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DISCUSSION PAPER

Western Finland Mental Health Survey 2014

Survey methods

34 | 2014

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For more information on the Western Finland Mental Health Survey visit www.thl.fi/mhsurvey

ISBN 978-952-302-346-8 (printed)
ISBN 978-952-302-347-5 (online publication)
ISSN 2323-363X (online publication)
http://urn:fi/URN:ISBN:978-952-302-347-5

Juvenes Print – Finnish University Print Ltd
Tampere, Finland 2014

YMPÄRISTÖMERKKI
MILJÖMÄRKT
441 729
Painotuote

Preface

Three hospital districts in Western Finland, i.e. the Vaasa, South Ostrobothnia and Central Ostrobothnia hospital districts, have since almost ten years implemented a programme to improve population mental health. In 2005, the three districts, with a total catchment area population of about 446,000 people, set up the Ostrobothnia Project with support from the government. The project aims at mental health promotion, prevention of mental disorders and substance use problems as well as developing mental health and addiction services, especially at primary care level.

To evaluate the project outcomes on population level, a postal survey has been performed at baseline in 2005 and every three years since that. In addition to the three intervention districts, the survey has been performed also in the Hospital District of Southwest Finland, to enable comparison with a non-intervention area. This report describes the survey methods and instruments of the fourth survey wave in 2014, in order to provide technical background information for outcome reports. It is my hope that the current report will help readers to assess and interpret our published and forthcoming outcome reports. Published reports so far are listed in Appendix 4.

The population survey has largely been funded by EVO special government funding from the Vaasa Hospital District and government research funding from the Hospital District of Southwest Finland.

The population survey has been planned, implemented and analysed by a dedicated multi-disciplinary team of researchers. The questionnaire was designed by professor Kristian Wahlbeck (THL, Helsinki), professor Kaj Björkqvist (Åbo Akademi University, Vaasa), researcher Kjell Herberts (Åbo Akademi University, Vaasa), Fredrica Nyqvist, PhD (Åbo Akademi University, Vaasa and THL, Vaasa) and Anna Forsman, DrPH (Åbo Akademi University, Vaasa and THL, Vaasa), doctoral student Johanna Nordmyr (Åbo Akademi University, Vaasa and THL, Vaasa), Marina Näsman (Åbo Akademi University, Vaasa and THL, Vaasa), Annika Wentjärvi (Yrkeshögsskolan Novia, Vaasa) and Carita Tuohimäki (Vaasa Hospital District). Coding of the questionnaires was carried out by Carolina Herberts, Siv Herberts and Kjell Herberts, all familiar with coding of previous surveys 2005, 2008 and 2011.

My thanks go to the highly motivated survey research team, but also to all the respondents who have participated in the four rounds of the Western Finland Mental Health Surveys without aspiring for personal gain.

Kristian Wahlbeck
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Abstract

Kaarina Reini et al. Western Finland Mental Health Survey 2014: Survey methods. National Institute for Health and Welfare (THL). Discussion paper 34/2014. 58 pages. Helsinki, Finland 2014. ISBN 978-952-302-346-8 (printed); ISBN 978-952-302-347-5 (online publication)

This report aims to describe the regional population survey on mental health performed in 2014 and to introduce the questions and survey instruments included. The survey was a continuation of the population surveys carried out in 2005, 2008 and 2011.

A large scale development project for the mental health and substance abuse services, the Ostrobothnia Project, has been implemented since 2005 by the hospital districts of the Ostrobothnia, South Ostrobothnia and Central Ostrobothnia regions. In addition, the 'Pohjalaiset masennustalkoot' project aimed at promoting identification and management of depression, was implemented by the Vaasa and South Ostrobothnia hospital districts in 2004–2007. Both projects were co-funded by the Finnish Ministry of Social Affairs and Health. To lay the basis for an evaluation of the outcome and effectiveness of these projects, a baseline population survey was performed in spring 2005. The aim of the survey was to assess the status prior to implementing the project interventions. Sequel surveys were conducted in spring 2008, 2011 and 2014. The random population sample consisted of 5000 persons aged 15 to 80 from the intervention area and another 5000 persons of the same age from the hospital district of Southwest Finland, which was set as a control area. The number of inhabitants and the demography of the Southwest Finland region can be considered similar to the intervention area.

The survey objective was to collect information about mental health determinants, respondents' mental health, their attitudes towards mental disorders and their use and experience of mental health and substance abuse services. Age, gender, municipality, marital status, mother tongue, the most advanced degree of education, current main activity, internet use and activities in associations and societies were set as background questions. Standardized survey instruments were used in the questionnaire to define different indicators related to mental health. Positive aspects of mental health were studied with the Warwick-Edinburgh Mental Well-being scale (WEMWBS) and with the Pearlin's Sense of Mastery scale. The Oslo-3 instrument was used to define social support. Exposure to physical abuse during childhood was measured with the Brief Physical Punishment Scale (BPPS). Six items from the RAND health survey were used to define role limitations due to emotional problems and physical health. Respondents' psychological distress was measured with the General Health Questionnaire (GHQ-12) scale and alcohol problems with the AUDIT-C test. The Lie/Bet tool was included as a screening instrument to identify problem gambling behaviours. Questions based on the Composite International Diagnostic Interview Short Form (CIDI-SF) were used for assessing prevalence of major depressive disorder. Use of social and health care services for mental health or alcohol problems was studied with the same questions used in the Finnish health examination studies Health 2000 and Health 2011. One of the questions included in this survey for measuring aspects of social capital was also used in the Health 2000 study. Respondents' attitudes towards mental ill health were examined with questions that were partly constructed for this survey.

The survey response rate was 36.7 per cent. The Vaasa Hospital District had the highest response rate (40.6 %) whereas the South Ostrobothnia district had the lowest rate (31.7 %). An obvious gender difference was also noted with regards to response rates; 43.3 per cent of women responded to the questionnaire but only 31.4 per cent of men. A higher proportion of Swedish speaking respondents participated in the survey (47.8 %) compared with Finnish speaking respondents (36.2 %). The age group 71–80 years had the highest response rate (54.2 %) and the 21-30 year age group the lowest (25.1 %). Responses could be submitted by mail or online on the web. Only 6.2 % of all the survey answers were given online. Younger respondents utilized the web-response opportunity at a higher rate. The final dataset is adjusted for age, gender, language, and hospital district.

Keywords:
population survey, mental health, mental well-being, mental disorder, depression, attitude study, method description, evaluation study

Tiivistelmä

Kaarina Reini ym. Western Finland Mental Health Survey 2014: Survey methods [Länsi-Suomen mielenterveyskysely 2014: Menetelmäraportti]. Terveyden ja hyvinvoinnin laitos (THL). Työpaperi 34/2014. 58 sivua. Helsinki 2014. ISBN 978-952-302-346-8 (painettu); ISBN 978-952-302-347-5 (verkkojulkaisu)

Menetelmäraportin tavoitteena on kuvata vuonna 2014 suoritettua mielenterveyttä koskevaa alueellista väestökyselyä ja siinä käytettyjä kysymyksiä ja mittareita. Kysely on jatkoa vuonna 2005, 2008 ja 2011 toteutetuille väestökyselyille.

Vaasan, Etelä-Pohjanmaan ja Keski-Pohjanmaan sairaanhoitopiirien alueella aloitettiin vuonna 2005 laaja mielenterveys- ja päihdetyön kehittämishanke, Pohjanmaa-hanke. Lisäksi vuosina 2004–2007 toteutettiin Vaasan ja Etelä-Pohjanmaa sairaanhoitopiirien yhteishanke Pohjalaiset masennustalkoot. Molempiin hankkeisiin saatiin rahoitusta myös sosiaali- ja terveysministeriöstä. Hankkeiden tavoitteiden toteutumista arvioidaan erillisellä arviointitutkimuksella, johon sisältyy mielenterveyttä koskeva väestökyselytutkimus. Väestökyselyllä kartoitettiin lähtötilannetta ennen kehittämishankkeita vuonna 2005, ja kysely toistettiin keväällä 2008, 2011 ja 2014. Kunakin vuonna kyselylomake lähetettiin yhteensä 5000 satunnaisotannalla valitulle 15–80 -vuotiaalle henkilölle Pohjanmaa-hankkeen alueella. Vertailuasetelman luomiseksi sama lomake lähetettiin 5000 henkilölle myös Varsinais-Suomen sairaanhoitopiirissä, joka on väestöpohjaltaan ja asukasluvultaan samankaltainen kuin projektialue.

Kyselyllä pyritään saamaan kokonaiskuva pohjalaisten mielenterveydestä, mielenterveyteen vaikuttavista tekijöistä, mielenterveys- ja päihdepalveluiden käytöstä sekä asennoitumisesta mielenterveyshäiriöihin. Kyselyssä käytettyjä taustamuuttujia ovat ikä, sukupuoli, kotikunta, siviilisääty, äidinkieli, korkein koulutus, pääasiallinen toiminta, internetin käyttö ja yhdistystoiminta. Kyselylomakkeessa käytettiin standardoituja kyselymittareita, kuten psyykkistä hyvinvointia kartoittavat Warwick-Edinburgh Mental Well-being scale (WEMWBS) ja Pearlin's Sense of Mastery scale -mittarit. Sosiaalisen tuen mittarina käytettiin Oslo 3 -mittaria. Altistuminen fyysiselle kuritukselle lapsuudessa kysyttiin lyhyellä tätä varten kehitetyllä asteikolla. Toimintakykyä mitattiin RAND–terveyskyselyn kuudella psyykkistä ja fyysistä roolitoimintaa mittaavalla kysymyksellä. Psyykkistä kuormittuneisuutta kartoitettiin General Health Questionnaire (GHQ-12) -mittarilla ja alkoholiongelmaa AUDIT-C -mittarilla. Lie/Bet-mittari sisällytettiin peliongelmien seulomiseksi. Masennustilan esiintyvyyttä arvioitiin Composite International Diagnostic Interview Short Form (CIDI-SF) -mittariin pohjautuvilla kysymyksillä. Mielenterveysongelmiin ja päihteisiin liittyvää sosiaali- ja terveyspalvelujen käyttöä tutkittiin Terveys 2000 ja Terveys 2011 -tutkimusten kysymyksillä. Vastaajien asenteita mielenterveysongelmia kohtaan selvitettiin osittain tätä kyselyä varten kehitetyillä kysymyksillä.

Väestökyselyn kokonaisvastausprosentti oli 36,7. Korkein vastausprosentti oli Vaasan sairaanhoitopiirissä (40,6 %) ja matalin Etelä-Pohjanmaan sairaanhoitopiirissä (31,7 %). Sukupuolten vastausaktiivisuudessa oli selvä ero. Miesten vastausprosentti oli vain 31,4 prosenttia, kun naisten vastausprosentti puolestaan nousi 43,3 prosenttiin. Ruotsinkieliset vastasivat suomenkielisiä aktiivisemmin, ruotsinkielisten vastausprosentti oli 47,8 ja suomenkielisten 36,1. Ikäryhmistä 71–80 -vuotiaat olivat kaikkein aktiivisimpia vastaajia (54,2 %) ja vähiten aktiivisia 21–30 -vuotiaat (25,1 %). Kyselyyn oli mahdollista vastata postitse tai verkossa. Vain 6,2 prosenttia kaikista vastauksista annettiin verkkolomakkeen kautta. Kaikista aktiivisimmin verkkovastausmahdollisuutta hyödynsivät nuorimmat ikäryhmät. Kyselyn tuottama tietokanta on painotettu ikäjakauman, sukupuolen, kielen ja sairaanhoitopiirin suhteen tulosten yleistämiseksi koko yli 15-vuotta olevaan väestöön.

Avainsanat:
väestökysely, mielenterveys, psyykkinen hyvinvointi, mielenterveysongelma, masennus, asennetutkimus, menetelmäkuvaus, arviointitutkimus

Sammandrag

Kaarina Reini m.fl. Western Finland Mental Health Survey 2014: Survey methods [Enkät om psykisk hälsa i västra Finland: Metodbeskrivning]. Institutet för hälsa och välfärd (THL). Diskussionsunderlag 34/2014. 58 sidor. Helsingfors, Finland 2014. ISBN 978-952-302-346-8 (tryckt); ISBN 978-952-302-347-5 (nätpublikation)

Metodrapportens syfte är att beskriva den år 2014 utförda enkäten om psykisk hälsa i västra Finland och de frågor och mätinstrument som användes. Enkätundersökningen var en fortsättning på de befolkningsenkäter som utfördes åren 2005, 2008 och 2011.

I Syd-Österbottens, Vasa och Mellersta Österbottens sjukvårdsdistrikt inleddes år 2005 ett omfattande utvecklingprojekt inom mental- och missbrukstjänsterna, det s.k. Österbotten-projektet. I Vasa och Syd-Österbottens sjukvårdsdistrikt genomfördes åren 2004–2007 även samprojektet Österbottniska depressionstalkot. Båda projekten har delfinansierats av social- och hälsovårdsministeriet. För att utvärdera projekten utförs en evaluering, som även omfattar den aktuella enkäten om psykisk hälsa. Enkäten utfördes första gången våren 2005 för att utreda utgångsläget före implementering av ovannämnda utvecklingsprojekt. Upprepningar gjordes våren 2008, 2011 och 2014. Ett frågeformulär postades till sammanlagt 5000 slumpmässigt utvalda personer i åldern 15–80 år i de tre sjukvårdsdistrikten. Enkäten sändes även till ett stickprov omfattande 5000 personer i åldern 15–80 år i Egentliga Finlands sjukvårdsdistrikt, som till befolkningsunderlag och invånarantal är snarlikt projektområdet i Österbotten.

Enkäten gjordes för att utreda österbottningarnas psykiska hälsa, den psykiska hälsans bestämningsfaktorer, attityder till psykisk ohälsa samt användning och erfarenheter av mental- och missbrukarvården. Bakgrundsfaktorer som inkluderades i formuläret var respondentens ålder, kön, hemkommun, civilstånd, modersmål, högsta utbildning, huvudsakliga verksamhet, internetanvändning och föreningsaktivitet. I frågeformuläret ingick standardiserade enkätinstrument, såsom Warwick-Edinburgh Mental Well-being Scale (WEMWBS) för att mäta positiv psykisk hälsa och Pearlins skala för bedömning av känsla av bemästring (Sense of Mastery). Socialt stöd mättes med Oslo 3–instrumentet. Fysiska övergrepp under barndomen mättes med skalan Brief Physical Punishment Scale (BPPS). För bedömning av funktionsförmåga användes sex frågor om psykisk och fysisk rollbegränsning ur mätinstrumentet RAND. Psykisk belastning kartlades med instrumentet General Health Questionnaire (GHQ-12) och för kartläggning av alkoholproblem användes mätaren AUDIT-C. Frågeinstrumentet Lie/Bet användes för att identifiera spelproblem. Förekomsten av depression utreddes med frågor baserade på instrumentet Composite International Diagnostic Interview Short Form (CIDI-SF). Användningen av hälsovårdstjänster för psykisk ohälsa och användningen av hälso- och socialtjänster för alkoholproblem utreddes med frågor som även använts i Hälsa 2000 och Hälsa 2011 -undersökningarna. En av de frågor som i enkäten mätte aspekter av socialt kapital hade också tidigare använts i Hälsa 2000-undersökningen. Respondenternas attityder gentemot psykisk ohälsa kartlades delvis med frågor som utvecklats för denna enkät.

Enkätens svarsprocent uppgick till 36,7 procent. Högst var responsen i Vasa sjukvårdsdistrikt (40,6 %) och lägst var svarsprocenten i Södra Österbottens sjukvårdsdistrikt (31,7 %). En klar skillnad i svarsbenägenhet finns mellan könen. Männens svarsandel uppgår till endast 31,4 %, medan kvinnornas svarsandel är 43,3 %. Svenskspråkiga uppnår en svarsprocent på hela 47,8, medan finskspråkigas andel stannar på 36,2. Ålderssegmentet 71–80 åringar uppvisar den högsta svarsbenägenheten (54,2 %) och 21–30 åringar den lägsta (25,1 %). Det var möjligt att svara per brev eller via en nätblankett. Bara 6,2 procent av alla svar lämnades in online. De yngre åldersgrupperna svarade bäst på webenkäten. Enkätdatabasen är viktad utgående från ålder, kön, språk och sjukvårdsdistrikt för att göra resultaten mera representativa för hela målgruppen.

Indexord:
befolkningsenkät, psykisk hälsa, psykiskt välbefinnande, psykisk ohälsa, depression, attityder, metodbeskrivning, evaluering

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Background

The Ostrobothnia project was a joint mental health and substance abuse development project by South Ostrobothnia, Vaasa and Central Ostrobothnia hospital districts, as well as the social care competence centre SONet Botnia and the 42 municipalities of the region.

The Ostrobothnia Project aimed to meet the challenges of mental health problems and substance abuse recognised by the Health 2015 Public Health Program, the National Development Programme for Social Welfare and Health Care (Kaste) and the National Alcohol Program, as specified by the key areas. The project also supports the objectives of the national mental health and substance abuse prevention plan, a.k.a. Mieli 2009. (Ministry of Social Affairs and Health 2010)

The Ostrobothnia Project started in 2005 with financial support from the Ministry of Social Affairs and Health (STM). Also with the support of the STM, in Vaasa and South Ostrobothnia hospital districts the project ”Pohjalaiset masennustalkoot” ("the Ostrobothnian depression project”) was developed, which worked towards prevention and early identification of depression and improvement of treatment and rehabilitation. This project also spread to the Central Ostrobothnia hospital district and was combined with the Ostrobothnia project in 2007. The depression project included a public information campaign on depression, which aimed to increase awareness of depression and self-help support, improve attitudes towards mental health disorders and enhance routes to receiving help.

The Ostrobothnia Project was a diverse and broad regional development project, which aims to develop mental health care and substance abuse work to promote the welfare of the population. The remits of the project were determined in accordance with the Finnish Mental Health Act (Mental Health Act 1990), and thus consists of mental health promotion, prevention of mental disorders as well as development of mental health care for treatment and rehabilitation. Substance abuse work of the project was based on the Act on Welfare for Substance Abusers and includes promotion of abstinence, prevention of problems, treatment and rehabilitation.

The aim of the project was to provide a clearly described and piloted regional model of mental health care and substance abuse work for national use. For this purpose, the project has developed comprehensive mental health care and substance abuse services regionally and locally. The six key principles of the implementation of the project are of community, participation, timeliness, planning, visibility and accountability.

Evaluation, which includes process as well as outcome evaluation, is an integral part both of the Ostrobothnia project and the Ostrobothnian depression project. The process evaluations of the Ostrobothnia project's first (2005–2007) and second phase (2007–2009) have been reported separately (Vuorenmaa & Löytty 2008; Seppälä et al. 2011). The outcome evaluation includes analysis of the effectiveness of the projects with regards to mental health determinants, population mental health, attitudes towards mental health and the use of services. The outcome evaluation is partly based on routinely collected administrative data and partly on the Western Finland Mental Health Survey which is described in this methodology report.

The project outcome will be analysed by comparing the psychosocial work and welfare development in the project area with a control region, i.e. Southwest Finland, and with the development in the whole country. The outcome evaluation takes into account both the indicators of the project (i.e. mental health and substance abuse strategy work status, implementation of first aid mental health training, staff resources within preventive mental health and substance abuse work and service level) and the desired results (i.e. alcohol sales, young people’s mental health, sick leave due to psychological reasons, outpatient services, suicide and alcohol- or drug related deaths). The outcome evaluation base increases every third year as the Western Finland Mental Health Survey is carried out to collect information on project outcomes.

