An Overview of the System of Mental Health Services in Estonia

Healthcare Association in collaboration
with Ministry of Social Affairs in Estonia
and World Health Organization

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1. Introduction

1.1. Goal of the document

Mental health is an integral part of a person's overall personal condition. Quality of life, coping, cultural environment, social processes and attitudes have an impact on mental health.

According to various surveys the state of the mental health of the population of Estonia is worse than that of the residents of other Western and Northern European countries.

In January 2005, Ministers of Health, researchers and experts from fifty-two member states of the European region of the World Health Organisation (hereinafter the WHO) met in order to get an overview of the state of mental health and endorse an action plan for the forthcoming years (*WHO Mental Health Declaration and Action Plan for Europe*) that all the Member States of Europe could take into account in developing the strategies of mental health and carrying out the action plans thereof.

Estonia's system of mental health services has considerably improved over the past ten to fifteen years, turning from a soviet psychiatry-oriented system into a more human-centred one and a system of services primarily improving clients' quality of life. A more effective integration of social and health services is needed in order for the system of mental health services to be based on clients' needs and to also have attention paid to society's overall needs and potentialities.

During recent years, several different institutions have assessed the Estonian system of mental health and the development thereof, and surveyed the changes that had taken place. Unfortunately, there is no document to give a generic overview of developments in both social and health sectors (in the sphere of mental health). The current document fulfils the particular objective by giving an overview of both fields (except addiction) and establishing an initial foundation for further, more integrated developments. The secondary objective of the document is to promote discussion between various parties with a view to solving mental health system related problems and finding appropriate possibilities for obtaining solutions.

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of Social Affairs. This has enabled a study of the situation of mental health in Estonia and created evidence-based information for this report.

This document expresses its authors' personal views and opinions, which might not coincide with the views of the institutions where they work. The WHO is not responsible for the outcomes and conclusions provided in this report.

1.2. Brief Overview of Health Insurance System and Health Care Services

Since regaining independence in 1991, the Estonian health system has undergone two major shifts: first, from a centralized, state-controlled system to a decentralized one; and second, from a system funded by the state budget to one funded through social health insurance contributions. At the same time, there has been a growing emphasis on primary care and public health.

The reforms that took place during the 1990s aimed to establish financing through social health insurance and to encourage decentralization. They were undertaken partly in response to the changing needs of the Estonian population and partly, given the state of the economy, in response to concerns about financial sustainability.

More recently, however, there have been further developments. For example, the Health Insurance Fund was transformed into an independent public body in 2000, a new version of the Health Services Organization Act was adopted by the parliament in 2001 and a new Health Insurance Act was adopted in 2002. As a result of these changes, all health service providers have been legally mandated to operate under private law, even though in most cases institutions continue to be publicly owned by the state or municipalities. In addition, the passing of the Law of Obligations (Võlaõigusseadus) in 2002 established a new relationship between patients and providers. For the first time, this relationship has been legally defined as a binding agreement with responsibilities on both sides[1].

1.2.1. Health Insurance System

The health insurance system commenced in Estonia in 1991. In 2001, the Estonian Health Insurance Fund in public law, which, by funding the prevention and treatment of the diseases of insured people, the purchase of medicinal products and appliances and by allowing them health insurance benefits, was founded pursuant to legal procedures.

Compulsory health insurance applies in Estonia. Health insurance is compulsory because an obligation is imposed on an employer by law to pay social tax for all working people whereas self-employed individuals must pay social tax on their own

[1] Health Care Systems in Transitions 2004, www.sm.ee

income themselves. Hence, 13% of gross wage is directed through the Tax Board to the health insurance system.

Permanent residents of Estonia or people residing in Estonia, on the basis of temporary residence permits for whom social tax has been paid or who themselves have paid social tax, are referred to as insured persons. Persons maintained by the insured are referred to as persons equal to insured persons.

The Estonian health insurance is social insurance and it follows a solidarity principle: the cost of health services, paid by the Health Insurance Fund to a medical institution in case of illness, is not subject to the amount of social tax paid for the person concerned. The Health Insurance Fund uses the social tax paid for the working population also for covering the cost of health services provided to persons who have no income with regard to work activities[2].

