Mental Health Strategy

Extracts from Description of the Situation and Recommendations

The Estonian Coalition of Mental Health and Wellbeing (VATEK) was established in Estonia in 2012 on the initiative of the Estonia-Swedish Mental Health and Suicidology Institute (ERSI) and with the support of the Ministry of Social Affairs, which from 2014-2016 developed the Mental Health Strategy for 2016-2025.

This is not a development document approved at the state level that would bring about obligations; it is a document created by Estonian mental health experts that can be used as a pointer in planning activities in the area of mental health. The summary of the strategy mainly contains information about the situation in Estonia and the recommendations of VATEK about further activities.

Description of situation

The prevalence of depression in the population of Estonia is 5.6%[1].

The number of suicides in Estonia increased during the recession – the number of cases per 100,000 residents was 18.1 in 2008, but it grew to 20.2 in 2009. Since 2010, the suicide coefficient in Estonia has remained lower than it was before the crisis of 2008 (15.9 suicides were committed per 100,000 residents in 2013, 14.8 in 2015). The risk groups in terms of suicide are the elderly (34.4% of suicides in 2013 were committed by persons aged 65 and older), and young people: among people aged 10-24, 22 young men and one young woman committed suicide in 2014, and 16 young men and two young women in 2013.

The number of students who have experienced depressive episodes has increased in comparison to 2010[2]. The incidence of mental and behavioural disorders among young people per 100,000 residents has risen[3]. Most mental and behavioural disorders that manifest themselves in adulthood began in childhood and youth[4,5].

Estonia does not have a harmonised mental health policy which would give recommendations for mental health promotion, reducing discriminating stigmatisation, increasing social inclusion, strengthening prevention and self-help, helping people with mental and behavioural disorders and their carers, and organising adequate treatment and rehabilitation. The various activities and interventions taking place in different areas have not been strategically planned, interdisciplinary responsibility is unclear and assessment of the results of the success of various interventions is inadequate[6].

---

[1] Kleinberg A. Major depression in Estonia: prevalence, associated factors, and use of health services. [Tartu]: University of Tartu Press; 2014.

[2] Aasvee K, Rahno J. Eesti kooliõpilaste tervisekäitumise uuring. 2013/2014 õppeaasta. /Study of the Health Behaviour of Estonian School Students. 2013/2014 Study Year./ Tallinn: National Institute for Health Development, 2015

[3] 2013-2014 Performance Report of "Public Health Development Plan (PHDP) 2009–2020" [Internet]. Ministry of Social Affairs; 2015. Available from: https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/rta_2013-2014_aasta_tulemusaruanne.pdf

[4] Barry MM, Jenkins R. Implementing Mental Health Promotion. Elsevier Health Sciences; 2007. 725 p.

[5] Kleinberg A. Major depression in Estonia: prevalence, associated factors, and use of health services. [Tartu]: University of Tartu Press; 2014.

[6] Laste vaimse tervise integreeritud teenuste kontseptsiooni alusanalüüs /Basic Analysis of the Concept of Integrated Mental Health Services for Children/ [Internet]. 2015. Available from: http://sm.ee/sites/default/files/content-

1. LEVEL OF INTERVENTION: MENTAL HEALTH PROMOTION

Activities:

- Development and consistent updating of a mental health policy at the state level; phrasing long-term goals and activities for mental health promotion; determination of interdisciplinary responsibilities.
- Integration of mental health promotion goals and activities in the development plans of local governments.
- Strengthening of the work of county health councils in the planning and implementation of mental health promotion activities.

Creation of a living and working environment that is safe and supports mental health

Activities:

- Ensuring that people have social and economic guarantees in the case of losses and problems that take account of their fundamental rights, prohibiting discrimination in ensuring them.
- Making communities more caring via the cooperation of local governments; businesses, health and educational institutions' and other social institutions (incl. professional associations and third sector organisations in the area of mental health).
- Increasing the efficiency of health-related activities in the community via inclusion and participation in the identification of regional needs, setting goals, and planning and implementing activities in such a manner that people take more responsibility for their health (e.g. health-related discussions on the initiative of local governments).
- Promoting the mutual connection of local community residents and social communication; highlighting the key importance of a pleasant environment, educational institutions, jobs, communities and other places of activity for the mental health of people (community initiatives, joint activities).

Raising the awareness of primary care specialists of mental health promotion throughout the human life cycle

Research has shown that primary care specialists often rate their knowledge of mental health as low but would like to know more about it[7,8].

Activities:

editors/Lapsed_ja_pered/Lapse_oigused_ja_heaolu/laste_vaimse_tervise_alusanaluus_lopparuanne_pwc_13.03.2015_loplike_parandustega.pdf

[7] Koolinoorte vaimne tervis. /Mental Health of Schoolchildren./ Summary - report [Internet]. Tallinn: Estonian-Swedish Mental Health and Suicidology Institute (ERSI); 2015. Available from: http://www.suicidology.ee/public/files/koolinoorte_tervis_15.06.2015_veebilehele.pdf

[8] Sisask M, Värnik P, Värnik A, Apter A, Balazs J, Balint M, et al. Teacher satisfaction with school and psychological well-being affects their readiness to help children with mental health problems. Health Educ J. 2014;73(4):382–93.

- Integrating the topic of mental health promotion, which covers the entire human life cycle, in the professional training curricula of primary care specialists (e.g. family doctor, social workers).
- Offering in-service training to primary care specialists to raise their awareness of mental health promotion throughout the life cycle.
- Creating opportunities for primary care specialists to implement their mental health knowledge in their everyday work, incl. sufficient time resources for serving people (the number of specialists corresponds to the number of residents).
- Creating opportunities for the promotion of the mental health of primary care specialists themselves (organisation of co-vision and accessibility of supervision).

Raising the population's awareness of opportunities of mental health preservation and promotion

Activities:

- Developing the population's awareness of mental health protection and risk factors in order to motivate people to make health behavioural choices and strengthen their self-help skills (public information campaigns, mental health fair, accessibility of reliable information).
- Guaranteeing the accessibility of mental health information to various age groups considering their characteristic features (language, information media).
- Improving the efficiency of cooperation between mental health organisations and media channels for the purpose of responsible coverage of mental health, emphasising the primary role of the media in shaping mental health-related attitudes (joint seminars for media representatives and mental health specialists).
- Maintaining and developing reliable web environments (portals, websites – vatek.ee, enesetunne.ee, peaasi.ee, amor.ee) to make mental health information accessible to the population (information).
- Developing smartphone applications for the benefit of mental health and assessing their effectiveness – apps for increasing the efficiency of self-help, screening mental and behavioural disorders, and connecting to the mental health service.

1.1. Mental health promotion among children and young people

The mental health of children and young people is an important priority in the strategic mental health documents of Europe as well as Estonia[9,10,11,12,13].

[9] European Pact for Mental Health and Well-being [Internet]. European Commission; 2008. Available from: http://ec.europa.eu/health/mental_health/docs/mhpact_et.pdf

[10] Public Health Development Plan 2009-2020 [Internet]. Ministry of Social Affairs; 2008. Available from: https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/2012_rta_pohitekst_ok_5.pdf

[11] Integreeritud teenused laste vaimse tervise toetamiseks: ennetus, varajane märkamine ja õigeaegne abi. /Integrated Services for Supporting the Mental Health of Children: Prevention, Early Recognition and Timely Help./ Concept [Internet]. Ministry of Social Affairs; 2015. Available from: https://www.sm.ee/sites/default/files/content-editors/Lapsed_ja_pered/Lapse_oigused_ja_heaolu/int_teenuste_kontseptsioon_laste_vaimse_tervise_toetamiseks_valmis_logodega.pdf

[12] Joint Action on Mental Health and Well-being. Mental health and schools: Situation analysis and recommendations for action [Internet]. 2016. Available from: http://www.mentalhealthandwellbeing.eu/assets/docs/publications/WP7%20Final.pdf

[13] Convention on the Rights of the Child [Internet]. RT II 1996, 16, 56; Available from: https://www.riigiteataja.ee/akt/24016

Creating a lifestyle and environment that supports the mental health of children and young people in the family, educational institutions and the community.

According to the survey of the health behaviour of schoolchildren 2013/2014, 62.9% of young people found that going to school was pleasant or very pleasant.

