theory, and theories related to the development of self-regulation, along with the associated research evidence. The self-help programs incorporate a cognitive behavioural therapy (CBT) framework.

¹ Kirjallisuuskatsaus lasten ja pienten lasten ohjatusta omahoidosta. HUS, Terapiat etulinjaan -toimintamalli (2024): <https://terapiatetulinjaan.fi/vaikuttavuus/kirjallisuuskatsaukset/kirjallisuuskatsaus-lasten-ja-pienten-lasten-ohjatusta-omahoidosta/> (accessed 14 March 2025)

² Pienten lasten ohjattumahoito, seurantatulokset 2024. HUS, Terapiat etulinjaan -toimintamalli. <https://terapiatetulinjaan.fi/wp-content/uploads/2025/02/Pienten-lasten-ohjattu-omahoito-seurantatulokset-2024.pdf> (accessed 14 March 2025)

23.2. Guided self-help for parents of primary school children

Primary target group: Parents of children aged 6–12

Level: Step 1

Length of treatment: 1–5 sessions, on average 3 sessions

Provider: Social and healthcare professionals in primary care child health clinics and family services

Procedure code: IHZ19 (Self-help, mental health or substance use disorder)

Guided self-help for parents of primary school children (procedure code IHZ19) is a brief method intended for parents of children aged 6–12, typically consisting of 1–5 sessions. Guided self-help combines the parent independently progressing through the materials available in the Mentalhub service with support and guidance from a social or healthcare professional. In the stepped care model, the method is positioned at Step 1. Guided self-help for parents of primary school children can be delivered in primary care services where children's mental health and family wellbeing are supported and promoted, and where the threshold for accessing help is low.

Guided self-help for parents of primary school children is not mentioned in the Current Care Guidelines. The use and maintenance of the method as part of the stepped care model are based on positive experiences gained in Finland, as well as on the lack of low-intensity methods in primary care child health clinics and family services. The evidence base for guided self-help for parents of primary school children has been assessed in a separate literature review (In Finnish): [Kirjallisuuskatsaus lasten ja pienten lasten ohjatusta omahoidosta](#).¹ The role of digitally supported guided self-help as a first-line treatment for mild to moderate anxiety and mood symptoms in children and adolescents is covered in the NICE guidelines².

The effectiveness of guided self-help for parents of primary school children can be explored in the results report related to the method³.

Implementation of guided self-help for parents of primary school children

Guided self-help for parents of primary school children is intended for mild symptoms that may be related, for example, to behavioural challenges, neurodevelopmental traits, or anxiety. The intervention can be initiated with a low threshold. In addition, guided self-help for parents of primary school children can be offered while the family is waiting to access more targeted support or for a longer intervention to begin.

Guided self-help for parents of primary school children typically consists of three sessions: an initial session (on average 30–45 minutes), a guidance session (15–45 minutes), and a concluding session (15–45 minutes). Weekly sessions are recommended and they can be delivered partly through remote sessions and/or phone calls. If necessary, the number of sessions can be increased to five. The balance between face-to-face guidance and independent work can be adapted to the client's preferences.

Collaboration in guided self-help emphasises goal-oriented guidance between the professional and the parent. However, recognising the child as an active participant together with the parent(s) is an important part of the guidance process. It is essential to agree on shared goals and home practice in mutual understanding with both the parents and the child, taking into account the child's age and developmental level. Even with a young child, it is important to go through together what the parents and the child/family will practise at home and why. The professional also acts as an "interpreter" between the child and the parents, ensuring that the child is heard and understood in the guided self-help process.

Guided self-help aims to strengthen the parent's or guardian's mentalization capacity in relation to the child, the parent-child interaction, and the parent's sense of agency as a parent. This may be reflected, for example, in increased confidence in parenting or a more positive interaction within the family. Often, the goal of guided self-help is to increase the parent's understanding of the child's symptoms and how they are expressed in the child's behaviour. Increased understanding can, in turn, strengthen parent-child interaction and support open communication.

Training in guided self-help for parents of primary school children

The method is intended particularly for use by professionals who support and promote children's mental health and family wellbeing in primary care services. Training does not require prior knowledge of mental health disorders or psychosocial interventions. Professionals trained in the method include, for example, nurses, psychologists, physicians, social workers, and social services professionals. The training is suitable for professionals with any level of experience.

Training in guided self-help for parents of primary school children is a short online course lasting 8–12 hours. The online training includes an induction to the guided self-help process and session-specific goals. The training provides tools for delivering guided self-help for children's neurodevelopmental traits, challenging behaviour, and anxiety. The self-help programs designed for parents of primary school children are based on up-to-date knowledge on child development and wellbeing.

In addition to the online training, two training interventions are completed, for which reports are produced. The delivery of the method can be further supported through skills practice and active monitoring of method delivery and treatment outcomes. The number and duration of support sessions and, for example, group size are determined by the unit being trained.

Theoretical framework of guided self-help for parents of primary school children

The self-help programs used incorporate a cognitive behavioural therapy (CBT) framework as well as exercises to strengthen parenting and interaction skills.

¹ Kirjallisuuskatsaus lasten ja pienten lasten ohjatusta omahoidosta: <https://terapiatetulinjaan.fi/vaiikutavuus/kirjallisuuskatsaukset/kirjallisuuskatsaus-lasten-ja-pienten-lasten-ohjatusta-omahoidosta/> (accessed 14 March 2025)

² Guided self-help digital cognitive behavioural therapy for children and young people with mild to moderate symptoms of anxiety or low mood: early value assessment: <https://www.nice.org.uk/guidance/hte3/chapter/1-Recommendations> (accessed 14 March 2025)

³ Seurantatulkoksia pienten lasten ohjatusta omahoidosta. HUS, Terapiat etulinjaan -toimintamalli (2024). <https://terapiatetulinjaan.fi/wp-content/uploads/2025/02/Pienten-lasten-ohjattu-omahoito-seurantatulkokset-2024.pdf> (accessed 14 March 2025)

23.3. Cognitive behavioural intervention for child and adolescent anxiety

Primary target group: Children and adolescents aged 7–17 with mild to at most moderate anxiety; a diagnosis of anxiety disorder is not required

Level: Step 2

Length of treatment: 3–8 sessions

Provider: Social and healthcare professionals

Procedure code: IDZ02 (cognitive behavioural therapy (CBT) – individual treatment)

Cognitive behavioural intervention for child and adolescent anxiety (CBIA) is a goal-oriented and time-limited psychosocial intervention consisting of 3–8 sessions. It is intended for the treatment of mild to at most moderate anxiety in children and adolescents aged 7–17. CBIA is positioned at Step 2 in the stepped care model for children and adolescents. It is suitable for use in primary healthcare and student welfare services, or in any setting where social and healthcare professionals encounter children and adolescents, such as family services, social services, or third sector settings.

The use and maintenance of the modules included in the cognitive behavioural intervention for anxiety as part of the stepped care model in the treatment of mental health disorders are based on the following evidence reviews included in the Current Care Guidelines:

Cognitive behavioural therapy is effective in the acute treatment of anxiety disorders in adolescents. Level of evidence: A.¹ (NOTE: The evidence review states: “...there is likely no difference in the effectiveness of CBT in the treatment of anxiety disorders between children and adolescents.”)

The effectiveness of the cognitive behavioural intervention for children and adolescents can be explored in the results report related to the method².

Target group of the cognitive behavioural intervention for child and adolescent anxiety

CBIA does not require a diagnosis of anxiety disorder. The intervention can be offered as soon as anxiety symptoms are perceived to interfere with daily life and are not transient in nature. The method can be used in the treatment of anxiety when the child’s overall level of functioning is sufficiently good and, based on the professional’s assessment, the child and their family appear capable of and motivated for brief therapeutic work.

The materials and methods of CBIA can also be applied, as appropriate, in situations where the child is waiting for further assessment, a group intervention, or access to another service. The earlier children and their parents receive information about anxiety and effective ways of coping with it, the shorter the support required may be. Under certain conditions, the brief intervention materials can also be used as an intensive intervention as part of other treatment.

Implementation of the cognitive behavioural intervention for child and adolescent anxiety

In the intervention, the professional works with the child or adolescent, or together with them and their parents, guardian, or other close adults (hereinafter referred to as *the child and the parent* in line with the target group described above). In cognitive behavioural therapy, the professional and the adolescent work in an equal collaborative relationship on a selected problem or symptom using a structured treatment program toward a jointly defined goal. The aim of the treatment is to identify the behavioural patterns that maintain the child's symptoms and to alleviate the symptoms as well as the psychological distress caused by them.

The cognitive behavioural intervention for anxiety combines work on features common to different anxiety disorders with symptom-specific approaches. Regardless of the specific symptoms, shared elements of the intervention include a collaborative and exploratory working relationship between the professional and the child, psychoeducation, exposure exercises in the child's everyday environments, examination and processing of thoughts, bodily exercises, and practising problem-solving skills. In addition, the content is structured into modules according to different symptoms. One of four modules can be selected as the core of the intervention: the *Facing Fears module*, the *Calming Panic module*, the *Reducing Worry module*, and the *Building Confidence module*.

Parents (or other close adults) are involved in the treatment whenever possible in order to increase their understanding of the child's anxiety and to enable them to support the child's skills practice between sessions, as appropriate. Parents may participate in some or all sessions together with the child. For primary school-aged children, parental attendance at every session is recommended. Sessions can also be conducted entirely without parents, for example at the adolescent's request; in such cases, the professional may arrange a separate guidance session for parents only, focusing on how they can support the child's or adolescent's treatment.

Progress toward goals and the child's experience of the intervention are monitored systematically throughout the intervention. In addition, changes in symptom scores are monitored using the RCADS (under 12 years) and GAD-7 (over 12 years) scales.

Training in the cognitive behavioural intervention for child and adolescent anxiety

Social and healthcare professionals working with children and adolescents in student welfare services and primary healthcare can be trained in the intervention. The training lasts approximately six months and includes online studies on the Mentalhub education section (approx. 20 hours), delivery of training interventions (at least 12 hours), and six 2-hour sessions of method-specific supervision in groups of 4–6 participants. Method-specific supervision takes place concurrently with the training interventions.

For the training interventions, the professional completes a training diary in which outcome data collected during the intervention are recorded, along with information on how the child and parents have experienced the intervention. The training diary also includes the professional's self-reflection related to the training interventions and their own learning process. The training is completed alongside daily clinical work.

Method-specific supervision

The CBIA training includes method-specific supervision, which is a combination of supervision and teaching, focusing on practising the core skills and delivery of the treatment model.

Method-specific supervision is needed in order to develop method-related skills and to ensure successful delivery of the method.

The CBIA training includes 6 × 2 hours of method-specific supervision, which is conducted in small groups of 4–6 participants approximately every three weeks throughout the training. Method-specific supervision takes place alongside the training interventions.

In certain cases, the method-specific supervision included in the CBIA training can also be implemented through mentoring, which is provided during the training as 2 × 1.5-hour sessions. A professional may complete the training with mentoring instead of the more extensive method-specific supervision if they have at least one year of experience in treating anxiety in children and/or adolescents using cognitive behavioural therapy methods (for example, a Cool Kids–certified practitioner or a CBT psychotherapist).