1.2.2. Healthcare System and Services

1.2.2.1. General Healthcare

In the event of illness, the first contact person of an individual is a family physician. A family physician provides general medical care and consultation on activities preventing illnesses, injuries or intoxications for any person on his or her list. In case of need, the family physician refers his or her patient to an appropriate medical specialist for consultation or to a hospital.

In most cases, a family physician is the one, who first diagnoses mental disorders, treats more prevalent minor mental disorders and in case of need refers his or her patient to a psychiatrist for consultation or for psychiatric treatment. Family physicians continue the treatment in the events when further treatment shall not necessarily require continuous monitoring by a medical specialist[3].

1.2.2.2. Specialised Medical Care

In spring 2003, the Government of the Republic approved the development plan of networking of hospitals. The development of the network of hospitals relies on the principle that any resident of Estonia could arrive in a health care institution, providing health care at the highest level, within at least one hour.

Psychiatry belongs to the sphere of specialised medical care. The diagnosis, treatment and rehabilitation of mental disorders are provided on outpatient basis in the events when constant monitoring of the patient for diagnosing or treating is not essential or if the patient's mental state enables out-of-hospital treatment. Psychiatric care is mainly provided on an outpatient basis in Estonia.

[2] Health insurance, www.haigekassa.ee

[3] Development plan of the speciality of psychiatry , www.sm.ee

Inpatient psychiatric care is mainly used as short-term crisis aid or for solving complex differential-diagnostic and treatment problems. Inpatient diagnosis, medical treatment and rehabilitation are justified in the events when in order to identify a mental disorder a patient has to be subject to continuous monitoring during a certain period of time or if the patient is dangerous to himself or herself or others depending on his or her state of health and is not able to cope without assistance out of hospital[4].

1.2.2.3. Emergency Medical care

In Estonia, a single telephone number for the alarm centre 112 answers calls for emergency medical care. Emergency medical staff provides first medical aid for all persons in the territory of Estonia regardless of their nationality or citizenship.

Activities of emergency medical stuff are organised, contracts with the owners of ambulance crews issued and supervision exercised by the Health Care Board since January 2002. Supply of emergency medical care is provided by both private and public ambulance crews whereas the other providers of medical health services are under private law. One ambulance crew services approximately 15,000 persons and makes 6 home calls a day[5].

1.2.3. Social Protection and Social Care

In Estonia, a principle that the state provides its citizens with social protection, which gives them a feeling of security with regard to the future and a possibility of living a decent life for the rest of their lives, is recognised. Social protection measures are divided into social security and welfare services.

The source document of the policy of the development of social services drawn up at the Ministry of Social Affairs as early as in 1999 treats the adoption of socio-political measures as an investment in people and through people in the economy and society as a whole. Welfare services-related instruments (operations) might be both social benefits and social services.

According to a historically developed practice, the public sector has a substantial role in the elaboration and carrying out of social policy. The provision of assistance is based on the principle of subsidiarity, according to which public obligations are generally and preferably performed by authorities closest to the citizens and the resources of the level closest to the person in need (first level resources) are used initially. The central power has the legislative authority of decision in the determination of the tasks of the first level [6].

Independent Estonia inherited a system of social care based on institutional provision. Although health care and social care were strictly separate in theory, in

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[4] Development plan of the speciality of psychiatry, www.sm.ee
[5] Health care, www.sm.ee
[6] Social welfare, www.sm.ee

practice many chronically ill people were looked after in social care homes, while many socially disadvantaged groups were kept in hospital for long periods.

When the health system was restructured after independence, a new concept of social services was also developed with the intention of reducing and restructuring institutional care and developing a system of open or community care.

The concept of welfare services, which was prepared at the Ministry of Social Affairs and approved by the Government of the Republic in spring 2004 (see www.sm.ee) defines the general bases of Estonia's policy of welfare services and measures for improving the situation in the forthcoming years. In planning the changes, the expectations of society and social rights, provided for in international documents, have been taken into account. The adoption of measures specified in the concept enables development of new working methods, improvement of customer service, more effective use of human and financial resources.