Activities:

- Educational institutions, in liaison with healthcare and health promotion organisations, take responsibility for the creation of a cultural environment that values and promotes mental health (mental health promotion is a priority in the development plan of the educational institution: it develops a supportive environment, attitudes of the school and nursery school family, and cooperation).
- Guidelines for the promotion of mental health and well-being are prepared upon the coordination of the area of education and all people connected with the school – students, school staff, support specialists, health care professionals, parents, community and youth organisations[14]. For example, the Ottawa Charter launched the Health Promoting Schools Programme, which is based on a comprehensive approach to the inclusion of the entire school family and which in Estonia is coordinated by the National Institute for Health Development[15].
- Amendments are made in the curricula and educational activities of educational institutions in such a manner that they are directly aimed at the development of the living and communication skills of children and young people as these are the factors that protect mental health (e.g. the development of school-based hobby education to guarantee equal access).
- The awareness of teachers and support staff for the mental health of children and young people is raised in educational institutions and their skills of including experienced counsellors and carrying out evidence-based social skill promotion programmes on the topic using standard methods are developed (development of programmes: University of Tartu Centre of Ethics, Tallinn University School of Educational Sciences, Estonian Association of Communication Coaches).

Developing the awareness of specialists who have contact with children and young people of factors that protect mental health and their promotion, improving the cooperation between specialists

Activities:

- Reviewing the professional development of the specialists working with children and young people in terms of mental health promotion and defining training needs[16].
- Reviewing the quality of the study programmes of specialists in the area of children and young people in terms of mental health and making the content of the study programmes comply with the local context and needs.
- Planning consistent in-service training for specialists working with children and young people to improve mental health competency; planning joint training for the purpose of improving

[14] Joint Action on Mental Health and Well-being. Mental health and schools: Situation analysis and recommendations for action [Internet]. 2016. Available from: http://www.mentalhealthandwellbeing.eu/assets/docs/publications/WP7%20Final.pdf

[15] Weare K. Promoting Mental, Emotional and Social Health: A Whole School Approach. London; New York: Routledge; 2000. 176 p.

[16] Joint Action on Mental Health and Well-being. Mental health and schools: Situation analysis and recommendations for action [Internet]. 2016. Available from: http://www.mentalhealthandwellbeing.eu/assets/docs/publications/WP7%20Final.pdf

cooperation with the participation of related specialties (family doctor, school nurse, family nurse, psychologist, social work specialist, school staff).

- Planning regular co-vision for specialists working with children, and in the event of complicated cases, supervision for the promotion of coping with mental health issues[17].

Regular assessment of the well-being and mental health of children and young people via objective and subjective indicators

Screening is not used to assess the well-being and mental health of children in Estonian schools at present[18].

A survey of the health behaviour of Estonian schoolchildren revealed that the satisfaction of the majority of school students aged 11-14 with their lives is above average (87.8%).

Activities:

- Regular assessment of the mental health of children and young people by primary care healthcare professionals on the basis of common criteria. Agreeing on the use of universal instruments and making the competencies of specialists comply with the needs of the assessment instrument. The WHO Well-being scale (WHO-5), Global School-Based Student Health Survey (GSHS), KIDSCREEN-52, and Physical Activities Questionnaire (PAQ) can be used as instruments. The topic is discussed in more detail in the 'Integrated Services for Supporting the Mental Health of Children: Prevention, Early Recognition and Timely Help', which was prepared by the Ministry of Social Affairs[19].
- Implementing the possibility of activities promoting mental health and preventing mental and behavioural disorders as a school health service.

1.2. Mental health promotion among working-age people

The increase in the number of permanently disabled persons has been significant in Estonia and has reached more than 10% of the working-age population. Permanent loss of the capacity for work means limited participation in working life, lower-paid jobs, or dropping out of the labour market altogether. Mental and behavioural disorders are among the most common diagnoses that lead to the loss of capacity for work and in their case, the probability of employment is smaller than in the case of other diagnoses[20].

[17] Laste vaimse tervise integreeritud teenuste kontseptsiooni alusanalüüs /Basic Analysis of the Concept of Integrated Mental Health Services for Children/ [Internet]. 2015. Available from: http://sm.ee/sites/default/files/content-editors/Lapsed_ja_pered/Lapse_oigused_ja_heaolu/laste_vaimse_tervise_alusanaluus_lopparuanne_pwc_13.03.2015_loplike_parandustega.pdf

[18] Laste vaimse tervise integreeritud teenuste kontseptsiooni alusanalüüs /Basic Analysis of the Concept of Integrated Mental Health Services for Children/ [Internet]. 2015. Available from: http://sm.ee/sites/default/files/content-editors/Lapsed_ja_pered/Lapse_oigused_ja_heaolu/laste_vaimse_tervise_alusanaluus_lopparuanne_pwc_13.03.2015_loplike_parandustega.pdf

[19] Integreeritud teenused laste vaimse tervise toetamiseks: ennetus, varajane märkamine ja õigeaegne abi. /Integrated Services for Supporting the Mental Health of Children: Prevention, Early Recognition and Timely Help./ Concept [Internet]. Ministry of Social Affairs; 2015. Available from: https://www.sm.ee/sites/default/files/content-editors/Lapsed_ja_pered/Lapse_oigused_ja_heaolu/int_teenuste_kontseptsioon_laste_vaimse_tervise_toetamiseks_valmis_logodega.pdf

[20] CentAR. The impact of working conditions on the development of incapacity for work. Tallinn: Estonian Centre for Applied Research CentAR; 2015.

Creating meaningful working life and a working environment that promotes mental health

Activities:

- Promoting the awareness of employers and the working-age population of workplace opportunities that support mental health (information campaigns, topical conferences).
- Increasing awareness of mental health as an important part of an employee's health and capacity for work among working environment specialists and representatives, and guaranteeing that factors affecting the mental capacity for work are assessed and emphasised when risk analyses are carried out.
- Explaining and mapping specific risk factors and working environment conditions in organisations. which have a significant negative impact on the mental health of employees, causing excessive mental exhaustion and reducing the capacity for work.
- Mapping and assessing the health statuses of employees in different employee groups.
- Developing management skills that support mental health and a health-promoting culture at workplaces (specification of roles and expectations, management skill training for managers).
- Carrying out activities that prevent stress and increase resilience in organisations (e.g. time management, work stress management and motivation promotion training).
- Promoting healthy lifestyle choices among employees at workplaces. If necessary, offering temporary additional support or changes in the organisation of work (e.g. organisation of work that meets the needs of an employee, flexitime).
- Planning support systems for people who have been away from work for a long time (e.g. employees on sick leave, unemployed persons) to help them start working successfully.

Consideration of gender aspects in mental health promotion

Activities:

- Guaranteeing equal opportunities for men and women for reconciliation of working, family and private life, and promoting quality everyday life that meets the needs of every family member.
- Above all, raising the awareness of men and women of the impact of gender stereotypes (beliefs and attitudes) on their mental and physical health (examples of best practices, public campaigns, media lessons and experience presentations).
- Planning mental health promotion interventions in such a manner that gender-specific factors are considered, which results in change and improvement in lifestyle.
- Raising the awareness of men of mental health via media channels (public campaigns, information leaflets at health centres, etc.).
- Increasing the awareness of the population of the signs of post-natal depression.

Supporting young adults in completing and/or continuing their education and entering the labour market.

There are *ca* 1/5 of NEET young people in the 18-24 age group in Estonia (40,000 as an absolute figure). At present, they are one of the most vulnerable groups in society who were negatively affected by the financial crisis and recession more than other groups[21,22].

Activities:

- Strengthening solidarity in society between NEET youth and different generations to prevent the problems that lead to the NEET status from being passed on from generation to generation.
- Supporting the completion of education, incl. offering flexible solutions for reconciling work and family life with the acquisition of education.
- Developing the education and in-service environment in such a manner that young people are motivated to continue with their education at least until they acquire a vocation and see this as an opportunity of finding a more suitable and secure place in working life.
- Offering psychological counselling to increase the motivation to complete one's education and commencing and continuing one's working life.
- Supporting young adults in entering the labour market by offering career counselling, relevant and quality training, and work practice (measures of the Unemployment Insurance Fund aimed at youth).

Developing attitudes in society that value positive couple and family relationships

Family life in Estonia has been changing constantly in the last two decades: the birth rate has fallen and people have children at an older age, the share of marriages has decreased and the relationships of couples are characterised by a high divorce rate. Cohabiting same-sex couples have also appeared and many of them are raising children[23]. Many children grow up in families where one or both parents work far away from the family.

Activities:

- Guaranteeing families permanent security via a system of combined support and services that support economic coping until the child reaches adulthood (incl. special needs children, families with the burden of care, etc.).
- Encouraging families to ask for assistance upon the emergence of family-related problems (informing the general public of opportunities to receive assistance and family therapy as well as about parenting programmes: media-based interventions and organizing training, seminars and workshops about family relationships and parenting in regions).
- Guaranteeing psycho-educational support for families: psychological counselling and improving the accessibility of training, counselling and therapy supporting couples and family relationships to prevent and mitigate conflicts.
- Supporting the accessibility of family conciliation.

