Conclusions and recommendations of the National Audit Office

Mental health and substance abuse services for young people in wellbeing services counties – Service availability, accessibility and coordination

The audit looked at mental health and substance abuse services for young people organised by the wellbeing services counties, the City of Helsinki and the HUS Group at primary level as well as in specialised medical care, student welfare and social welfare services. The audit focused on services for young people, as recent development indicates that mental health disorders among young people are increasing. It has been found that up to one half of adult mental health disorders begin by the age of 15 and as many as 75% by the age of 25. Young people's mental health and substance abuse problems have long-term impacts and significantly increase exclusion from education and the labour market. On the other hand, the possibilities of influencing young people's mental well-being are good. Studies indicate that the direct and indirect economic costs of mental health disorders in Finland are up to over EUR 10 billion a year.

The audit evaluated the functioning of mental health and substance abuse services for young people from the viewpoints of availability, accessibility and service coordination. The problems in mental health and subject abuse services for young people identified in studies and reports completed before the social welfare and health care reform was implemented included poor availability and fragmentation of the services, major regional differences in the provision of services, ineffective cooperation between different actors, and shortcomings in the knowledge base related to the services. Mental health and substance abuse services were assessed together in the same audit as they are typically developed as a functional entity. Simultaneous mental health and substance abuse disorders, or dual diagnoses, are common.

There are significant regional differences in mental health and substance abuse services for young people – regional equality is still not realised

With the exception of the wellbeing services counties of Kainuu and North Karelia, mental health and substance abuse services at the primary level were offered for young people in all counties in May 2024. However, the audit found major differences regarding the range of services offered and the available resources. Few uniform service structures exist in primary services at the national level. There

are major differences and also shortcomings particularly in substance abuse services for young people.

While the service structures are more uniform in youth psychiatry services provided as specialised medical care than at the primary level, there are major differences in the provision of care between wellbeing services counties. Significant differences exist regarding the costs, numbers of patients and visits in proportion to population of the same age, numbers of visits per patient, delay in access to treatment, share of inpatient care, use of outsourced services, and workload of the services. Substance abuse services at specialised medical care level are rarely available for minors.

Age limits for mental health and substance abuse services for young people are not based on a medical view of youth

There are significant variations in the age limits for mental health and substance abuse services for young people between the wellbeing services counties, especially in primary level services. While the most common age limit in May 2024 was 13 to 18 years, the upper age limit varied from 17 to 29 years. Within six counties, internal variations were also found in the age limits for primary level services. Youth psychiatry services at specialised medical care level were most commonly targeted at young people aged from 13 to 17.

The development stages of adolescence are deemed to take place between the ages of 12 and 22, and brain development continues throughout adolescence. The grounds for age limits set for mental health and substance abuse services for young people are rarely medical, however. The grounds for the age limits vary greatly between the wellbeing services counties and are diverse. The age limits in use are most often justified by avoiding overlaps with services for children and adults and by limited personnel and financial resources.

Outsourced services may put continuity of care at risk and reduce the quality of services

Services outsourced to private providers, including temporary agency work, are very common in primary services, specialised medical care, and mental health and substance abuse work in student welfare services alike. The main reason for outsourcing the services is problems with the availability of personnel. While a physician's services are the most common ones to be outsourced, a psychologist's and therapy services are also frequently procured.

In addition to their high costs, outsourced services hamper service coordination and cooperation. According to the wellbeing services counties, turnover of service providers means that treatments are disjointed and continuity

of care is jeopardised. Quality control and supervision of outsourced services is considered difficult. Especially in youth psychiatry services delivered as specialised medical care, quality is sometimes experienced as low compared to the costs, and the work is found ineffective. Outsourced labour's low level of commitment to development and networking efforts and a lack of cooperation between outsourced services and public service provision are also seen as problems.

Maximum waiting times in primary healthcare are not monitored – the preconditions for knowledge-based management of primary services are poor

Once a client's need for care has been assessed, they should be able to access non-urgent primary healthcare within 14 days. Only four wellbeing services counties (South Karelia, Central Finland, Pirkanmaa and Ostrobothnia) were able to estimate the share of young people who had accessed care within the statutory maximum waiting time set for primary healthcare. Some wellbeing services counties consider monitoring the waiting times difficult as they find that the definition of starting care provision given in legislation is ambiguous. While the statutory waiting times for specialised medical care were complied with in most counties in spring 2024, there were clear differences in how quickly patients accessed care. Only three wellbeing services counties were able to report that the need for care was assessed within three weeks as required by legislation. Internal queues are typically formed following the assessment of the need for care at the primary level and in specialised medical care, which further complicates the monitoring of actual access to care.