At the same time, the Social Welfare Act, currently in force, is institution-centred and fails to create a sufficiently effective legal basis for individual needs to be met in the best way possible. Due to lack of choices, the exercise of rights and independence of many people is limited and a decent coping in life is not guaranteed for everybody.

In 1998, the Minister of Social Affairs authorised the programme for developing special care for the years 1998-2002. Improving the quality of life, of the people who live in special care homes and/or need them, by way of arranging and developing the network of special care homes and special care services and rehabilitation services and improving the quality thereof, was its mission.

1.2.4. Psychological Counselling and Crisis Aid

Under this theme there is a reason for speaking primarily about provision of psychological counselling and aid in a crisis situation in the context of mental health.

In February-March 2005, the Ministry of Social Affairs conducted a web-based questionnaire regarding the mapping of counselling services, which referred to all organisations and institutions providing counselling services in both public, private and third sectors[7].

The objective of the questionnaire was to map the situation associated with social counselling in Estonia. The aim was to obtain an overview of the situation in the provision of services, the amount and quality of services and other related factors. Counselling categories, falling under social counselling, were primarily considered a counselling service in this questionnaire. Since substantially fewer organisations than expected answered this questionnaire, it is not possible to generalise the

[7] Mapping of counselling services (The Ministry of Social Affairs, 2005)

results regarding all of Estonia, however, certain assessments regarding the situation characterising the provision of counselling services may be provided.

Demand for psychological counselling is relatively large but it could be more available and more adequate. The evaluation of the need for crisis counselling, the availability thereof and the sufficiency of the volume of the service with regard to the demand, showed that the counselling category rather lacks availability having regard to the amount of necessity.

Both psychological and crisis counselling is provided either on the spot at the service provider's or by means of telephone or the Internet. With support from the Ministry of Social Affairs and private initiative, the Association "Trust" launched, in 2000, a nation-wide emergency psychological aid telephone service, which uses a free short number (126), is available round the clock and meets the requirements of the International Federation of Telephonic Emergency Services, both in Estonian and Russian languages.

1.2.5. Citizen Initiative

There are not many non-governmental organisations formed by people with mental disorders or in order to support such people, which is why the role of self-aid groups in influencing the policy of mental health, has not been very great. The organisations, the activity of which is aimed at people with mental disabilities, started to develop earlier in time. The rest of the world has experienced a similar trend.

Estonian Mentally Disabled People Support Organization (EMDPSO) is an association of organisations supporting mentally disabled people, which was founded in 1990 and has 22 members (see www.vaimukad.ee). The mission of the support association is to improve the position of mentally disabled people in society. The training and counselling centre of the association organises various courses, seminars and informal educational training sessions; the day centre offers possibilities of recreational activities for mentally disabled people and, in case of need, provides also other services (e.g. the services of personal assistants, everyday life support and case management) on the order of local governments. The support association represents an organisation dealing with mentally disabled people in several international and national organisations: *Inclusion International*, *Inclusion Europe*, The Estonian Chamber of Disabled People, Network of Estonian Non-profit Organisations, Estonian Non-formal Adult Education[8].

Self-aid groups and mental health support groups constituted by people with mental disorders are mostly located in bigger cities (see www.hot.ee/vaimsetervisetugigrupid), e.g. at Merimetsa Support Centre and Tallinn Mental Health Centre; a citizen's association "Davy" is operating in Tartu.

In 1999, the Estonian Association for Supporters of People with Mental Disorders (EAFPMD) was founded. Its activities are carried out in Tallinn and Tartu at the moment but it is known that members of families also get together in Hiiumaa,

[8] www.vaimukad.ee

Jõgeva, Viljandi and Põlva. The purpose of the organisation is to protect the rights of sick people and their family members, evolve the independence of mentally sick people and increase the quality of life of their close ones. The EAFPMD is a member of the World Schizophrenia Society[9].

In 1994, the Estonian psychiatric patients' advocacy association was founded as a non-profit organisation. The sphere of activities of the association has expanded by now – besides patients with mental disorders they also give advocacy for the users of other health and welfare services. The association bears the name of Estonian Patients' Advocacy Association (EPAA); the objective of its activities is to help people using health and welfare services to make use of rights provided by the Constitution and other legislation.