---

[21] Kasearu K, Trumm A. "NEET – Noored, kellega keegi ei arvesta ja kes kuskil ei käi"? /Youth neither in employment nor in education or training?/ In: Noorteseire Eestis /Youth Monitoring in Estonia/: Policy Review [Internet]. University of Tartu, Ministry of Education and Research, Praxis; 2013. p. 1–16. Available from: http://www.noorteseire.ee/system/resources/BAhbBlsHOgZmIjkyMDEzLzAxLzI0LzA4XzQ2XzU2XzMwMF9Qb2xpaXRpa2F5bGV2YWFkZV81X3ZlZWIucGRm/08_46_56_300_Poliitikaylevaade_5_veeb.pdf

[22] Archive: Young people not in employment, education or training - NEET - Statistics Explained [Internet]. Available from: http://ec.europa.eu/eurostat/statistics-explained/index.php/Archive:Young_people_not_in_employment,_education_or_training_-_NEET

[23] Development Plan for Children and Families: Smart Parents, Great Children, Strong Society [Internet]. Ministry of Social Affairs; 2011. Available from: http://sm.ee/sites/default/files/content-editors/Lapsed_ja_pered/laste_ja_perede_arengukava_2012_-_2020.pdf

1.3. Mental health promotion among the elderly

Estonia is a country with a rapidly ageing population – whilst the share of people aged 65 and over in Estonia in 1970 was 10.5% of the total population, the same indicator in 2000 was 15% and in 2015 19% (82,996 men and 163,356 women, 246,352 people in total), and according to forecasts, it will be 27.6% in 2040. People aged 55 and over comprised a third of the population in 2015 (32%, 417,523 men and women)[24].

Increasing the government's attention to preservation and promotion of the mental health of the elderly

Activities

- Consistently guaranteeing that the rights of the elderly are protected in legislation (infringement on the rights of the elderly must be avoided), incl. in labour market policy.
- Ensuring that the Gender Equality and Equal Treatment Commissioner observes the topics related to the treatment of the elderly (social, economic, psychological and/or physical discrimination; work and vocational training).
- Creating a structure between ministries (the field of social affairs, education and health), which generalises, concentrates and coordinates policies for promoting the health of the elderly (incl. mental health) in terms of poverty, pensions (flexible, partial, early, etc.).

Developing a positive attitude towards the elderly in the community, promoting social inclusion and eliminating discrimination

Activities:

- Using the potential of the elderly on the labour market without prejudice, implementing flexitime and flexible burden of work, offering training, helping with transport.
- Supporting the operation of support networks in the community (NGOs, volunteers, religious organisations, sponsorship from companies), including the elderly in programmes that cover all age groups, creating special programmes for the elderly to support and stimulate an active lifestyle among the elderly, training cognitive and physical capability, avoiding isolation and guaranteeing the spread of information.
- Detecting cases of elder abuse in the community and intervening in them, organising information campaigns about this.
- Covering active ageing and solidarity between generations positively in the media, avoiding harming the dignity of people in words or in pictures.

Raising the awareness of primary care specialists about the needs of the elderly, the specifics features of mental health and promotion opportunities

Activities:

- Primary care specialists should consistently acquire and implement knowledge of a lifestyle that supports the mental health of the elderly and is active.

[24] Statistics Database [Internet]. Available from: http://pub.stat.ee/px-web.2001/dialog/statfile2.asp

- Early diagnosis of the onset of disorders in the mental activities of the elderly, incl. cognitive deficit, alcohol abuse and thoughts of suicide using competent screening instruments.
- Early diagnosis of the physical illnesses of the elderly, controlling and treating them, informing about signs of violence.
- Allowing family doctors to extend the time spent on appointments with elderly people.

Raising the awareness of the elderly about active ageing as a factor that protects mental health, and the possibility of staying in good health and increasing healthy life years.

Activities:

- Sharing knowledge of the possibilities of active ageing (school, family, primary care specialists).
- Encouraging the elderly to actively avoid isolation (social workers, other primary care specialists, friends and family).
- The elderly themselves should take responsibility for their health by choosing a healthy lifestyle.

2. LEVEL OF INTERVENTION: PREVENTION OF MENTAL AND BEHAVIOURAL DISORDERS AND EARLY INTERVENTION

Raising the awareness of the population of the most common mental and behavioural disorders (e.g. depression, anxiety disorders, addiction disorders) so they are detected early, and encouraging people to seek help

Depression and anxiety disorders are frequent and under-treated health disorders[25,26], which harm people's social and work-related coping ability, and create healthcare costs. Many people don't notice their own development of disorders, don't think they need to ask for help or do not visit a specialist for fear of being stigmatised and excluded. The negative attitude and lack of awareness of society of the symptoms of disorders means that people who potentially need help do not get it.

Activities:

- Giving people information about the most common symptoms of mental and behavioural disorders (it's unclear whether this is about the most common symptoms or the symptoms of most common mental and behavioural disorders) and possible treatment options, and encouraging people who need help to see specialists.
- Systematically implementing the measures for prevention of addiction, reducing damage and restricting the accessibility of alcohol and drugs described in the Green Paper on Alcohol Policy[27] and the White Paper on Drug-Use Reduction Policy[28].

Evaluation of mental health and well-being by primary care specialists in order to detect the emergence of mental and behavioural disorders before their exacerbation

Activities:

- Improving the knowledge and skills of primary care specialists in order to detect mental and behavioural disorders early by offering relevant training (raising awareness within the scope of university education and in-service training).
- Making the evidence-based guidelines and instruments used for evaluation of mental and behavioural disorders accessible to primary care specialists.

Improving the accessibility of psychological help during periods of crisis in life

Activities:

[25] Kleinberg A, Jaanson P, Lehtmets A, Aluoja A, Vasar V, Suija K, et al. Depression treatment guidelines for family doctors. Eesti Arst. 2011;90(9):431–46.

[26] Võhma Ü, Suija K, Kristjan V, Raid U. Valmis uus ravijuhend „Generaliseerunud ärevushäire ja paanikahäire (agorafoobiaga või ilma) käsitlus perearstiabis". /Completion of new treatment guidelines "Treatment of generalised anxiety disorder and panic disorder (with or without agoraphobia) in family medicine"./ Eesti Arst. 2015;94(1):46–8.

[27] Green Paper on Alcohol Policy [Internet]. Ministry of Social Affairs; 2014. Available from: https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/alkoholi_roheline_raamat-19.02.14.docx

[28] White Paper on Drug-Use Reduction Policy [Internet]. Ministry of Social Affairs; 2014. Available from: https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/valge_raamat.pdf

- Guaranteeing the readiness of psychological crisis aid teams to react immediately to accidents and acts of terror by driving to the scene of the event.
- Guaranteeing the accessibility of immediate psychological assistance after traumatic events to heads of organisations to ensure they have the capacity to act adequately.
- Guaranteeing the existence of psychological crisis aid teams and their readiness to carry out crisis aid on the request of the heads of organisations, incl. postvention.
- Guaranteeing the accessibility of post-crisis postvention to rescue teams (rescuers, police officers, ambulance crews).
- Guaranteeing the accessibility and active offering of individual counselling in crisis aid (e.g. suicidal crisis) and psychiatric crisis aid in the emergency medicine departments of general hospitals.
- Keeping and developing the existing helplines (Eluliin, Usaldustelefon) operated by volunteers by guaranteeing consistent recruitment of volunteers, basic training, follow-up training and supervision.
- Launching self-help groups for the friends and families of suicide victims to help them cope with bereavement and reduce suicide risk.
- Guaranteeing psychological support to the members of the Defence Forces who have returned from missions (veterans) and/or assistance before a mission, during a mission and after a mission.

Increasing the awareness of the population and specialists of suicidal behaviour

Suicide is a complex problem of public health. The number of suicides per 100,000 people in Estonia was 14.8 in 2015, which is higher than the average in the world. The suicidal behaviour of different nationalities as well as men and women in various regions is different and related to several risk factors.

Activities:

- Raising the awareness of primary care health care professionals and representatives of other professions that have direct contact with people (the fields of health care, welfare, and social and legal protection) so they can detect the signs of depression and suicidal behaviour early.
- Regarding alcohol abuse, drug use, social exclusion and depression as suicide risks.
- Raising the awareness of the population of the reasons for suicide and the possibilities of its prevention.
- Supporting the activities of support groups aimed at people who are suffering from depression and have attempted suicide, and their friends and families.
- Guaranteeing the accessibility of qualified emotional assistance by telephone and/or internet to people who have attempted suicide and the friends and families of people who committed suicide.