Method-specific supervision is organised either as an in-house activity of the wellbeing services county or as an outsourced service. A new supervisor must complete an induction module on method-specific supervision, and they are provided with support (see the chapter on method-specific supervision for more details).

In CBIA, a method-specific supervisor must be:

- a psychotherapist with cognitive orientation (CBT, cognitive)
- a psychotherapist of another orientation familiar with cognitive behavioural methods
- a social and healthcare professional undergoing cognitive (behavioural) psychotherapy training
- a psychologist familiar with cognitive behavioural methods
- a social and healthcare professional with training in a cognitive behavioural approach and at least two years of experience in delivering interventions based on CBT framework
- a professional who has completed the CBIA training and has delivered at least 24 hours of treatment according to the model after the training.

Theoretical framework of the cognitive behavioural intervention for child and adolescent anxiety

CBIA is based on the components and well-established methods of CBT which according to current knowledge and research evidence are effective and central to the treatment of anxiety. These components recur in various manualised, evidence-based interventions and treatment programs (e.g. cognitive behavioural therapy for children and adolescents: Current Care Guideline, 2016).

The positive changes observed in cognitive brief therapy are also thought to be explained by effective factors common to all forms of therapeutic work, including the client's expectations, the collaborative relationship between the client and the professional, the characteristics of the client and the therapist, and situational factors.

¹ Kognitiivinen käyttäytymisterapia nuorten ahdistuneisuushäiriöiden akuuttihoidossa. Duodecimin näytönastekatsaus. Suomalainen lääkäriseura Duodecim, Helsinki. 7.1.2019. <https://www.kaypa-hoito.fi/nak09092> (viitattu 14.3.2025)

² Lasten ja nuorten ahdistuksen kognitiivisen lyhytintervention (ALI) seurantatulokset. HUS, Terapiat etulinjaan -toimintamalli (2024). <https://terapiatetulinjaan.fi/vaikuttavuus/raportit-ja-tulokset/lasten-ja-nuorten-ahdistuksen-kognitiivisen-lyhytintervention-ali-seurantatulokset/> (viitattu 14.3.2025)

23.4. Cognitive behavioural therapy for children (CBT-C)

Primary target group: Children with mild to moderate mental health disorders

Level: Step 3

Length of treatment: Approximately 12–13 sessions

Provider: Public healthcare professionals and units responsible for the treatment of mental health disorders

Procedure code: IDZ02 (cognitive behavioural therapy (CBT), individual treatment)

Cognitive behavioural therapy for children is a Step 3 treatment model (IDZ02) intended for the treatment of children aged (6/7)–12. In cognitive behavioural therapy for children, the professional, the child, and the parents work in an equal collaborative relationship toward a defined goal. Treatment typically includes 12–13 sessions. Cognitive behavioural therapy for children is intended for use by social and healthcare professionals working in units responsible for the treatment of mental health disorders.

Cognitive behavioural therapy for children differs clearly from the earlier cognitive behavioural intervention for child and adolescent anxiety (CBIA) as a more therapeutic intervention. In terms of content, cognitive behavioural therapy for children covers, in addition to the anxiety treatment model, treatment models for low mood, obsessive–compulsive symptoms, and challenging behaviour. CBIA is targeted at milder anxiety in student welfare services, whereas cognitive behavioural therapy for children is intended for more treatment-oriented units and moderate symptoms.

The use and maintenance of the modules included in cognitive behavioural therapy for children as part of the stepped care model in the treatment of mental health disorders are based on the following evidence reviews included in the Current Care Guidelines:

- *Cognitive behavioural therapy is effective in the acute treatment of anxiety disorders in adolescents. Level of evidence: A¹.* (NOTE: The evidence review states: “...there is likely no difference in the effectiveness of CBT in the treatment of anxiety disorders between children and adolescents.”)
- *Cognitive behavioural therapy reduces obsessive–compulsive symptoms in children and adolescents. Level of evidence: A².*
- *Cognitive-behavioural treatment programs targeted at school-aged children and adolescents appear to reduce behavioural symptoms. Level of evidence: B³.*

Target group of cognitive behavioural therapy for children (CBT-C)

The training in cognitive behavioural therapy for children includes treatment models for anxiety, low mood, obsessive–compulsive symptoms, and challenging behaviour. The treatment models are designed for children aged (6/7)–12 with mild to moderate symptoms and for their parents. Under certain conditions, the treatment models of cognitive behavioural therapy for children can also be applied in the treatment of severe mental health disorders or as an intensive intervention as part of other treatment.

Cognitive behavioural therapy for children does not require a diagnosis; however, before starting treatment it is important to carry out an initial assessment in collaboration with the child and the parents in order to select the appropriate treatment model. The treatment can be

started when the child and the parents are, in the professional's assessment, sufficiently committed and motivated for brief therapeutic work.

Implementation of cognitive behavioural therapy for children

The aim of cognitive behavioural therapy for children is to identify behavioural patterns that maintain the child's symptoms and to alleviate the symptoms and the resulting impairments in everyday life. Guidance to treatment may occur either directly on the basis of an assessment or referral, or, for example, after lower-step interventions (guided self-help for parents of primary school children, cognitive behavioural intervention for child and adolescent anxiety) have not been sufficient.

The treatment models of cognitive behavioural therapy for children are structured to include on average approximately 12–13 sessions (maximum 20). Parents are actively involved in the treatment, with both parent-only sessions and joint sessions with the child. Weekly sessions lasting 45-60 minutes are recommended.

Common features across the treatment models include establishing a collaborative and exploratory working relationship, case formulation, setting goals, psychoeducation about symptoms, and treatment model-specific work focusing on the core components of cognitive behavioural therapy: thoughts, feelings, and behaviour.

Parental involvement plays a central role in the child's treatment, both in supporting the child's skills practice and in identifying and working on the parents' own behavioural patterns. Parents participate in sessions regularly, at least at the beginning and end of sessions. The extent of parental involvement is determined by the child's age, developmental level, and symptoms. In addition, parents have separate sessions with the professional.

Training in cognitive behavioural therapy for children

Training in cognitive behavioural therapy for children is primarily intended for nurses, psychologists, and physicians working at the primary care level in children's services. Ideally, the professional has the support of a multidisciplinary team.

The training lasts one year and includes approximately 70 hours of online studies, 30 hours of method-specific supervision, and 70 hours of delivering treatments. The training is completed alongside daily clinical work. In addition to learning the treatment models, the professional acquires general skills that support the formation of a collaborative relationship and the delivery of therapeutic interaction. The training also provides knowledge about the developmental stages of children and their impact on therapy, as well as skills for working with parents.

During the training, a training diary is completed for the training treatments, collecting outcome measurement data during treatment as well as feedback on the treatment from the child and the parents. In addition, the training diary includes the professional's self-reflection related to the training treatments and their own learning.

Method-specific supervision in cognitive behavioural therapy for children (CBT-C)

The training in cognitive behavioural therapy for children includes method-specific supervision. Method-specific supervision is a combination of supervision and teaching, focusing on practising the core skills and delivery of the treatment model. Method-specific supervision is

required in order to develop method-related competence and to ensure the successful delivery of the method. Method-specific supervision is carried out in small groups of approximately four participants on a regular basis throughout the entire training year.

Method-specific supervision is organised either as an in-house activity of the wellbeing services county or as an outsourced service. A new supervisor must complete an induction module on method-specific supervision, and they are provided with support (see the chapter on method-specific supervision for more details).

In cognitive behavioural therapy for children, a method-specific supervisor must be:

- a psychotherapist with cognitive orientation (CBT, cognitive)
- a psychotherapist with another orientation familiar with cognitive behavioural methods
- a social and healthcare professional undergoing cognitive behavioural psychotherapy training
- a psychologist familiar with cognitive behavioural methods
- a nurse with training in a cognitive behavioural approach and at least two years of experience in delivering interventions based on CBT framework
- a healthcare professional who has completed cognitive behavioural therapy training and has delivered at least 70 hours of treatment according to the model after the training.

In addition, the method-specific supervisor must have at least one year of experience in therapeutic work with the relevant age group (children 0–12 years, adolescents 13–18 years, and adults 16+).

Theoretical framework of cognitive behavioural therapy for children (CBT-C)

The overall structure of cognitive behavioural therapy for children is based on the theoretical framework and methods of CBT, as well as evidence-based manualised treatment models for children and parenting skills programs. The treatment models include methods, which in light of current research evidence, are considered central to the treatment of children's anxiety, low mood, obsessive–compulsive symptoms, and challenging behaviour, and which recur in several evidence-based treatment programs. The training program is a multidisciplinary, nationally co-developed, university hospital–certified training. Follow-up data from training treatments are collected continuously, and results are compiled once sufficient data have been accumulated.

¹ Cognitive behavioural therapy in the acute treatment of anxiety disorders in adolescents (Kognitiivinen käyttäytymisterapia nuorten ahdistuneisuushäiriöiden akuuttihoidossa). Duodecim evidence review. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09092> (accessed 14 March 2025)

² Cognitive behavioural therapy in the treatment of obsessive–compulsive disorder in children and adolescents (Kognitiivinen käyttäytymisterapia lasten ja nuorten pakko-oireisen häiriön hoidossa). Duodecim evidence review. Finnish Medical Society Duodecim, Helsinki. Published 24 January 2023. <https://www.kaypahoito.fi/nak09798> (accessed 14 March 2025)

³ Cognitive-behavioural therapy in conduct disorders. Duodecim evidence review (Kognitiivis-behavioraalinen terapia käytöshäiriöissä). Finnish Medical Society Duodecim, Helsinki. Published 12 December 2018. <https://www.kaypahoito.fi/nak09060> (accessed 14 March 2025)

23.5. Other methods

Cool Kids for children

Primary target group: Children and adolescents with anxiety (aged 7–17) and their parents

Level: Step 3

Length of treatment: 10 sessions

Provider: A social and healthcare professional working in units responsible for the prevention and treatment of mental health disorders in children and adolescents

Procedure codes: IDZ04 (Cool Kids, individual treatment)

Cool Kids (IDY19) is a cognitive behavioural therapy–based treatment program for anxiety for children and adolescents aged 7–17 and their parents. The Cool Kids treatment program can be delivered by a social and healthcare professional in training or already qualified in the program, working in units responsible for the prevention and treatment of mental health disorders. In the stepped care model for children and adolescents, the method is positioned at Step 3.

In line with the Current Care Guidelines, Cool Kids is considered to have an evidence-base comparable to that of the cognitive behavioural intervention for child and adolescent anxiety (CBIA) and cognitive behavioural therapy for children (CBT-C).

Cool Kids – target group

Cool Kids is intended for children and adolescents aged 7–17 who experience anxiety that interferes with their everyday life. The Cool Kids treatment program is suitable for the treatment of various fears and worries, such as specific phobias, separation anxiety, generalised anxiety, social anxiety, and panic symptoms. However, Cool Kids is not suitable for treating anxiety that is caused by an adverse environment or by real threats or dangers directed at the child.