The forum of mental health policy "We make the decisions" has been operating under the leadership of the EPAA since March 2002. The goal of the forum is to determine problems associated with mental health by regions and initiate concrete activities with a view to solving them. The members of the forum are various parties interested in mental health – service users, their family members, social workers, representatives of organisations, psychiatrists, officials, and also journalists. The principle of the forum is a consumer-oriented approach – 33% of the participants are service users. The different initiatives of the forum have enhanced the network of mental health, activated the service users, and inculcated in them self-confidence and willingness to act.

[9] www.zone.ee/epity

2. Policy and legislative framework

2.1. Brief Overview of Mental Health Legislation

The following acts and codes regulate the sphere of mental health to a smaller or larger extent

- Juvenile Sanctions Act (initial date of entry into force 01.09.1998);
- Estonian Health Insurance Fund Act (01.10.2000);
- Forensic Examination Act (01.01.2002);
- Code of Criminal Procedure (01.07.2004);
- Code of Criminal Procedure Implementation Act(01.07.2004);
- Family Law Act (01.01.1995)
- Social Benefits for Disabled Persons Act (01.01.2000);
- Mental Health Act 12.02.1997);
- Public Health Act (14.06.1995);
- Health Insurance Act (01.10.2002);
- Medicinal Products Act (16.12.2004);
- State Pension Insurance Act (01.01.2002);
- Social Welfare Act (01.04.1995);
- Social Tax Act (01.01.2001);
- Health Services Organisation Act (01.01.2002);
- Code of Civil Procedure (01.09.1998, new as of 2006)
- General Part of the Civil Code Act (01.07.2002);
- Social Protection of the Unemployed Act (01.10.2002);
- Law of Obligations Act (01.07.2002);
- Law of Obligations Act, General Part of the Civil Code Act and Private International Law Act Implementation Act (01.07.2002).

The consolidated texts of all the listed legislation can be consulted by reading the electronic State Gazette at www.riigiteataja.ee.

2.2. Mental Health Policy, Policymakers, Other Stakeholders

The majority of the Member States of the European Union have a clearly defined national mental health policy. The report for 2004 of the speciality committee of psychiatry states, “In Estonia, the draft source document of mental health policy was compiled on the order of the Ministry of Social Affairs some years ago but further developments at the state level have stopped.”[10]

Hence, there is still no nationwide (or national) and integrated mental health policy in Estonia but attempts are made to obtain this. The first step, with a view to preparing mental health policy, as mentioned above, was made as early as the end

[10] Report of the speciality committee of psychiatry regarding problems of the speciality as of 2004. (2005)

of 2001 while the Ministry of Social Affairs ordered the compilation of the source document of mental health policy from the foundation Praxis.

The aim of the document was to produce, in the order of importance, the most important mental health problems together with their possible solutions. Development patterns eligible for Estonia were described, associating them with the already existing development plans. The source document of mental health policy was intended to be the starting point for the to-be-developed mental health policy.

The compilers of the document note, "Noteworthy is the precedent that the state, i.e. the Ministry of Social Affairs has ordered the development of the policy source document from the third sector. The fact that consensual balance, between different parties and interest groups has been achieved in the source document, due to bottom-up participation process at the grass-root level, makes the source document of mental health policy valuable. This document has not been compiled by a few officials in secret office silence, which often ends up remaining on paper without the target groups concerned having any idea of it."[11]

According to modern concepts, service users and their close ones (family members) should play the most important role in designing mental health policy. Despite the fact that the contribution of the aforementioned has substantially increased over the recent years, it is proportionally still too small in comparison with the contribution of mental health professionals (social workers, psychiatrists, psychiatric nurses, members of rehabilitation teams and others).

The development of mental health belongs to the area of government of the Ministry of Social Affairs. Relevant obligations are provided for, e.g., in the Social Welfare Act, the Public Health Act, the Public Health and Health Services Organisation Act, as well as the Health Insurance Act and the Estonian Health Insurance Fund Act.