2.1. Prevention of mental and behavioural disorders and early intervention among children and young people

Surveys have indicated that being absent from school without permission is unjustifiably common in Estonia, and this is related to poorer mental health indicators and risk behaviour[29].

Every fifth schoolchild fell victim to bullying in 2014[30]. 474 students in total (277 boys and 197 girls) dropped out of general education schools in the 2013/2014 study year.

Early detection of poor well-being and mental and behavioural disorders (e.g. depression and eating disorders) among children and young people

The results of research suggest that the prevalence of mental disorders related to addiction disorders in Estonia is higher than the average in Europe[31].

Research (SEYLE) has indicated that only 12% of teachers rate their knowledge of mental health as adequate.

In the event of doubts, an educational specialist must consult a specialist (every county has a Rajaleidja Centre) and not wait for the situation to resolve itself. If a family nurse and/or doctor notices risk factors and other deviations in the development and/or growing environment of a child or adolescent, they are obliged to take steps to provide help[32].

Activities:

- Implementing evidence-based evaluation tools for early detection of the mental and behavioural disorders of children and adolescents and assess the actual need for treatment (e.g. the Children's Depression Inventory or CDI; the Depression Anxiety Stress Scale or DASS).
- Making parents and specialists working with children aware of the symptoms of mood and emotional disorders. Offering opportunities for meetings and training at the level of counties and communities (e.g. health promoters of counties) which includes primary care specialists, teachers and families.
- Reviewing the existing professional development practice of primary care specialists in the field of mental health, defining training needs and carrying out training in accordance with needs and the local context.
- Promoting educational institutions as a suitable environment for supporting the mental health of children, promoting the prevention and early detection of mental and behavioural disorders[33].
- The operators and managers of educational institutions must guarantee that attention is given to the mental health of the employees of educational institutions via consistent support and mentoring.

---

[29] Koolinoorte vaimne tervis. /Mental Health of Schoolchildren./ Summary - report [Internet]. Tallinn: Estonian-Swedish Mental Health and Suicidology Institute (ERSI); 2015. Available from: http://www.suicidology.ee/public/files/koolinoorte_tervis_15.06.2015_veebilehele.pdf

[30] Strategy for Preventing Violence 2015-2020 [Internet]. 2015. Available from: https://valitsus.ee/sites/default/files/content-editors/arengukavad/vagivalla_ennetamise_strateegia_2015-2020_kodulehele.pdf

[31] Laste- ja noorukitepsühhiaatria kõrvaleriala arengukava 2012-2020 /Development Plan for Child and Adolescent Psychiatry as Minor Speciality 2012-2020/ [Internet]. 2012. Available from: http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervishoiususteem/Arstide_erialade_arengukavad/laste-ja_noorukitepsuhhiaatria_korvaleriala_arengukava.pdf

[32] Laste vaimse tervise integreeritud teenuste kontseptsiooni alusanalüüs /Basic Analysis of the Concept of Integrated Mental Health Services for Children/ [Internet]. 2015. Available from: http://sm.ee/sites/default/files/content-editors/Lapsed_ja_pered/Lapse_oigused_ja_heaolu/laste_vaimse_tervise_alusanaluus_lopparuanne_pwc_13.03.2015_loplike_parandustega.pdf

[33] Joint Action on Mental Health and Well-being. Mental health and schools: Situation analysis and recommendations for action [Internet]. 2016. Available from: http://www.mentalhealthandwellbeing.eu/assets/docs/publications/WP7%20Final.pdf

Integrated cross-sectoral cooperation for guaranteeing the accessibility of mental health assistance when problems emerge

Activities:

- Increasing the cooperative capability of primary care specialists at the individual, organisational and community levels (seminars of regional cooperation networks, regular meetings).
- Regulating and creating standards in cross-sectoral cooperation – describing processes and determining responsibilities for the implementation of the case management principle. The responsibility of a case manager lasts for as long as the child/adolescent who needs help has been referred to a specialist.
- Organising regular cross-sectoral meetings to raise the awareness and improve the skills of specialists, and harmonise terminology.
- Planning and calculating the resources for promoting and improving the cooperation of specialists (human resources, work premises and tools, time required for cooperation).

Evaluating the mental health of children exposed to the biggest risk of mental and behavioural disorders, preserving health and preventing problems

Standardised evaluation tools are currently not used for the routine screening of the mental and behavioural disorders (e.g. ADHD, depression, addiction, etc.).

Activities:

- Developing awareness of mental health in society so that young people themselves and their friends and families or the specialists working with them are able to recognise signs of disorders (the topic of mental health in the curricula of specialities that involve working with children and young people, training for primary care and education specialists, mental health workshops at youth centres, etc.).
- Guaranteeing the children and young people who have experienced trauma access to crisis aid according to their needs and the needs of their families (referring children who have experienced and witnessed violence to a psychotherapist or creative arts therapist; bereavement camps to help children who have lost a loved one).
- Guaranteeing immediate and quick options for the evaluation of mental and behavioural disorders by primary care specialists (e.g. ChEAT for the evaluation of eating disorders; the Children's Depression Inventory or CDI, the Depression Anxiety Stress Scale or DASS).
- Guaranteeing evidence-based and effective interventions for young people suffering from mental and behavioural disorders, incl. young people with primary experience of psychosis (guided self-help for individuals and groups, cognitive-behavioural therapy, psychotherapy, family therapy).

Preventing self-destructive behaviour

The prevalence of risk behaviour among Estonian schoolchildren is high: a little over two-thirds of girls and boys aged 14-15 consume alcohol, two-thirds of boys and half of girls have smoked cigarettes, one-

fifth of boys and one-tenth of girls have taken drugs, and two-thirds of boys and girls have experienced bullying[34].

Self-harming behaviour on a larger scale can also include deliberate self-harming[35] the prevalence of which among Estonian schoolchildren is also very high – one-third of young people aged 14-15 have deliberately harmed themselves at least once (by cutting, scratching, hitting, burning)[36].

Activities:

- Making the everyday environment of children and young people (at home, educational institutions, the community's public spaces) such that opportunities for self-destructive behaviour are limited (e.g. improve the efficiency of the measures taken to restrict the accessibility of alcohol).
- Making mental health services accessible and providing them to the children and young people who display self-destructive behaviour (e.g. creative arts therapies make it possible to communicate in the cases where verbal communication is limited, obstructed, unwanted or impossible, and to reach important resources and progressive solutions that may not emerge in verbal communication).
- Increasing the awareness of children and young people and their families about the reasons of self-destructive behaviour and its harmful consequences both in the short and the long term, and options for intervention (incl. self-help and social competency).
- Increasing the awareness of children and young people about healthy ways of life and supporting their self-realisation via active inclusion in hobby activities.
- Consistently organising interactive intervention activities similar to forum theatres at school to help children and young people acknowledge various behavioural patterns and change them if necessary.
- Consistently carrying out intervention activities at schools to decrease and prevent bullying (e.g. KiVa).

2.2. Prevention of mental and behavioural disorders and early intervention among working-age people

Protecting the mental health of representatives of professions with high stress levels, empowering and supporting them

Activities:

- Promoting the creation and preservation of a safe and emotionally supportive working environment which allows people to work efficiently and rest optimally during the working time (allowing for breaks pursuant to the procedure set out by law; considering the specific features of a person's health).

[34] Koolinoorte vaimne tervis. /Mental Health of Schoolchildren./ Summary - report [Internet]. Tallinn: Estonian-Swedish Mental Health and Suicidology Institute (ERSI); 2015. Available from: http://www.suicidology.ee/public/files/koolinoorte_tervis_15.06.2015_veebilehele.pdf

[35] Gratz KL. Measurement of Deliberate Self-Harm: Preliminary Data on the Deliberate Self-Harm Inventory. J Psychopathol Behav Assess. 2001;23(4):253–63.

[36] Koolinoorte vaimne tervis. /Mental Health of Schoolchildren./ Summary - report [Internet]. Tallinn: Estonian-Swedish Mental Health and Suicidology Institute (ERSI); 2015. Available from: http://www.suicidology.ee/public/files/koolinoorte_tervis_15.06.2015_veebilehele.pdf

- Organising and giving time for the regular supervision and co-vision by specialists.
- Developing the skills of specialists to help them look after themselves and avoid burnout (e.g. stress and self-management skills).
- Developing the IT competency of specialists both in basic training and in-service training to reduce technological stress in everyday work.

Counselling and re-socialising vulnerable and marginalised groups and supporting their entry into the labour market

Activities:

- Increasing the efficiency of prevention, giving more attention to the mental health of risk groups and planning specific activities that make it possible to prevent the emergence of mental disorders.
- At the community level, planning activities that help people released from detention facilities cope after their release: improving social skills, supporting them in finding jobs, encouraging motivation, inclusion of support persons in the period before and after the detention, guaranteeing support services (in the areas of social affairs, healthcare and education).
- Launching suicide prevention programmes at detention facilities.