This population survey was carried out for the first time in spring 2005. The initial sampling, survey and analysis methods have been described previously (Herberts et al. 2006) and several reports of the results have been published. The first survey was followed by a sequel in spring 2008 (Forsman et al. 2009) and 2011 (Herberts et al. 2012). In 2008, questions on mental health and substance abuse awareness were added to the survey and clarifications of some questions were made as well as amendments to some answer options. To

preserve the comparability of the questionnaires, the changes were, however, minimal. The sampling, survey and analysis methods have also been reported for the 2008 survey (Forsman et al. 2009).

The second sequel to the original postal survey was conducted in spring 2011. In 2011, questions on gambling habits, physical punishment in childhood and schizotypal personality traits were added to the questionnaire. The details of sampling, survey and analysis methods of the 2011 survey have been separately reported (Herberts et al. 2012).

This report describes the sampling and methodology of the 2014 survey that was executed during spring of 2014. In this follow-up, questions on mental wellbeing were added, questions on drinking habits were changed, and questions on schizotypal traits were omitted. The opportunities that the new information technology offers were taken into account. A new background question was added concerning respondents'internet use. In contrast to the previous surveys, the respondents also had an opportunity to answer online via a web questionnaire.

According to the evaluation plan of the Ostrobothnia project, this was the final follow-up to be performed. The four survey rounds have resulted in a valuable database for mental health reseach that enables the study of various aspects of mental health including trends and regional similarities and differences in Finland.

Method and response rate

The aims of the survey and the methods used

The Western Finland Mental Health Survey aims to evaluate the outcome of the Ostrobothnia Project, but also to monitor mental health resources, risk factors, attitudes and service use in the population. It aims to emphasise measurement of social determinants, attitudes and mastery. In this sense the Western Finland Mental Health Survey is not a traditional mental health epidemiologic survey, as they tend to focus on morbidity. The principle of the citizens' perspective is reflected in both the covering letter and the choice of questions.

In general, population surveys' response rates have declined over time. Even though mental health and substance abuse problems are common, they are also linked with strong prejudices and stigmatizing attitudes, which may further impact the willingness to respond.

To enhance response rate a short questionnaire was aimed at. The selection of measures was based to their validity and reliability, in addition to their clarity and length. The majority of questionnaire items and scales selected allow for direct comparability with Finnish and international studies.

The collected information includes socio-demographic background variables in addition to the individual's psychological as well as community resources, mental health problems and use of health and social services. Depressive disorder was given special attention, because depression, in Finland and globally alike, is major public health challenge. Information about attitudes was collected due to their crucial role in help-seeking and in the development, maintenance and use of services. In all waves of the survey, the questionnaire ended with open questions, which aims to provide respondents an opportunity to voice their thoughts.

The target group

The population survey was targeted at individuals in the age group 15–80 years in the study area and control area. In the 2014 sample the respondents were born 1934–1998. The study area consists of Vaasa, Central Ostrobothnia and Southern Ostrobothnia hospital districts. The catchment area of the three hospital districts forming the study area has a population of 446 000 inhabitants living in 42 separate municipalities. The control area was the hospital district of Southwest Finland, comprising 474 000 inhabitants, divided in 29 municipalities.

The South Ostrobothnia hospital district consists of 19 Finnish-speaking municipalities: the central area of the region, Seinäjoki (60 000 inhabitants) and the municipalities Alajärvi, Alavus, Evijärvi, Ilmajoki,

Isojoki, Isokyrö, Jalasjärvi, Karijoki, Kauhajoki, Kauhava, Kuortane, Kurikka, Lappajärvi, Lapua, Soini, Teuva, Vimpeli, and Ähtäri. Of the three hospital districts comprising the study area, the South Ostrobothnia region is the largest with a population of almost 200 000.

Vaasa hospital district includes 13 municipalities, with a population of 169 000. A third of the inhabitants (approximately 66 000) live in the city of Vaasa. Linguistically, the region differs from most other hospital districts in the country as the Finnish and Swedish-speaking population is divided almost equally; the proportion of Swedish speakers is slightly higher (51 %, while 45 % Finnish-speakers and 4 % with other languages). The hospital district consists of three completely Swedish-speaking municipalities (Korsnäs, Larsmo and Närpes), seven bilingual municipalities with a Swedish-speaking majority (Jakobstad/Pietarsaari, Korsholm/Mustasaari, Kristinestad/Kristiinankaupunki, Malax/Maalahti, Nykarleby/Uusikaarlepyy, Pedersöre and Vörå/Vöyri), two bilingual municipalities with a Finnish-speaking majority (Kaskinen/Kaskö and Vaasa/Vasa) as well as one fully Finnish-speaking municipality (Laihia).

The Central Ostrobothnia (Kiuru) hospital district is also a bilingual region. There are two bilingual municipalities within the district (the city of Kokkola/Karleby and Kronoby/ Kruunupyy) and the remaining eight municipalities are Finnish-speaking (Halsua, Kannus, Kaustinen, Lestijärvi, Perho, Reisjärvi, Toholampi and Veteli). The number of inhabitants is approximately 78 000, of whom 47 000 live in Kokkola.

Business and industry in the three hospital districts are structurally quite similar. Agricultural, industrial and service sectors are rather equally represented. The distances between services are relatively short, as the municipalities are fairly small and the services have so far been situated locally to the inhabitants.

To enable comparison with a non-intervention control area, collaboration with the Hospital District of Southwest Finland was undertaken. The survey was hence also distributed in the Southwest Finland hospital district, because the area with almost 475 000 inhabitants and 29 municipalities can be compared to the three hospital districts in Ostrobothnia. The central area of the Southwest Finland hospital district is Turku, with a population of 182 000 inhabitants. The other municipalities in the region are relatively small. A random sample of 5 000 persons from Southwest Finland was chosen for the survey[1].

The study sample was constructed by applying stratified random sampling. Stratification was performed for mother tongue and hospital district. A random sample of individuals aged 15 to 80 years was requested from the population information system of the Population Register Centre as follows: 2 000 from the South Ostrobothnia hospital district, 2 000 respondents from the Vaasa hospital district, 1 000 from the Central Ostrobothnia hospital district and 5000 from the hospital district of Southwest Finland. The stratified sampling reflected the catchment area population and linguistic distribution of the hospital districts. The requested information from the population register was first and last name, year of birth, mother tongue and permanent address.

These four hospital districts represent 17 per cent of the population in Finland with a total of 920 000 inhabitants. In general, the sample represents a very wide range of Finnish municipalities: from small rural areas in the archipelago and countryside with populations of a few hundred people to middle sized more urban areas and a few larger cities. The 71 municipalities even vary linguistically: 3 completely Swedish speaking municipalities, 14 bilingual municipalities and 54 fully Finnish speaking municipalities.

An extensive structural reform aiming to reduce the number of municipalities is underway in Finland in. The number of municipalities in the survey areas has decreased from 112 in 2005 to 71 in 2014. The total number of municipalities in the country is 320 (1.1.2014, Statistics Finland). In the future, provision of health care services is likely to be more centralised than now due to a reduced number of municipalities, but it is unlikely that this process of change has yet influenced the survey data.

[1] In addition to Turku/Åbo, the bilingual municipalities are Kimioön/Kemiönsaari and Pargas/Parainen. The Finnish speaking municipalities are in alphabetical order Aura, Kaarina, Koski, Kustavi, Laitila, Lieto, Loimaa, Marttila, Masku, Mynämäki, Naantali, Nousiainen, Oripää, Paimio, Punkalaidun, Pyhäranta, Pöytyä, Raisio, Rusko, Salo, Sauvo, Somero, Taivassalo, Tarvasjoki, Uusikaupunki and Vehmaa.

The sample

Prior to the actual questionnaire being sent out, advance information (in the form of a postcard) was posted to the sample of respondents. The information, which was written in Finnish and Swedish, related to the research and the questionnaire that would follow. A link to the survey website, an e-mail address and a phone number were provided for further information.

Two weeks following this information the questionnaires (appendices 2 & 3) were sent out. The envelope contained a pen sponsored by the Finnish Association of Mental Health, a pre-paid response envelope and a questionnaire either in Finnish or Swedish depending on the registered mother tongue. A total of 455 individuals (4.6 %) with other mother tongues got a questionnaire in the majority language of their municipality.

The National Institute for Health and Welfare (THL) published information on the survey on their website, where background information about the study and contact information could be found. The website was available in three language versions (Finnish, Swedish and English).

The survey was promoted in the media in advance. An article describing the significance and goals of the survey was published in the local newspaper. Also a press conference was held together with the Ostrobothnia hospital district (1.4.2014) and a press release was sent out.

The main bulk of information cards were sent by post in March 2014. The actual questionnaires were posted a couple of weeks later. The majority of the questionnaires were returned during April. Follow-up cards which thanked those who had already submitted the questionnaire and reminded those who had not yet participated to do so were also sent to the sample in April and June. A second reminder was sent to young respondents, in light of the low response rate in this age group. Åbo Akademi University in Vaasa (Samforsk, the Social Science Research Institute) was responsible for posting the material, coding the data and undertaking the preliminary analysis. The survey has been approved by the ethical board of THL (30.1.2014 / §606)

Response rates

Although the response rate achieved can be considered acceptable by international standards, it is noticeable that it has gradually declined from the first survey in 2005. This decreased response rate does, however, exist in all responder categories, which means that response profiles across various measurements have not changed significantly. In view of the interpretation, the use of weighting is, nonetheless, important.

The response rate of population postal surveys has decreased in the last 50 years. Nowadays a 50 per cent response rate is regarded as acceptable and in some instances even good. The response rate is generally directly related to how important respondents perceive the survey topic (Frankfort-Nachmias & Nachmias 1992, Tourangeau et al. 2000, Groves et al. 2001, Presser et al. 2004, Bishop 2005).

A lower response has been observed in many other similar citizen surveys in recent years. In the Gerda Botnia survey, which is targeted at older people in Västerbotten in Sweden and Ostrobothnia in Finland, the response rate decreased between 2005 and 2010 in a proportionally similar manner.

A lower response rate can be explained by people's increased mobility (time of collection of responses tends to increase), less authoritarianism (academic research has previously had higher status), increased concern of own integrity and resistance to opinion polls (in protest against a "Big Brother" society). Relatively modest coverage of the survey in local media may also have contributed to a weaker interest in comparison with earlier surveys.

It is possible to follow up the non-responders in a survey by identification numbers on the return envelope or questionnaire. The advantage of this method is that reminder letters can be sent to those who have not returned their questionnaire. The disadvantage is that many respondents feel that they are identifiable and hence either modify their answers or withstand from participating in the survey. The risk of this occurring increases in line with the sensitivity of the questions. In this survey many of the questions could be perceived as intrusive and sensitive, which is why the use of identification numbers was avoided. In order to increase response rate advance information was initially sent out followed by the questionnaires. Reminder cards were

also sent to the residents of Ostrobothnia. Due to the decline in response rates, future surveys might, nevertheless, consider using more effective follow-up protocols such as the use of identification numbers, reminders and even contacting non-responding participants by phone.

Table 1. The original sample, the adjusted sample, number of responses 2014 and response rates 2005–2014 according to hospital district.

Hospital district	Sample	Adjusted sample	Number of responses	Response rate in percentage			
				2014	2011	2008	2005
Vaasa hospital district	2 000	1 973	803	40.6	50.4	55.9	57.3
Central Ostrobothnia hospital district	1 000	994	363	36.5	40.8	52.5	54
South Ostrobothnia hospital district	2 000	1 987	630	31.7	42.4	52.6	54.4
Total – Ostrobothnia	**5 000**	**4 954**	**1 796**	**36.2**	45.3	53.9	55.5
Southwest Finland hospital district	**5 000**	4 966	1 844	**37.1**	47.3	49.3	55.1
TOTAL	**10 000**	**9 920**	**3 640**	**36.7**	46.2	51.6	55.2

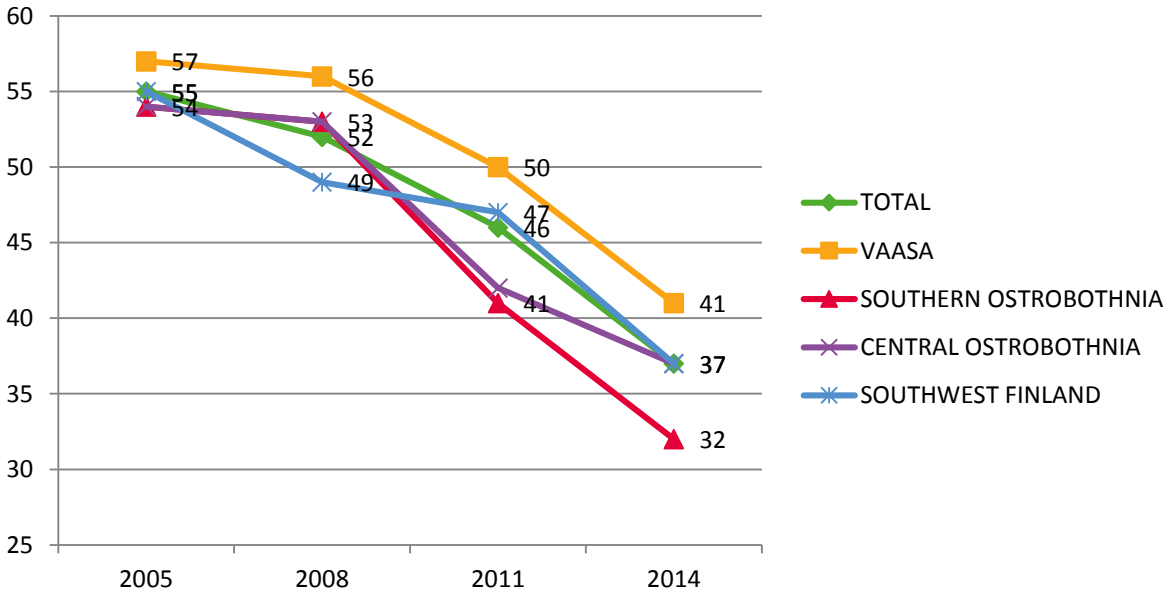

Figure 1. Response rates by hospital district and in total 2005, 2008, 2011 and 2014.

A few envelopes were returned, some with comments about sickness, indisponibility or refusal. These were excluded from the sample and are reflected in the adjusted sample (Table 1).

Although the profiles of respondents across the board appeared similar, differences in activity rates in relation to background variables (hospital district, gender, age and mother tongue) should be inspected more closely. Since identification numbers were not used, it was not possible to create a profile of respondents at an individual level but rather for the whole sample. Whether the person who completed the questionnaire is the individual whom the survey was sent to cannot be determined for certain. By comparing the number of respondents to the proportion of sent out questionnaires, it is, nonetheless, possible to get a reliable picture of the representativeness of the sample.

Response rates by municipality

It is possible that some respondents perceived the questions as intrusive, and have therefore wanted to ensure anonymity. This may be the reason for the low response rates in some of the smaller municipalities: sex, age, education and municipality may be sufficient to identify respondents in small municipalities. About five per cent of the survey respondents did not reveal their municipality.

Response rates by age

When the response rates of the population survey are examined more closely, the differences between the age groups become apparent (Figure 2). The group with the lowest response rate was the 21–30 year olds, then response rate was growing by age group quite regularly reaching a peak in the oldest age group 71–80 year olds.

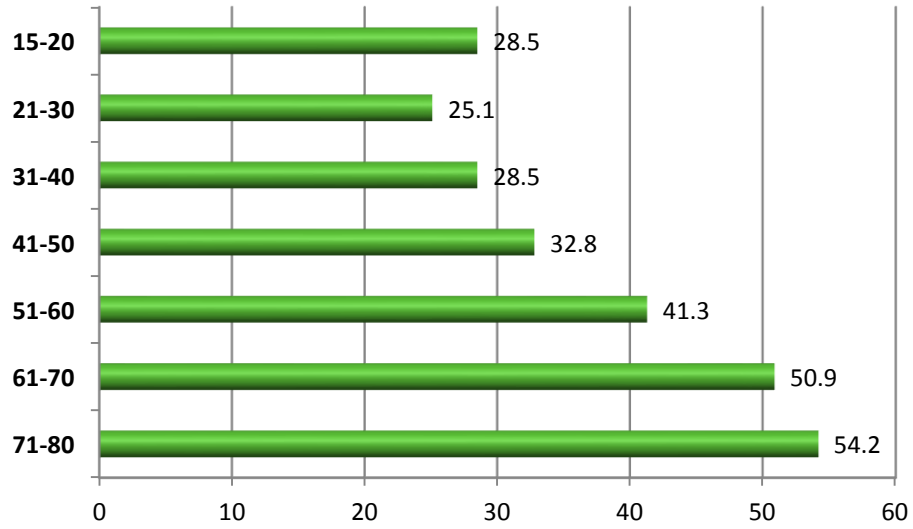

Figure 2. Response rates by age (%).

Response rates by gender

Considerable differences in response rates were found between genders and between language groups. Women are generally more active in participating in surveys as there is usually a five per cent difference in response rate between the genders in population studies.

In this population survey the difference was substantially higher with 43.3 per cent of women and 31.4 per cent of men completing the questionnaire. It is obvious that these types of questionnaires interest or affect women more than men, who seem to have greater difficulties in approaching the subject.

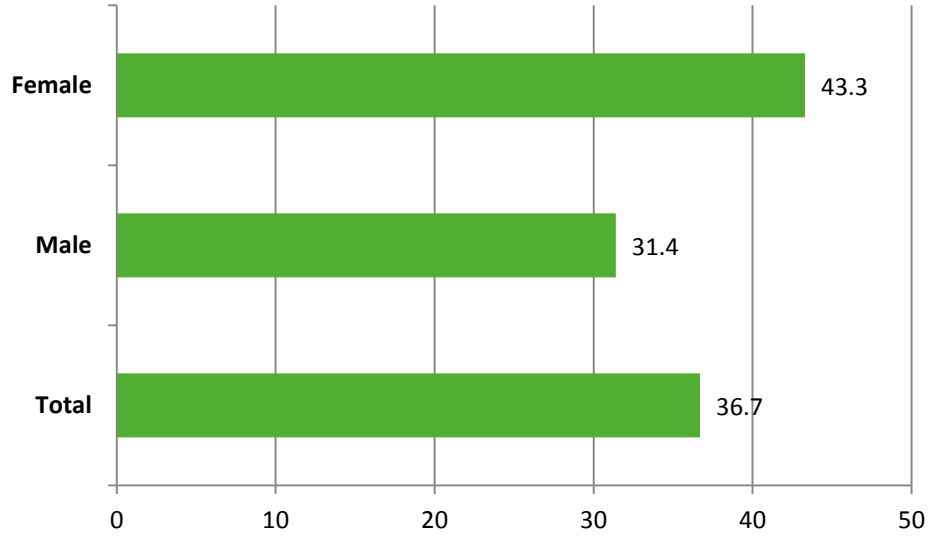

Figure 3. Response rates by gender (%).

Response rates by language

The Finnish and Swedish speaking samples also differed: the Finnish-speaking response rate was 36.2 per cent and the Swedish-speaking response rate 47.8 per cent.

In contrast to many other European countries, Finland has experienced a relatively late rise in immigration levels. In accordance with Finnish language law, language registration is applied to all residents in Finland, regardless of citizenship. This means that information and questionnaires can be provided in the languages of minorities and migrants as well as in the country's official languages of Finnish and Swedish. As a group, migrants require mental health care at least to the same extent as the Finnish population in general. Some migrants, however, such as refugees and job seekers, are probably in greater need of support measures from society.