Implementation of the Cool Kids treatment program

Cool Kids consists of ten (10) sessions and can be delivered as group-based family treatment, individual family treatment, or an adolescent-focused treatment, delivered either individually or in a group format. Whatever the format of delivery, parents are always involved in the treatment.

The Cool Kids treatment program consists of weekly sessions lasting approximately 60 minutes (120 minutes in group format). Toward the end of the treatment program, sessions are spaced out and held every other week. Both the child/adolescent and their parents participate in the treatment. Children, adolescents, and parents are provided with workbooks that are actively used during the sessions. The content of the treatment program is similar for children and adolescents, but adolescents have their own version of the workbook (the adolescent version is called *Chilled*).

In the Cool Kids treatment program, the child or adolescent learns new skills for managing anxiety, such as cognitive restructuring of unrealistic threat and worry thoughts and gradual exposure to anxiety-provoking situations. Parents of children and adolescents also play an active role in the treatment. Parents learn to support their child to use new skills and to modify their own responses to the child's behaviour. Practising these skills in everyday family life between sessions is important, and the program includes home practice.

Cool Kids training

The training is open to social and healthcare professionals who have at least one year of prior experience of working with children and adolescents with mental health difficulties. In addition, prior experience or training in cognitive behavioural therapy (CBT) is required.

The Cool Kids training lasts one year and includes online studies (approximately 9 hours), two training days (16 hours), method-specific supervision (at least 20 hours), delivery of training treatments, and written assignments.

The Cool Kids program is copyright protected. HUS holds an agreement for providing the training. More detailed training criteria, schedules, and further information can be requested at: cool.kids@hus.fi.

Effectiveness and theoretical framework of the Cool Kids treatment program

Cool Kids is based on cognitive behavioural therapy (CBT). The core principle of CBT is that individuals and their environment are in constant interaction. This interaction includes environmental characteristics as well as the individual's thoughts, feelings, behaviour, and bodily reactions.

The treatment program was developed at Macquarie University in Australia, and its effectiveness has been extensively studied both in Australia and internationally.

24. Methods in adolescent services

The trainings targeted at adolescent services currently include the following methods: guided self-help for adolescents, guided internet cognitive behavioural therapy (guided iCBT), interpersonal counselling for adolescents (IPC-A), interpersonal therapy for adolescents (IPT-A), cognitive behavioural therapy for adolescents (CBT-A), and Cool Kids. The following sections provide a concise description of the methods. Each method has a procedure code used in healthcare information systems to monitor the implementation of the method. Appendix 6 describes the evidence reviews on psychotherapy frameworks included in the Current Care Guidelines for children's and adolescent services.

24.1. Guided self-help for adolescents

Primary target group: Adolescents with mild to moderate mental health problems or life difficulties

Level: Step 1

Length of treatment: 1–5 sessions, on average 3

Provider: Public-sector professionals and units supporting adolescent mental health, responsible for the prevention and support of mental health disorders, such as student welfare services and low-threshold mental health services

Procedure code: IHZ19 (Self-help, mental health or substance use disorder)

Guided self-help for adolescents (IHZ19) is a Step 1, brief intervention for common mental health disorders and life difficulties among adolescents, typically consisting of 1–3 (maximum 5) sessions. The intervention combines the adolescent independently progressing through the self-help program on the Mentalhub website with support from a professional. Guided self-help is intended to be delivered in primary care units where adolescents seek support and help, for example, pupil and student welfare services, mental health units, and social services.

Guided self-help for adolescents is not included in the Current Care Guidelines. The use and maintenance of the method as part of the stepped care model are based on positive experiences gained in Finland, as well as on the lack of systematically implemented, low-intensity methods that can be broadly targeted at different problems in student welfare services and low-threshold mental health services for adolescents. Evidence on the effectiveness of guided self-help in adolescent services has been discussed in a Finnish review article¹. The role of digitally supported guided self-help as a first-line treatment for mild to moderate anxiety and mood symptoms in children and adolescents is covered in the NICE guidelines².

Target group of guided self-help for adolescents

Self-help programs are available for a wide range of symptoms, life situations, and mental wellbeing. Guided self-help is particularly suitable for adolescents with mild anxiety or depressive symptoms, common life challenges, or a desire for change in a specific problem area. Guided self-help is especially appropriate for mild to moderate mental health disorders, but with more severe symptoms it can also serve as a good starting point for treatment when other options are not yet available.

Implementation of guided self-help for adolescents

Guided self-help is positioned at Step 1 in the stepped care model for children and adolescents and should be initiated with minimal delay once a need for support is identified. A physician's assessment is not required. Adolescents can complete the self-help programs independently, regardless of time and place.

Guided self-help can be delivered as a primary intervention, in combination with other support, or while the adolescent is waiting for other services. If necessary, the intervention can be extended, and the balance between guidance sessions and independent work can be flexibly adjusted based on the adolescent's level of functioning and independent engagement.

Guided self-help typically consists of three sessions: an initial session (on average 30–45 minutes), a guidance session (15–45 minutes), and a concluding session (15–45 minutes). Session lengths may vary between approximately 15 and 60 minutes. If necessary, the intervention can be extended by adding guidance sessions (maximum five). Weekly sessions are recommended, and they can be delivered either face-to-face or remotely.

Training in guided self-help for adolescents

The training is intended for all social and healthcare professionals to support mental health and challenging life situations and does not require prior knowledge of mental health disorders or psychosocial interventions. Professionals trained to use guided self-help include, for example, public health nurses and nurses, psychologists, physicians, social workers, and social services professionals. The training is suitable for professionals with any level of experience.

Training in guided self-help for adolescents is a short online course of approximately 8 hours. The online training includes induction to the guided self-help process and session-specific goals, as well as to the exercises used in self-help programs for anxiety, depression, and insomnia. In addition, the online training provides information on applying guided self-help with adults, involving guardians, and practical tips for delivering the intervention.

In addition to the online training, delivery of the method is supported through skills practice and active monitoring of method delivery and treatment outcomes. The number, duration, and format (e.g. group size) of support sessions during training are determined by the unit being trained.

Theoretical framework of guided self-help for adolescents

Both the method and the self-help programs are based on the framework of cognitive behavioural therapy, which is founded on the principle that a person's thoughts, feelings, and behaviour are interconnected.

¹ Mikkonen, K., Bombino, A., Villa, A., Nurminen, S., Roiha, R. M., Roslund, P., ... & Saarni, S. (2024). Guided Self-help in the Treatment of Common Mental Health Disorders: The development of the Finnish guided self-help (F-GSH) model. *Psychiatria Fennica*, 55, 30–47.

² Guided self-help digital cognitive behavioural therapy for children and young people with mild to moderate symptoms of anxiety or low mood: early value assessment: <https://www.nice.org.uk/guidance/hte3/chapter/1-Recommendations> (viitattu 14.3.2025)

24.2. Guided internet cognitive behavioural therapy (guided iCBT)

Guided internet cognitive behavioural therapy (guided iCBT) is described in Section 16.2 of the handbook.

24.3. Cognitive behavioural intervention for child and adolescent anxiety

The adolescent training portfolio also includes the cognitive behavioural intervention for child and adolescent anxiety. As the method is also intended for children, it has already been described in the Methods in children's services (Section 23.3).

24.4. Interpersonal counselling for adolescents (IPC-A)

Primary target group: Adolescents with mild to moderate depressive symptoms

Level: Step 2

Length of treatment: 4–6 sessions

Provider: Public healthcare professionals and units responsible for preventive and mental health–supportive care (e.g. student welfare services, public health nurses, school counsellors, school psychologists)

Procedure code: IDY27

Interpersonal counselling for adolescents (IPC, Interpersonal Counselling) is a time-limited intervention consisting of 4–6 sessions, intended for adolescents aged 12–18 for the prevention and treatment of mild to moderate depressive symptoms. IPC is positioned at Step 2 in the stepped care model and is offered, for example, in comprehensive schools, upper secondary education institutions, and mental health services.

IPC is not mentioned in the Current Care Guidelines; however, it is a shortened version of interpersonal therapy (IPT), which has Level A evidence for the treatment of depression in adolescents. The use and maintenance of IPC as part of the stepped care model are also based on positive experiences gained in Finland in the treatment of mood symptoms and mild depression. The adaptation of IPC used in Finland has been described in a national publication.¹

The effectiveness of IPC can be explored in the results report related to the method.²

Target group of IPC-A

IPC-A is intended for adolescents with mild to moderate depressive symptoms. A diagnosis of depression is not required. IPC materials and methods can also be applied, as appropriate, in situations where an adolescent is waiting to access further assessment, a group intervention, or another treatment setting.

Implementation of IPC-A

IPC can be initiated directly without a referral if the adolescent experiences low mood and feels that their symptoms interfere with daily life. Adolescent may arrange the appointment independently, or it may be scheduled at the initiative of parents or a teacher.

Weekly sessions typically lasting 45 minutes are held. The intervention is delivered through individual sessions, either face to face or remotely. With adolescents, collaboration with parents is recommended.

In IPC, the professional and the adolescent work in an equal collaborative relationship toward a jointly defined goal, based on the selected focus area. IPC addresses interpersonal relationships and life events through discussion and exercises. The aim is to prevent and reduce depressive symptoms, strengthen interpersonal relationships, and alleviate related difficulties. One of four focus areas is selected: role transition, role dispute, grief, or social anxiety / social withdrawal.

Parents (or other close adults) are involved in the treatment whenever possible to increase their understanding of the adolescent's symptoms and to enable them to support the adolescent. The issues discussed in joint sessions with the parents or in the parents' session, are agreed upon/discussed with the adolescent. The intervention can also be delivered entirely without parents, for example at the adolescent's request. Progress toward goals and the adolescent's experience of the intervention are monitored systematically throughout the intervention. In addition, changes in symptom severity are monitored using the PHQ-9 scale.

Training in IPC-A

The IPC-A method can be delivered by a social and healthcare professional trained in the method. In primary mental health and substance use services, trained professionals include public health nurses, social workers, school counsellors, and school psychologists. At least one year of experience working with adolescents is a requirement for the training.

IPC-A training lasts slightly over one year. The training includes online studies, 20 hours of method-specific supervision, and the delivery of at least three training interventions during the training.

During skills workshop days, trainees learn to apply the theory they have learned through practical exercises. These days can be delivered either remotely or face to face. Trainees must complete the theoretical part of the online training before attending the skills workshops, after which they may begin method-specific supervision.

Method-specific supervision is organized regionally and is provided by a professional who has completed IPC method-specific supervisor training and is qualified to deliver supervision. Method-specific supervision is usually conducted in groups of six participants. A single supervision session typically lasts two hours and is held approximately every three weeks.

Effectiveness and theoretical framework of IPC-A

The method is based on the framework of interpersonal therapy, which is founded on the idea that depressive symptoms are linked to the individual's interpersonal relationships and related difficulties. In the interpersonal approach, the sense of self is understood to develop through the individual's position in the social system and the roles they assume or are given. The aim is to alleviate symptoms by bringing about changes in the individual's interpersonal relationships and by identifying new ways to address interpersonal problems.