Guaranteeing access to professional help for victims of violence and reducing their stigmatisation

The number of violent crimes and people who have lost their lives as a result of violence has decreased in Estonia in the last ten years[37]. One-fifth of women aged 15-74 in Estonia have experienced physical or sexual violence from their partner in the last 12 months[38]. According to the FRA survey of 2014, only one-tenth of women reported cases of serious physical and/or sexual violence to the police; *ca* one quarter of the victims turned to healthcare institutions.

There has been no integrated development of services for victims of violence in Estonia and there is no clearly understandable system of services – who offers the service, where and when. Some exceptions excluded (women's shelters, special services for victims), there are not enough special services for different target groups and victims of different types of violence, the services do not proceed from the victim's individual needs and the funding of some services is not sustainable[39].

Activities:

- Promoting the development of attitudes in society that condemn violence (e.g. public campaigns) and raising awareness to help people detect cases of violence.

---

[37] Ahven A, Klopets U, Kruusmaa K-C, Leps A, Salla J, Surva L, et al. Kuritegevus Eestis 2013 /Crime in Estonia 2013/ [Internet]. Ministry of Justice; 2014. Available from: http://www.kriminaalpoliitika.ee/sites/www.kriminaalpoliitika.ee/files/elfinder/dokumendid/18._kuritegevus_eestis_2013.pdf

[38] Salla J. Kriminaalpoliitika arvudes: võrdlusi statistikast ja uuringutest /Criminal Policy in Numbers: Comparisons from Statistics and Surveys/ [Internet]. Ministry of Justice; 2013. Available from: http://www.kriminaalpoliitika.ee/et/kriminaalpoliitika-arvudes-vordlusi-statistikast-ja-uuringutest

[39] Strategy for Preventing Violence 2015-2020 [Internet]. 2015. Available from: https://valitsus.ee/sites/default/files/content-editors/arengukavad/vagivalla_ennetamise_strateegia_2015-2020_kodulehele.pdf

- Evaluating and analysing the principles of protecting victims of violence and methods of intervention – how much protection do they really offer to victims and how well do they meet the needs of victims?
- Guaranteeing psychosocial crisis aid for victims of violence who end up in the social, healthcare and legal system (incl. their children).

Protecting the well-being and mental health of the family members of disabled people and carers looking after family members, psychological support for carers looking after family members, empowering and supporting them

The burden of care of family members and other close persons is increasing[40].

Activities:

- Setting the mental health and well-being of disabled persons and carers looking after family members as a priority, guaranteeing them the necessary social and economic security both at the level of state and community.
- Encouraging carers looking after family members to ask for help in order to better perform their duty or care and protect their rights; information from the areas social welfare and healthcare.
- Evaluating the well-being and mental health indicators of disabled persons, people needing care and carers looking after family members in primary care and social welfare, and planning interventions as necessary.
- Planning services at the national and local level for families to help them perform their duty in looking after young, elderly and disabled family members.

2.3. Prevention of mental and behavioural disorders and early intervention among the elderly

Estonia is a country with a rapidly ageing population – whilst the share of people aged 65 and over in Estonia in 1970 was 10.5% of the total population, the same indicator in 2014 was 18.4% and according to forecasts, it will be 27.6% in 2040[41]. The prevalence of cognitive disorders is increasing among the elderly, and depression is also rather frequent[42].

The average suicide rate of people aged 65 and over in Estonia is high in comparison with other European countries - 23.4 from 2008-2010, and the rate ratio (RR) is 1.5 times higher in comparison with the age group of people under 65 years of age[43].

Evaluating the mental status and need for help of the elderly as part of the work of family doctors and registration of results

[40] Eesti omastehoolduse arengukava 2013-2020 /Estonian Family Care Development Plan 2013-2020/. Estonian Regional and Local Development Agency; 2012.

[41] Statistics Database [Internet]. Available from: http://pub.stat.ee/px-web.2001/dialog/statfile2.asp

[42] Bowker L, Price J, Smith S. Oxford Handbook of Geriatric Medicine [Internet]. Oxford University Press; 2012. Available from: http://oxfordmedicine.com/view/10.1093/med/9780199586097.001.0001/med-9780199586097

[43] Wu J. European older adults' well-being and suicide in the societal and family context. [Tallinn]: Tallinn University; 2014.

The interRAI methodology, for example, has been used as the standardised assessment of people needing care, as it can be used in the case of both physical and mental disorders[44].

Activities:

- Increasing the awareness of primary care specialists of normal ageing and early diagnosis of disorders.
- Implementing contemporary geriatric instruments for the assessment of health status and need for help.
- Recognising the mental and behavioural disorders of the elderly in health statistics separately for at least five-year or ten-year (preferably five-year) age groups, as the status of people aged 65 and over is rather different in different age groups.
- Establishing databases of people who need services in order to guarantee consistency and link them to the existing health databases (electronic health record).

Increasing the efficiency of cross-sectoral cooperation in helping the elderly (safe living environment for the elderly, violence-free ageing)

Activities:

- Implementing measures to support carers, developing nursing and long-term care guidelines to help avoid mistreatment of the elderly and allow them a dignified life in a suitable environment.
- Comprehensive geriatric assessment by primary care specialists; helping the elderly who are mistreated, guaranteeing access to psychological help in the case of bereavement.

Timely diagnosis of depression

Activities

- Development of treatment guidelines for the most frequent mental disorders of the elderly (depression, dementia, delirium) by the Estonian Health Insurance Fund.
- Screening elderly patients receiving outpatient or inpatient treatment for symptoms of depression.
- Using treatment with medicines in optimal doses as well as other methods of treatment in the case of clinical depression.

Early detection of signs of cognitive deficit and supporting elderly people suffering from cognitive deficit and their family members

The level of welfare of persons with cognitive deficit is still very low in Estonia[45]. The biggest problem is the shortage of resources (money, qualified staff, absence and/or inaccessibility of services)[46], which

[44] InterRAI tarkvara kasutuselevõtmise võimaluste analüüs. /Analysis of Options for Implementing InterRAI Software./ Final Report [Internet]. Tartu: University of Tartu Centre for Applied Social Sciences (CASS); 2011. Available from: https://www.sm.ee/sites/default/files/content-editors/Ministeerium_kontaktid/Uuringu_ja_analuusid/Sotsiaalvaldkond/interrai_tarkvara_kasutuselevotmise_voimaluste_analyys.pdf

[45] Saks K, Kolk H, Allev R, Soots A, Kõiv K, Paju I, et al. Health status of the older population in Estonia. Croat Med J. 2001;42(6):663–8.

[46] Saks K, Võrk E, Tammaru M, Tiit E-M. Dementsusega inimeste hooldamise probleemid ja hooldusteenuste arendamise vajadus Eestis. /Problems of Caring for People Suffering from Dementia and the Need for Development of Care Services in Estonia./ Tartu; 2007.

creates new problems (e.g. inadequate development/provision of new services and specialised services, exclusion of a person from the service market, lack of qualification of staff, etc.).

Activities:

- Implementing specialised services for persons suffering from cognitive deficit (geriatric medicine departments in active treatment hospitals, outpatient appointments with geriatric physicians).
- Improving the accessibility of respite care as a service.
- Expanding home care services and improving their accessibility.

3. LEVEL OF INTERVENTION: TREATMENT OF MENTAL AND BEHAVIOURAL DISORDERS AND RECOVERY

Irrespective of the serious consequences of depression, the majority of patients suffering from depression receive no treatment or the treatment is inadequate. Approximately one-third of adults suffering from depression who need help actually seek treatment. The main reasons why so few people seek help is that depression is under-diagnosed, people's limited awareness of their mental disorder and low motivation[47, 48], which lead to abnormal use of health services and create unjustified expenses[49]. There is reason to believe that whilst the treatment gap of depression, which is relatively well recognised by family doctors and psychiatrists, is 67% in Estonia[50], it is considerably larger in the case of addiction disorders due to stigmatisation and lack of treatment options.

Knowledge of the prevention of exacerbation of mental and behavioural disorders has improved considerably in recent decades[51]. Specialists have acquired new knowledge of more cost-effective and efficient interventions[52], which include, for example, effective treatment of epilepsy with appropriate medicines[53], combining medicines and psychotherapy in the treatment of depression[54], combining medicines and psychosocial support in the treatment of psychosis, and taxation of alcoholic beverages and restricting their accessibility and marketing.