The sample therefore was not restricted to respondents whose mother tongue was Finnish or Swedish. From the sample of 10 000 people, 527 (5.3 %) had another language as their mother tongue. A total of 69 languages were represented, of which the most common were Russian (78), Estonian (47), Arabic (31), Chinese (25) and Kurdish (22).

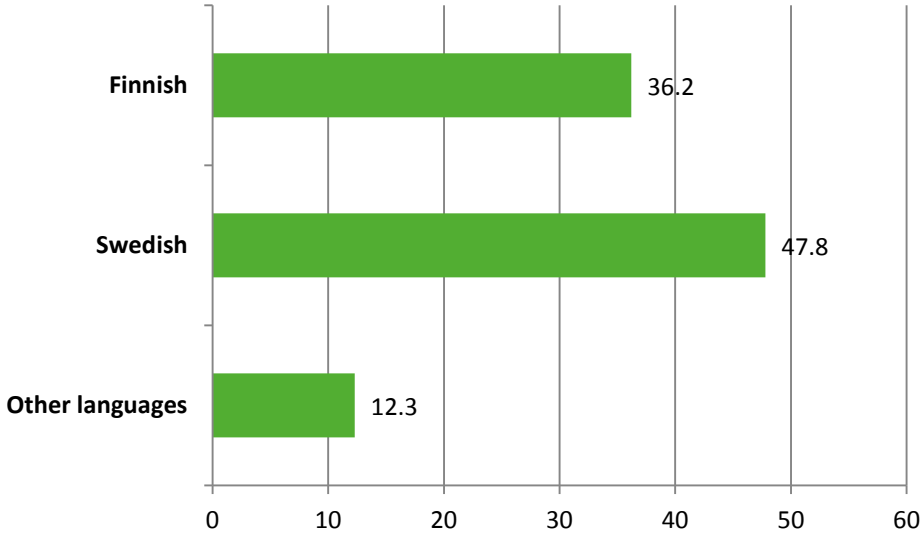

Figure 4. Response rates by language (%).

In total, only 12 per cent of the sample with another mother tongue participated in the survey, which was probably due to poor knowledge of Finnish or Swedish. It could also be considered that different cultural persuasions regarding participation in an intrusive survey of mental health decreased responsiveness. Face to face interviews might therefore provide a more effective method of canvassing this heterogeneous group. THL has performed a separate health interview survey of Russian, Somali and Kurdish migrants in Finland (Castaneda et al. 2012).

The complete survey data material has been weighted in order to balance the uneven response rates within different parts of the population. The background variables gender, age and language have been weighted against the population sample and the four hospital districts have been weighted against their respective demographic base. Consequently, each respondent has received a specific aggregated weight according to these four criteria.

This means that a response category with a low response rate, e.g. a man in his 20s with a mother tongue other than Swedish or Finnish has been given a considerately upgraded weight; while a Swedish speaking woman in her 60s has been given a downgraded weight.

The significant number of responses to the two open questions indicates that people perceive mental health issues as important. Two open ended questions about mental health and substance misuse services gave a good response, 37.8 per cent (N = 1 371) had opinions about changes during the last three years and 44.2 per cent (N = 1 609) gave their opinions about what kind of services should be available in the future. Of 3 640 respondents in 2014, 23.6 per cent provided comments on the last open ended question which offered participants the opportunity to give comments or thoughts on the survey.

Web-responses

In order to support the threatened response rates especially among young respondents a web-questionnaire was created. However, the first contact with the target group was made through postal questionnaire. The sample is drawn from the official register of inhabitants in Finland including names, year of birth, mother tongue and home address, which gave no ways to directly use e-mail addresses.

The printed questionnaire was therefore sent to everybody, although an opportunity to give the response online was given by using a special survey entry page including a given individual pin code.

Altogether 227 of 3639 or 6.2 per cent of all respondents used this method (Table 2). As could be expected younger respondents were more anxious to use the online questionnaire, with a peak in age group of 31–35 years (Table 3). The average age among web-respondent was 43.4 years, compared to traditional paper

respondents 52.1 years of age. There was a slightly higher web response among female than male respondents and higher response among Finnish speakers than Swedish and other language groups.

Table 2. Comparison of paper and web-response per cents according to gender and language.

		Gender		Language		
Responses	Total	Female	Male	Finnish	Swedish	Other
Web, %	6.2	5.8	6.9	6.5	5.1	9.1
Web, N	227	122	105	187	35	5
Paper; %	93.8	94.2	93.1	93.5	94.9	90.9
Paper, N	3 412	1 995	1 418	2 707	656	50

Table 3. Number of web-responses according to age group.

Age	**15-20**	**21-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**	**71-75**	**76-80**
%	7.5	11.8	10.6	13.1	11.3	6.3	5.4	6.0	3.7	5.7	5.3	1.6	0.4
N	19	21	22	29	22	12	15	20	13	24	24	5	1

Open comments

A sample of comments from respondents show different views and opinions about the project and the questionnaire. As a whole most of the comments are supportive, but some of the respondents have doubts about the necessity of such a project.

Can this research be of any use? (man, 71 years old)
What can you get out of this survey? (woman, 33)
Difficult for a teenager to give adequate answers. (woman, 17)
I cannot understand how this research can be of any help! (man, 59)
It has been difficult to answer, especially due to all the difficult words.(man, 43)
There should be more "I do not know" alternatives. (man, 36)
Difficult to give exact answers due to different personalities, backgrounds, experiences. (woman, 55)
Good to focus on mental problems and caring methods. (woman, 47)
It seems to be very pertinent and necessary. (man, 69)
Good questions, I became full of gratitude for my own life. (woman, 68)
Hopefully I could be of some help (man,16)
Very good that you are conducting this research, it was important to respond. (woman, 16)
Good that you ask why people do not feel well. (woman, 52)
Important questions – good design and layout! (woman, 50)
Good to consider these matters for once (man, 24)

The questionnaire

The questionnaire consisted of 35 questions of which the majority were multiple-choice. The total number of variables amounted to approximately 150. The demographic background questions included age, gender, municipality of residence, mother tongue, marital status, number of people in the household, highest level of education (respondents and his/her parents), occupation, use of internet, and associational activity.

The instruments and scales used

The language versions of the questionnaire are attached as Appendix 1 (English), Appendix 2 (Finnish) and Appendix 3 (Swedish). The survey instruments utilised are briefly presented below.

1. Mental well-being

The World Health Organization's definition of mental health states that mental health is 'a state of well-being' in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (World Health Organization 2007). It is widely agreed that that mental wellbeing is a complex subjective state and there are several approaches to conceptualizing and measuring mental wellbeing. In a systematic review, Windle and coworkers (2010) found a wide range of measurements and self-reported indicators to conceptualise mental wellbeing such as life satisfaction, self-esteem, mental health, happiness and mastery.

Recently the Warwick-Edinburgh Mental Well-being scale (WEMWBS) was developed by researchers at Warwick and Edinburgh Universities to enable the monitoring of mental wellbeing in the general population (Tennant et al., 2007). WEMWBS differs from other scales of mental health in that it covers only positive aspects of mental health. The original scale includes 14 positively worded items, with five response categories. WEMWBS is included in the annual Scottish Health Survey (from 2008) and is also being widely used throughout the UK and beyond[2].

A short 7-item version of the Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS), has been developed and tested (Stewart-Brown et al., 2009). The short version of the scale is used in the Western Finland Mental Health Survey as well as in the Finnish Regional Health and Well-being Study. The scores range from 7 to 35, with higher scores reflecting a higher level of mental well-being[3].

The mental well-being questions are as follows:

[2] http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/

[3] For detailed descrition on scaling properties see: http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/development/swemwbs

33. Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each other over the last 2 weeks.

	None of the time	Rarely	Some of the time	Often	All of the time
I have been feeling optimistic about the future	☐	☐	☐	☐	☐
I have been feeling useful	☐	☐	☐	☐	☐
I have been feeling relaxed	☐	☐	☐	☐	☐
I have been dealing with problems well	☐	☐	☐	☐	☐
I have been thinking clearly	☐	☐	☐	☐	☐
I have been feeling close to other people	☐	☐	☐	☐	☐
I have been able to make up my own mind about things	☐	☐	☐	☐	☐

2. Sense of mastery

Pearlin's (Pearlin & Schooler 1978) Sense of Mastery scale with its seven statements was used as an indicator for positive mental health and coping abilities. A sense of mastery is a vital psychological resource in stressful situations (Pearlin et al. 1981). Conceptually, sense of mastery can be regarded as a measure of positive mental health as well as a protective determinant of mental health problems.

The following seven statements form the Sense of Mastery scale, which was included in the survey:

11. The following statements concern your experience of your ability to control and master things in your life. *Choose the alternative that best describes yourself.*

	Strongly agree	Agree	Disagree	Strongly disagree
a. I have little control over the things that happen to me.	☐	☐	☐	☐
b. There is really no way I can solve some of the problems I have.	☐	☐	☐	☐
c. There is little I can do to change many of the important things in my life.	☐	☐	☐	☐
d. I often feel helpless in dealing with the problems of life.	☐	☐	☐	☐
e. Sometimes I feel that I'm being pushed around in life.	☐	☐	☐	☐
f. What happens to me in the future mostly depends on me.	☐	☐	☐	☐
g. I can do just about anything I really set my mind to.	☐	☐	☐	☐

The scale was scored as follows:
Statements a–e: ‘strongly agree’ (1), ‘agree’ (2), ‘disagree’ (3), ‘strongly disagree’ (4).
Statements f–g: ‘strongly agree’ (4), ‘agree’ (3), ‘disagree’ (2), ‘strongly disagree’ (1).
The total score was obtained by summing up the item scores. As reported in previous research (Stephens et al. 2000), a good sense of mastery was defined for a total score of 23 or higher.

The scale was originally developed for interviews in Pearlin’s study of stress and mechanisms for coping with stress (Pearlin & Schooler 1978), but has later been used in population studies, such as the longitudinal Canadian National Population Health Survey (1994/95 (Wilkins & Beaudet 1998), 2000/01, 2002/03, 2004/05, 2006/07, 2008/09 and 2010/11) and in the United States in the National Longitudinal Cohort Surveys. In. the National Longitudinal Survey of Youth which started in 1979 (NLSY79, n = 12.686), sense of mastery data was collected in 1992 using the Pearlin Sense of Mastery scale. In the NLSY79 Young Adult Study children (n = 8.323) of the members of the original NLSY79 cohort have been followed up by interviews from age 15 at two years intervals (from 1994 to 2012) with the Pearlin Sense of Mastery scale. An abbreviated version of the scale including only five statements has been used in a comparative telephone survey funded by the European Commission (Korkeila et al. 2003).

Research has revealed a correlation between a weak sense of mastery and later depression (Colman et al. 2011) and health status in general among young Americans (Caputo 2003). Analysis of the Canadian

population survey in 1994/95 (n = 17 626) found that men exhibited a greater sense of mastery (Stephens et al. 2000). The age of the participants was ≥18 years and the results indicated that sense of mastery was reduced as age increased. Nearly a quarter of the participants were found to have a good sense of mastery (a score of ≥ 23). The analysis implied that there is a strong correlation between actual stress load and a weakened sense of mastery. Weaker social support and reports of traumatic events in childhood were also associated with a reduced sense of mastery, while a higher education was linked with a stronger sense of mastery.

In the Canadian 1994/95 population survey the reliability of the scale was satisfactory (Cronbach's α = 0.76) (Wilkins & Beaudet 1998). The psychometric properties of the Swedish version of the scale have recently been extensively analysed by Eklund and colleagues (2012).

3. Perceived social support

In the Western Finland Mental Health Survey the OSS-3 scale is used to measure social support. The Oslo 3-item Social Support Scale (OSS-3) (Brevik & Dalgard 1996) is the result of statistical analyses of a total sample of 1717 adults above the age of 17 from different types of neighbourhoods in Norway (suburban, industrial, rural and coastal). The data were collected by postal questionnaires as part of health profile surveys with focus on mental health and psychosocial variables. The response rate was 60-75%. Perceived social support was measured using 12 questions covering family, friends and neighbourhood. To identify which single items did explain most of the variance in mental health, multiple linear regression analysis was carried out. The results indicated that the three items, now constituting the OSS-3 scale, explained most of the variance in the mental health measure used.

The OSS-3 instrument below was included in the questionnaire:

12 a. How many people are so close to you that you can count on them if you have serious personal problems? ☐ None ☐ 1 or 2 ☐ 3 – 5 ☐ More than 5

b. How much concern do people show in what you are doing?

☐ A lot of concern and interest ☐ Some concern and interest ☐ Uncertain
☐ Little concern and interest ☐ No concern and interest

c. How easy is it to get practical help from neighbours if you should need it?

☐ Very easy ☐ Easy ☐ Possible ☐ Difficult ☐ Very difficult

Scoring of the OSS-3:
Question a: 1, 2, 3, 4 points
Question b: 5, 4, 3, 2, 1 points
Question c: 5, 4, 3, 2, 1 points

To obtain a total score for the Oslo-3 scale, the points from each question are added. The scale is between 3 to 14 points with higher scores indicating stronger social support.

According to the scores, respondents can be divided into three categories: weak social support (3-9 points), moderate social support (10-12 points) and strong social support (13-14 points). In the studies mentioned above the proportion of respondents were divided into the three groups as follows: weak social support 19-26 per cent, moderate social support 53-59 per cent and strong social support 21-22 per cent.

The OSS-3 has been used in two international European telephone surveys (the European Opinion Research Group (EORG) 2003, Korkeila et al. 2003) with the average total score ranging between 10,5 +2,4 (Greece) and 11,5 +1,8 (Norway). It has been recommended for use in European health surveys (Meltzer 2003) and has for example recently been included in the Collaborative Research on Ageing (COURAGE) in Europe Project that collected health related data in Finland, Poland and Spain.

Currently, it is recommended to use the OSS-3 for each separate item as well as for the total score (Dalgard et al. 2006, Dalgard 2008). Cronbach's α-score, an indicator for the reliability of a scale, is 0.60 for OSS-3

which is considered relatively low. For OSS-3, however, the low Cronbachs's alpha does not necessarily reflect a low reliability, but rather the multidimensional structure of the index.

4. Social capital

Social capital is often used as an umbrella term including concepts such as social networks, social support and social participation (Almedom 2005). The social capital concept is multi-dimensional and various indicators and instruments for assessment have been used in previous research (De Silva et al. 2005). The concept is often divided into structural and cognitive aspects (Almedom 2005).

In the Western Finland Mental Health Survey, the structural aspect of social capital was measured by asking the frequency of social contacts with friends, relatives and work colleagues. This question has previously been used in the European Social Survey[4]. In addition, a single question on associational activities was included to assess social participation.

Trust and sense of belonging are important aspects of cognitive social capital (Nyqvist et al. 2008). These aspects were covered in the survey by questions on sense of belonging in the neighbourhood and experienced trust both in the neighbourhood and on a general level. The questions on sense of belonging and trust in the neighbourhood have previously been used in the American South-eastern Pennsylvania Household Health Survey (Axler et al. 2003), while the question on general level trust has been previously used in the Finnish Health 2000 and 2011 surveys, as well as in Finnish research on social capital that was based on the Health 2000 data material (Nyqvist et al. 2008). Furthermore, a single question measuring subjective sense of being strong and influential in society was included. This question has been previously used in the Gerda Botnia survey.

Moreover, social support is often seen as an important component of cognitive social capital and the OSS-3 instrument included in the survey can be used for measuring the level of perceived social support among the respondents.

Previous research has pointed out a stronger association between mental health status and the cognitive aspects of social capital, compared to the structural aspects (De Silva et al. 2005, Nyqvist et al. 2008). Studies looking at the social capital level in the two language groups in Finland have previously emphasised that Swedish-speaking Finns have a higher level of both structural and cognitive social capital than Finnish-speaking Finns (Hyyppä & Mäki 2001, Nyqvist et al. 2008). Furthermore, it has been suggested that these differences may partly explain the evidenced differences in experienced health between the language groups (Hyyppä & Mäki 2001, Nyqvist et al. 2008).

The following social capital questions were included in the survey:

9. How active are you when it comes to association activities?

☐ Very active ☐ Fairly active ☐ Not very active ☐ Not active at all

13. How often do you meet socially with friends, relatives or work colleagues? (members of your household do not count)

☐ Never ☐ Less than once a month ☐ Once a month
☐ Several times a month ☐ Once a week ☐ Several times a week
☐ Daily

[4] http://europeansocialsurvey.org/

14. Choose the alternative that best describes your opinion.

	Fully correct	Quite correct	Quite incorrect	Fully incorrect
I feel I belong and am part of my neighbourhood	☐	☐	☐	☐
Most people in my neighbourhood can be trusted	☐	☐	☐	☐
It is better not to trust anyone	☐	☐	☐	☐

15. I feel strong and influential in society

☐ I totally agree ☐ I agree to some extent ☐ I do not agree

5. Physical punishment during childhood

Physical punishment of children has been shown to be a risk factor for the development of a variety of unwanted personality traits, such as increased aggressiveness (e.g. Gershoff 2002, Straus 1991), depression and low self-esteem (e.g. Turner & Muller 2004). In Björkqvist, Österman and Berg (2011), it was found to be a risk factor for victimization to school bullying, too.

Victimisation from physical punishment during childhood was measured with The Brief Physical Punishment Scale (BPPS; Österman & Björkqvist, 2007; Björkqvist & Österman, 2014) which consists of four items. The respondents estimated on a five - point scale (from 0 never to 4 very often) how often they had been subjected to the following things by an adult during their childhood: (a) their hair was pulled, (b) their ear was pulled, (c) they were slapped, and (d) they were beaten with an object. The scale has been shown to have high reliability with a Cronbach's α-score of 0.84 (Österman et al. 2008).

Österman and coworkers (2014) report BPPS results from the Western Finland Mental Health Survey data collection in 2011. The BPPS results of the 2011 survey have also been presented elsewhere (Björkqvist & Österman, 2012; Björkqvist et al., 2014; Österman et al., 2012).

The questions included in the questionnaire were:

17. Choose the alternative that comes closest to your experience as a child. Have you been subjected to any of the following things by an adult?

	Never	Seldom	Sometimes	Often	Very often
Pulled your hair	☐	☐	☐	☐	☐
Pulled your ear	☐	☐	☐	☐	☐
Slapped you	☐	☐	☐	☐	☐
Hit you with an object	☐	☐	☐	☐	☐

6. Role limitations

Role functioning can be divided into physical, psychological and social functioning. Limitations in psychological role functioning refer to functioning difficulties in different areas of life due to emotional problems or psychological distress. The Western Finland Mental Health Survey questionnaire uses items 17, 18, and 19 from the RAND-36 item health survey to measure role limitations due to emotional problems (Aalto et al. 1999). This measure is identical to the psychological role limitation measure in the 36-item Short Form Health Survey (SF-36).

The RAND 36-item Health Survey (Hays et al. 1993; Hays & Morales 2001) was developed in the United States at the research institute RAND as a generic measure of impact assessment in health care in the Medical Outcomes Study (MOS). RAND-36 measures health-related quality of life in eight dimensions, and it can be used for people who are 14 years and older. The SF-36 and RAND-36 include the same set of items. Scoring of the general health and pain dimensions is different, however (Hays et al. 1993).