IPC-A is an interpersonal counselling intervention aimed at alleviating depressive symptoms in adolescents. Research findings on the intervention are encouraging, and studies conducted in Finland and the United Kingdom have shown that IPC-A effectively alleviates adolescent depression and can be delivered in primary services.

¹ Seilo, N., Mämki, K., & Linnaranta, O. (2024). Adaptation of interpersonal counselling for adolescent (IPC-A) for Finnish student welfare services-retrospective evaluation by using the framework for reporting adaptations and modifications-enhanced (FRAME). *Psychiatria Fennica*, 55, 48–63. (accessed 14 March 2025)

² Seurantatuloksia nuorten IPC- ja Cool Kids -interventioista. HUS, Terapiat etulinjaan -toimintamalli. Julkaistu 27.4.2023) <https://terapiatetulinjaan.fi/ajankohtaista/tiedotteet/2023/04/27/seurantatuloksia-nuorten-ipc-ja-cool-kids-interventioista/> (accessed 14 March 2025)

24.5. Interpersonal therapy (IPT)

Primary target group: Adolescents with moderate depression

Level: Step 3

Length of treatment: 12–16 sessions

Provider: Specialised healthcare or primary mental health units, or student welfare services' professionals with a core mental health profession (e.g. school psychologist or psychiatric nurse)

Procedure code: IDY05 (interpersonal therapy (IPT), individual treatment)

Interpersonal therapy for adolescents (IPT-A, procedure code IDY05) is a brief therapeutic intervention for the treatment of moderate depression in adolescents aged 12–18. IPT-A consists of 12–16 sessions. In the stepped care model for adolescents, the method is positioned at Step 3 and is suitable for use, for example, in specialised healthcare and mental health and substance use units.

The use and maintenance of IPT in the treatment of mood symptoms and depression in adolescents as part of the stepped care model are based on the following evidence reviews included in the Current Care Guidelines:

- Interpersonal individual psychotherapy (IPT-A) is an effective treatment for depression in adolescents. Level of evidence: A.¹

Target group of IPT-A

IPT-A is primarily intended for adolescents with moderate depression. Under certain conditions, the method is also suitable for the treatment of severe symptoms.

Implementation of IPT-A

The treatment can be accessed either through referral or on the basis of an assessment conducted within the unit. IPT can be delivered by a social and healthcare professional trained in the method.

Weekly sessions typically lasting 45 minutes are held. Face-to-face sessions are recommended but the treatment can also be delivered remotely.

During the treatment, the therapist works with the adolescent. The aim of the treatment is to alleviate depression, the factors maintaining symptoms, and thereby the resulting impairments in everyday life as well as psychological distress. The therapist and the adolescent work in an equal collaborative relationship toward a jointly defined goal based on the selected focus area. One of four focus areas is selected: role transition, role dispute, grief, and social anxiety/social withdrawal.

Parents (or other close adults) are involved in the treatment whenever possible to increase their understanding of the adolescent's depression and to enable them to support the adolescent. The issues discussed in joint sessions with parents or the parents' sessions, are agreed upon/discussed with the adolescent. The treatment can also be implemented entirely without

parents, for example at the adolescent's request. Progress toward goals and the adolescent's experience of the treatment are monitored systematically throughout the therapy. In addition, changes in symptom severity and functioning are monitored using the PHQ-9 and GAD-7 scales at each session, and the YP-CORE scale at baseline and at the end of treatment.

IPT-A training

In mental health services primarily nurses, social workers, psychologists, and physicians are trained. The training is suitable for professionals with at least two years of experience of working in adolescent mental health.

IPT-A training lasts just over one year. In total, the training entails approximately 120–130 hours, corresponding to about 5 ECTS credits. However, no official ECTS credits are awarded due to the structure of the training. The training includes self-paced online studies, two separate skills workshop days, and year-long method-specific supervision during which at least three training treatments are delivered.

During the skills workshop days, trainees learn to apply the theory they have learned through practical exercises. The days can be delivered either remotely or face to face. Trainees must complete the theoretical part of the online training before attending the skills workshop days, after which they may begin method-specific supervision.

IPT-A training provides basic skills for therapeutic interaction and offers practical tools for working on interpersonal issues.

IPT-A method-specific supervision

Method-specific supervision is a combination of supervision and teaching, focusing on practising the core skills and delivery of interpersonal therapy. Method-specific supervision is required in order to develop method-related competence and to ensure the successful delivery of the method.

A professional who has qualified in the method and completed IPT-A method-specific supervision induction can act as a supervisor. Trainees are required to complete at least 16 hours of method-specific supervision during the training year. Supervision is usually delivered in groups of six participants approximately every three weeks and a single supervision session typically lasts two hours.

Effectiveness and theoretical framework of IPT-A

The core principle of the interpersonal therapy framework is that depressive symptoms are linked to the individual's interpersonal relationships and related difficulties. In the interpersonal approach, the sense of self is understood to develop through the individual's position in the social system and the roles they assume or are given. The aim is to alleviate symptoms by bringing about changes in the individual's interpersonal relationships and by identifying new ways to address interpersonal problems.

Research findings on the treatment are encouraging, and the official level of evidence is A, indicating an effective treatment for adolescent depression. Based on studies and meta-analyses, IPT-A has been shown to be more effective than comparison treatments in the treatment of moderate depression in adolescents, and it has also been effective in the acute treatment of adolescent depression. In studies reporting follow-up data, treatment outcomes have been maintained for 6–18 months.

¹ Interpersonal individual psychotherapy (IPT-A) in the acute treatment of adolescent depression (Interpersonaalinen yksilöpsykoterapia (IPT-A) nuorten depression akuuttihoidossa). Duodecim evidence review. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypa-hoito.fi/nak04392> (accessed 14 March 2025)

24.6. Cognitive behavioural therapy for adolescents (CBT-A)

Primary target group: Adolescents with mild to moderate mental health disorders

Level: Step 3

Length of treatment: 5–10 sessions, on average 7 sessions

Provider: Public healthcare professionals and units responsible for the treatment of mental health disorders

Procedure codes: IDZ02 (cognitive behavioural therapy (CBT), individual treatment)

Cognitive behavioural therapy for adolescents (IDZ02) is intended for young people aged 13–22 with mild to moderate mental health disorders. Cognitive behavioural therapy is intended for use by social and healthcare professionals working in units responsible for the prevention and treatment of mental health disorders. The method is positioned at Step 3 in the stepped care model for children and adolescents and is suitable for use, for example, in mental health and substance use units and in student welfare services (upper secondary level). Cognitive behavioural therapy can also be delivered in a group format.

The use and maintenance of the treatment models included in cognitive behavioural therapy as part of the stepped care model in the treatment of mental health disorders are based on the following evidence reviews included in the Current Care Guidelines:

- *Cognitive behavioural therapy is effective in the acute treatment of anxiety disorders in adolescents. Level of evidence: A¹*
- *Cognitive behavioural therapy (CBT) is effective in the acute treatment of social anxiety disorder in adolescents. Level of evidence: A²*
- *Cognitive behavioural therapy is probably effective in the acute treatment of panic disorder in adolescents compared with symptom monitoring. Level of evidence: B³*
- *Cognitive-behavioural individual and group therapy (CBT) are effective in the acute treatment of depression in adolescents. Level of evidence: A⁴*
- *Continuation and relapse prevention treatment of adolescent depression with CBT probably improves treatment outcomes and protects against relapse. Level of evidence: B⁵*
- *Cognitive behavioural therapy reduces obsessive–compulsive symptoms in children and adolescents. Level of evidence: A⁶*
- *Cognitive-behavioural treatment programs targeted at school-aged children and adolescents probably reduce behavioural symptoms. Level of evidence: B⁷*

Target group of cognitive behavioural therapy for adolescents (CBT-A)

Cognitive behavioural therapy is intended for the treatment of mild to moderate mental health symptoms in young people. Cognitive behavioural therapy for adolescents includes treatment models for generalised anxiety, depression, insomnia, addiction, social anxiety, and panic disorder. Under certain conditions, the treatment models of cognitive behavioural therapy for adolescents can also be applied in the treatment of severe mental health disorders or as an intensive intervention as part of other treatment.

Implementation of cognitive behavioural therapy for adolescents

Access to cognitive behavioural therapy for adolescents may occur either directly through referral to treatment or following first- and second-step interventions (such as guided self-help or IPC). The brief therapy treatment models typically include an average of 5–10 sessions with the adolescent. Weekly sessions lasting 45 minutes are recommended, and they can be delivered either face to face or remotely. Cognitive behavioural therapy can also be delivered in a group format, in sessions lasting 1 hour and 45 minutes, with two facilitators.

Parents' participation in the adolescent's treatment depends on the adolescent's age, developmental level, and symptoms. Parents may be seen together with the adolescent or separately in their own sessions. The role of the parent is to support and encourage the adolescent during the treatment. In addition, parents are provided with psychoeducation about symptoms and ways to support the adolescent in everyday life.

In cognitive behavioural therapy, the professional and the adolescent work in an equal collaborative relationship on a selected problem or symptom using a structured treatment program toward a jointly defined goal. The aim of the treatment is to identify the behavioural patterns that maintain the adolescent's symptoms and to alleviate the symptoms as well as the resulting impairments in daily life.

Across the different treatment models of cognitive behavioural therapy for adolescents, shared features of the treatment include establishing a collaborative and exploratory working relationship, case formulation, setting goals, psychoeducation about symptoms, and treatment model-specific work focusing on the core elements of cognitive behavioural therapy: thoughts, feelings, and behaviour.

Training in cognitive behavioural therapy for adolescents

The training is suitable for professionals with any level of experience. In primary mental health and substance use services, trained professionals include nurses, social workers, psychologists, and physicians and in student welfare services (upper secondary level), psychologists and psychiatric nurses. Ideally, the professional has the support of a multidisciplinary team. Training tailored for specialised healthcare is also available.

Training in cognitive behavioural therapy for adolescents lasts one year. The training includes approximately 90 hours of online studies, 30 hours of method-specific supervision, and 70 hours of delivering training treatments. The professional acquires general skills that support the formation of a collaborative relationship and the delivery of therapeutic interaction. In addition, trainees gain knowledge about developmental and life-stage factors that should be taken into account in adolescent therapies. The training also includes addressing parental involvement, for example, which issues are useful to discuss with the parents of adolescents in treatment.

The training includes treatment models for the following mental health problems: generalised anxiety, depression, insomnia, addictions, social anxiety, and panic disorder. In addition, the training provides professionals with tools for professional development and coping at work.

A training tailored for specialist healthcare is also available. Its core principles are the same as those of standard cognitive behavioural therapy, but it includes training content specific to specialised healthcare. Training interventions delivered in this context may be longer, although limited to a maximum of 20 sessions.