The following institutions mainly deal with the sphere of mental health:

- Ministries and institutions of their area of administration: the Ministry of Social Affairs, the Ministry of Education and Research, the Ministry of Justice, the Health Care Board, the Social Insurance Board, the State Agency of medicines, the Health Protection Inspectorate, other state authorities (such as social and health departments of county governments);
- Citizens' associations, e.g. the Estonian Chamber of Disabled People, the Estonian Mentally Disabled People Support Organization, the Estonian Patients' Advocacy Association and others;
- Speciality organisations, e.g. the Estonian Psychosocial Rehabilitation Association, the Estonian Association of Psychiatrists and others;
- Providers of social and health services (including court-appointed providers of the psychiatric health service), specialised schools, educational and research institutions.

[11] Source document of mental health policy, www.praxis.ee

Achievements and success in the field of mental health is impossible without one of the named parties. Co-operation between different institutions is absolutely indispensable. Today, state authorities play the substantial role but during the forthcoming years, it is necessary to increase the percentage of citizens' associations and speciality organisations, whose main task is to satisfy their clients' needs in the best way possible.

3. Mental Health Services

3.1. General Framework of Mental Health Services

Over the times, people have used very different forms of cohabitation and co-operation in order to survive, being at the same time guided by different fundamental value attitudes and orientations. Despite differences, all forms of community can still be placed between two fundamental extremities, which, in a responsibility-based way, are primarily expressed either in people's own responsibility for their well-being and coping or, first and foremost, in society's responsibility for people's well-being and coping. In other words – either in the maximisation or minimisation of people's responsibility.

As a rule, there are no totally universal equivalents for theoretical constructs in real life. The majority of real societies tend towards either one or another value attitude or world-view and/or uses the combination of the elements of two different world-views in order to social problems[12].

It is not easy to describe the Estonia's system of mental health services. There seem to exist two entirely independent systems – the system of welfare services and the health care system, the mutual relations of which seem to be clear at an organisational level, but which often give rise to inconvenient situations at the customer level in solving both everyday life related and health problems.

Knowing that a paradigm is an example, pattern, model or a complex of tenets on which our activities are based, and that we use the standpoints, proceeding from this paradigm, to solve our problems and now, observing these systems, in this light from the client's viewpoint, it is quite clearly obvious that mental health services are based on a medical paradigm in Estonia. In fact the welfare services system is, in general, also based on the medical paradigm despite the fact that the elements of a social paradigm came into being in the world already in 1960's in the course of the intensification of the human rights related movement, and certain positive developments in the promotion of social services (e.g. in the sphere of rehabilitation) have already been observed for several years. However, regarding the overall situation, they remain to be insignificant.

Although most mental disorders fail to leave irreversible traces in those suffering from them, some of them are so serious and long-lasting that they give rise to disability. That is why it is appropriate to use here, for the purpose of clarity and simplicity, an example of disability, for comparing the social and medical paradigms. If we replace the word "disability" by the word "mental disorder", the comparison of paradigms is totally comprehensible in the context of mental health.

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[12] Welfare services for people with special mental needs in Estonia. V. Paavel, J. Kõrgesaar, A. Sarjas, S. Sõmer. V. Vasar. (2000/2001)

The medical paradigm carries the following information [13]:

- Lesions (also including mental disorders) cause difficulties for the client and put him or her in a worse situation;
- The problem lies in the client (person);
- A disabled person deviates from the standard of "normality";
- Lesions (disorders, deviations from the "standard") are believed to be (at least to some extent) correctible, the focus lies on rehabilitation;
- Disability is a word with a negative meaning, which is often understood as a disorder, incapability or defect;
- Disability is a "personal tragedy";
- Requires that a disabled person be identified as a "normal person";
- Either assistance (services) or financial compensation (allowances or benefits) are proposed as solutions. The focus lies on individual treatment (including therapeutic treatment and rehabilitation) and supervision;
- Professionals are a dominant power;
- Policy is seen as an impelling force or, in other words, mental health is improved and the system of services is developed through mental health policy.

The social paradigm focuses on external causes, the so-called barriers causing disability.