One of the RAND-36 dimensions relates to limitations in psychological role functioning due to emotional problems during the past four weeks, and this was chosen as the measurement of functional ability in the survey.

The following questions were included in the questionnaire:

18 b. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
Cut down the amount of time you spent on work or other activities	☐	☐
Accomplished less than you would like	☐	☐
Did work or other activities less carefully than usual	☐	☐

Normative population data for the RAND-36 can be found for several countries, such as the United States, Finland and Sweden. In Finland, the RAND-36 has been validated in a Finnish population sample of the age group 18 to 79 years (Aalto et al. 1999). The instrument has been validated in several other Western European countries including Sweden (Sullivan et al. 1995). In the Finnish general population sample (n = 3 400, 2 112 responders), the weighted functional ability for the age group 18 to 79 years was 75.1 per cent (± 36.5%). Limitations in functioning tended to increase for those aged 55 years and older. Women exhibited slightly higher limitations in functioning than men when age was controlled for (Aalto et al. 1999).

The Finnish study also reported a weighted average and the standard deviation for the three separate questions outlined above. The question related to reduced time spent on work (item 17 in RAND-36) had an average score of 1.8 + 0.4 (20 % 'yes' and 80 % 'no'), the question focusing on whether one had accomplished less than desired (question 18) had an average score of 1.7 + 0.5 (31 % 'yes' and 69 % 'no') and the average points for the question on doing activities less carefully (question 19) was 1.8 + 0.4 (24 % 'yes' and 76 % 'no') (Aalto et al. 1999).

The role limitations due to emotional problems dimension of RAND-36 has in the Finnish validity study been found to have good internal reliability (consistency) (Cronbach's $\alpha = 0.80$) (Aalto et al. 1999).

The RAND-36 measurement of psychological role limitation has been used also in the Netherland's Mental Health Survey and Incidence Study (NEMESIS, n = 7 147) (Bijl & Ravelli 2000).

The score for 'yes' answers is 1 point and for'no'answers it is 2 points. Role limitations due to emotional problems is reported as a percentage and calculated as follows: (a+b+c-3/3 x 100). Individuals with a total value of ≤ 65 per cent are diagnosed as having limited psychological role functioning.

In the 2014 questionnaire, the questions concerning role limitations due to emotional problems from the SF-36 were complemented with two items measuring role limitations due to physical problems and one item measuring problems in social functioning due to physical or emotional problems from the SF-12 version of the Health Survey (Ware et al. 1996). The second and third items measuring role limitations due to emotional problems mentioned above can also be applied as part of the SF-12. All three items from the SF-36 were however kept intact in the questionnaire in order to maintain comparability over time (survey years 2005-2014).

The following SF-12 questions were included in the questionnaire:

18 a. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
Accomplished less than you would like	☐	☐
Were limited in the kind of work or activities	☐	☐

18 c. During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting friends or relatives, etc)?

All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time ☐

Response options for role limitations due to physical problems are "yes" and "no", while response alternatives for social functioning are on a Likert scale (response options ranging from "all of the time" to "none of the time"). Scoring of individual items is identical to that of the SF-36 Health Survey.

Similarly to the SF-36, the SF-12 instrument has proven reliable and valid in several population studies in varying sociocultural contexts, e.g. Greece (Kontodimopoulos et al. 2007), China (Lam et al. 2005) and Iran (Montazeri et al. 2011).

7. Psychological distress

In the Western Finland Mental Health Survey Respondents' mental health is measured with the 12-item General Health Questionnaire (GHQ-12).

The General Health Questionnaire (Goldberg & Hillier 1979) is a generic measure of current mental health. The GHQ is a self-assessment tool which has been developed in the UK for screening of mental health problems in a community setting. There are different versions of the GHQ which comprise 12, 28, 30 or 60 questions. The 12-item version GHQ-12 (Pevalin 2000) assesses psychological health/mental well-being and psychological symptoms, such as anxiety and depression in particular.

The GHQ itself is not a diagnostic instrument, but can with a confidence level of 95% predict whether respondent meet the criteria for a psychiatric diagnosis (Goldberg 2000). The GHQ-12 has been evaluated in population studies (Pevalin 2000, Penninkilampi-Kerola et al. 2006). The estimated completion time of the GHQ-12 is five minutes.

The GHQ-12 questions in the Western Finland Mental Health Survey are:

19. Have you recently:

a. ... been able to concentrate on your work?

☐ Better than usual ☐ Same as usual ☐ Less than usual ☐ Much less than usual

b. ... lost much sleep over worry?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

c. ... felt that you were playing a useful part in things?

☐ More so than usual ☐ Same as usual ☐ Less than usual ☐ Much less than usual

d. ... felt capable of making decisions about things?

☐ More so than usual ☐ Same as usual ☐ Less than usual ☐ Much less than usual

e. ... felt constantly under strain?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

f. ... felt you couldn't overcome your difficulties?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

g. ... been able to enjoy your normal day to day activities?

☐ More so than usual ☐ Same as usual ☐ Less than usual ☐ Much less than usual

h. ... been able to face up to your problems?

☐ More so than usual ☐ Same as usual ☐ Less than usual ☐ Much less than usual

i. ... been feeling unhappy and depressed?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

j. ... been losing confidence in yourself?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

k. ... been thinking yourself as a worthless person?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

l. ... been feeling reasonably happy, all things considered?

☐ More so than usual ☐ Same as usual ☐ Less so than usual ☐ Much less than usual

The reliability, construct and content validity of the GHQ are regarded as good (Goldberg & Huxley 1980,

Goldberg 1985, Goldberg 2000). The reliability for identifying psychiatric problems is 80-84% (Goldberg 2000) and the tool is quite independent of respondents' gender and age up until the age of 75, after which the symptom score tends to increase (Goldberg 2000). Respondents who have severe somatic illnesses may receive a false-positive GHQ score.

The GHQ-12 questionnaire has been used in the Finnish Health 2000 and 2011 health examination study (Aromaa & Koskinen 2004, Koskinen et al. 2012) and it was also included in the 'Hälsa på lika villkor' population study (n= 65 000) in Sweden (Boström & Nykvist 2004).

The GHQ-12 items are scored 0, 0, 1 and 1 and the points from all questions are summarised to obtain a total score. Generally, respondents with a total score of ≥4 are diagnosed as suffering from psychological distress. The overall five-group classification is: 0, 1, 2, 3 and ≥ 4 points.

Different versions of GHQ-12 instrument have also been developed. A French study has tested the factorial structure and the internal consistency of the GHQ-12 adapted to work-related psychological distress (GHQW) (Lesage et al. 2011). The developed GHQW instrument was found to be reliable and valid for measuring work-related psychological distress in workers. Instrument can be useful in epidemiological research at work, in the study of psychosocial risk factors, and in the occupational health activities.

8. Depression

Depressive disorders are mental disorders and major public health problems. The term major depressive disorder (MDD) refers to prolonged depressive syndromes, lasting for a minimum of two weeks. The key symptoms of MDD are lowered mood, loss of interest or pleasure and reduced energy or fatigue (American Psychiatric Association 1994).

The prevalence of MDD in the general population can be measured through interviews, telephone surveys or postal studies. The participants are then categorised as depressive or non-depressive. Depression can, however, also be regarded as a continuum, with the extremes being complete absence of symptoms of depression and severe major depressive disorder. A scale can measure the number of depressive symptoms, which determines the individual's placement on this severity continuum.

The Composite International Diagnostic Interview (CIDI) is a structured psychiatric tool used for adults. CIDI can be conducted by a person with no psychiatric training. The interview can identify more than 40 psychiatric syndromes listed in the WHO International Classification of Diseases (ICD), 10th edition and the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM), 4th edition. The CIDI can determine the occurrence of a psychiatric diagnosis during the previous year, the last six months, the previous month and the last two-weeks. CIDI is available as a full-length and an abbreviated version, the Short Form (CIDI-SF).

For the present survey, only the depression section of the CIDI-SF was chosen as it is an appropriate version for a postal survey. Respondents' depressive symptoms were measured with questions obtained from the depression section of the CIDI-SF (Robins et al. 1988, Wittchen et al. 1991, Kessler et al. 1998). The selected questions enable an assessment of whether respondents have experienced an episode of MDD during the previous year. In order to determine the occurrence of MDD in the previous 12 months, a 'yes' is required for either question 25a or 25b (or both). Additionally, a positive reply must be provided for question 26a (the feelings lasted for at least most of the day) and 26b (feeling this way almost every day or more frequently).

Alternatively, the series of questions can be used to describe depression severity in during the past year. In this case, the respondents are not categorised according to level of depression, but the analysis uses the sums of the scores. A continuous depression severity variable is constructed by summarising the scores of the sub-questions 25a-b and 26c-i.

'Yes' answers to questions 25a-b provide 1 point each and 'no' answers equal no points. The score for question 25 can therefore total 0, 1 or 2 points.

Question 26f does not apply to respondents who have answered 'no' on question 26e (not trouble falling asleep nearly every night). Questions 26e-f are calculated as outlined below:

26e 'no' = 0 points
26e 'yes' and 26f 'no' = 0 points
26e 'yes' and 26f 'yes' = 1 point

Thereafter the scores from questions 26c-i are added; however, questions 26e-f are scored according to the scheme above. The total score for 26c-i can range from 0 to 6 points.

The respondents who scored two points for question 25 and ≥ 3 points for questions 26c-i were defined as meeting the criteria for major depressive disorder during the previous year, provided that they responded positively to questions 26a and 26b. The respondents who scored 1 point for question 25 and ≥ 4 points for questions 26c-i were also defined as meeting the criteria for depression, provided that they had responded positively to questions 26a and 26b. When both of these mutually exclusive categories were added, the number or respondents who were likely to have suffered from major depressive disorder during the past year were identified.

The following adapted version of the CIDI-SF section for major depressive disorder is used in the Western Finland Mental Health Survey:

25 a. During the past 12 months, was there ever a time when you felt sad, blue, or depressed for two weeks or more in a row? ☐ Yes ☐ No

b. During the past 12 months, was there ever a time lasting two weeks or more when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?

☐ Yes ☐ No

*If you answered NO to BOTH questions, continue to **question 27!***

26. For the next few questions, please think of the *two-week period* during the past 12 months when the feelings of sadness or depression were worst or you had the most complete loss of interest in things.

a. Did these feelings usually last...

☐ all day long ☐ most of the day ☐ about half of the day ☐ less than half of the day

b. Did you feel this way...

☐ every day ☐ almost every day ☐ less often

During these two weeks, did you experience any of the following problems?

	Yes	No
c. Did you feel tired out or low on energy all the time?	☐	☐
d. Did you gain weight or lose weight (5 kilos or more) unintentionally?	☐	☐
e. Did you have more trouble falling asleep than you usually do?	☐	☐
f. Was it every night or nearly every night you had trouble falling asleep?	☐	☐
g. Did you have a lot more trouble concentrating than usual?	☐	☐
h. At these times, people sometimes feel down on themselves, no good or worthless. Did you feel this way?	☐	☐
i. Did you think a lot about death – either your own, someone else's, or death in general?	☐	☐

9. Alcohol problems

Alcohol misuse continues to be a public health issue in Finland. The proportion of deaths in the population aged 15 to 64 years which was attributable to alcohol related diseases and alcohol poisoning was 16 % in 2012 (Official Statistics of Finland, 2013). The consumption of alcohol in the population varies from complete abstinence to severe alcohol dependence. Population surveys can establish issues such as the prevalence of alcohol disorders, alcohol consumption and attitudes towards alcohol use. Due to the limited

survey length, this questionnaire measured alcohol misuse with the AUDIT Consumption questions brief screen (AUDIT-C). Previously in this survey, the CAGE tool (Ewing 1984) was included in the questionnaire as a screening tool for alcohol misuse. Illegal drug use was not examined in this survey as it was feared that including questions about illegal drugs would decrease the response rate.

The Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organization (WHO) and designed to identify alcohol use disorders and/or harmful alcohol consumption (Babor et al. 1992; Saunders et al. 1993; Babor et al. 2001). The AUDIT-C is a brief version of the original 10-item AUDIT instrument, encompassing three items concerning alcohol consumption (Bush et al. 1998). Both the AUDIT screen and its abbreviated versions have been confirmed as valid and efficient in identifying harmful alcohol use consumption and alcohol use disorders in multiple contexts (de Meneses-Gaya et al. 2009).

The following alcohol-related questions were included in the questionnaire:

27. a. How often do you have a drink containing alcohol?

- ☐ Never
- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

If you answered Never, please continue to **question *30.***

b. How many standard drinks containing alcohol do you have on a typical day?

- ☐ 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 or more

1 standard drink is:
Bottle (33 cl) of beer or cider (alc. cont. 2,8-4,7%)
Glass (12 cl) of wine
Glass (8 cl) of fortified wine
4 cl strong alcohol

c. How often do you have six or more drinks on one occasion?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

The AUDIT-C instrument is scored on a scale from zero to twelve points. The response choices for the three items, five alternatives per question, are scored from zero to four points. For the first question and the third question, the scoring starts with zero points for the first response option "never" and then increases with one point per option. For the second question the scoring system is identical with the first alternative "0 drinks" scored as zero points.

In initial development and testing among Veterans Affairs clientele in the United States, the brief instrument performed as well as the original AUDIT when screening for risky drinking and/or possible alcohol use disorder with a cut-off of 4 ≥ points for men and 3 ≥ points for women (Bush et al., 1998; Bradley et al. 2003). When screening a United States population sample aged 18 years and over however, optimal cut-off scores were found to be 4 ≥ points for any alcohol use disorder and 3 ≥ points for harmful alcohol consumption among women, and 5 ≥ points for men for any alcohol use disorder as well as harmful alcohol consumption (Dawson et al. 2005). This finding is reflected in review results by Reinert and Allen (2007), who noted that if the purpose of screening is to identify alcohol use disorders, with less interest in harmful consumption, it could be useful to raise the cut-off score with one point for both men and women.

Tuunanen et al. (2007) have concluded that the AUDIT-C is also an applicable instrument in populations with dominating binge drinking patterns. Previous study results would however suggest applying a raised cut-off score for both men and women when screening Finnish samples. Tuunanen and coworkers (2007)

compared the performance of different versions of the AUDIT instrument in a sample of Finnish men (n = 555). In the sample of 45-year old men from the city of Tampere, a cut-off score of 6 ≥ points was found to be optimal (sensitivity 0.70, specificity 0.77). Aalto and coworkers (2006) similarly compared the performance of different AUDIT instruments among 40-year old Finnish women in Tampere (n = 971). In that sample of women, a cut-off score of 5 ≥ points was found to be optimal (sensitivity 0.84, specificity 0.88). These findings regarding a suitable cut-off score were later corroborated in a study of Finnish occupational health-care patients (Kaarne et al. 2010).

In addition to considering gender differences for optimal cut-off scores, recommendations can also be found for suitable cut-off scores when considering different age groups, e.g. older adults (Aalto et al. 2011).

Regarding the internal consistency of the AUDIT-C, several studies have compared values between the full AUDIT and the AUDIT-C items evidencing good consistency. For example in a sample of primary health care patients in Spain, Cronbach's alpha value was 0.84 for the AUDIT-C compared to 0.81 for the full-AUDIT (Gómez et al. 2005). On the other hand, Rumpf and coworkers (2002) found that the internal consistency of the AUDIT-C was relatively low (alpha 0.56) in a general population sample in Germany.

In addition to the AUDIT-C instrument, the survey questionnaire included items regarding use of health or social care services due to alcohol problems. These questions derive from the Health 2000 survey (Aromaa & Koskinen 2004).

28. During the past 12 months have you used any help or social services due to drinking problems?

☐ Yes ☐ No *If you answered NO, continue to **question 30!***

29. Did the treatment you received help you?

☐ Very much ☐ Quite a lot ☐ To some extent ☐ Only a little ☐ Very little or not at all

10. Gambling and problem gambling

Gambling is common in Finland – 78 % of Finns (approximately 3.1 million individuals) aged 15 to 74 had engaged in some form of gambling during the previous 12 months in 2011 (Turja et al. 2012). While the majority of those engaging in gambling activities do not experience any problems due to their gambling, some gamblers experience adverse consequences. Problem gambling can be viewed as a public mental health issue. In 2011 the past-year prevalence of gambling problems among Finns aged 15 to 74 years was 2.7 % (approximately 110 000 individuals), with one per cent fulfilling diagnostic criteria for gambling disorder (Turja et al. 2012). When considering past-year prevalence rates of problem gambling in a global context, utilizing rates from national studies, Finland is one of the countries showing a somewhat higher prevalence than the average standardized rate of 2.3 per cent (Williams et al. 2012).

The respondents' gambling habits were studied using the following question concerning types of games played, if games were played online or in real life and frequency of play. The questions are identical to those included in 2011, with the exception of the alternative concerning engaging in slot machine gambling online being added. If the respondents had not engaged in any gambling activities during the previous 12 month period they were instructed to skip the following question.

30. During the past 12 months, how often have you engaged in the following gambling activities?

	Never	Occasionally	Several times a month	Several times a week	Daily/almost daily
Scratch and win tickets, lottery tickets and similar lottery games	☐	☐	☐	☐	☐
Lotto, Joker, and similar lottery games ***on the internet***	☐	☐	☐	☐	☐
Betting (e.g. sports, horses)	☐	☐	☐	☐	☐
Betting ***on the internet***	☐	☐	☐	☐	☐
Slot machines	☐	☐	☐	☐	☐
Slot machines **on the internet**	☐	☐	☐	☐	☐
Casino games (e.g. card games, roulette)	☐	☐	☐	☐	☐
Casino games (e.g. netpoker, roulette) ***on the internet***	☐	☐	☐	☐	☐

*If you HAVE NOT engaged in ANY gambling activities during the past 12 months, continue to **question 32!***

The Lie/Bet tool (Johnson et al. 1998, Johnson et al. 1997) is a validated screening instrument, which was included in the survey questionnaire to rule out problematic gambling behaviour. The instrument consists of two questions with yes or no response options. The questions were derived from the 10 diagnostic criteria for pathological gambling in DSM 4th Edition (American Psychiatric Association 1994). It can be noted that the diagnosis pathological gambling was reclassified and revised in the 5th edition of the DSM, the diagnosis has for example been renamed and is now labelled gambling disorder (American Psychiatric Association 2013). Initial results from testing and follow-up when developing the instrument using a sample of individuals fulfilling criteria for a pathological gambling diagnosis and controls evidenced a sensitivity of 0.99 to 1.00 and a specificity of 0.85 to 0.91. The validity of the instrument has been tested in normal population samples, for example in Norway (Götestam et al. 2004) and was evidenced to be a well-functioning instrument for identifying individuals with problematic gambling behaviour. Answering no to both questions in the instrument indicates a non-problematic gambling behaviour, while answering yes to one or both of the statements implies at-risk gambling and gambling disorder, warranting the use of a diagnostic tool. The two-item tool is convenient for usage in comprehensive questionnaire studies with population samples as in this case, where longer diagnostic tools may be too extensive and irrelevant for the majority of respondents.

The Lie/Bet questions are as follows:

31. Have you ever felt the need to bet more and more money?

☐ Yes ☐ No

Have you ever had to lie to people important to you about how much you gambled?

☐ Yes ☐ No

11. Attitudes towards mental ill-health

Stigmatising attitudes of the population were examined by evaluating the respondents' personal views on stereotypical statements of mental health problems in general. The responses were collected on a four-item scale with the options 'strongly disagree', 'disagree', 'agree' and 'strongly agree'.