Method-specific supervision in cognitive behavioural therapy for adolescents (CBT-A)

Method-specific supervision is a combination of supervision and teaching, focusing on practising the core skills and delivery of the intervention. Method-specific supervision is needed in order to develop method-related competence and to ensure the successful delivery of the method. Method-specific supervision is carried out in small groups of approximately four participants on a regular basis throughout the entire training year. Method-specific supervision is organised either as an in-house activity of the wellbeing services county or as an outsourced service. A new supervisor must complete an induction on method-specific supervision and is provided with support (see the chapter on method-specific supervision for more details).

In cognitive behavioural therapy, a method-specific supervisor must be:

- a psychotherapist with cognitive orientation (CBT, cognitive)
- a psychotherapist of another orientation familiar with cognitive behavioural methods
- a social and healthcare professional undergoing cognitive (behavioural) psychotherapy training
- a psychologist familiar with cognitive behavioural methods
- a nurse with training in a cognitive behavioural approach and at least two years of experience in delivering interventions based on CBT framework
- a healthcare professional who has completed cognitive behavioural therapy training and has delivered at least 70 hours of treatment according to the model after the training.

In addition, the method-specific supervisor must have at least one year of experience in therapeutic work with the relevant age group (children 0–12 years, adolescents 13–18 years, and adults 16+).

Theoretical framework of cognitive behavioural therapy for adolescents (CBT-A)

The foundation of cognitive behavioural therapy is based on the components and well-established methods of CBT which according to current knowledge and research evidence are effective and central to the treatment of anxiety. These elements recur in various manualised, evidence-based interventions and treatment programs.

The positive changes observed in cognitive behavioural therapy are also thought to be explained by effective factors common to all forms of therapeutic work, including the client's expectations, the collaborative relationship between the client and the professional, the characteristics of the client and the therapist, and situational factors.

¹ Cognitive behavioural therapy in the acute treatment of anxiety disorders in adolescents (Kognitiivinen käyttäytymisterapia nuorten ahdistuneisuushäiriöiden akuuttihoidossa). Duodecim evidence

review. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09092> (accessed 14 March 2025)

² Cognitive behavioural therapy (CBT) in the acute treatment of social anxiety disorder in adolescents (Kognitiivinen käyttäytymisterapia (CBT) nuorten sosiaalisten tilanteiden pelon akuuttihoiossa). Duodecim evidence review. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09097> (accessed 14 March 2025)

³ Cognitive behavioural therapy in the acute treatment of panic disorder in adolescents (Kognitiivinen käyttäytymisterapia nuorten paniikkihäiriöiden akuuttihoiossa). Duodecim evidence review. Finnish Medical Society Duodecim, Helsinki. Published 7 January 2019. <https://www.kaypahoito.fi/nak09101> (accessed 14 March 2025)

⁴ Cognitive behavioural psychotherapy (CBT) in the acute treatment of adolescent depression (Kognitiivis-behavioraalinen psykoterapia (CBT) nuorten depression akuuttihoiossa). Duodecim evidence review. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak04389> (accessed 14 March 2025)

⁵ Continuation and relapse prevention treatment of adolescent depression with cognitive behavioural therapy (Nuorten depression jatko- ja estohoito kognitiivis-behavioraalisella terapialla). Duodecim evidence review. Finnish Medical Society Duodecim, Helsinki. Published 8 January 2020. <https://www.kaypahoito.fi/nak06969> (accessed 14 March 2025)

⁶ Cognitive behavioural therapy in the treatment of obsessive-compulsive disorder in children and adolescents (Nuorten depression jatko- ja estohoito kognitiivis-behavioraalisella terapialla). Duodecim evidence review. Finnish Medical Society Duodecim, Helsinki. Published 24 January 2023. <https://www.kaypahoito.fi/nak09798> (accessed 14 March 2025)

⁷ Cognitive-behavioural therapy in conduct disorders (Kognitiivis-behavioraalinen terapia käytöshäiriöissä). Duodecim evidence review. Finnish Medical Society Duodecim, Helsinki. Published 12 December 2018. <https://www.kaypahoito.fi/nak09060> (accessed 14 March 2025)

24.7. Other methods

Cool Kids for adolescents

The Cool Kids method is intended for children and adolescents and has therefore already been described in Methods in children's services (Section 23.5).

24.8. Development of the training portfolio in children's and adolescent services

The First Line Therapies training portfolio is continuously expanded by following research literature and treatment guidelines and by responding to the needs of the service system. When developing the trainings, attention is given not only to the factors mentioned above, but also to how easily the method can be adopted in primary care services and how the acquired competence can be maintained as part of the unit's routine practice.

Key methods currently missing from the training portfolio in children's and adolescent services:

- Psychotherapy frameworks for children and adolescents recommended in the Current Care Guidelines with Level A and B evidence:

- ADHD: parent guidance
- depression: family therapy, mindfulness-based therapy (MBT)
- conduct disorders: parent guidance

More information on the development of the training portfolio can be found in Section 15.10 of the handbook.

25. Methods for families

25.1. NaP-MIDI (Nurture and Play-Midi)

Primary target group: Families with an infant or a preschool-aged child

Length of treatment: 6 sessions

Provider: A social and healthcare professional who has completed the training

Procedure code: IDZ40

NaP-MIDI (Nurture and Play-Midi; Manualised Intervention for Developing Interaction) is a structured and manualised brief intervention that supports emotional availability and parent-child interaction in early childhood. NaP-MIDI provides the professional with a structured, yet flexible method for supporting parental emotional awareness, sensitivity, and reflectiveness in everyday interaction with the child.

Theoretical framework of NaP-MIDI (Nurture and Play-Midi)

The method is based on the well-researched and evaluated *Nurture and Play* intervention (www.nuturi.net), which is included among the approved growth support methods of ITLA.

The method has been developed by Saara Salo, PhD, licensed psychotherapist, Theraplay® and *Nurture and Play* trainer, and MBT-F trainer (Anna Freud Centre).

The theoretical component of the method consists of key perspectives on early interaction: emotional availability theory, parental reflectiveness, parental emotion regulation, a reflective working approach for the professional, and the effectiveness of interaction interventions.

Target group of NaP-MIDI

NaP-MIDI is intended for families with an infant or preschool-aged child (6 months–5 years). The intervention is particularly helpful in situations where there are concerns about:

- parental emotional availability and sensitivity
- the child's initiative, emotion regulation, or behaviour
- parental coping or strain within family interactions.

Implementation of NaP-MIDI

The NaP-MIDI intervention consists of six guided sessions that follow a clearly structured framework. Each session has distinct objectives, discussion structure, and home practice.

The sessions address, among other things, the collaborative relationship between the parent and the child, as well as parental reflectiveness and emotion regulation. In addition, sensitivity and guidance skills are practised, and the child's initiative and responsiveness are supported.

The method is suitable for both home-based work and clinic-based work, and it can be used in family centres, child health clinic psychology services, or child welfare outpatient services.

The effectiveness of the intervention is assessed using the Emotional Availability (EA) self-report questionnaire completed by the parent and the Parental Reflective Functioning Questionnaire (PRFQ) before and after the intervention.

Training in NaP-MIDI

The training is intended for social and healthcare professionals who have an interest in early interaction, a reflective working approach, and experiential work with families.

NaP-MIDI training provides a strong foundation for professional development and for the use of early interaction methods. The training lasts approximately four months and includes 10–15 hours of online studies, two online seminars (1.5 hours each), six method-specific supervision sessions (2 hours each), the implementation of one training intervention, and completion of a training diary.

The training also lays the foundation for further development of expertise, for example in NaP group interventions or family interventions.

Method-specific supervision in NaP-MIDI

The training includes 6 × 2 hours of method-specific supervision in small groups (3–4 participants). Supervision supports learning, enables reflection, and increases the effectiveness of the work.

Method-specific supervisors are expected to have an interest in experiential and play-based work, as well as experience in working with families and supporting early interaction. Competence in NaP or Theraplay® is considered an advantage.

Each trainee delivers at least one training intervention and reflects on it together with the group and supervisor using a training diary. Supervision can be delivered either regionally or in groups organised nationally by the *First Line Therapies*- coordinator.

25.2. Emotionally Focused Family intervention

Primary target group: Families with school-aged children

Length of treatment: 9–10 (15) sessions

Provider: A social and healthcare professional working with families

Procedure code: IDP02

Emotionally Focused Family intervention (IDP02) is a semi-structured intervention consisting of 9–10 (15) sessions, which can be flexibly applied to different family situations and tailored to the needs of the family. The model is designed for use as part of social services' child-rearing and family counselling and can also be used alongside an emotionally focused couple intervention. The method offers the professional a concrete and experiential way to work with families with problematic interaction and disrupted emotional connection.

Theoretical framework of the Emotionally Focused Family intervention

In services for children and families, children's symptoms are increasingly linked to deficits in secure attachment, disruptions in the family's emotional connection, or parental overload. Responding to these situations requires methods that recognise the central role of emotion regulation, attachment, and family interaction dynamics. The Emotionally Focused Family intervention has been developed to meet this need and is based on the theory and practical applications of Emotionally Focused Family Therapy (EFFT; Johnson).

Implementation of the Emotionally Focused Family intervention

The intervention includes 9–10 (15) sessions, during which the aim is to strengthen the emotional connection between the parent and the child, interrupt negative interaction cycles, and support parental resilience.

The first session involves an initial assessment of the family's situation and joint planning of the intervention with the family. Subsequent sessions focus, among other things, on identifying and interrupting negative interaction cycles, supporting parental resources, experientially building a sense of secure emotional connection, and consolidating change. In the final session, the work is reviewed, positive changes are reinforced, and potential needs for further treatment are discussed.

Training in the Emotionally Focused Family intervention

Professionals in the training are required to work with families and to have experience in psychosocial work. The training is particularly intended for social and healthcare professionals working in child-rearing and family counselling, but it is also suitable for professionals in, for example, rehabilitative family social work (minimum of a university of applied sciences degree or equivalent previous education is required).

Working in pairs also enables participation for those who do not yet have extensive experience in family work. Trainees are advised to ensure that their working conditions allow the delivery of calm and focused client work.

The training lasts approximately one year. It includes around 25 hours of independent online studies, 5 training interventions, and 10 group-based method-specific supervision sessions.

The aim of the training is to increase professionals' understanding of:

- how a lack of emotional connection and insecure attachment relationships are reflected in children's symptoms
- how to work with parental vulnerability and strengthen parental resources
- how attachment relationships can be treated experientially in the parent–child relationship
- how to deliver a family intervention based on an emotionally focused approach.

Theoretical content:

- attachment perspective in working with families
- theory of emotionally focused therapy and principles of the intervention
- fundamentals of experiential work
- processes of strengthening parenting and building emotional connection.

The training is led by Eira Eklund-Mikola, psychologist, couple and family psychotherapist, and trainer in emotionally focused therapy. The training is delivered in cooperation with child and family counselling service operators in Helsinki and a national steering group consisting of social welfare actors.

Method-specific supervision in the Emotionally Focused Family intervention

Method-specific supervision is a combination of supervision and teaching, focusing on practising the core skills and delivery of the intervention. Method-specific supervision is required in order to develop method-related competence and to ensure the successful delivery of the method.