Guaranteeing the accessibility of treatment of mental and behavioural disorders and supporting rehabilitation services for people

The population's increased awareness of mental health has increased the demand for outpatient psychiatric help, and it is also necessary to improve the accessibility of psychotherapy. The accessibility of inpatient day care in Estonia is limited to one service provider (Pärnu Hospital)[55]. Decreasing the number of hospital beds for patients treated for mental and behavioural disorders is no longer possible and it may be necessary to increase their number in some more specific fields (e.g. youth psychiatry, eating disorders and unstable mental disorders).

Activities:

- Increasing the competence of family doctors in the treatment of less serious mental and behavioural disorders (light and moderate mood and anxiety disorders), thereby improving the accessibility of primary care.

---

[47] Kleinberg A. Major depression in Estonia: prevalence, associated factors, and use of health services. [Tartu]: University of Tartu Press; 2014.

[48] Kleinberg A, Aluoja A, Vasar V. Help-seeking for emotional problems in major depression: findings of the 2006 Estonian health survey. Community Ment Health J. 2013;49(4):427–32.

[49] Kleinberg A. Major depression in Estonia: prevalence, associated factors, and use of health services. [Tartu]: University of Tartu Press; 2014.

[50] Kleinberg A, Aluoja A, Vasar V. Help-seeking for emotional problems in major depression: findings of the 2006 Estonian health survey. Community Ment Health J. 2013;49(4):427–32.

[51] Mental Health Atlas 2014 [Internet]. World Health Organization; 2015. Available from: http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1&ua=1

[52] Mental Health Atlas 2014 [Internet]. World Health Organization; 2015. Available from: http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1&ua=1

[53] Haldre S, Sander V, Talvik T, Beilmann A, Nurmiste A, Sööt A, et al. Epilepsia käsitlusjuhend. /Epilepsy Treatment Guideline./ Eesti Arst. 2003;82(2):140–9.

[54] Kleinberg A, Jaanson P, Lehtmets A, Aluoja A, Vasar V, Suija K, et al. Depression treatment guidelines for family doctors. Eesti Arst. 2011;90(9):431–46.

[55] Psühhiaatria eriala arengukava kaasajastamine ja täiendamine 2012. aastal /Updating and Supplementing the Development Plan of the Speciality of Psychiatry in 2012/. Estonian Psychiatric Association; 2012.

- Developing principles of regional responsibility for guaranteeing the accessibility of psychiatric care. Guaranteeing outpatient team-based psychiatric care in all counties.
- Guaranteeing in-service training for psychiatric care staff for the development of both professional and communication skills. Guaranteeing supervision of medical teams. Launching co-vision groups.
- Guaranteeing the accessibility of outpatient appointments with clinical psychologists and psychotherapy (e.g. group therapies of primary psychoses) in addition to psychiatric care.
- Improving the accessibility of psychotherapeutic care (incl. training nurses and social workers, and using them in psychotherapeutic care and counselling).
- Creating the position of a mental health nurse in primary care centres. Guaranteeing the services of a mental health nurse upon discharge from hospital.

Organising the accessibility of clearly differentiated treatment and rehabilitation services according to the needs of age groups (children, adults, the elderly)

Activities:

- Ascertaining at the regional level the spread of mental and behavioural disorders, the treatment needs of the population and the necessary rehabilitation services.
- Implementing mobile team-based practices, thereby guaranteeing the accessibility of treatment for mental and behavioural disorders according to the population's needs. Guaranteeing a sufficient number of qualified specialists in medical teams (incl. experience advisors).

Description of the quality standards of treatment of mental and behavioural disorders and rehabilitation services

Ensuring the universal design of treatment and rehabilitation services upon the planning, provision and evaluation of services.

- Creating quality standards for medical institutions that offer inpatient psychiatric care in terms of staff (incl. security staff), premises and other material and therapeutic environments, and to providers of outpatient psychiatric care.

Guaranteeing consistent and integrated treatment and rehabilitation of mental and behavioural disorders

Activities:

- Developing specific guidelines for guaranteeing the consistency of treatment. A clear record of options for getting treatment and a referral procedure are important.
- Developing co-vision and supervision options and making them accessible to all specialists working with psychiatric patients irrespective of where they work.

Development of integrated programmes between services that support mental health and home care services to support people with mental and behavioural orders living in the community

Activities:

- Guaranteeing people with mental and behavioural disorders the accessibility of mental health and social services that consider the context of their life cycle, correspond to their needs, and are human-centred, coordinated and community-based.
- Promoting opportunities for acquiring an education and finding work (part-time work, a safe and calm working environment, etc.) that meet the needs of people with mental and behavioural disorders and help people achieve important goals and the highest possible quality of life.
- Increasing society's awareness of mental health and promoting tolerance of the participation of people with mental and behavioural disorders in the community and their employment.

Guaranteeing a sufficient quantity of mental health specialists with sustainable training and in-service training programmes, and describing competency requirements

The number of psychiatrists, clinical psychologists and mental health nurses does not meet the need for such specialists. Although the evaluation of the qualification of psychologists via the Estonian Qualifications Authority has started, the training required for specialisation in clinical psychology is not guaranteed to psychologists (e.g. a year of qualification similar to the residency of those who study to become medical specialists)[56]. The qualification of mental health nurse/specialist can be acquired in Tartu Health Care College. Everyone who has acquired the qualification of mental health specialist is registered in the register of the Health Board. Confirmation in the register of the Health Board is a precondition for working as a specialist of mental health nursing. A mental health nurse may provide independent nursing care and the service is regulated by the Estonian Health Insurance Fund. Unfortunately, there are not enough mental health nurses who provide independent nursing care and give advice to clients/patients.

Activities:

- Guaranteeing the training volumes of psychiatrists (incl. paediatric psychiatrists), mental health nurses and clinical psychologists according to the needs of the health system to provide psychiatric care to Estonian residents at least in the same volume as today.
- Increasing the volume of training of mental health nurses and the specialisation opportunities of nurses who are already working.
- Creating cross-institutional or institution-centred positions of advisers of mental health nursing specialists and mental health promoters in the education system.

Social inclusion of people with mental and behavioural disorders and supporting their participation in society

Activities:

- Guaranteeing people with disabilities and mental and behavioural disorders the accessibility of mental health and social services that correspond to their needs, and are human-centred, coordinated and community-based (incl. support of trained experience advisors).
- Supporting community initiatives in planning and providing specific rehabilitation programmes and services to persons with disabilities and mental and behavioural disorders; ensuring the consistency of community-based services.

[56] Psühhiaatria eriala arengukava kaasajastamine ja täiendamine 2012. aastal /Updating and Supplementing the Development Plan of the Speciality of Psychiatry in 2012/. Estonian Psychiatric Association; 2012.

- Guaranteeing opportunities for acquiring an education and finding work (part-time work, a safe and calm working environment, etc.) that meet the needs of people with mental and behavioural disorders and help people achieve the highest possible quality of life.
- Raising the awareness of the population of the nature of disabilities and mental and behavioural disorders, and encouraging communities in supporting the participation of such people and their inclusion.

Implementing a culture aimed at recovery in mental health interventions via the development of attitudes, values and services

Activities:

- Guaranteeing the accessibility of the support required for recovery in the form of experience advice, people's empowerment, use of various methods of self-help, the support of the environment and control of one's life.
- Creating the conditions for the development of recovery courses and a network of experience advisors.
- Take the idea of recovery that values and empowers all people and includes them in community to those who provide and use services, and members of community. Raising the awareness of the population of possible treatments for mental and behavioural disorders and rehabilitation opportunities (targeted training).

3.1. Treatment of mental and behavioural disorders and recovery among children and young people

Epidemiological research has shown that mental and behavioural disorders are rather common among children and young people. In addition to this, considering the trends of the study of the health behaviour of Estonian school students and the ESPAD, we can presume that the prevalence of mental disorders related to addiction disorders in Estonia is higher than the average in Europe[57]. The share of students who have attempted suicide (0.5%) and thought about suicide (2%) reflects inadequate access to psychiatric care in Estonia[58].

The lack of specialists has impeded the development of child and adolescent psychiatry for years. This applies to child psychiatrists as well as the clinical child psychologists, creative arts therapists, speech therapists and psychiatric nurses they need for their medical teams. The lack of specialists and limited possibilities in the form of the service provided by the Health Insurance Fund have created a situation where the help of child psychiatrists is only accessible to a limited number of patients and improving the accessibility is impossible. Care is guaranteed only in larger centres and developing priority outpatient care and equal regional accessibility at the level of central and regional hospitals is impossible in practice. The limited number of specialists means that guaranteeing consultative

[57] Laste- ja noorukitepsühhiaatria kõrvaleriala arengukava 2012-2020 /Development Plan for Child and Adolescent Psychiatry as Minor Speciality 2012-2020/ [Internet]. 2012. Available from: http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervishoiususteem/Arstide_erialade_arengukavad/laste-ja_noorukitepsuhhiaatria_korvaleriala_arengukava.pdf

[58] Koolinoorte vaimne tervis. /Mental Health of Schoolchildren./ Summary - report [Internet]. Tallinn: Estonian-Swedish Mental Health and Suicidology Institute (ERSI); 2015. Available from: http://www.suicidology.ee/public/files/koolinoorte_tervis_15.06.2015_veebilehele.pdf

assistance for primary care in Estonia is not possible and there is an additional need for psychiatric care and rehabilitation of children with mental disorders[59].