The main problem of validity in attitude surveys is the respondents' tendency to provide socially acceptable answers. Nonetheless, this source of error tends to be less prevalent in postal surveys than in

interviews (Tourangeau et al. 2000). It is also vital to consider that a predicted behaviour in a hypothetical situation does not necessarily match a true action in a real life event.

The choice of questions on attitudes towards mental health was guided by the key objectives of the development projects campaigns in Ostrobothnia. Existing items in research publications such as Hayward and Bright (1997), Link et al. (2004, 2000), Link (1987) and Crisp et al. (2000) were utilised.

The attitude questions are as follows:

32. Choose the alternative that best describes your opinion.

	Strongly disagree	Disagree	Agree	Strongly agree
Mental health problems are a sign of weakness and sensitivity	☐	☐	☐	☐
You don't recover from mental problems	☐	☐	☐	☐
Patients suffering from mental illnesses are unpredictable	☐	☐	☐	☐
Society should invest more in community care instead of hospital care for people with mental problems	☐	☐	☐	☐
If you talk about your mental problems, all friends will leave you	☐	☐	☐	☐
Health care professionals do not take mental problems seriously	☐	☐	☐	☐
It is difficult to talk with a person who suffers from mental illness	☐	☐	☐	☐
If the employer finds out that the employee is suffering from mental illness, the employment will be in jeopardy	☐	☐	☐	☐

Conclusion

The population-based repeated evaluation of the Ostrobothnia Project by the Western Finland Mental Health Survey has created a model for large-scale population mental health assessments. Our experience shows that an extensive population-based follow-up for a development project is feasible. The survey covers the main goals of the project.

The survey has indicated that mental health themed population survey response rates are similar to those of other health surveys. Although stigma is generally associated with mental health problems, the respondents appear to have acknowledged the importance in taking part.

We have also demonstrated that declining response rates constitute a severe threat to the validity of population-based surveys. Since the beginning of the Western Finland Mental Health Survey, response rates have declined steadily. In 2005 the survey response rate was highest 55.2 per cent. In this final round of the survey 2014, the response rate was only 36.7 per cent. We found especially low response rates in younger age groups and in the male population. Swedish-speakers participated more actively in the survey compared with Finnish-speakers. In 2014 the survey questionnaire could also be completed online. However, only 6.2 per cent of the survey answers were submitted online. In the future, specific measures need to be considered to improve survey participation rates, for instance reminders by SMS or e-mail messages and rewards (e.g. gift certificate) for survey completion.

The survey provides a good coverage of the impact of the regional mental health work and offers excellent opportunities for research. Individuals working for the project, researchers and evaluators have elaborated the experiences and opinions of the public in reports and research, which support local and national mental health work. The four survey rounds have resulted in a valuable database for mental health reseach that enables the study of various aspects of mental health including trends and regional similarities and differences in Finland. The data is available for interested researchers who can contact the National Institute for Health and Welfare (THL) in Vaasa, Finland. Contact details and further information can be found on the survey website www.thl.fi/mhsurvey.

The success of the survey is credited to the thousands of respondents. Residents of Ostrobothnia and Southwest Finland have recognised mental health as an important subject and have taken the time to respond to the survey.

References

Aalto, M., Alho, H. Halme, J. T., & Seppä, K. (2011). The Alcohol Use Disorders Identification Test (AUDIT) and its derivatives in screening for heavy drinking among the elderly. *International Journal of Geriatric Psychiatry*, 26, 881-885.

Aalto, A. M., Aro, A. R., & Teperi, J. (1999). RAND-36 terveyteen liittyvän elämänlaadun mittarina. Stakes Tutkimuksia 101. Helsinki: Stakes.

Aalto, M., Tuunanen, M., Sillanaukee, P., & Seppä, K. (2006). Effectiveness of structured questionnaires for screening heavy drinking in middle-aged women. *Alcoholism: Clinical and Experimental Research,* 30, 1884-1888.

Almedom, A. M. (2005). Social capital and mental health: An interdisciplinary review of primary evidence. *Social Science and Medicine* 61, 943-964.

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental disorders (4th ed.). Washington DC: American Psychiatric Association 1994.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Washington, DC: American Psychiatric Association 2013.

Aromaa, A., & Koskinen, S. (2004). (Eds) Health and functional capacity in Finland. Baseline results of the Health 2000 health examination study. B12/2004. Helsinki: National Public Health Institute. http://www.ktl.fi/attachments/suomi/julkaisut/julkaisusarja_b/2004b12.pdf

Axler, F., Kotranski, L., Klein, G., Levengood, D., Stalberg, I., & Wilcox, R. (2003). Social capital and health behaviors: Does a relationship exist? Philadelphia Health Management Corporation, Community Health Data Base. http://www.phmc.org/chdb/uploads/datareports/APHA%20Presentation.pdf

Babor, T. F., De La Fuente, J. R., Saunders, J., & Grant, M. (1992). AUDIT: The Alcohol Use Disorder Identification Test. Guidelines for use in primary health care. Geneva, Switzerland: World Health Organization.

Babor, T. F., Higgins-Biddle, J., Saunders, J. B., & Monteiro, M. G. (2001). The Alcohol Use Disorder Identification Test. Guidelines for use in primary health care. Geneva, Switzerland: World Health Organization.

Bijl, R. V., & Ravelli, A. (2000). Current and residual functional disability associated with psychopathology: findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). *Psychological Medicine*, 30, 657-668.

Bishop, G. F. (2005). The illusion of public opinion. Lanham: Rowman & Littlefield Publishers.

Björkqvist, K., Österman, K., & Berg, P. (2011). Higher rates of victimization to physical abuse by adults found among victims of school bullying. *Psychological Reports,* 109:167-168.

Björkqvist, K., & Österman, K. (2012). Corporal punishment as an antecedent of victimization to and perpetration of aggression and bullying in schools. XXth World Meeting of the International Society for Research on Aggression, Luxembourg, July 17-21.

Björkqvist, K., & Österman, K. (2014). Does childhood physical punishment predispose to a "victim personality"? Pediatrics and Therapeutics, 4, 1. doi: 10.4172/2161-0665.1000190

Björkqvist, K., Österman, K., & Wahlbeck, K. (2014). Twenty-eight years after the complete ban on the physical punishment of children in Finland. XXIth World Meeting of the International Society for Research on Aggression, Atlanta, GA, July 15-19.

Boström, G., & Nykvist, K. (2004). Levnadsvanor och hälsa -de första resultaten från den nationella folkhälsoenkäten. R 2004:48. Stockholm: Statens folkhälsoinstitut. http://www.fhi.se/upload/ar2005/rapporter/r200448levnadsvanorhalsa0504.pdf

Bradley, K. A., Bush, K. R., Epler, A. J., Dobie, D. J., Davis, T. M., Sporleder, J. L., Maynard, C., Burman, M. L., & Kivlahan, D. R. (2003). Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT) – Validation in a female veterans affairs patient population. *Archives of Internal Medicine*, 163, 821-829.

Brevik, J. I., & Dalgard, O. (1996). The Health Profile Inventory. Oslo.

Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., & Bradley, K. A. (1998). The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Alcohol Use Disorders Identification Test. *Archives of Internal Medicine*, 158, 1789-1795.

Caputo, R. K. (2003). The effects of socioeconomic status, perceived discrimination and mastery on health status in a youth cohort. *Social Work in Health Care*, 37, 17-42.

Castaneda, A. E., Rask, S., Koponen, P., Mölsä, M., & Koskinen, S. (2012). Maahanmuuttajien terveys ja hyvinvointi. Tutkimus venäläis-, somalialais- ja kurditaustaisista Suomessa. THL Raportti 61/2012.

Colman, I., Naicker, K., Zeng, Y., Ataullahjan, A., Senthilselvan, A., & Patten, S. B. (2011). Predictors of long-term prognosis of depression. *Canadian Medical Association Journal,* 183, 1969-1976.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, 177, 4-7.

Dalgard, O. S. (2008). Explanation of OSS-3. RIVM, Bilthoven. http://preview.euphix.org/object_document/o5563n27411.html

Dalgard, O. S., Dowrick, C., Lehtinen, V., Vazquez-Barquero, J. L., Casey, P., Wilkinson, G., Ayuso-Mateos, J. L., Page, H., Dunn, G., & ODIN Group (2006). Negative life events, social support and gender difference in depression. A multinational community survey with data from the ODIN study. *Social Psychiatry and Psychiatric Epidemiology,* 41, 444-451.

Dawson, D. A., Grant, B. F., Stinson, F. S., & Zhou, Y. (2005). Effectiveness of the derived alcohol use disorders identification test (AUDIT-C) in screening for alcohol use disorders and risk drinking in the US general population. *Alcoholism: Clinical and Experimental Research*, 29, 844-854.

de Meneses-Gaya, C., Zuardi, A. W., Loureiro, S. R., & Crippa, J. A. S. (2009). Alcohol use disorders identification test (AUDIT): An updated systematic review of psychometric properties. *Psychology & Neuroscience*, 2, 83-97.

De Silva, M. J., McKenzie, K., Harpham, T., & Huttly, S. R. A. (2005). Social capital and mental health: a systematic review. *Journal of Epidemiology and Community Health,* 59, 619-627.

Eklund, M., Erlandsson, L-K., & Hagell, P. (2012). Psychometric properties of a Swedish version of the Pearlin Mastery Scale in people with mental illness and healthy people. *Nordic Journal of Psychiatry*, 66, 380-388.

Ewing, J. A. (1984). Detecting alcoholism. The CAGE questionnaire. *Journal of the American Medical Association*, 252, 1905-1907.

Forsman, A., Herberts, K., Aromaa, E., Tuulari, J., & Wahlbeck, K. (2009). Kohti pohjalaista hyvinvointia: Mielenterveyttä koskeva kyselytutkimus 2008: Menetelmäraportti. Avauksia 3/2009. Helsinki: Terveyden ja hyvinvoinnin laitos.

Frankfort-Nachmias, C., & Nachmias, D. (1992). Research methods in the social sciences. London: Edward Arnold.

Gershoff, E. (2002). Corporal punishment by parents and associated child behaviors and experiences: a meta-analytic and theoretical review. *Psychological Bulletin,* 128, 539-579.

Goldberg, D. (1985) Identifying psychiatric illnesses among general medical patients. *British Medical Journal,* 291, 161-162.

Goldberg, D. P. (2000). General Health Questionnaire (GHQ). In: Task Force for the Handbook of Psychiatric Measures(Ed) Handbook of Psychiatric Measures. Washington,DC: American Psychiatric Association.

Goldberg, D. P., & Hillier, V. F. (1979). A scaled version of the General Health Questionnaire. *Psychological Medicine*, 9, 139-145.

Goldberg, D., & Huxley, P. (1980). Mental Illness in the community: The pathway to psychiatric care. London: Tavistock Publications

Gómez, A., Conde, A., Santana, J. M., & Jorrín, A. (2005). Diagnostic usefulness of brief versions of Alcohol Use Disorders Identification Test (AUDIT) for detecting hazardous drinkers in primary care settings. *Journal of Studies on Alcohol*, 66, 305-308.

Groves, R. M., Dillman, D. A., Eltinge, J. L., & Little, R. J. A. (2001). Survey nonresponse. New York: Wiley Interscience.

Götestam, K. G., Johansson, A., Wenzel, H. G., & Simonsen, I-E. (2004). Validation of the Lie/Bet screen for pathological gambling on two normal population data sets. *Psychological Reports,* 95, 1009-13.

Hays, R. D., Sherbourne, C. D., & Mazel, R. M. (1993). The RAND 36-Item Health Survey 1.0. *Health Economics*, 2, 217-227.

Hays, R. D., & Morales, L. S. (2001). The RAND-36 measure of health-related quality of life. *Annals of Medicine,* 33, 350-357.

Hayward, P., & Bright, J. (1997). Stigma and mental illness: a review and critique. *Journal of Mental Health*, 6, 345-354.

Herberts, K., Wahlbeck, K., Aromaa, E., & Tuulari, J. (2006). Enkät om mental hälsa 2005. Metodbeskrivning. Diskussionsunderlag 13/2006. Helsinki: Stakes.

Hyyppä, M. T., & Mäki, J. (2001). Individual-Level Relationships between Social Capital and Self-Rated Health in a Bilingual Community. *Preventive Medicine*, 32**,** 148-155.

Johnson, E. E., Hamer, R. M., & Nora, R. M. (1998). The Lie/Bet Questionnaire for screening pathological gamblers: a follow-up study. *Psychological Reports,* 83, 1219-1224.

Johnson, E. E., Hamer, R., Nora, R. M., Tan, B., Eisenstein, N., & Engelhart, C. (1997). The Lie/Bet Questionnaire for screening pathological gamblers. *Psychological Reports*, 80, 83-88.

Kaarne, T., Aalto, M., Kuokkanen, M., & Seppä, K. (2010). AUDIT-C, AUDIT-3 and AUDIT-QF in screening risky drinking among Finnish occupational health-care patients. *Drug and Alcohol Review*, 29, 563-567.

Kessler, R. C., Andrews, G., Mroczek, D., Ustun, B., & Wittchen, H-U. (1998). The World Health Organization composite international diagnostic interview short form (CIDI). *International Journal of Methods in Psychiatric Research* 7, 171-185.

Kontodimopoulos, N., Pappa, E., Niakas, D., & Tountas Y. (2007). Validity of SF-12 summary scores in a Greek general population. *Health and Quality of Life Outcomes*, 5:55 doi:10.1186/1477-7525-5-55.

Koskinen, S., Lundqvist, A., & Ristiluoma N. (Toim.) (2012). Terveys, toimintakyky ja hyvinvointi Suomessa 2011. Terveyden ja hyvinvoinnin laitos (THL), Raportti 68/2012. Helsinki 2012.

Lam, C. L. K., Tse, E. Y. Y., & Gandek, B. (2005). Is the standard SF-12 Health Survey valid and equivalent for a Chinese population? *Quality of Life Research*, 14, 539-547.

Lesage, F-X., Martens-Resende, S., Deschamps, F., & Berjot, B. (2011). Factor structure and reliability of the General Health Questionnaire (GHQ-12) adapted to a work-related context: The General Health Questionnaire at Work (GHQW-12). *Open Journal of Preventive Medicine*. 1, 44-48. doi: 10.4236/ojpm.2011.12007

Link, B. G. (1987). Understanding labelling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review,* 52, 96-112.

Link, B. G., Struening, E., Cullen, F. T., Shrout, P. E., & Dohrenwend, B. P. (2000). A modified labelling theory approach to mental disorders: an empirical assessment. *American Sociological Review,* 54, 400-423.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin,* 30, 511-541.

Meltzer, H. (2003). Development of a common instrument for mental health. In: Nosikov & Gudex (eds). EUROHIS: Developing Common Instruments for Health Surveys. Amsterdam: IOS Press

Mental Health Act (1990). Available: http://www.finlex.fi/en/laki/kaannokset/1990/en19901116.pdf

Ministry of Social Affairs and Health (2010). Plan for mental health and substance abuse work. Proposals of the Mieli 2009 working group to develop mental health and substance abuse work until 2015. Reports 2010:5. Helsinki: Ministry of Social Affairs and Health. Available: http://www.stm.fi/c/document_library/get_file?folderId=1082856&name=DLFE-12329.pdf

Montazeri, A., Vahdaninia, M., Mousavi, S. J., Asadi-Lari, M., Omidvari, S., & Tavousi, M. (2011). The 12-item medical outcomes study short form health survey version 2.0 (SF-12v2): A population-based validation study from Tehran, Iran. *Health and Quality of Life Outcomes*, 9, 12. doi: 10.1186/1477-7525-9-12.

Nyqvist, F., Finnäs, F., Jakobsson G., & Koskinen, S. (2008). The effect of social capital on health: The case of two language groups in Finland. *Health & Place*, 14, 347-360.

Official Statistics of Finland (OSF) (2013). Causes of death in 2012 Helsinki: Statistics Finland. ISSN=1799-5078. Available at: http://www.stat.fi/til/ksyyt/2012/ksyyt_2012_2013-12-30_kat_001_en.html

Österman, K., & Björkqvist, K. (2007). Brief Physical Punishment Scale (BPPS). Åbo Akademi University, Vaasa, Finland.

Österman, K., Björkqvist, K., & Backström, H. (2008). The relationship between physical abuse during childhood, cyber bullying, and traditional bullying in adolescence. XVIII World Meeting of the International Society for Research on Aggression, July 8-13, Budapest, Hungary.

Österman, K., Björkqvist, K., Wahlbeck, K., Herberts, K., Nordmyr, J., & Stenvall, L. (2012). Childhood corporal punishment, adult psychosocial concomitants, and attempted suicide. A representative survey 28 years after the complete ban on corporal punishment of children in Finland. XXth World Meeting of the International Society for Research on Aggression, Luxembourg, July 17-21.

Österman, K., Björkqvist, K., & Wahlbeck, K. (2014). Twenty-eight years after the complete ban on the physical punishment of children in Finland: Trends and psychosocial concomitants. *Aggressive Behavior*, 40, 568-581. doi: 10.1002/ab.21537

Pearlin, L., & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behavior,* 19, 2-21.

Pearlin, L. I., Lieberman, M. A., Menaghan, E. G., & Mullan, J. T. (1981). The stress process. *Journal of Health and Social Behavior*, 22, 337-356.

Penninkilampi-Kerola, V., Miettunen, J., & Ebeling, H. (2006). A comparative assessment of the factor structures and psychometric properties of the GHQ-12 and the GHQ-20 based on data from a Finnish population-based sample. *Scandinavian Journal of Psychology*, 47, 431-440.

Pevalin, D. J. (2000). Multiple applications of the GHQ-12 in a general population sample: an investigation of long-term retest effects. *Social Psychiatry and Psychiatric Epidemiology*, 35, 508-512.

Presser, S., Rothgeb, J. M., Couper, M. P., Lessler, J. T., Martin, E., Mertin, J., & Singer, E. (2004). Methods for Testing and Evaluating Survey Questionnaires. New York: Wiley.

Reinert, D. F., & Allen, J. P. (2007). The alcohol use disorders identification test: An update of research findings. *Alcoholism: Clinical and Experimental Research,* 31, 185-199.

Robins, L. N., Wing, J., Wittchen, H. U., Helzer, J. E., Babor, T. F., Burke, J., Farmer, A., Jablenski, A., Pickens, R., & Regier, D. A. (1988). The Composite International Diagnostic Interview. An epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different cultures. *Archives of General Psychiatry,* 45, 1069-1077.

Rumpf, H-J., Hapke, U., Meyer, C., & John, U. (2002). Screening for alcohol use disorders and at-risk drinking in the general population: psychometric performance of three questionnaires. *Alcohol & Alcoholism*, 37, 261-268.

Saunders, J. B., Aasland, O. G., Babor, T. F., de la Fuente, J. R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption. II. *Addiction*, 88, 791-804.

Seppälä, M., Uusitalo, M., & Vuorenmaa, M. (2011). Kohti pohjalaista hyvinvointia: Arviointinäkökulmia Pohjanmaa-hankkeen toiseen toimintakauteen 2007-2009. Raportti 32/2011. Helsinki: Terveyden ja hyvinvoinnin laitos (THL). Available: http://www.thl.fi/thl-client/pdfs/41676c86-bb5f-4245-a170-3d49d6900d72

Stephens, T., Dulberg, C., & Joubert, N. (2000). Mental health of the Canadian population: A comprehensive analysis. *Chronic Diseases in Canada,* 20, 118-126.