The training in the Emotionally Focused Family intervention includes 10 method-specific supervision sessions, delivered in groups of four participants in three-hour sessions.

Method-specific supervisors are required to have basic training in EFFT or other equivalent competence in emotionally focused therapy, training in emotionally focused couple therapy, and a social and healthcare educational background (e.g. psychologist, nurse, social worker).

26. Data collection, knowledge-based management, and effectiveness in routine clinical practice

The measures and indicators used have been selected based on both national and international recommendations, as well as domestic reviews. The selected indicators complement the national indicators compiled in Sotkanet with concise indicators suitable for organisation-specific monitoring. With regard to measures (e.g. symptom scales), the recommendations of THL are followed, supplemented by the recommendations of the international ICHOM consortium (International Consortium for Health Outcomes Measurement). The selection of measures aims for specificity in relation to the target of the service provided and the problem, symptom, or disorder being treated.

The measures used in youth services and the associated cut-off values are listed in Table 5. The corresponding measures for children are listed in Table 6. In addition, jointly defined indicators guide knowledge-based management and effectiveness evaluation.

Note! Together, the measures and indicators form a functional basis for assessing the implementation of the Act on Therapy Guarantee for children and young people (under 23 years of age):

- Delay from initial contact to assessment of the need for treatment (days)
- Delay from assessment of the need for treatment to intervention (days)
- Number of people waiting for services (waiting for assessment of the need for treatment after initial contact & waiting for intervention after assessment of the need for treatment)
- Target symptom/problem of the interventions
- Previous psychosocial treatment/support for the same target symptom/problem among those seeking help during the past year
- Service provided (procedure code)
- Adherence to Current Care / PALKO recommendations
- Duration of interventions (days & number of visits)
- Change in symptoms
- Change in functioning
- Need for further treatment/support
- Client experience

26.1. Measures used in youth services and their cut-off values

Target symptom	Measure	Clinical cut-off ¹	Threshold for clinically significant change ²
Depression	PHQ-9-A (1)	10	≥ 5
Generalised anxiety	GAD-7	10	≥ 4
Social anxiety	SPIN-FIN	24 (2)	≥ 10
Panic	PDSS-SR	8	≥ 5
Insomnia	ISI	10	≥ 5
Addictions	Measure defined according to the type of addiction	According to the type of addiction, e.g. AUDIT ≥ 4 (3)	No clear cut-off score

Table 7 Measures used in youth services and their cut-off value.

¹ The cut-off values for clinical severity are largely the same as those used in adult services, unless otherwise stated. The measures have mainly been studied in adult populations, and their validity and reliability in use with adolescents are not fully known.

² The thresholds for clinically significant change are, as above, the same as those used in adult services.

Table references:

1. Kaljadin, J., Linnaranta, O., Myllyniemi, A., Seilo, N., Lindgren, M., Therman, S. *Translation and validation of the Patient Health Questionnaire modified for Adolescents*

(PHQ-9-A) (2024). <https://www.julkari.fi/handle/10024/149739> (accessed 16 Oct 2024)

2. Ranta, K., Kaltiala-Heino, R., Rantanen, P., Tuomisto, M. T., Marttunen, M. *Screening social phobia in adolescents from the general population: The validity of the Social Phobia Inventory (SPIN) against a clinical interview*. *European Psychiatry*, 2007 May;22(4):244–251.
3. Häkkinen, M., Niemelä, E., Väänänen, P. *Adolescents who use substances* (2022). <https://www.duodecimlehti.fi/duo16657> (accessed 16 Oct 2024)

26.2. Measures used in children's services and their cut-off values

Target symptom	Measure	Clinical cut-off ⁷	Threshold for clinically significant change
Depression	Child RCADS-47 (1,2) Depression subscale ¹	Defined by subscale according to gender and grade level (T-score ≥ 65) (3)	No clear cut-off score
General anxiety	Child RCADS-47 (1,2) Generalised anxiety subscale ²	–	–
Separation anxiety	Child RCADS-47 (1,2) Separation anxiety subscale ³	–	–
Social anxiety	Child RCADS-47 (1,2) Social anxiety subscale ⁴	–	–
Panic	Child RCADS-47 (1,2) Panic subscale ⁵	–	–
Obsessive-compulsive symptoms	Child RCADS-47 (1,2) Obsessive-compulsive subscale ⁶	–	–
Challenging behaviour	Child SDQ Conduct problems subscale ⁷	≥ 3	–

Table 8 Measures used in children's services and their cut-off values.

¹ Sections: 2, 6, 11, 15, 19, 21, 25, 29, 40, 47

² Sections: 1, 13, 22, 27, 35, 37

³ Sections: 5, 9, 17, 18, 33, 45, 46

⁴ Sections: 4, 7, 8, 12, 20, 30, 32, 38, 43

⁵ Sections: 3, 13, 24, 26, 28, 34, 36, 39, 41

⁶ Sections: 10, 16, 23, 31, 42, 44

⁷ Sections: 5, 7, 12, 18, 22

Table references:

1. ICHOM. *Patient-Centred Outcome Measures* (2024). Depression & Anxiety for Children & Young People. <https://www.ichom.org/patient-centered-outcome-measure/anxiety-depression-ocd-and-ptsd-in-children-and-young-people/> (accessed 16 Oct 2024)
2. Law, D., Wolpert, M. *Guide to Using Outcomes and Feedback Tools with Children, Young People and Families* (2014). 201404guide_to_using_outcomes_measures_and_feedback_tools-updated.pdf (accessed 16 Oct 2024)
3. Chorpita, B. F., Ebesutani, C., Spence, S. H. *Revised Children's Anxiety and Depression Scale User's Guide*. UCLA: Child First (2020). <https://www.childfirst.ucla.edu/wp-content/uploads/sites/163/2020/12/RCADSUsersGuide20201201.pdf> (accessed 16 Oct 2024)

26.3. Goals for access to treatment and effectiveness

The following goals are derived from international treatment models as well as domestic reviews. Current and upcoming legislation must also be considered. The goals describe what primary mental health services can realistically achieve: timely and effective support that helps meet people's needs while preserving the system's capacity.

- Step 1 treatment can be initiated for suitable clients of all ages within one week.
- Step 2 treatment can be initiated for suitable clients of all ages within one month (including the therapy guarantee for children and adolescents).
- The proportion of clients who reliably recover from common mental health disorders, symptoms, or problems is at least 50% after Step 1 and Step 2 treatments in primary-level services.

IMPLEMENTATION AND MAINTENANCE OF THE FIRST LINE THERAPIES MODEL

This chapter describes the construction of a stepped care model using a phased approach. The model includes phases of negotiation, preparation, implementation, and maintenance and further development. In addition, a separate subchapter presents a risk management tool that facilitates development work.

In practice, building a stepped care model means harmonising regional treatment pathways and strengthening the regional range of treatments. Achieving this requires dialogue between different actors within the wellbeing services counties, identification of interfaces, and the definition of a shared objective and the necessary measures. For example, in adult services a key interface is the division of work between general practice appointments in health centres and more specialised mental health and substance use services. In children's and young people's services, interfaces exist, for example, between student welfare services, mental health services for children and adolescents, and social services.

27. Roles and responsibilities in change management

The implementation of the First-Line Therapies model in a wellbeing services county is a long-term strategic effort. It requires a shared commitment across the entire service organisation, clear goal-setting, an action plan, monitoring, and maintenance structures. The objective is a change in organisational culture, which requires commitment from everyone: management, supervisors, and professionals working with clients. If the chain breaks at any organisational level, the likelihood of success decreases significantly. The chain must also function in both directions to ensure commitment to the change.

The most important task of **senior management** is to clearly express a shared commitment to addressing the mental health crisis. They understand the seriousness of the current situation and are able to justify why change is necessary. This means that top management must commit to the objectives required by the change process and ensure that organisational strategies and resources support them. Clear and well-justified strategic decisions help to ensure that all levels of the organisation understand and support the change.

At the level of **service managers and supervisors**, practical support and systematic day-to-day management are needed. Data-informed and systematic everyday management also helps to ensure that operations are consistent and that all parties adhere to agreed practices.

It is important for the **professionals** to feel that they are involved in the change process. This means that they must be given opportunities to participate in the decision-making and development work. Participation increases commitment and motivation, which in turn improves the quality and effectiveness of the services.

As the development work takes place at different organisational levels and across various networks, the coordination of development activities and the flow of information between these forums are prerequisites for success. The structures for implementation and maintenance therefore include the identification of roles and responsibilities related to change management, as well as the coordination in which the therapy or intervention coordinators play a central role.

Therapy and intervention coordinators collaborate at multiple levels, starting from professionals, supervisors, service managers, and lead developers within their own area, and extending to responsible lead professionals in their cooperation area (YTA), therapy and intervention coordinators in other wellbeing services counties, and the lead experts developing the First-Line Therapies model. The work of the therapy coordinator is described in Chapter 12.1, and the work of the intervention coordinator in Chapter 18.1.

Within the wellbeing services county, therapy and intervention coordination functions should be positioned close to the key partners, such as managers and supervisors of mental health and substance use services or first-line service units. The service line director is responsible for ownership of the model, with support from the therapy and intervention coordinators. A proven good practice is to establish a separate steering group that meets regularly to support and oversee the functioning of the stepped care model. Especially to support the implementation of children's and adolescents' services, many areas have established an implementation group to ensure that the stepped model of support and treatment responds to regional needs and that there is commitment to it.

28. Phases of implementation

The construction of a stepped care model can be conceptualised as a series of successive phases, each with its own questions and actions.

Experience has shown that building and regionally adapting a stepped care model is neither simple nor achievable through a one-off effort. The work is long-term and requires repetition. The more strongly both the wellbeing services county and individual service units experience opportunities for influencing and ownership of the change, the more smoothly the process progresses. Smooth progress is challenged by several factors, many of which are unavoidable. For example, information gaps, competing priorities or acute issues among stakeholders, as well as internal ambiguities or unfinished decision-making processes within the wellbeing services county, can hinder progress.

28.1. Negotiation phase

During the negotiation phase, the wellbeing services county's therapy or intervention coordinator, or another designated responsible person, collaborates with the operational units' line management and middle management. The negotiation phase focuses on the fundamentals of the stepped care model, support services for the implementation process, the importance of monitoring effectiveness, and the phases of change process. The negotiation phase is also a time for getting to know one another and taking the first steps in collaboration. It is important that actors within the wellbeing services county receive answers to unclear issues and are given sufficient time to make their own decisions.

Key questions in this phase:

- Does the stepped care model respond to the needs and development goals of the operational unit?
- Does the stepped care model address problems that have been jointly identified within the operational unit?

- What kind of internal collaboration is needed between different actors within the wellbeing services county?

28.2. Preparation phase

The preparation phase is a time of close collaboration, during which it is recommended to involve the professionals working with clients and to utilise nationally accumulated benchmarking data on building a stepped care model and implementing individual methods. The preparation phase concludes with the launch of tool and/or method trainings.