Several wellbeing services counties were unable to report even the most essential monitoring data and key figures on services to the National Audit Office. In addition to information on the waiting times, many counties lacked data concerning the total costs of services, costs of outsourced services, compliance with legislation in assessing patients' need for care, and numbers of outpatient visits and clients. Monitoring data concerning access to student welfare services and compliance with regulation on staffing levels were also unreliable.

The level of integration varies and continuity of care is fraught with risks

The level of integration of mental health and substance abuse services in wellbeing services counties varies. Separate provision of social welfare and health care services mainly continues, with the exception of a few counties. Some well-being services counties are experiencing problems in transitions from youth to adult services, during which a young person is at risk of being excluded from the services. The queues for adult services are often longer, and young people are

expected to show more initiative in them than in the youth services. These problems are particularly highlighted in wellbeing services counties where the age limits are strict and inflexible.

The transition from the primary level to specialised medical care is not smooth in all wellbeing services counties. Under the Health Care Act (1326/2010), a physician's referral is required to access specialised medical care. In some counties, however, referrals to youth psychiatry services provided as specialised medical care may also be made by other social welfare or healthcare professionals in practice. Some wellbeing services counties experience significant problems with the functioning of the referral practices. At its highest, the share of rejected referrals was 47%. The most common reason for rejecting a referral was not meeting the criteria. The criteria for specialised medical care were often considered excessively strict at the primary level, which means that suitable services cannot be organised for a young person with severe symptoms. According to specialised medical care representatives, shortcomings at the primary level increase the demand for specialised medical care. Problems also arise when a young person transfers from specialised medical care to primary services. The continuity of care is jeopardised as cooperation and communication between specialised medical care and the primary level are ineffective and the young person or the care provider are unclear about how the treatment should be continued.

The continuity of care can be improved by building effective care and service chains and by planning effective levels of care. The care and service chains and levels of care had been defined in less than a half of the wellbeing services counties at the time of the audit. The realisation of care chains and levels of care were not systematically monitored, and the practices varied considerably. Consultation practices were also variable. In several wellbeing services counties, service coordination was hampered by overlapping and poorly functioning information systems. The practices for ensuring continuity of care in transitions between services are not systematic or on a permanent footing.

Shortcomings in mental health and substance abuse services burden student and social welfare services

Student welfare services often direct clients to primary services and specialised medical care. The role of student welfare services is emphasised particularly in wellbeing services counties where separate primary level mental health and substance abuse services for young people are not provided or they are limited. If there are shortcomings in the services, it may be difficult for student welfare services to focus on their actual tasks, and they are forced to concentrate on therapeutic work. A significant shortage of physicians and psychologists contributes to making mental health and substance abuse work in student welfare services more difficult.

Providing treatment is not a statutory part of social welfare services' tasks. The audit found, however, that a large volume of therapeutic services may also spill over to social welfare if there are shortcomings in mental health and substance abuse services. Some social welfare professionals feel that they do not have sufficient professional skills for therapeutic work. Young people in substitute care continue to experience problems with accessing mental health and substance abuse services in some wellbeing services counties.

Accessibility of services could be improved further

The accessibility of services has been improved in most wellbeing services counties, for example by offering young people different digital solutions and mobile services. Most primary level services can be accessed without a referral. In May 2024, low-threshold walk-in services remained relatively rare. The role of remote clinics varied from county to county, and messaging applications favoured by young people were rarely used. The volume of services provided at home was low, and the outsourcing of services resulted in staff turnover. Few wellbeing services counties systematically collected feedback on service development from young people.

Recommendations

The Ministry of Social Affairs and Health and the wellbeing services counties, the City of Helsinki and the HUS Group

1. should ensure that the range of mental health and substance abuse services for young people will be more consistent in all wellbeing services counties and that they can be accessed as required under the Health Care Act and the Social Welfare Act.
2. should ensure that the age limits for mental health and substance abuse services for young people will be more uniform and based on a medical view of adolescence in healthcare services.
3. should ensure continuity of care, quality of services and cost-effectiveness in outsourced services.
4. should ensure uninterrupted continuity of care and young people's access to the services they need when transitioning from youth to adult services; when transitioning between the primary level and specialised medical care; in child welfare substitute care and in situations where the young person has a dual substance abuse and mental health disorder.
5. should develop referral practices with the aim of reducing the current share of referrals rejected by youth psychiatry services in specialised medical care.
6. should develop their information systems and recording practices, ensuring that sufficient monitoring data are also collected on primary mental health

and substance abuse services for young people (including student welfare services) and on the implementation of care levels.

The Ministry of Social Affairs and Health

7. should ensure that the statutory time limits for accessing care are interpreted and monitored consistently in the wellbeing services counties.