Stewart-Brown, S. L., Tennant, R., Tennant, A., Platt, S., Parkinson, J., & Weich, S. (2009) Internal construct validity of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS): a Rasch analysis using data from the Scottish Health Education Population Survey. *Health and Quality of Life Outcomes*, 7, 15. doi:10.1186/1477-7525-7-15

Straus, M. A. (1991). Discipline and deviance: physical punishment of children and violence and crime in adulthood. *Social Problems, 38*, 133-154.

Sullivan, M., Karlsson, J., & Ware, J. (1995). The Swedish SF-36 Health Survey - I.Evaluation of data quality, scaling assumptions, reliability and construct validity across general population in Sweden. *Social Science & Medicine*, 41, 1349-1358.

Tennant, R., Hiller, L., Fishwick, R., Platt, P., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcome*; 5, 63. doi:101186/1477-7252-5-63.

The European Opinion Research Group (EORG). (2003). The mental health status of the European population. Eurobarometer 58, 2.

Luxemburg: European Commission, Directorate-General Health and Consumer Protection (SANCO).

Tourangeau, R., Rips, L. J., & Rasinski, K. (2000). The psychology of survey response. Cambridge: Cambridge University Press.

Turja, T., Halme, J., Mervola, M., Järvinen-Tassopoulos, J., & Ronkainen, J-E. (2012). Suomalaisten rahapelaaminen 2011. [Finnish gambling 2011.] National Institute for Health and Welfare (THL). Report 14/2012. Helsinki: THL.

Turner, H. A., & Muller, P. A. (2004). Long-term effects of child corporal punishment on depressive symptoms in young adults: potential moderators and mediators. *Journal of Family Issues, 25*, 760─781.

Tuunanen, M., Aalto, M., & Seppä, K. (2007). Binge drinking and its detection among middle-aged men using AUDIT, AUDIT-C and AUDIT-3. *Drug and Alcohol Review*, 26, 295-299.

Vuorenmaa M., & Löytty L. (2008). Kohti pohjalaista hyvinvointia. Arviointinäkökulmia Pohjanmaa-hankkeen ensimmäiseen toimintakauteen vuosina 2005-2007. Työpapereita 13/2008. Helsinki: Stakes.

Ware, J. E., Kosinski, M., & Keller, S. D. (1996). A 12-Item Short-Form Health Survey: Construction of scales and preliminary tests of reliability and validity. *Medical Care*, 34, 220-233.

Wilkins, K., & Beaudet, M. P. (1998). Work stress and health. *Health Reports*, 10, 47-62.

Williams, R. J., Volberg, R. A., & Stevens, R. M. G. (2012). The Population Prevalence of Problem Gambling: Methodological Influences, Standardized Rates, Jurisdictional Differences, and Worldwide Trends. Report prepared for the Ontario Problem Gambling Research Centre and the Ontario Ministry of Health and Long Term Care. May 8, 2012. Available at: http://hdl.handle.net/10133/3068

Windle, G., Hughes, D., Linck, P., Russell, I., & Woods, B. (2010). Is exercise effective in promoting mental well-being in older age? A systematic review. *Aging and Mental Health*, 14, 652-69.

World Health Organization (2007, 2011). What is mental health? http://www.who.int/features/qa/62/en/index.html

Appendix 1.
Survey questionnaire 2014

BACKGROUND

1. Year of birth 19_____

2. Gender ☐ Man ☐ Woman

3. Municipality of residence? _____

4. Mother tongue ☐ Finnish ☐ Swedish ☐ Other:_____

5. Marital status ☐ Married ☐ Common-law marriage/in a relationship ☐ Divorced ☐ Unmarried ☐ Widow/widower

6. How many people belong to your household (including yourself)? _____pers.

7. What is the highest level of education you and your parents have?

	Your education	Your mother's education	Your father´s education
Elementary school	☐	☐	☐
Middle school	☐	☐	☐
Comprehensive school	☐	☐	☐
Vocational school	☐	☐	☐
High school	☐	☐	☐
Higher vocational school	☐	☐	☐
University	☐	☐	☐

8. Which of the following alternatives best describes your current main occupation?

☐ Fulltime employment
☐ Part-time employment/Part-time retirement
☐ Fulltime student
☐ Retired
☐ Unemployed or on temporarily lay-off
☐ Military service/non-military (civil) service
☐ At home taking care of the household of family member
☐ Other, please specify:_____

9. How active are you when it comes to association activities?

☐ Very active ☐ Fairly active ☐ Not very active ☐ Not active at all

10. a. Do you use the internet (via computer, tablet, smartphone or comparable device)**?**

☐ Yes ☐ No If you answered No, **continue to question 11**

b. During the past month have you used the internet for the following purposes?

(You may choose more than one option)

☐ Public or commercial services (e.g.online banking or social security services, shopping or travel ticket booking)
☐ Work or studies
☐ Following news or information search (e.g. newspapers, news forums)
☐ Hobbies/entertainment (e.g. music, movies, discussion forums, games)
☐ Communication with family and/or friends (e.g. via email, Skype, Facebook or other social networks)
☐ Obtaining new companionships (e.g. via Facebook or dating sites)
☐ Different support groups
☐ Other, please specify? _____

11. The following statements concern your experience of your ability to control and master things in your life. Choose the alternative that best describes yourself.

	Strongly agree	Agree	Disagree	Strongly disagree
I have little control over the things that happen to me	☐	☐	☐	☐
There is really no way I can solve some of the problems I have	☐	☐	☐	☐
There is little I can do to change many of the important things in my life	☐	☐	☐	☐
I often feel helpless in dealing with the problems of life	☐	☐	☐	☐
Sometimes I feel that I'm being pushed around in life	☐	☐	☐	☐
What happens to me in the future mostly depends on me	☐	☐	☐	☐
I can do just about anything I really set my mind to	☐	☐	☐	☐

SOCIAL RELATIONSHIPS

12 a. How many people are so close to you that you can count on them if you have serious personal problems? ☐ None ☐ 1 or 2 ☐ 3 – 5 ☐ More than 5

b. How much concern do people show in what you are doing?

☐ A lot of concern and interest ☐ Some concern and interest ☐ Uncertain
☐ Little concern and interest ☐ No concern and interest

c. How easy is it to get practical help from neighbours if you should need it?

☐ Very easy ☐ Easy ☐ Possible ☐ Difficult ☐ Very difficult

13. How often do you meet socially with friends, relatives or work colleagues ? (members of your household do not count)

☐ Never ☐ Less than once a month ☐ Once a month
☐ Several times a month ☐ Once a week ☐ Several times a week
☐ Daily

14. Choose the alternative that best describes your opinion.

	Fully correct	Quite correct	Quite incorrect	Fully incorrect
I feel I belong and am part of my neighbourhood	☐	☐	☐	☐
Most people in my neighbourhood can be trusted	☐	☐	☐	☐
It is better not to trust anyone	☐	☐	☐	☐

15. I feel strong and influential in society

☐ I totally agree ☐ I agree to some extent ☐ I do not agree

16. Do you feel lonely? ☐ Often ☐ Sometimes ☐ Seldom ☐ Never

17. Choose the alternative that comes closest to your experience as a child. Have you been subjected to any of the following things by an adult?

	Never	Seldom	Sometimes	Often	Very often
Pulled your hair?	☐	☐	☐	☐	☐
Pulled your ear?	☐	☐	☐	☐	☐
Slapped you?	☐	☐	☐	☐	☐
Hit you with an object?	☐	☐	☐	☐	☐

HEALTH

18. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities…

a. …as a result of your physical health?	Yes	No
Accomplished less than you would like	☐	☐
Were limited in the kind of work or activities	☐	☐
b. …as a result of any emotional problems (such as feeling depressed or anxious)**?**		
Cut down the amount of time you spent on work or other activities	☐	☐
Accomplished less than you would like	☐	☐
Did work or other activities less carefully than usual	☐	☐

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
c. During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives etc)**?**	☐	☐	☐	☐	☐

19. Have you recently:

a. ... been able to concentrate on your work?

☐ Better than usua ☐ Same as usual ☐ Less than usual ☐ Much less than usual

b. ... lost much sleep over worry?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

c. ... felt that you were playing a useful part in things?

☐ More so than usual ☐ Same as usual ☐ Less than usual ☐ Much less than usual

d. ... felt capable of making decisions about things?

☐ More so than usual ☐ Same as usual ☐ Less than usual ☐ Much less than usual

e. ... felt constantly under strain?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

f. ... felt you couldn't overcome your difficulties?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

g. ... been able to enjoy your normal day to day activities?

☐ More so than usual ☐ Same as usual ☐ Less than usual ☐ Much less than usual

h. ... been able to face up to your problems?

☐ More so than usual ☐ Same as usual ☐ Less than usual ☐ Much less than usual

i. ... been feeling unhappy and depressed?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

j. ... been losing confidence in yourself?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

k. ... been thinking yourself as a worthless person?

☐ Not at all ☐ No more than usual ☐ Rather more than usual ☐ Much more than usual

l. ... been feeling reasonably happy, all things considered?

☐ More so than usual ☐ Same as usual ☐ Less so than usual ☐ Much less than usual

20. Do you know anyone who gas has a mental health problem? *You may choose several alternatives*.

☐ Among your family or relatives ☐ Among your friends ☐ From work
☐ Through your hobbies ☐ Elsewhere. From where? _____
☐ No, I don't know anyone

21. Have you during the past 12 months used any health services because of mental problems?

☐ Yes ☐ No *If you answered NO, continue to **question 24**!*

22. a. Has the treatment you received helped you?

☐ Very much ☐ Quite a lot ☐ To some extent ☐ Quite little ☐ Very little or not at all

b. Did the treatment include pharmacotherapy (medicines)? ☐ Yes ☐ No

23. Have you because of mental health problems during the last 12 months visited any of the following:
You may choose more than one option.

☐ Health care centre ☐ Emergency room
☐ Private consultation (doctor, psychologist...) ☐ Occupational health care
☐ School/Student health care ☐ Psychiatric hospital
☐ Psychiatric polyclinic or mental health clinic ☐ Other hospital
☐ Child health clinics dealing with family issues and child care
☐ Rehabilitation centre ☐ A-clinic/substance misuse services
☐ From somewhere else? Where?_____

24 a. During the past 12 months, have you had suicidal thoughts?

☐ Yes ☐ No

b. During the past 12 months, have you tried to commit suicide?

☐ Yes ☐ No

25 a. During the past 12 months, was there ever a time when you felt sad, blue, or depressed for two weeks or more in a row? ☐ Yes ☐ No

b. During the past 12 months, was there ever a time lasting two weeks or more when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?

☐ Yes ☐ No

*If you answered NO to BOTH questions, continue to **question 27!***

26. For the next few questions, please think of the *two-week period* during the past 12 months when the feelings of sadness or depression were worst or you had the most complete loss of interest in things.

a. Did these feelings usually last...

☐ all day long ☐ most of the day ☐ about half of the day ☐ less than half of the day

b. Did you feel this way...

☐ every day ☐ almost every day ☐ less often

During these two weeks, did you experience any of the following problems?

	Yes	No
c. Did you feel tired out or low on energy all the time?	☐	☐
d. Did you gain weight or lose weight (5 kilos or more) unintentionally?	☐	☐
e. Did you have more trouble falling asleep than you usually do?	☐	☐
f. Was it every night or nearly every night you had trouble falling asleep?	☐	☐
g. Did you have a lot more trouble concentrating than usual?	☐	☐
h. At these times, people sometimes feel down on themselves, no good or worthless. Did you feel this way?	☐	☐
i. Did you think a lot about death – either your own, someone else's, or death in general?	☐	☐

DRINKING HABITS

27. a. How often do you have a drink containing alcohol?

☐ Never
☐ Monthly or less
☐ 2-4 times a month
☐ 2-3 times a week
☐ 4 or more times a week

If you answered Never, please continue to **question *30.***

b. How many standard drinks containing alcohol do you have on a typical day?

☐ 1 or 2
☐ 3 or 4
☐ 5 or 6
☐ 7 to 9
☐ 10 or more

1 standard drink is:
Bottle (33 cl) of beer or cider (alc. cont. 2,8-4,7%)
Glass (12 cl) of wine
Glass (8 cl) of fortified wine
4 cl strong alcohol

C. How often do you have six or more drinks on one occasion?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

28. During the past 12 months have you used any help or social services due to drinking problems?

☐ Yes ☐ No *If you answered NO, continue to **question 30!***

29. Did the treatment you received help you?

☐ Very much ☐ Quite a lot ☐ To some extent ☐ Only a little ☐ Very little or not at all

GAMBLING HABITS

30. During the past 12 months, how often have you engaged in the following gambling activities?

	Never	Occasionally	Several times a month	Several times a week	Daily/almost daily
Scratch and win tickets, lottery tickets and similar lottery games	☐	☐	☐	☐	☐
Lotto, Joker, and similar lottery games ***on the internet***	☐	☐	☐	☐	☐
Betting (e.g. sports, horses)	☐	☐	☐	☐	☐
Betting ***on the internet***	☐	☐	☐	☐	☐
Slot machines	☐	☐	☐	☐	☐
Slot machines **on the internet**	☐	☐	☐	☐	☐
Casino games (e.g. card games, roulette)	☐	☐	☐	☐	☐
Casino games (e.g. netpoker, roulette) ***on the internet***	☐	☐	☐	☐	☐

*If you HAVE NOT engaged in ANY gambling activities during the past 12 months, continue to **question 32!***

31. Have you ever felt the need to bet more and more money?

☐ Yes ☐ No

Have you ever had to lie to people important to you about how much you gambled?

☐ Yes ☐ No

32. Choose the alternative that best describes your opinion.

	Strongly disagree	Disagree	Agree	Strongly agree
Mental health problems are a sign of weakness and sensitivity	☐	☐	☐	☐
You don't recover from mental problems	☐	☐	☐	☐
Patients suffering from mental illnesses are unpredictable	☐	☐	☐	☐
Society should invest more in community care instead of hospital care for people with mental problems	☐	☐	☐	☐
If you talk about your mental problems, all friends will leave you	☐	☐	☐	☐
Health care professionals do not take mental problems seriously	☐	☐	☐	☐
It is difficult to talk with a person who suffers from mental illness	☐	☐	☐	☐
If the employer finds out that the employee is suffering from mental illness, the employment will be in jeopardy	☐	☐	☐	☐

33. Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each other over the last 2 weeks.

	None of the time	Rarely	Some of the time	Often	All of the time
I have been feeling optimistic about the future	☐	☐	☐	☐	☐
I have been feeling useful	☐	☐	☐	☐	☐
I have been feeling relaxed	☐	☐	☐	☐	☐
I have been dealing with problems well	☐	☐	☐	☐	☐
I have been thinking clearly	☐	☐	☐	☐	☐
I have been feeling close to other people	☐	☐	☐	☐	☐
I have been able to make up my own mind about things	☐	☐	☐	☐	☐

34. In your experience how have the mental health and substance misuse services changed during the last three years?

_____

_____

_____

35. What kind of mental health and substance misuse services will you see in the future?

_____

_____

_____

COMMENTS. **Please feel free to write any additional thoughts or opinions on this survey.**
THANK YOU!

Appendix 2.
Mielenterveyttä koskeva kyselytutkimus 2014

TAUSTATIEDOT

1. Syntymävuotesi 19_____

2. Sukupuolesi ☐ Mies ☐ Nainen

3. Missä kunnassa asut? _____

4. Mikä on äidinkielesi? ☐ Suomi ☐ Ruotsi ☐ Joku muu, mikä kieli?

5. Siviilisäätysi ☐ Avioliitossa ☐ Avoliitossa/suhteessa ☐ Eronnut ☐ Naimaton ☐ Leski

6. Kuinka monta henkilöä kuuluu kotitalouteesi tällä hetkellä itsesi mukaan luettuna? _____henk.

7. Mikä on korkein suorittamasi koulutus ja mikä on vanhempiesi korkein suorittama koulutus?

	Sinun koulutuksesi	Äitisi koulutus	Isäsi koulutus
Kansakoulu	☐	☐	☐
Keskikoulu	☐	☐	☐
Peruskoulu	☐	☐	☐
Ammattikoulu/ Ammattiopisto	☐	☐	☐
Lukio	☐	☐	☐
Ammattikorkeakoulu	☐	☐	☐
Yliopisto	☐	☐	☐

8. Mikä seuraavista vaihtoehdoista kuvaa parhaiten tämänhetkistä pääasiallista toimintaasi?

☐ Kokopäivätyössä ☐ Osa-aikatyössä / osa-aikaeläkeläinen
☐ Opiskelija ☐ Eläkkeellä
☐ Työtön tai lomautettu ☐ Varusmies- tai siviilipalvelussa
☐ Hoitamassa omaa kotitaloutta tai perheenjäseniä
☐ Muu, mikä? _____

9. Kuinka aktiivisesti osallistut yhdistystoimintaan?

☐ Erittäin aktiivisesti ☐ Melko aktiivisesti ☐ Melko vähän ☐ En ollenkaan

10. a. Käytätkö internetiä (tietokoneen, tabletin, älypuhelimen tai vastaavan kautta)**?**

☐ Kyllä ☐ En Jos vastasit En, ***siirry kysymykseen 11.***

b. Oletko kuluneen kuukauden aikana käyttänyt internetiä seuraaviin tarkoituksiin?

(Voit valita useamman vaihtoehdon)

☐ Hyötypalvelut (esim. pankki- tai KELA-palveluja, ostoksia tai matkavarauksia)
☐ Työ tai opiskelu
☐ Uutisten seuraaminen tai tiedonhaku (esim. sanomalehdet, uutisfoorumit)
☐ Harrastukset/viihde (esim. musiikki, elokuva, keskustelufoorumit, pelit)
☐ Yhteydenpito sukulaisten ja/tai ystävien kanssa (esim. sähköpostitse, Skypen, Facebookin tai muiden sosiaalisten verkostojen kautta)
☐ Uusien tuttavuuksien saaminen (esim. Facebookin tai treffisivustojen kautta)
☐ Erilaiset tukiryhmät
☐ Muuhun, mihin? _____

11. Esitämme Sinulle seuraavaksi elämän hallintaan liittyviä väitteitä.
Valitse Sinua parhaiten kuvaava vaihtoehto.

	Täysin samaa mieltä	Osittain samaa mieltä	Osittain eri mieltä	Täysin eri mieltä
Voin vaikuttaa vain vähän minulle tapahtuviin asioihin	☐	☐	☐	☐
En pysty millään ratkaisemaan joitain ongelmiani	☐	☐	☐	☐
En voi tehdä paljoakaan muuttaakseni asioita elämässäni	☐	☐	☐	☐
Tunnen usein avuttomuutta elämän ongelmien edessä	☐	☐	☐	☐
Joskus minusta tuntuu että elämä kohtelee minua miten tahtoo	☐	☐	☐	☐
Se mitä minulle tulevaisuudessa tapahtuu riippuu lähinnä minusta itsestäni	☐	☐	☐	☐
Kykenen tekemään lähes kaiken sen minkä todella päätän tehdä	☐	☐	☐	☐

IHMISSUHTEET

12 a. Kuinka monta sellaista läheistä Sinulla on, joihin voit luottaa kun Sinulla on vakavia henkilökohtaisia vaikeuksia? ☐ Ei yhtään ☐ 1-2 ☐ 3-5 ☐ Enemmän kuin 5

b. Kuinka paljon ihmiset osoittavat mielenkiintoa siihen, mitä teet?