The smooth progress of the preparation phase is supported by systematic planning and a structured working approach. Planning and structure are supported by the use of the Implementation ABC- and the Implementation Risk Management-tools. In addition, nationally accumulated benchmarking data and experiences of good practices support the decision-making in wellbeing services counties.

From the perspective of the responsible key professionals in wellbeing services counties, the preparation phase is often the most demanding. Many issues must be decided and aligned, and at times supervisors may be uncertain about what decisions they are authorised to make. During the preparation phase, staff experiences and perceptions of the upcoming change also become visible for the first time.

Key questions in this phase:

- What does our regional stepped care model look like?
- How do we manage risks related to implementation (with support from the risk management tool)?
- What are the best regional solutions and nationally identified good practices?
- Which professionals will participate in the trainings?
- What support structures are needed for the professionals working with clients and for the line management?
- How is the work of professionals organised in a way that supports learning?
- What kinds of client guidance practices are needed?
- What are the uniform documentation practices?
- How do we implement feedback-informed practice, i.e. collect and use data as part of everyday work and development?
- How do we communicate the change to all stakeholders?

28.3. Implementation phase

During the implementation phase, new methods are used as part of client work. The use of methods is monitored as part of the agreed support structures and data collection practices. Most commonly, support services include method-specific supervision (e.g. in cognitive behavioral therapy (CBT) and IPC) and skills workshops (e.g. guided self-help and The First Assessment). For successful implementation, it is important that during the implementation phase there is time for discussion, sharing experiences, reviewing accumulated data, and making decisions based on that data, within the units' regular structures, such as team meetings.

During the implementation phase, supervisors gain visibility into how new practices or methods fit into the everyday work of professionals providing client services. Supervisors begin to form an understanding of what appears useful and which issues cause problems at both the unit and professional level. The implementation phase is a good time to return to the Risk Management-tool together with the wellbeing services county's coordinator and assess whether any of the anticipated risks have materialised and whether the planned mitigation measures have been effective. The implementation phase is an ideal time to make adjustments. It is important to understand the root causes of implementation challenges so that solutions are effective and sustainable. The causes may lie elsewhere than initially was assumed. During the implementation phase, supervisors' decision-making and actions are supported by nationally accumulated benchmarking data and experiences of good practices.

28.4. Maintenance and further development phase

In the maintenance and further development phase, trainings and any related training treatments, method-specific supervision, and skills workshops have been completed. Any issues identified during the implementation phase have been addressed and necessary adjustments made. At best, the methods are used and their effects are monitored smoothly as part of everyday work, and the implementation of the stepped care model has improved the timeliness of access to care and interventions, appropriate targeting, and effectiveness.

The maintenance and further development phase often also involves challenges that in one way or another weaken the effective use of the stepped care model. Most commonly, these challenges are related to turnover among supervisors or staff, incomplete internalisation of methods, failure to monitor individual-level effectiveness, or the absence of an entire step in the care pathway. At worst, an already established stepped care model begins to erode, and operations revert to ad hoc referrals to care and infrequent, potentially ineffective support visits.

In everyday work, the maintenance of the stepped care model is influenced by many factors. Together with wellbeing services counties, the most significant factors challenging the embedding of the stepped care model and its integration into services have been identified.

Lack of coordination

The most significant risk factor for the maintenance and further development of the stepped care model is the absence of wellbeing services county-level therapy or intervention coordination, or insufficient integration of this function into the line organisation's operations. The absence of coordination affects each of the key areas listed below.

Day-to-day management.

- Internal roles and responsibilities within the wellbeing services county are unclear, and there are insufficient structures for development and collaboration.
- Support from senior management is lacking.
- A line supervisor or service manager is missing.
- The objectives and phases of the intended change are unclear.
- Staff turnover is high and induction structures are lacking.
- Factors affecting the effectiveness of psychosocial treatments and psychotherapies are not sufficiently well understood.

The coordinator builds and maintains regional and inter-unit networks and structures and operates as part of the national development network, which is a key prerequisite for success. They also act as an introducer and facilitator of the model.

Guidance to support or treatment

- The Finnish Therapy Navigator system and The First Assessment are underused among clients and staff relative to their potential.
- Regional guidance-to-treatment practices vary and/or not all professional groups are familiar with the range of the regional stepped care model.
- The client is not involved in decision-making regarding their guidance to support or treatment.
- The professional conducting The First Assessment does not have sufficient knowledge of the treatments to which clients are referred.
- The First Assessment is not trusted, and the assessment of treatment need is repeated.
- Assessments of the need for further treatment are sporadic.

The coordinator provides training in the use of the navigators and The First Assessment and is responsible for developing and implementing guidance-to-treatment models.

Delivery of support and treatments

- Support or treatment is not goal-oriented.
- Brief interventions are not appropriately targeted.
- The effectiveness of support and treatment is not monitored at the individual level.
- Support and treatment are not tailored based on the client's individual needs.
- Regular mentoring structures for maintaining and developing method competence have not been established.
- There are no agreed practices for problem situations or consultations, such as utilising the coordinator or a method supervisor.
- Documentation of treatments does not utilise standard phrases or procedure codes.

The coordinator plays a key role in the practical organisation of trainings and, in many regions, is also responsible for method-specific supervision and mentoring.

Service range and guidance practices of the stepped care model

- The service range of the stepped care model has not been jointly validated by the key actors in the wellbeing services county.
- Care pathways and processes between steps are unclear or ad hoc.
- First-step interventions, such as guided self-help, are underused relative to their suitability and benefits.
- Internal method supervisor resources (e.g. CBT, IPC, ALI) or post-training mentoring are not available or are insufficient relative to need.
- Third-step brief psychotherapies are not part of the service range.
- Timely access to care and the intensive delivery of treatments deteriorate.

- The regional service range does not sufficiently meet the needs of all client groups; for example, some clients with long-term symptoms or those not suitable for therapy are left without support that would benefit them.

The coordinator maintains and facilitates the collaboration network between different key professionals in the development of the stepped support and care model and in the construction of care processes.

Everyday effectiveness and data-informed management

- Information on service use and effectiveness is not collected.
- Information is collected, but it is not utilised in supervisory work or in the everyday practice of professionals working with clients.

The coordinator supports the development of practices for collecting and utilising effectiveness data in collaboration with supervisors. They also promote the introduction and use of procedure codes.

28.5. Risk management tool

The risk management tool creates a manageable structure for implementation. Successful implementation and embedding require attention to quality management throughout the entire process. In the First-Line Therapies model, the Risk Management Excel-tool for risk analysis has been developed to help creating a plan for the successful implementation and embedding of new methods. The tool is used to identify risks threatening the implementation and embedding of the stepped care model in local services, to assess their likelihood and criticality, and to plan protective measures and their implementation to reduce risks.

The Risk Management-tool is suitable for all age groups and for all methods and tools. The tool has been developed based on nationally accumulated experiences and lessons learned. The risk management tool includes 17 pre-filled common risks, in addition to which specific region-level risks can be added to the analysis. The risks have been identified based on national implementation and embedding experiences related to the Finnish Therapy Navigator, guided self-help, and cognitive behavioral therapy (CBT). Likewise, the impact of risks on success and effective protective measures has been assessed based on accumulated experience. In the substantive formulation of risks, the Normalization Process Theory on the embedding and normalization of new practices in the work environment, the EPIS model of the implementation process, and the NoMAD measure used to assess embedding, have been utilised.

During the negotiation and preparation phases, the foundation for the implementation and embedding of methods is built. This phase includes resolving many practical issues and taking into account all actors affected by the forthcoming change. Without a shared understanding of what is being changed, why the change is needed, and how it will be implemented, many risks are likely to materialise.

FROM A PROJECT TO A PERMANENT OPERATION

The development of the First-Line Therapies model and adapting its services across different wellbeing services counties was funded with grants from the Finnish Ministry of Social Affairs and Health and from NextGenerationEU between 2020 and 2025. After five project years, the First-Line Therapies model and its services have become established as part of the mental health services structures of the wellbeing services counties that began operating in 2023.

From 2026 onwards, the model will be further developed through national network-based collaboration between wellbeing services counties. The national services will be maintained as part of the Mental Health Services Support Centre of HUS Psychiatry. The aim is to establish a dedicated competence centre for each YTA area. In this arrangement, the YTA competence centres would function as a national development network and as support for the development of mental health services within their own YTA areas.

The maintenance structures of the First-Line Therapies model evolved as needed. An up-to-date description of the services is available on our website: <https://terapiatetulinjaan.fi/en>

PUBLICATIONS AND LITERATURE REVIEWS

Articles, research papers and theses related to the model are listed on the First-Line Therapies model website.

Reports and results: <https://terapiatetulinjaan.fi/vaikuttavuus/raportit-ja-tulokset/>

Literature reviews: <https://terapiatetulinjaan.fi/vaikuttavuus/kirjallisuuskatsaukset/>

Other publications: <https://terapiatetulinjaan.fi/vaikuttavuus/julkaisut/>

APPENDICES

Appendix 1. Criteria for applying to become a method-specific supervisor in cognitive methods

Cognitive Behavioral Therapy (CBT)	Cognitive Behavioural Intervention for Child and Adolescent Anxiety (CBIA)
A CBT method instructor may be: • a psychotherapist with cognitive orientation (CBT, cognitive) • a psychotherapist of another orientation familiar with cognitive behavioural methods • a social and healthcare professional undergoing cognitive (behavioural) psychotherapy training • a psychologist familiar with cognitive behavioural methods • a nurse with training in a cognitive behavioural approach and at least two years of experience in delivering interventions based on CBT framework • a healthcare professional who has completed cognitive behavioural therapy training and has delivered at least 70 hours of treatment according to the model after the training. In addition, the applicant must have: • at least one year of experience in therapeutic work with the relevant age group (children 0–12 years, adolescents 13–18 years, or adults 16+ years).	A CBIA method-specific supervisor may be: • a psychotherapist with cognitive orientation (CBT, cognitive) • a psychotherapist of another orientation familiar with cognitive behavioural methods • a social and healthcare professional undergoing cognitive (behavioural) psychotherapy training • a psychologist familiar with cognitive behavioural methods • a social and healthcare professional with training in a cognitive behavioural approach and at least two years of experience in delivering interventions based on CBT framework • a professional who has completed the CBIA training and has delivered at least 12 hours of treatment according to the model after the training.

Appendix 2. Criteria for applying to become a method-specific supervisor in interpersonal methods.

Interpersonal Counselling (IPC)	Interpersonal Therapy (IPT)
Educational background A core mental health profession (psychologist, social worker [specialised in mental health work], registered nurse, physician) working in: • specialised healthcare • a basic-level mental health unit* • student welfare services*. In addition to the educational background, the applicant must be: • an accredited interpersonal therapy for adolescents (IPT-A) therapist (3 completed treatments) • an accredited interpersonal counselling for adolescents (IPC-A) practitioner (5 completed treatments)*. *) Admission is assessed on a case-by-case basis (regional need/service system, opportunity to conduct IPT-A interventions, suitability of educational background, additional qualifications). Work experience Three years of experience working with adolescents in either: • specialised healthcare • a basic-level mental health unit • student welfare services. In addition Ongoing IPT/IPC practice for at least one year and the ability to commit to the training.	Minimum requirements for an IPT-A method instructor: • at least 3 years of experience using IPT-A • IPC method instructor training or other clinical supervision training (or other suitable educational background) • at least 6 completed IPT-A treatment episodes • active personal IPT practice.