- Underlines cultural and environmental factors;
- Disability (in this case mental disorder) is referred to as a social construction, i.e. unfavourable situations are created by society by way of using ("normal") people without disabilities as a standard;
- The social model is positive, laying stress on abilities and skills. Focus is on adaptation, use of rights and universal design (suitable for everybody);
- Responsibility is shared between an individual and a collective (society), the focus is set on social changes, the importance of self-aid and experience and discretion is underlined;
- Politics, in which disabled people participate as all other society members, i.e. mental health is being enhanced and the mental health system developed through political parties-related policy, is seen as an impelling force;
- The right of reasonable adaptation and comprehensive inclusion are proposed as a solution;
- At the same time, it is necessary to point out that in many cases the social paradigm is too optimistic. In the event of extremely severe disabilities (including mental disorders), changing or adapting social and environmental factors as a "magic remedy" cannot be applied.

Having regard to local conditions it would be useful to find a reasonable balance between the two paradigms in the development of services.

Amongst different professional activities, in the assistance of people with mental disorders, the three most essential and/or substantial ones stand out:

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[13] The unpublished training material of the *European Disability Forum „Disability Rights Activists and Advocates Training Manual"* has been used for comparing the medical and the social paradigms (2005).

- Medical treatment, as the result of which a person recovers fully or partially, i.e. within certain limits;
- Rehabilitation, as the result of which a person's residual abilities are developed and necessary support systems are designed;
- Supporting, as the result of which a person's condition and/or coping remains stable in general outlines.

The aforementioned three activities are mutually and dynamically connected to each other, which is why they occur (should occur) on both simultaneous and sequential bases. These activities are basic in case of the people, whose condition's key feature is the so-called mental disorder with pathological character and progression. Additionally, there are a lot of people whose mental disorder is primarily expressed as retardation in their intellectual development. The primary leading professional activity in case of people with retarded intellectual development is teaching, which may, depending on the person's condition, include to a lesser or larger extent elements of medical treatment and rehabilitation.[14]

Services referred to people with mental disorders, in the context of general public services, are specified in Table 1.[15]

[14] Welfare services for people with special mental needs in Estonia. V. Paavel, J. Kõrgesaar, A. Sarjas, S. Sõmer. V. Vasar. (2000/2001)

[15] Welfare services for people with special mental needs in Estonia. V. Paavel, J. Kõrgesaar, A. Sarjas, S. Sõmer. V. Vasar. (2000/2001); the table is in this document is given in a modified form.

Table 1. Services referred to people with mental disorders in the context of general public services

	General public services	Related services	Supporting services	Special services
Target group	The whole population	People who are not able or cannot use general public services	People for whom the available public services fail to suffice for their ability to cope	People who put themselves or others in danger without 24-hour personal assistance
Outcome and/or content of a service	General needs are satisfied	A person who is living without assistance is associated with general public services so that a need for supporting services becomes redundant or is minimal	A person can lead quite an independent life and use general public services while being provided with the service on a continuous basis	People live in an institution, which provides them with 24-hour qualified assistance and supervision
Services	E.g. Educational, labour market, health, transport and housing services (incl emergency care, general medical care and special medical care)	Case management Rehabilitation Primary care Out-patient psychiatric care Psychiatric day care	Supported living Supported working Supporting everyday life Living in a community	24-hour care (incl. care determined by the court) In-patient medical treatment (incl. medical treatment determined by the court) In-patient emergency psychiatric care, involuntary emergency psychiatric care and coercive care determined by the court)

3.2. Mental health services

Mental health services may be classified and described in several different ways. This document is based on the definitions of the WHO Assessment Instrument[16]. Definitions unfolding the essence of all services are specified in Annex 1, and descriptions corresponding to Estonian conditions are specified below.

The psychiatry services in the Register of Activity Licences of the Health Board are classified as follows:

- Psychiatric services
- Out-patient psychiatric services :
- Out-patient children's psychiatry services:
- Out-patient psychiatric services (including children's psychiatry):
- Children's psychiatry services:
- Psychiatric services of day medical treatment:
- Psychiatric services (including children's psychiatry):
- In-patient psychiatric services.

Auxiliary psychotherapy services:

- Psychotherapy:
- Out-patient psychotherapy.