☐ Paljon mielenkiintoa ☐ Jonkin verran mielenkiintoa
☐ Olen epävarma ☐ Vähän mielenkiintoa ☐ Ei lainkaan

c. Kuinka helppoa Sinun on tarvittaessa saada naapureiltasi käytännön apua?

☐ Erittäin helppoa ☐ Helppoa ☐ Mahdollista ☐ Vaikeaa ☐ Erittäin vaikeaa

13. Kuinka usein Sinä tapaat ystäviäsi, sukulaisiasi tai työtovereitasi muuten kuin työasioissa? (saman kotitalouden jäseniä ei lasketa)

☐ En koskaan ☐ Harvemmin kuin kerran kuukaudessa ☐ Kerran kuukaudessa
☐ Useita kertoja kuukaudessa ☐ Kerran viikossa ☐ Useita kertoja viikossa
☐ Päivittäin

14. Valitse väittämien paikkansapitävyyttä kuvaavista vaihtoehdoista mielestäsi sopivin.

	Pitää täysin paikkansa	Pitää melko lailla paikkansa	Ei juuri pidä paikkansa	Ei lainkaan pidä paikkansa
Tunnen kuuluvani naapurustooni ja olevani osa sitä	☐	☐	☐	☐
Useimmat ihmiset naapurustossani ovat luotettavia	☐	☐	☐	☐
On parasta olla luottamatta kehenkään	☐	☐	☐	☐

15. Tunnen itseni vahvaksi ja vaikutusvaltaiseksi yhteiskunnan jäseneksi

☐ Pitää paikkansa ☐ Pitää osittain paikkansa ☐ Ei pidä paikkansa

16. Tunnetko itsesi yksinäiseksi? ☐ Usein ☐ Joskus ☐ Harvoin ☐ En koskaan

17. Valitse se vaihtoehto joka parhaiten kuvaa *Sinun lapsuudenkokemuksiasi*.
Alistiko joku *aikuinen* Sinua seuraavin tavoin?

	Ei koskaan	Harvoin	Joskus	Usein	Hyvin usein
Tukistettiinko Sinua?	☐	☐	☐	☐	☐
Vedettiinkö Sinua korvasta?	☐	☐	☐	☐	☐
Lyötiinkö Sinua kämmenellä?	☐	☐	☐	☐	☐
Lyötiinkö Sinua jollain esineellä?	☐	☐	☐	☐	☐

TERVEYS

18. Onko Sinulla *viimeisen neljän viikon aikana* ollut alla mainittuja ongelmia työssäsi tai muissa tavanomaisissa päivittäisissä tehtävissäsi…

a. …*ruumiillisen terveydentilasi* takia*?*	Kyllä	Ei
Olen saanut aikaan vähemmän kuin halusin	☐	☐
Terveydentilani on asettanut minulle rajoituksia joissakin työ- tai muissa tehtävissä	☐	☐
b. …*tunne-elämään* liittyvien vaikeuksien takia (esim. masentuneisuus tai ahdistuneisuus)**?**		
Olen vähentänyt työhön tai muuhun toimintaan käyttämääni aikaa	☐	☐
Olen saanut aikaan vähemmän kuin halusin	☐	☐
En ole suorittanut töitäni tai muita tehtäviäni yhtä huolellisesti kuin tavallisesti	☐	☐

	Koko ajan	Suurimman osan aikaa	Jonkin aikaa	Vähän aikaa	Ei lainkaan
c. Kuinka suuren osan ajasta *ruumiillinen terveydentilasi* tai *tunne-elämän* vaikeudet ovat viimeisen neljän viikon aikana häirinneet tavanomaista sosiaalista toimintaasi (esim. ystävien, sukulaisten, muiden ihmisten tapaaminen)**?**	☐	☐	☐	☐	☐

19. Oletko viime aikoina….

a. … pystynyt keskittymään töihisi?

☐ Paremmin kuin tavallisesti ☐ Yhtä hyvin kuin tavallisesti ☐ Huonommin kuin tavallisesti ☐ Paljon huonommin …kuin tavallisesti

b. … valvonut paljon huolien vuoksi?

☐ En ollenkaan ☐ En enempää ☐ Jonkin verran enemmän ☐ Paljon enemmän …kuin tavallisesti

c. … tuntenut, että mukana olosi asioiden hoidossa on hyödyllistä?

☐ Tavallista hyödyllisempää ☐ Yhtä hyödyllistä ☐ Vähemmän hyödyllistä ☐ Paljon vähemmän hyödyllistä …kuin tavallisesti

d. … tuntenut kykeneväsi päättämään asioista?

☐ Paremmin kuin tavallisesti ☐ Yhtä hyvin kuin tavallisesti ☐ Huonommin kuin tavallisesti ☐ Paljon huonommin …kuin tavallisesti

e. … tuntenut olevasi jatkuvasti rasituksen alaisena?

☐ En ollenkaan ☐ En enempää ☐ Jonkin verran enemmän ☐ Paljon enemmän …kuin tavallisesti

f. … tuntenut, ettet voisi selviytyä vaikeuksistasi?

☐ En ollenkaan ☐ En enempää ☐ Jonkin verran enemmän ☐ Paljon enemmän …kuin tavallisesti

g. … kyennyt nauttimaan tavallisista päivittäisistä toimistasi?

☐ Enemmän ☐ Yhtä paljon ☐ Vähemmän ☐ Paljon vähemmän …kuin tavallisesti

h. … kyennyt kohtaamaan vaikeutesi?

☐ Paremmin kuin tavallisesti ☐ Yhtä hyvin kuin tavallisesti ☐ Huonommin kuin tavallisesti ☐ Paljon huonommin …kuin tavallisesti

i. … tuntenut itsesi onnettomaksi ja masentuneeksi?

☐ En ollenkaan ☐ En enempää ☐ Jonkin verran enemmän ☐ Paljon enemmän …kuin tavallisesti

j. … kadottanut itseluottamuksesi?

☐ En ollenkaan ☐ En enempää ☐ Jonkin verran enemmän ☐ Paljon enemmän …kuin tavallisesti

k. … tuntenut itsesi ihmisenä arvottomaksi?

☐ En ollenkaan ☐ En enempää ☐ Jonkin verran enemmän ☐ Paljon enemmän …kuin tavallisesti

l. … tuntenut itsesi kaiken kaikkiaan kohtalaisen onnelliseksi?

☐ Enemmän ☐ Yhtä paljon ☐ Vähemmän ☐ Paljon vähemmän …kuin tavallisesti

20. Tunnetko jonkun mielenterveysongelmista kärsivän henkilön? *Voit valita useamman vaihtoehdon*.

☐ Perhe- tai sukulaispiiristä ☐ Ystäväpiiristä ☐ Työn kautta ☐ Harrastusten kautta
☐ Muuta kautta. Kuinka?_____
☐ En tunne ketään

21. Oletko viimeksi kuluneiden 12 kk aikana käyttänyt mielenterveydellisten ongelmien takia jotain terveyspalvelua? ☐ Kyllä ☐ Ei *Jos vastasit EI,* ***siirry kysymykseen 24.***

22. a. Onko saamastasi hoidosta ollut Sinulle apua?

☐ Erittäin paljon ☐ Melko paljon ☐ Jonkin verran ☐ Melko vähän ☐ Hyvin vähän tai ei lainkaan

b. Sisälsikö hoitosi lääkehoitoa? ☐ Kyllä ☐ Ei

23. Oletko käynyt mielenterveysongelmien takia terveyspalveluissa viimeksi kuluneiden 12 kuukaudenaikana? *Voit valita useamman vaihtoehdon.*

☐ Terveyskeskus ☐ Päivystyspoliklinikka ☐ Yksityisvastaanotto (lääkäri, psykologi...)
☐ Työterveyshuolto ☐ Oppilas/opiskelijaterveydenhuolto ☐ Psykiatrinen sairaala
☐ Psykiatrinen poliklinikka tai mielenterveystoimisto ☐ Muu sairaala
☐ Perhe- tai kasvatusneuvola ☐ Kuntoutuslaitos ☐ A-klinikka
☐ Muualla, missä? _____

24. a. Onko Sinulla viimeisen 12 kuukauden aikana ollut itsemurha-ajatuksia?

☐ Kyllä ☐ Ei

b. Oletko viimeisen 12 kuukauden aikana yrittänyt itsemurhaa?

☐ Kyllä ☐ Ei

25. a. Onko Sinulla viimeksi kuluneen vuoden aikana ollut 2 viikkoa tai pitempään kestänyt jakso, jolloin olit surullinen, alakuloinen tai masentunut?

☐ Kyllä ☐ Ei

b. Onko Sinulla viimeksi kuluneen vuoden aikana ollut vähintään 2 viikkoa tai pitempään kestänyt jakso, jonka aikana menetit mielihyvän kokemuksen tai kiinnostuksesi melkein kaikkeen, kuten työhön, harrastuksiin tai muihin Sinulle tavallisesti mieluisiin tekemisiin?

☐ Kyllä ☐ Ei

*Jos vastasit EI molempiin kysymyksiin, siirry **kysymykseen 27.***

26. Seuraavan muutaman kysymyksen kohdalla, ajattele *kahden viikon jaksoa* viimeisen 12 kuukauden aikana, jolloin mielihyväsi menetys oli suurimmillaan tai masennus pahimmillaan.

a. Kestikö mielihyväsi tai mielenkiintosi menetys...

☐ koko päivän ☐ suurimman osan päivästä ☐ suunnilleen puolet päivästä ☐ vähemmän aikaa

b. Tuntuiko Sinusta tällaiselta...

☐ joka päivä ☐ miltei joka päivä ☐ Harvemmin

Tuon kahden viikon aikana, mitä ongelmia esiintyi?

	Kyllä	Ei
c. Olitko voimattomampi tai väsyneempi kuin tavallisesti?	☐	☐
d. Nousiko painosi tai laihduitko tahattomasti (5 kiloa tai enemmän)?	☐	☐
e. Oliko Sinun tavallista vaikeampaa saada unta?	☐	☐
f. Oliko Sinun tuon kahden viikon aikana vaikea saada unta joka yö tai lähes joka yö?	☐	☐
g. Oliko Sinun selvästi vaikeampaa keskittyä asioihin kuin tavallisesti?	☐	☐
h. Jotkut voivat tuntea toisinaan itsensä arvottomiksi, hyödyttömiksi tai arvostella itseään. Tuntuuko Sinusta tällaiselta?	☐	☐
i. Ajattelitko kuolemaa joko omasi tai jonkun muun, tai kuolema ylipäänsä?	☐	☐

ALKOHOLIN KÄYTTÖ

27. a. Kuinka usein juot olutta, viiniä tai muita alkoholijuomia?

☐ en koskaan
☐ noin kerran kuussa tai harvemmin
☐ 2-4 kertaa kuussa
☐ 2-3 kertaa viikossa
☐ 4 kertaa viikossa tai useammin

*Jos vastasit En koskaan, siirry **kysymykseen 30.***

b. Kuinka monta <u>annosta</u> alkoholia yleensä olet ottanut niinä päivinä, jolloin käytit alkoholia?

- ☐ 1-2 annosta
- ☐ 3-4 annosta
- ☐ 5-6 annosta
- ☐ 7-9 annosta
- ☐ 10 annosta tai enemmän

1 alkoholiannos on:
Pullo (33 cl) keskiolutta tai mietoa siideriä
Lasi (12 cl) mietoa viiniä
Pieni lasi (8 cl) väkevää viiniä
4 cl väkevää viinaa

c. Kuinka usein olet juonut kerralla kuusi tai useampia annoksia?

- ☐ en koskaan
- ☐ harvemmin kuin kerran kuussa
- ☐ kerran kuussa
- ☐ kerran viikossa
- ☐ päivittäin tai lähes päivittäin

28. Oletko käynyt alkoholin käyttöösi liittyen terveys- ja sosiaalipalveluissa viimeksi kuluneiden 12 kuukauden aikana?

☐ Kyllä ☐ Ei *Jos vastasit Ei, siirry **kysymykseen 30**.*

29. Onko saamasi hoidosta ollut Sinulle apua?

☐ Erittäin paljon ☐ Melko paljon ☐ Jonkin verran
☐ Melko vähän ☐ Hyvin vähän tai ei lainkaan

RAHAPELIEN PELAAMINEN

30. Kuinka usein viimeksi kuluneiden 12 kuukauden aikana olet pelannut seuraavia rahapelejä?

	En kertaakaan	Joitakin yksittäisiä kertoja	Muutaman kerran kuussa	Muutaman kerran viikossa	Lähes päivittäin
Arvontapelit kuten raaputusarvat, Lotto, Jokeri, Keno	☐	☐	☐	☐	☐
Arvontapelit kuten Lotto, Jokeri, Keno ***internetissä***	☐	☐	☐	☐	☐
Vedonlyönti (esim. urheilu tai ravi, pitkäveto, moniveto, V-75)	☐	☐	☐	☐	☐
Vedonlyönti ***internetissä***	☐	☐	☐	☐	☐
Rahapeliautomaatit	☐	☐	☐	☐	☐
Rahapeliautomaatit ***internetissä***	☐	☐	☐	☐	☐
Kasinopelit (esim. korttipelit, ruletti)	☐	☐	☐	☐	☐
Kasinopelit ***internetissä*** (esim. nettipokeri, ruletti)	☐	☐	☐	☐	☐

*Jos et ole pelannut mitään rahapelejä viimeksi kuluneiden 12 kuukauden aikana, siirry **kysymykseen 32.***

31. a. Oletko koskaan tuntenut tarvetta käyttää pelaamiseen yhä enemmän ja enemmän rahaa?

☐ Kyllä ☐ Ei

b. Oletko koskaan joutunut valehtelemaan läheisillesi siitä, kuinka paljon pelaat?

☐ Kyllä ☐ Ei

32. Valitse väittämien paikkansapitävyyttä kuvaavista vaihtoehdoista sopivin.

	Täysin eri mieltä	Osittain eri mieltä	Osittain samaa mieltä	Täysin samaa mieltä
Mielenterveysongelma on merkki ihmisen heikkoudesta ja yliherkkyydestä	☐	☐	☐	☐
Mielenterveysongelmat eivät koskaan parane	☐	☐	☐	☐
Mielenterveyspotilaat ovat arvaamattomia	☐	☐	☐	☐
Yhteiskunnan tulisi panostaa enemmän mielenterveysongelmaisten avohoitoon (ei sairaalahoitoon)	☐	☐	☐	☐
Jos kertoo omista mielenterveysongelmista, ystävät jättävät	☐	☐	☐	☐
Terveydenhuollon henkilökunta ei ota vakavasti mielenterveysoireita	☐	☐	☐	☐
On vaikeaa puhua henkilön kanssa, joka kärsii mielenterveysongelmista	☐	☐	☐	☐
Jos työnantaja saa tietää työntekijän mielenterveysongelmista, työsuhde vaarantuu	☐	☐	☐	☐

33. Alla on väittämiä tunteista ja ajatuksista. Merkitse rastilla kohta, joka parhaiten kuvaa kokemuksiasi viimeisen kahden viikon aikana.

	Ei koskaan	Harvoin	Silloin tällöin	Usein	Koko ajan
Olen tuntenut itseni toiveikkaaksi tulevaisuuden suhteen	☐	☐	☐	☐	☐
Olen tuntenut itseni hyödylliseksi	☐	☐	☐	☐	☐
Olen tuntenut itseni rentoutuneeksi	☐	☐	☐	☐	☐
Olen käsitellyt ongelmia hyvin	☐	☐	☐	☐	☐
Olen ajatellut selkeästi	☐	☐	☐	☐	☐
Olen tuntenut läheisyyttä toisiin ihmisiin	☐	☐	☐	☐	☐
Olen kyennyt tekemään omia päätöksiä asioista	☐	☐	☐	☐	☐

34. Miten koet mielenterveys- ja päihdepalvelujen muuttuneen viimeisten kolmen vuoden aikana?

_____

_____

_____

35. Millaisia mielenterveys- ja päihdepalveluja haluat nähdä tulevaisuudessa?

_____

_____

KOMMENTTEJA. Tähän voit kirjoittaa ajatuksiasi tästä kyselytutkimuksesta. *KIITOS!*

_____

_____

Appendix 3.
Frågeformulär om psykisk hälsa 2014

BAKGRUND

1. Födelseår 19_____

2. Kön ☐ Man ☐ Kvinna

3. I vilken kommun bor du? _____

4. Modersmål ☐ Svenska ☐ Finska ☐ Annat:_____

5. Civilstånd ☐ Gift ☐ Sambo/parförhållande ☐ Skild ☐ Ogift ☐ Änka/änkling

6. Hur många personer hör till ditt hushåll för närvarande (räknat med Dig själv)**?** _____personer

7. Vilken är din och dina föräldrars högsta utbildning?

	Din egen	Din mors	Din fars
Folkskola	☐	☐	☐
Mellanskola	☐	☐	☐
Grundskola	☐	☐	☐
Yrkesskola/ Yrkesinstitut	☐	☐	☐
Gymnasium	☐	☐	☐
Yrkeshögskola	☐	☐	☐
Universitet	☐	☐	☐

8. Vilket av följande alternativ beskriver bäst Din nuvarande huvudsakliga verksamhet?

☐ Heltidsarbetande
☐ Deltidsarbetande/deltidspensionerad
☐ Studerande
☐ Pensionerad
☐ Arbetslös eller permitterad
☐ Beväring eller i civiltjänst
☐ Hemma och sköter hushåll eller familjemedlemmar
☐ Annat, vad?_____

9. Hur aktiv deltar du i föreningslivet? ☐ Mycket aktivt ☐ Ganska aktivt ☐ Ganska lite ☐ Inte alls

10. a. Använder du internet (via dator, surfplatta, smarttelefon eller dylikt)**?**

☐ Ja ☐ Nej *Om du svarat Nej gå vidare till **fråga 11.***

b. Har du använt internet i följande syften under den senaste månaden?(Flera alternativ möjliga)

☐ Nyttotjänster(t.ex. bank- eller FPA-tjänster, inköp eller resebokning)
☐ Arbete eller studier
☐ Nyhetsuppföljning eller informationssökning (t.ex. dagstidningar, nyhetsforum)
☐ Hobby/underhållning (t.ex. musik, film, intresseforum, spel)
☐ Kontakt med släkt och/eller vänner (via t.ex. e-post, Skype, Facebook eller andra sociala nätverk)
☐ Kontakt för att stifta nya bekantskaper (via t.ex. Facebook eller dejtingsajter)
☐ Olika stödgrupper
☐ Annat, vad? _____

11. Nedan följer några påståenden om kontroll över det egna livet.

Välj det svarsalternativ som bäst beskriver dig själv.

	Helt av samma åsikt	Delvis av samma åsikt	Delvis av annan åsikt	Helt av annan åsikt
Jag har liten kontroll över vad som händer mig	☐	☐	☐	☐
Jag saknar möjligheter att lösa vissa av mina problem	☐	☐	☐	☐
Jag förmår inte göra mycket för att förändra saker i mitt liv	☐	☐	☐	☐
Jag känner mig ofta hjälplös inför livets problem	☐	☐	☐	☐
Ibland känns det som om jag skulle kastas omkring i livet	☐	☐	☐	☐
Det som händer mig i framtiden beror främst på mig själv	☐	☐	☐	☐
Jag kan göra nästan allt jag faktiskt besluter mig att göra	☐	☐	☐	☐

RELATIONER

12 a. Hur många personer står dig så nära, att du kan lita på dem om du har allvarliga personliga problem?