Guaranteeing the accessibility of age- and problem-specific psychiatric care based on the needs of the child and the family, preferring an approach based on outpatient care and outreach teams

Four regional children's mental health centres have been created in Estonia and their duty is to organise the diagnosis and treatment of mental and behavioural disorders in accordance with contemporary principles and evidence-based practices. Regional mental health centres have the leading role in the organisation of children's mental health services and treatment[60].

Activities:

- Guaranteeing the sustainable development of the regional centres of children's mental health (in Northern, Southern, Western and Eastern Estonia), taking into account the need for systematic cooperation with other specialists participating in the treatment and rehabilitation of children suffering from mental disorders.
- Establishing outpatient appointments with child psychiatrists as a separate service of the Health Insurance Fund.
- Guaranteeing the sustainability of the special residence of child psychiatry and an even increase in the number of child psychiatrists (minimal number of residents is four per year).
- Guaranteeing that the training of family doctors includes teaching child psychiatry to the extent that would allow them to detect, intervene and decide on the need of further referral of patients.
- Guaranteeing suitable services and support for children with normal intellect who suffer from mental and behavioural disorders (children for whom the environment of an ordinary school is not suitable and who drop out of school).
- Decide on regulation of cases where a parent does not want their child to receive psychiatric help to ensure that the best interests of the child are protected.
- Guaranteeing regular supervision for all specialists in the field of child psychiatry.

Guaranteeing children and adolescents with serious mental and behavioural disorders special care options with strengthened supervision for long-term treatment and rehabilitation.

Activities:

- Guaranteeing the necessary staff for and the integrated work of related fields in milieu therapy centres according to the service descriptions.
- Guaranteeing that families and children are reunited by guaranteeing them family therapy at the time of milieu therapy.
- Guaranteeing that adolescents are reunited with their home schools or provided vocational training if necessary.

---

[59] Development Plan for Children and Families: Smart Parents, Great Children, Strong Society [Internet]. Ministry of Social Affairs; 2011. Available from: http://sm.ee/sites/default/files/content-editors/Lapsed_ja_pered/laste_ja_perede_arengukava_2012_-_2020.pdf

[60] Laste vaimse tervise integreeritud teenuste kontseptsiooni alusanalüüs /Basic Analysis of the Concept of Integrated Mental Health Services for Children/ [Internet]. 2015. Available from: http://sm.ee/sites/default/files/content-editors/Lapsed_ja_pered/Lapse_oigused_ja_heaolu/laste_vaimse_tervise_alusanaluus_lopparuanne_pwc_13.03.2015_loplike_parandustega.pdf

3.2. Treatment of mental and behavioural disorders and recovery among working-age people

Depression and anxiety are the most common mental and behavioural disorders among working-age people. The prevalence of depression among the adult population of Estonia is 5.6%. The prevalence of depression per month is 8.7% and of anxiety 7.7%. Women suffer from depression more frequently than men[61].

Depression is thought to be one of the most widespread reasons for long-term incapacity for work and forecasts indicate that it will increase[62, 63].

Activities:

- Raising the awareness and improving the skills of primary care specialists (e.g. family doctors, family nurses) in the implementation of combined treatment (lifestyle, psychotherapy, medicines) in the case of depression and anxiety.
- Supporting the implementation of web-based guided self-help programmes (e.g. iFightDepression) by primary care specialists to support coping with the less serious forms of the most common mental disorders.
- Improving information exchange between primary care specialists (family doctor) and medical specialists (psychiatrist) to optimise the treatment and rehabilitation offered to patients and avoid possible harm (e.g. due to duplicate ordination of medicines).
- Promoting the launch and consistent work of support groups for patients suffering from depression and anxiety disorders (both therapy groups and self-help groups, both face-to-face and web-based).
- Training other primary care specialists (e.g. social workers) to improve their knowledge and skills in the area of psychological counselling and thereby improve the accessibility of psychotherapeutic first aid.

Guaranteeing the accessibility of rehabilitation services to people with mental and behavioural disorders

Activities:

- Guaranteeing the accessibility of a safe and suitable place of residence in the community to people with a permanent mental and behavioural disorder.
- Supporting social enterprise and guaranteeing the accessibility of the supported and protected work service to people with permanent mental and behavioural disorders.
- Creating mobile rehabilitation teams that support and help people with permanent mental and behavioural disorders and are able to substitute for institutional services and support community services.

---

[61] Kleinberg A, Aluoja A, Vasar V. Depressiooni ja ärevuse esinemine Eesti inimestel: depressiivse häire hetkelevimus, depressiivsuse ja ärevuse levimuse muutus kümne aasta jooksul /Depression and anxiety among the Estonian people: changes in prevalence of depression and anxiety in ten years/. Eesti Arst. 2008;88 (Annex 2):80–6.

[62] Murray CJ, Lopez AD. Alternative projections of mortality and disability by cause 1990–2020: Global Burden of Disease Study. The Lancet. 1997;349(9064):1498–504.

[63] Nystuen P, Hagen KB, Herrin J. Mental health problems as a cause of long-term sick leave in the Norwegian workforce. Scand J Public Health. 2001;29(3):175–82.

- Guaranteeing the accessibility of welfare and rehabilitation services to people with permanent mental and behavioural disorders (incl. special welfare services and social and work-related rehabilitation) according to their recovery level and need for assistance.
- Starting self-help and support groups for persons with permanent mental and behavioural disorders and their family members and keeping them consistently working, incl. DUO groups (in the cooperation of an experience advisor and specialist).
- Promoting the adaptation among primary care specialists of a way of thinking that is aimed at recovery by spreading it as a part of base education and via in-service training.
- Expanding the network of experience advisors and empowering and supporting them, organising recovery courses.

Accessibility of multidisciplinary addiction (drugs, alcohol, gambling) treatment and social rehabilitation after addition treatment

Alcohol consumption and the prevalence of alcohol addiction in Estonia is high compared to the EU average[64]. The possibilities of treating addiction are clearly smaller than the demand for them[65].

Activities:

- Moving the treatment of withdrawal delirium to departments with intensive care capability.
- Guaranteeing replacement therapy for opiate addicts and improving rehabilitation possibilities.
- Raising the awareness of primary care specialists (in the areas of health and social affairs) of the signs of addiction, the options for recovery, the ways to motivate the addict, and the possibilities of the addiction treatment and rehabilitation system.
- Encouraging addicted persons to contact the health and social system. Regulating the cooperation of the health system with the social system and rehabilitation facilities.
- Guaranteeing the regional accessibility of short-term inpatient rehabilitation for people who need help and combining it with the social coping skills programme, as well as helping former addicts acquire new skills, return to the labour market and organise everyday activities.
- Regularly evaluating the extent of addictive behaviour in Estonia and planning changes in policies as a result of this.

Integration between the interdisciplinary treatment of comorbidity (physical illness and mental disorder; alcohol addiction and mental disorder; tuberculosis and mental disorder)

Activities:

- Treating comorbid physical and mental illnesses by approaching the body and mind as a whole.
- In cases of comorbidity, coordinating the treatment plan of the specialists treating the same patient to avoid medical complications.
- During the training and in-service training for primary care specialists and specialist physicians, including techniques in the programme that help prevent the accumulation of psychiatric

[64] Green Paper on Alcohol Policy [Internet]. Ministry of Social Affairs; 2014. Available from: https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/alkoholi_roheline_raamat-19.02.14.docx

[65] Psühhiaatria eriala arengukava kaasajastamine ja täiendamine 2012. aastal /Updating and Supplementing the Development Plan of the Speciality of Psychiatry in 2012/. Estonian Psychiatric Association; 2012.

problems in the case of physical illnesses both when the initial diagnosis is made as well as in the terminal state.

- Diagnosing and treating suicidal tendencies with interviews and tests, considering the possibility that patients who are suicidal, addicted to drugs or suffering from the onset of dementia do not follow the treatment plan.
- Acting in accordance with subsection 11 (1) of the Mental Health Act.