Appendix 3. Criteria for supervisors of method-specific supervisors.

Criteria for supervisors of method-specific supervisors:

A supervisor of method-specific supervisors must meet the baseline criteria for a method-specific supervisors in the method they supervise (criteria vary by training program).

1. In addition to the above, the applicant must score at least 3 points from the following categories (a, b, c):

a) Educational background (0–3 points)	3 points = trainer psychotherapist in a relevant therapeutic framework 2 points = psychotherapist in a relevant therapeutic framework 1 point = psychiatrist, psychologist, or a professional undergoing psychotherapy training in a relevant therapeutic framework 0 points = other educational background
b) Method-specific supervisor experience in the specific method* (0–4 points)	4 points = supervised 7 or more method-specific supervisor groups 2 points = supervised 3–6 method-specific supervisor groups 0 points = supervised fewer than 3 method-specific supervisor groups
c) Method-specific supervisor experience in other methods (CBT, Cognitive behavioural intervention for child and adolescent anxiety, IPT, IPC, Cool Kids) (0–2 points)	2 points = supervised 7 or more method-specific supervisor groups 1 point = supervised 3–6 method-specific supervisor groups 0 points = supervised fewer than 3 method-specific supervisor groups.

*) During the transition period (2024–2027), for cognitive behavioral therapy for adolescents (CBT-A) and cognitive behavioral therapy for children (CBT-C), method-specific supervisor experience may include experience in Cool Kids or adult cognitive behavioral therapy (CBT), together with sufficient additional experience of working with children and/or adolescents.

Appendix 4. Evidence reviews of psychotherapeutic frameworks included in the Current Care Guidelines for adult services.

Current Care Guideline title	Trauma-focused psychotherapy	Solution-focused psychotherapy	Integrative psychotherapy	Cognitive and behavioral psychotherapy	Couple and family psychotherapy	Psychodynamic psychotherapy Psychoanalytic psychotherapy	Cognitive analytic psychotherapy	Gestalt psychotherapy	Group psychotherapy (therapeutic framework to be specified separately)	Other notes
ADHD (04/2019)	-	-	-	<u>++</u>	-	-	-	-	<u>B</u>	
Anxiety Disorders (01/2019)	-	-	-	Panic disorder: <u>A B B B C C C</u> Social anxiety: <u>A A A B B C</u> GAD: <u>A A A A A B C</u>	-	Panic disorder: <u>C</u> Social anxiety: <u>B</u> GAD: <u>C</u> <u>+</u>	-	-	<u>A</u> (CBT)	<u>C</u> (IPT) <u>C</u> (ACT)
Alcohol Use Problems (08/2018)	-	-	-	<u>A</u> (motivational interviewing) <u>B</u>	<u>B</u>	(Limited benefit of psychodynamic therapies: <u>++ ++ ++ ++</u>)	-	-	<u>B</u> (AA-grups)	<u>A</u> (psychosocial treatment > no treatment)
Depression (05/2024) – Adults	-	<u>C</u>	<u>+</u>	<u>A A A A A A A B B B C C</u>	<u>B</u>	<u>A B</u>	<u>+</u>	-	<u>A</u> (CBT) <u>C</u> (CBT, IPT)	<u>A</u> (IPT) <u>C</u> (ACT)
Borderline Personality Disorder (06/2020)	-	-	<u>B</u> (schema therapy)	<u>A A B B</u> (DKT) <u>A</u> (CBT) <u>B</u> (other CBT) <u>C</u> (time-limited CBT)	<u>C</u>	<u>A</u> (time-limited PDT) <u>B B</u> (transference-focused PDT) <u>A A</u> (mentalization-based therapy MBT)	-	-	<u>A</u> (DKT)	
Drug Use Problems (09/2022)	-	<u>+</u>	-	<u>B B</u> (cannabis) <u>B</u> (opioids)	<u>+</u>	<u>+</u>	-	-	<u>+</u> (AA- and NA-groups)	<u>A B B</u> (therapy regardless of therapeutic framework > no therapy)

Suicide Prevention (02/2022)	-	-	-	<u>A</u> (CBT focused on suicide prevention)	-	-	-	-	-	
Key: A/B/C/D = level of evidence; + = mention or individual reference cited; – = not mentioned										
Bipolar Disorder (02/2024)	-	-	-	<u>C</u> ; <u>C</u> (treatment of depression; prevention of recurrence of depressive episodes) <u>C</u> (CBT model for insomnia during the recovery phase) <u>C</u> (guided iCBT for the treatment of mild depression) <u>C</u> ; <u>C</u> (cognitive remediation)	<u>C</u> ; <u>B</u> (FFT: treatment of depression; prevention of recurrence of depressive episodes)	-	-	-	<u>A</u> (psychoeducational group therapy)	<u>C</u> ; <u>C</u> (IPSRT: depression; prevention of recurrence of mood episodes)
Obsessive-Compulsive Disorder (01/2023)	-	-	-	<u>A</u> <u>A</u> (CBT-based self-help programs and guided internet cognitive behavioral therapy (guided iCBT)) <u>C</u> (comorbid OCD + ASD)	-	-	-	-	-	<u>B</u> (Bergen model)
Key: A/B/C/D = level of evidence; + = mention or individual reference cited; – = not mentioned										
Schizophrenia (02/2024)	-	-	-	<u>A</u> <u>A</u> <u>A</u> (cognitive remediation for negative symptoms)	<u>A</u> <u>A</u> (psychoeducational family interventions)	<u>C</u> (supportive PDT is beneficial; interpretation-based PDT may be ineffective <u>C</u>)	-	-	+ (CBT) <u>C</u> <u>C</u> (various peer support groups)	<u>A</u> (integrated treatment programs for first-episode psychosis) <u>B</u> <u>B</u> (psychoeducational therapies)

				<u>A</u> <u>B</u> (CBT for positive symptoms) <u>B</u> (training in identifying early warning signs is important for relapse prevention, as symptom-focused CBT alone is not sufficient <u>C</u>) <u>B</u> (metacognitive therapy) <u>C</u> (recovery-oriented CBT)						
Eating Disorders (09/2024)	-	-	-	Anorexia: <u>C</u> Bulimia: <u>A</u> <u>A</u> <u>C</u> <u>C</u> <u>D</u>	Anorexia: <u>A</u> <u>A</u> <u>B</u> <u>B</u> <u>B</u> Bulimia: <u>A</u>				<u>B</u> (family therapy)	third-wave therapies, including DBT and ACT: <u>A</u> IPT: <u>A</u> DBT: <u>B</u> <u>C</u>
Post-Traumatic Stress Disorder (12/2022)	(<u>A</u>) <u>+</u> <u>+</u>	-	-	<u>A</u> <u>B</u> <u>C</u> <u>C</u>		<u>+</u>	-	-	<u>C</u> (trauma-focused CBT)	
Insomnia (01/2023)	-	-	-	<u>A</u> <u>A</u> <u>B</u> <u>B</u> <u>+</u>			-	-		
Key: A/B/C/D = level of evidence; + = mention or individual reference cited; – = not mentioned										

Appendix 5. Measures used in adult services and their cut-off values, referenced table.

Measures used in adult services and their cut-off values

Target symptom	Measure	Threshold for disorder-level symptoms	Threshold for clinically significant change
Depression	PHQ-9 [1,2]	10 [1]	≥ 5 [3]
Generalized anxiety	GAD-7 [2,4]	10 [4]	≥ 4 [5]
Social anxiety	SPIN-FIN [2,6]	19 [6]	≥ 10 [7]
Panic disorder	PDSS-SR [2,8]	≥ 9 [9]	≥ 5 [7]
Insomnia	ISI [10]	10 [10]	≥ 6 [11]
Substance use disorders	measure determined by the target of the addiction	According to the target of the addiction. E.g. AUDIT (men ≥ 8, women ≥ 6) [12]	No clear cut-off score ¹
Attention and concentration difficulties	ASRS	No clear cut-off score ²	No clear cut-off score ³

¹ There are no clear cut-off values for identifying clinically significant change, and the assessment of outcomes should always be considered in relation to the target of the intervention (reduction or cessation of substance use). The systematic measurement of an individual treatment goal can be used to support the evaluation of effectiveness.

² The ASRS questionnaire consists of two parts. Part A serves as an ADHD screening tool. Items are scored on a scale from 0 to 4, and the total score for Part A ranges from 0 to 24. If four or more of the patient's responses fall within the shaded boxes of the instrument, the patient's symptoms are consistent with ADHD and further assessment is warranted.

³ When evaluating the effectiveness of the ASRS, both Parts A and B of the instrument should be used. In assessing clinical effectiveness, particular emphasis is placed on evaluating the impairment caused by the symptoms. Clear cut-off scores are not currently available.

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Appendix 6. Evidence reviews of psychotherapeutic frameworks included in the Current Care Guidelines for child and adolescent services.

Current Care Guideline title	Trauma-focused psychotherapy	Solution-focused psychotherapy	Integrative psychotherapy	Cognitive and behavioural psychotherapy	Couple and family psychotherapy	Psychoanalytic psychotherapy Psychodynamic psychotherapy	cognitive analytic psychotherapy	Gestalt psychotherapy	Group psychotherapy (therapeutic framework to be specified separately)	Other notes
ADHD (04/2019)	-	-	-	<u>B</u> <u>B</u> <u>+</u>	<u>B</u> (structured guidance)	<u>+</u>	-	-	<u>C</u> (CBT)	
Anxiety Disorders, children and adolescents (09/2024)	-	-	-	Adolescents: <u>A</u> <u>A</u> <u>B</u> <u>C</u> <u>D</u> <u>D</u>	Children and adolescents: <u>+</u> <u>+</u>	Adolescents: <u>D</u> <u>+</u>	-	-	-	Children and adolescents: <u>+</u> (exercise)
Depression (05/2024) – adolescents	-	-	-	<u>A</u> <u>B</u> <u>C</u> (behavioral activation)	<u>B</u>	<u>C</u>	-	-	-	<u>A</u> (IPT) <u>B</u> (mindfulness MBT) <u>C</u> (supportive psychotherapy)
Depression (05/2024) – children	-	-	-	-	-	-	-	-	-	
Borderline personality disorder	-	-	-			<u>C</u> (MBT for adolescents)				
Obsessive-Compulsive Disorder (01/2023)	-	-	-	<u>A</u> (Children and adolescents)						
Conduct Disorders, children and adolescents (12/2018)		<u>D</u>	-	<u>B</u> <u>C</u>	<u>A</u> (parent management training) <u>B</u> <u>B</u>	-	-	-	<u>D</u> (CBT-based anger management)	<u>B</u> (psychosocial treatments most appropriate for different age groups)
Key: A/B/C/D = level of evidence; + = mention or individual reference; – = not mentioned.										