☐ Ingen ☐ 1 or 2 ☐ 3 – 5 ☐ Flera än 5

b. I vilken omfattning visar andra människor intresse för det du gör?

☐ Stort intresse ☐ Måttligt intresse ☐ Osäker ☐ Litet intresse ☐ Inget intresse

c. Hur lätt är det för dig att vid behov få praktisk hjälp av dina grannar?

☐ Mycket lätt ☐ Lätt ☐ Möjligt ☐ Svårt ☐ Mycket svårt

13. Hur ofta umgås du med vänner, släktingar eller arbetskamrater (i andra sammanhang än arbete)? (här avses inte medlemmar i ditt eget hushåll)

☐ Aldrig ☐ Mer sällan än en gång i månaden ☐ En gång i månaden
☐ Flera gånger i månaden ☐ En gång i veckan ☐ Flera gånger i veckan
☐ Varje dag

14. Ange det svarsalternativ som bäst beskriver din åsikt.

	Stämmer helt	Stämmer ganska så bra	Stämmer knappast	Stämmer inte alls
Jag känner samhörighet med mitt grannskap och jag är en del av det	☐	☐	☐	☐
De flesta i mitt grannskap kan man lita på	☐	☐	☐	☐
Det är bäst att låta bli att lita på någon	☐	☐	☐	☐

15. Jag känner mig stark och inflytelserik i samhället

☐ Instämmer helt ☐ Instämmer till viss del ☐ Instämmer inte alls

16. Händer det att du känner dig ensam? ☐ Ofta ☐ Ibland ☐ Sällan ☐ Aldrig

17. Välj det alternativ som passar bäst in på *dig själv när du var barn*.
Blev du utsatt för något av de följande av en *vuxen*?

	Aldrig	Sällan	Ibland	Ofta	Mycket ofta
Luggad	☐	☐	☐	☐	☐
Dragen i örat	☐	☐	☐	☐	☐
Slagen med handen	☐	☐	☐	☐	☐
Slagen med något föremål	☐	☐	☐	☐	☐

HÄLSA

18. Under de *senaste fyra veckorna,* har du haft något av följande problem i ditt arbete eller med andra regelbundna dagliga aktiviteter…

	Ja	Nej
a. … som följd av ditt *kroppsliga tillstånd?*		
Uträttat mindre än jag skulle ha önskat	☐	☐
Varit hindrad att utföra vissa arbetsuppgifter eller andra aktiviteter	☐	☐
b. … som en följd av *känslomässiga problem* (som t.ex. nedstämdhet eller ängslan)**?**		
Skurit ned den tid jag normalt ägnat åt arbete eller andra aktiviteter	☐	☐
Uträttat mindre än jag skulle ha önskat	☐	☐
Inte utfört arbete eller andra aktiviteter så noggrant som vanligt	☐	☐

	Hela tiden	Största delen av tiden	En del av tiden	Lite av tiden	Inget av tiden
c. Under de senaste fyra veckorna, hur stor del av tiden har ditt *kroppsliga hälsotillstånd* eller dina *känslomässiga problem* stört dina möjligheter att umgås (t.ex. hälsa på släkt, vänner etc.)**?**	☐	☐	☐	☐	☐

19. Har du den senaste tiden...

a. ... kunnat koncentrera dig på dina uppgifter?
☐ Bättre än vanligt ☐ Lika bra som vanligt ☐ Sämre än vanligt ☐ Mycket sämre än vanligt

b. ...vakat på grund av bekymmer?
☐ Inte alls ☐ Inte mer än vanligt ☐ Något mer än vanligt ☐ Mycket mer än vanligt

c. ... känt att du har en betydelsefull roll i vad som händer?
☐ Mer än vanligt ☐ Lika mycket som vanligt ☐ Mindre än vanligt ☐ Mycket mindre än vanligt

d. ... känt dig kapabel att fatta beslut?
☐ Bättre än vanligt ☐ Lika bra som vanligt ☐ Sämre än vanligt ☐ Mycket sämre än vanligt

e. ... känt dig hela tiden vara utsatt för påfrestning?
☐ Inte alls ☐ Inte mer än vanligt ☐ Något mer än vanligt ☐ Mycket mer än vanligt

f. ... haft en känsla av att du inte klarar av Dina svårigheter?
☐ Inte alls ☐ Inte mer än vanligt ☐ Något mer än vanligt ☐ Mycket mer än vanligt

g. ... kunnat njuta av dina vanliga dagliga förehavanden?

☐ Mer än vanligt ☐ Lika mycket som vanligt ☐ Mindre än vanligt ☐ Mycket mindre än vanligt

h. ... kunnat möta dina svårigheter?

☐ Bättre än vanligt ☐ Lika bra som vanligt ☐ Sämre än vanligt ☐ Mycket sämre än vanligt

i. ... känt dig olycklig och nedstämd?

☐ Inte alls ☐ Inte mer än vanligt ☐ Något mer än vanligt ☐ Mycket mer än vanligt

j. ... förlorat ditt självförtroende?

☐ Inte alls ☐ Inte mer än vanligt ☐ Något mer än vanligt ☐ Mycket mer än vanligt

k. ... känt dig värdelös som människa?

☐ Inte alls ☐ Inte mer än vanligt ☐ Något mer än vanligt ☐ Mycket mer än vanligt

l. ... på det hela känt dig rätt lycklig?

☐ Mer än vanligt ☐ Lika mycket som vanligt ☐ Mindre än vanligt ☐ Mycket mindre än vanligt

20. Känner du någon med psykiska problem? *Flera alternativ är möjliga*.

☐ I familjen eller släkten ☐ I vänkretsen ☐ I arbetet
☐ I fritidsaktiviteterna ☐ På annat sätt. Hur? _____ ☐ Nej, jag känner ingen

21. Har du under de senaste 12 månaderna anlitat någon hälsovårdstjänst på grund av psykiska problem?

☐ Ja ☐ Nej *Om du svarat Nej,* ***gå till fråga 24****!*

22. a. Har den behandling du fått varit till hjälp?

☐ Väldigt mycket ☐ Ganska mycket ☐ I någon mån ☐ Ganska litet ☐ Mycket litet eller inte

b. Omfattade behandlingen medicinering? ☐ Ja ☐ Nej

23. Har du under de senaste 12 månaderna använt någon av följande hälsovårdstjänster på grund av psykiska problem? *Flera alternativ är möjliga.*

☐ Hälsovårdscentral ☐ Akutmottagning ☐ Privatmottagning (läkare, psykolog...)
☐ Företagshälsovård ☐ Skol/studenthälsovård ☐ Psykiatriskt sjukhus
☐ Psykiatrisk poliklinik eller mentalvårdsbyrå ☐ Annat sjukhus
☐ Rådgivningsbyrå för familjefrågor eller uppfostringsfrågor ☐ Rehabiliteringsanstalt
☐ A-klinik
☐ Annat ställe? Vilket?_____

24 a. Har du någon gång under de senaste 12 månaderna haft tankar på självmord?

☐ Ja ☐ Nej

b. Har du under de senaste 12 månaderna försökt begå självmord?

☐ Ja ☐ Nej

25 a. Har du under de senaste 12 månaderna vid något tillfälle känt dig ledsen, nedstämd eller deprimerad under två veckor i sträck eller längre?

☐ Ja ☐ Nej

b. Har det under de senaste 12 månaderna funnits någon period då du förlorat välbefinnandet eller intresset för det mesta här i livet såsom arbete, hobby eller annan sysselsättning som du annars vanligtvis brukar tycka om, som varat i två veckor eller mer i sträck?

☐ Ja ☐ Nej

Om du svarat Nej på båda frågorna, gå till ***fråga 27!***

26. När det gäller de frågor som kommer härnäst, vill vi att du tänker på *den tvåveckorsperiod,* under de senaste 12 månaderna då känslan av att vara ledsen, nedstämd eller deprimerad eller förlusten av intresse var som värst.

a. Hade du denna känsla…

☐ hela dagen ☐ största delen av dagen ☐ ungefär halva dagen ☐ mindre än halv dagen

b. Kändes det så...

☐ varje dag ☐ nästan varje dag ☐ mindre ofta

Under de här två veckorna, vilka av följande problem hade du?

	Ja	Nej
c. Kände du dig orkeslös, trött eller helt utan energi?	☐	☐
d. Ökade du eller minskade du i vikt (5 kilo eller mera) utan att det var din avsikt?	☐	☐
e. Hade du större problem med att somna in än vad du vanligtvis har?	☐	☐
f. Var det varje natt eller nästan varje natt som du hade svårt att somna?	☐	☐
g. Hade du mycket svårare för att koncentrera dig än vad du brukar?	☐	☐
h. Ibland ser människor ner på sig själva, känner sig dåliga eller värdelösa. Kände du själv på samma sätt?	☐	☐
i. Tänkte du mycket på döden – din egen eller någon annans eller på döden över huvud taget?	☐	☐

ALKOHOLANVÄNDNING

27. a. Hur ofta dricker du öl, vin eller andra alkoholhaltiga drycker?

☐ aldrig
☐ cirka en gång i månaden eller mindre
☐ 2-4 gånger i månaden
☐ 2-3 gånger i veckan
☐ 4 gånger i veckan eller oftare

*Om du svarat aldrig, gå till **fråga 30.***

b. Hur många <u>portioner</u> alkohol har du vanligen druckit de dagar då du använt alkohol?

☐ 1-2 portioner
☐ 3-4 portioner
☐ 5-6 portioner
☐ 7-9 portioner
☐ 10 portioner eller mer

1 portion är:
En flaska (33 cl) mellanöl eller svag cider
Ett glas (12 cl) vin
Ett litet glas (8 cl) starkvin
4 cl starksprit

c. Hur ofta har du druckit sex alkoholportioner eller mer per gång?

☐ aldrig
☐ mindre än en gång i månaden
☐ en gång i månaden
☐ en gång i veckan
☐ dagligen eller nästan dagligen

28. Har du under de senaste 12 månaderna utnyttjat några hälso- eller socialvårds-tjänster på grund av alkoholproblem? ☐ Ja ☐ Nej

*Om du svarat Nej, gå till **fråga 30.***

29. Har den behandling du fått varit till hjälp?

☐ Väldigt mycket ☐ Ganska mycket ☐ I någon mån ☐ Ganska litet ☐ Mycket litet eller inte alls

SPELVANOR

30. Hur ofta har du under de senaste 12 månaderna ägnat dig åt följande penningspel?

	Ingen gång	Någon enstaka gång	Flera gånger per månad	Flera gånger per vecka	Så gott som dagligen
Skraplotter, Lotto, Joker, Keno eller dylika lotterispel	☐	☐	☐	☐	☐
Lotto, Joker, Keno eller dylika lotterispel ***på internet***	☐	☐	☐	☐	☐
Vadslagning (t.ex. sport eller trav, pitkäveto, moniveto, V-75)	☐	☐	☐	☐	☐
Vadslagning ***på internet***	☐	☐	☐	☐	☐
Spelautomater	☐	☐	☐	☐	☐
Spelautomater ***på internet***	☐	☐	☐	☐	☐
Kasinospel (t.ex. kortspel, roulett)	☐	☐	☐	☐	☐
Kasinospel ***på internet*** (t.ex. nätpoker, roulett)	☐	☐	☐	☐	☐

*Om du INTE spelat någon form av penningspel under det senaste året, gå till **fråga 32.***

31. a. Har du någon gång upplevt ett behov av att spela om större och större summor?

☐ Ja ☐ Nej

b. Har du varit tvungen att ljuga för personer som är viktiga för dig om hur mycket du spelat?

☐ Ja ☐ Nej

32. Ange det svarsalternativ som bäst beskriver din åsikt.

	Helt av annan åsikt	Delvis av annan åsikt	Delvis av samma åsikt	Helt av samma åsikt
Psykiska problem är tecken på svaghet och överkänslighet	☐	☐	☐	☐
Man tillfrisknar inte från psykiska problem	☐	☐	☐	☐
Psykiatriska patienter är oberäkneliga	☐	☐	☐	☐
Samhället borde satsa mer på öppenvård (inte sjukhusvård) för personer med psykiska problem	☐	☐	☐	☐
Om man berättar om sina psykiska problem överges man av sina vänner	☐	☐	☐	☐
Hälsovårdspersonalen tar inte psykiska problem på allvar	☐	☐	☐	☐
Det är svårt att prata med en person med psykiska problem	☐	☐	☐	☐
Arbetsförhållandet riskeras om arbetsgivaren får vetskap om arbetstagarens psykiska problem	☐	☐	☐	☐

33. Här nedan finns några påståenden om känslor och tankar. Kryssa för de rutor som bäst beskriver dina känslor och tankar de senaste två veckorna.

	Inte överhuvudtaget	Sällan	Ibland	Ofta	Alltid
Jag har känt mig optimistisk inför framtiden	☐	☐	☐	☐	☐
Jag har känt mig vara till nytta	☐	☐	☐	☐	☐
Jag har känt mig avslappnad	☐	☐	☐	☐	☐
Jag har lyckats hantera problem	☐	☐	☐	☐	☐
Mina tankar har varit klara	☐	☐	☐	☐	☐
Jag har känt närhet till andra människor	☐	☐	☐	☐	☐
Jag har kunnat fatta egna beslut	☐	☐	☐	☐	☐

34. Hur upplever du att mentalvårds- och missbrukartjänsterna har förändrats under de senaste tre åren?

_____

_____

_____

35. Hurudana mentalvårds- och missbrukartjänster vill du se i framtiden?

_____

_____

_____

KOMMENTARER. *Har du tankar om denna undersökning, så finns det utrymme att skriva ner dem här nedan. TACK !*

_____

_____

Appendix 4. Publications related to the survey

Aromaa, E. (2011). Attitudes towards people with mental disorders in a general population in Finland. National Institute for Health and Welfare (THL). Research 69. Helsinki, Finland 2011. Academic dissertation. Available: https://www.julkari.fi/bitstream/handle/10024/79867/6dfaa7bd-b631-48fd-9b42-67a26c57d3fc.pdf?sequence=1

Aromaa, E., Tolvanen, A., Tuulari, J., & Wahlbeck, K. (2009). Attitudes towards people with mental disorders: The psychometric characteristics of a Finnish questionnaire. *Social Psychiatry and Psychiatric Epidemiology*, 45, 265-273.

Aromaa, E., Tolvanen, A., Tuulari, J., & Wahlbeck, K. (2011) Personal stigma and use of mental health services among people with depression in a general population in Finland. *BMC Psychiatry*, 11, 52.

Aromaa, E., Tolvanen, A., Tuulari, J., & Wahlbeck, K. (2011) Predictors of stigmatizing attitudes towards people with mental disorders in a general population in Finland. *Nordic Journal of Psychiatry*, 65,125-132.

Aromaa, E., Tuulari, J., Herberts, K., & Wahlbeck, K. (2007). Pohjalaisen väestön suhtautuminen masennukseen ja mielen hoitamiseen. *Suomen Lääkärilehti*, 62, 788-789.

Aspvik, U., Kiikkala, I., & Lassila A. (2007). Mielenterveyspalvelujen kehittäminen kansalaistenehdotusten perusteella. *Suomen Lääkärilehti*, 62, 794–795.

Björkqvist, K., Wahlbeck, K., Nordmyr, J., & Österman, K. (2013). Sex differences in psychosocial concomitants to alcohol problems in a representative sample from Western Finland. Global Addiction, Palazzo dei Congressi, Pisa, Italy, May 7–10.

Eriksson, S. (2007). Kvinnors och mäns sociala relationer och sociala stöd. Pro gradu study, Åbo Akademi, Vaasa.

Forsman, A. K., Herberts, K., Aromaa, E., Tuulari, J. & Wahlbeck, K. (2009). Kohti pohjalaista hyvinvointia: Mielenterveyttä koskeva kyselytutkimus 2008: Menetelmäraportti. Avauksia 3/2009. Helsinki: Terveyden ja hyvinvoinnin laitos.

Forsman, A. K., Nyqvist, F., & Wahlbeck, K. (2011). Cognitive components of individual social capital and mental health status among older adults: a population-based cross-sectional study. *Scandinavian Journal of Public Health,* 39, 757-65.

Forsman, A. K., Nyqvist, F., Herberts, C., Wahlbeck, K., & Schierenbeck, I. (2013). Understanding the role of social capital for mental well-being among older adults. *Ageing & Society*, 33, 804-825.

Herberts, C., Aromaa, E., Björkqvist, K., Forsman, A. K., Herberts, K., Nordmyr, J., Nyqvist, F., Salokangas, R., Tuulari, J., & Wahlbeck, K. (2012). Western Finland Mental Health Survey 2011. Survey methods. National Institute of Health and Welfare (THL). Report 39/2012. Available: http://www.thl.fi/thl-client/pdfs/586c52b7-69e4-47df-8b96-21f348a8f67c

Herberts, K., Wahlbeck, K., Aromaa, E., & Tuulari, J. (2006). Enkät om mental hälsa 2005. Metodbeskrivning. Diskussionsunderlag 13/2006. Helsinki: Stakes. Available: http://groups.stakes.fi/NR/rdonlyres/E89F1D09-3B7D-4EA5-B27B-7233DC365313/0/T132006VERKKO.pdf

Nordmyr, J., Forsman, A. K., Wahlbeck, K., Björkqvist, K., & Österman, K. (2013). Associations between problem gambling, sociodemographics, mental health factors and gambling type: sex differences among Finnish gamblers. *International Gambling Studies.* Online publication October 2013. doi: 10.1080/14459795.2013.840328

Nyqvist, F., Forsman, A.K., & Cattan, M. (2013). A comparison of older workers' and retired older people's social capital and sense of mastery. *Scandinavian Journal of Public Health*, 41, 792-798.

Tuulari, J., Aromaa, E., Herberts, K., & Wahlbeck, K. (2007). Pohjalainen masennus ja hakeutuminen hoitoon. *Suomen Lääkärilehti*, 62, 790-791.

Wahlbeck, K., Kaivosoja, M., Lassila, A., & Syväoja, S.-M. (2007). Mielenterveyden edistäminen on yhteistyötä. *Suomen Lääkärilehti*, 62, 721.

Posters

Aromaa, E., Björkqvist, K, Forsman, A. K., Herberts, K.,, Kulmala, J., Nordmyr, J., Nyqvist, F., Näsman, M., Reini, K., Tuulari, J., Wahlbeck, K., Wentjärvi, A., & Österman, K. (2014). Western Finland Mental Health Survey: 2005, 2008, 2011, 2014 [Enkät om psykisk hälsa i Västra Finland: 2005, 2008, 2011, 2014]. Health Science Days, 18.–19.9.2014, Vaasa, Finland.

Salokangas, R. K. R., Kallio, M. M., Nordling, E., & Wahlbeck, K. (2007). Problematic use of alcohol in elderly in Varsinais-Suomi and Pohjanmaa. NorAge -kongressi ”Prevention of old age plagues”, 14.–15.6.2007, Turku.

Salokangas, R. K. R., Kallio, M. M., Tuulari, J., & Wahlbeck, K. (2007). Depression and stress symptoms in elderly. NorAge – kongressi ”Prevention of old age plagues”, 14.–15.6.2007, Turku.

Wahlbeck, K., Aspvik, U., Aromaa, E., Häikiö, M., Kaivosoja, M., & Lassila, A. (2007). The Ostrobothnia Project. A regional project for mental health and substance abuse intervention. European Conference on Mental Health: Joining forces across Europe for Prevention and Promotion in Mental Health, Barcelona 13.–15.9.2007.