Regulation of involuntary hospitalisation and treatment

The Constitution of the Republic of Estonia stipulates that everyone has the right to liberty and security of person. No one may be deprived of his or her liberty except in the cases and pursuant to a procedure provided by law, incl. to detain a person suffering from an infectious disease, a person of unsound mind, an alcoholic or a drug addict, if such a person is a danger to himself or herself or to others. Psychiatric care is provided on a voluntary basis, that is, at the request or with the informed consent of a person. In certain cases, it is possible to apply involuntary treatment to a person either as involuntary emergency psychiatric care (by civil procedure) or as coercive treatment (by criminal procedure). Upon the application of involuntary care, a person is admitted to the psychiatric department of a hospital for emergency psychiatric care without the consent of the person or his or her legal representative, or the treatment of a person is continued regardless of his or her wishes (hereinafter involuntary psychiatric treatment) only if all of the following circumstances exist: the person has a severe mental disorder which restricts his or her ability to understand or control his or her behaviour; without in-patient treatment, the person endangers the life, health or safety of himself or herself or others due to a mental disorder; other psychiatric care is not sufficient. The objective of psychiatric coercive treatment is the treatment of mental disorders, decreasing the risk resulting from mental disorders and restoring the person's coping skills for independent coping in society.
The Convention on the Rights of Persons with Disabilities stipulates that persons with disabilities have the right to recognition everywhere as persons before the law was ratified in Estonia in 2012. Persons with disabilities also enjoy legal capacity on an equal basis with others in all aspects of life. Pursuant to the Convention, it must be guaranteed that persons with disabilities are not deprived of their liberty unlawfully or arbitrarily. Any deprivation of liberty must be in conformity with the law and the existence of a disability shall in no case justify a deprivation of liberty.

Activities:

- Implementing specific measures to allow for the application of less intensive measures upon the restriction of personal liberty by developing social services (alternative services) at the level of community.
- Increasing the efficiency of preventive measures and raising the awareness of persons with disabilities and their families so that problems can be detected early and dealt with.
- Establishing national regulations which allow persons themselves to initiate proceedings for replacement of coercive inpatient treatment with outpatient treatment, or termination of coercive treatment.
- Guarantee dignified treatment and comprehensive treatment to people given involuntary or coercive treatment, incl. in the form of counselling and therapeutic services. Every person has the right to the application of lee-intensive measures in the event of interference with their body, which guarantee aid that corresponds to his or her health status.

- Preparing practical guidelines with good practices for officials (judges, local government employees, physicians), who evaluate the person's risk in the event of the application of involuntary treatment. It is also necessary to train lawyers, attorneys and local government officials so they do not see the existence of a mental disorder as the equivalent of a risk.

Treatment of the mental and behavioural disorders and rehabilitation of detainees

The prevalence of serious mental and behavioural disorders (psychotic disorders, serious depression, antisocial personality disorder) among detainees is considerably higher than among the population in general, and these disorders are often related to alcohol and drug abuse[66,67]. These disorders are also a significant factor in suicide[68]. The resources for treatment of mental and behavioural disorders are often limited at detention facilities and the accessibility of the necessary help is insufficient[69,70].

Activities:

- Guaranteeing regular monitoring of the mental health of detainees to diagnose mental and behavioural disorders and determine the suitable manner of intervention (preferably combined intervention using medicines, psychotherapy and social measures).
- Guaranteeing the possibility of regular psychiatric consultations for detainees with mental and behavioural disorders.
- Offering training to detention facility staff to guarantee their adequate qualification for early detection of suicide risk and intervention in the suicide process.
- Guaranteeing active referral of detainees with mental and behavioural disorders to mental health services after their release from the detention facility.

3.3. Treatment of mental and behavioural disorders and recovery among the elderly

The quality of the services of care institutions is uneven and their accessibility is a problem[71,72,73].

Guaranteeing the timely diagnosis, documentation and contemporary treatment of disorders considering the specific features of the bodies of the elderly and multimorbidity

Activities:

- Increasing the competence of all doctors and primary care specialists in respect of the mental and behavioural disorders of the elderly (addition to the study programmes in-service courses

[66] Brugha T, Singleton N, Meltzer H, Bebbington P, Farrell M, Jenkins R, et al. Psychosis in the Community and in Prisons: A Report From the British National Survey of Psychiatric Morbidity. Am J Psychiatry. 2005;162(4):774–80.

[67] Fazel S, Danesh J. Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. Lancet. 2002;359(9306):545–50.

[68] Kerkhof A, Blaauw E. Suicide in prisons and remand centres: Screening and prevention. In: Wasserman D, Wasserman C, editors. Suicidology and Suicide Prevention: A Global Perspective. Oxford: Oxford University Press; 2009. p. 267–72.

[69] Fazel S, Danesh J. Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. Lancet. 2002;359(9306):545–50.

[70] Kerkhof A, Blaauw E. Suicide in prisons and remand centres: Screening and prevention. In: Wasserman D, Wasserman C, editors. Suicidology and Suicide Prevention: A Global Perspective. Oxford: Oxford University Press; 2009. p. 267–72.

[71] Jané-Llopis E, Gabilondo A. Mental Health in Older People. Consensus paper [Internet]. Luxembourg: European Communities; 2008. Available from: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/consensus_older_en.pdf

[72] Gelder M, Andreasen N, Lopez-Ibor J, Geddes J. New Oxford Textbook of Psychiatry [Internet]. Oxford: Oxford University Press; 2009. Available from: https://global.oup.com/academic/product/new-oxford-textbook-of-psychiatry-9780199696758

[73] WHO | Mental health and older adults [Internet]. WHO. 2015. Available from: http://www.who.int/mediacentre/factsheets/fs381/en/

of geriatric medicine and social workers), incl. orientation when a patient needs a psychiatrist's consultation.
- Extending the duration of the appointments of family doctors with elderly patients.
- Solving tasks primarily on a case basis (not just a guideline basis).
- Documenting the symptoms particularly accurately, incl. cognitive deficit and subthreshold delirium.

Regularly evaluating and optimising the use of medicines by the elderly

The use of medicines by the elderly must be checked and coordinated[74].

Activities:
- Side effects and interaction as well as the specified features of the bodies of the elderly must be considered (doses must be smaller than average).
- The use of medicines by the elderly must be regularly monitored in cooperation with family and home nurses to prevent undesirable effects and mistakes in the use of medicines.
- Reducing the use of medicines by the elderly by removing potentially unnecessary or unsuitable medicines from the treatment scheme. In some cases, this means that the elderly person must stay in the inpatient department (of geriatrics).
- Implementing 'electronic' memory, i.e. the tools that remind people of necessary activities, e.g. to take medicines.
- Observing the principle of complexity in treatment: use of medicines, psychological treatment, making changes in the person's lifestyle, treatment that considers physical illnesses and a spiritual approach in the case of patients with a certain background.

Implementing integrated care and preferred application of home care considering the actual needs of the elderly person and the ability of the family

According to the last census (2011), 38% of elderly people (65+) in Estonia live alone[75]. Elderly people want to continue living in their own homes in conditions that they're used to for as long as possible; this is generally considered a factor that protects mental health[76].

Activities:
- Supporting the independent coping of elderly people living alone by offering them integrated care services, incl. home care.
- Developing descriptions, minimal requirements and quality requirements of integrated care services.
- Supporting the safety and security of elderly people living at home by helping them adapt their home environment and involving innovative technological aids.
- Alleviating the loneliness and social exclusion of elderly people living alone by offering them opportunities for communication and participation in cultural life.

---

[74] Fortin M, Lapointe L, Hudon C, Vanasse A, Ntetu AL, Maltais D. Multimorbidity and quality of life in primary care: a systematic review. Health Qual Life Outcomes. 2004;2:51.

[75] Statistics Database [Internet]. Available from: http://pub.stat.ee/px-web.2001/dialog/statfile2.asp

[76] Mental Health Promotion: Older People's Residential Setting Handbook. MHP Hands Consortium; 2013.

- Strengthening community activities and support as well as voluntary work by involving the elderly as the persons who receive and provide help.
- Differentiating the cost-sharing by elderly people themselves and their families when paying for services by considering their capabilities.

Guaranteeing general and special nursing home services and an adapted environment for elderly people with mental and behavioural disorders, securing the accessibility of specialised services

Activities:

- Optimising welfare services for the elderly at the national level.
- Monitoring at the county and local government level that welfare institutions act according to their articles of association.
- Local governments should expand and promote home care options.
- Supporting diaconic institutions and promoting their establishment.
- Preparing the staff of medical institutions and nursing homes about the topic of death.
- Apply the supervision of nursing home staff in practice.
- The Ministry of Social Affairs should create a position for a geriatrics adviser similar to other medical specialties.