74 natural or legal persons, providing health services, hold a valid activity licence for the provision of psychiatry services. Some of them provide services to mainly or only a certain target group (e.g. people suffering from mental disorders caused by the consumption of psychoactive substances and to those suffering from sexual dysfunctions), which is not covered by this document.

Social services, referred to people with severe and long-lasting mental special needs, are provided by 86 service providers who provide seven services in total:

- Supported living;
- Living in a community;
- Supported employment;
- Supporting everyday life;
- 24-hour care;
- 24-hour care with intensified monitoring;
- 24-hour care with intensified support.

Clients with less severe mental disorders use general social services, which are not covered by this document.

3,899 adults in total, with special mental needs, were involved with social welfare services at the end of 2002 while the number thereof totalled 4,118 at the end of 2003. It is hereby important to have regard to the fact that some of the service users used several welfare services, consequently, by summing up the number of

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[16] *World Health Organization Assessment Instrument for Mental Health Systems* (WHO, 2005)

people who have used different services at the end of the accounting year, we will get a bigger amount than the total number of people who used the service at the end of the year. An overview of the number of people involved with different welfare services at the end of 2002 and the end of 2003, and movement of people between services during 2003 is given in the following table.

Table 2. Number of people subjected to services and movement of people 2002-2003

Service category	Users of the service as of the end of 2002	People who started to use the service in 2003	People who stopped using the service in 2003	Users of the service as of the end of 2003	Number of users of the service per 100000 inhabitants as of the end of 2003
Supporting everyday life	1,098	463	302	1259	90.18
Supported living	447	120	66	501	35.88
Living in a community	26	2	0	28	2.00
Supported employment	441	85	70	456	32.66
24-hour care	1,979	141	159	1961	140.47
24-hour care with intensified support	98	9	5	102	7.30
24-hour care with intensified monitoring	160	29	24	165	11.81
Total	**4,249**	**849**	**626**	**4472**	**320.34**

Most adults with special mental needs came to use welfare services from home (430 persons or 50.6%; 301 of them started to use the service of supporting everyday life), and from other welfare services (254 persons or 29.9%; 90 of them started to use the service of supporting everyday life, 55 - the service of supported living, 55 - the service of supporting employment and 47 - the service of 24-hour care).

The majority of those who stopped using the service comprised the people who started to lead an independent life (209 persons or 33.4%; 161 of them stopped using the service of supporting everyday life) and the people who moved on to use other welfare services (206 persons or 32.9%; 105 of them had stopped using the service of supporting everyday life).

52.6% of those who were subjected to services in 2003 were men and 47.4% of them were women. The majority of the service users or 77.8% were aged 18-59, hence at their productive age.

Unfortunately, tendencies regarding social services cannot be specified since services belonging to the sphere of mental health are treated differently both on substantial and statistical bases in different countries. No relevant data base on a uniform basis.

3.2.1. Community Based Services[17]

In the context of this document, mental health services, which can be provided outside psychiatric hospitals and special care homes, can be referred to as community based services. They may be provided, for example, in health care institutions (including family health centres and specialised medical units, central, general and local hospitals), social welfare institutions, and self-aid organisations.

Based on the form of provision, community-based services can be divided into inpatient services and outpatient services. Therefore, services provided in special care homes (i.e. except 24-hour care with all sub-forms) may be included in community-based services.

The percentage of community-based services has increased year by year. It is hereby difficult to specify any concrete numbers. Assessment of the growth in financing, which has so far been used, fails to provide an adequate outcome, given the increase in service prices. The fact that some clients are simultaneously using several services, adds confusion.

3.2.1.1. Supporting Everyday Life

The service is intended for persons with a mental special need at their productive age who have a prognosis of moderate, severe or profound disability or who have at least 10% loss of capacity for work. The purpose of this service is to teach a person the best possible ability to cope, for leading an independent life in a traditional environment (also with their families and/or close ones).

Operational expenditure, related to the provision of the service, is paid from the state budget; operating expenses of the rooms, which are used for the provision of the service, is paid from the budget of local governments or other sources.

3.2.1.2. Personal Assistant

A personal assistant is the helper of adults with profound physical disability or visually impaired persons with profound disability and persons with severe or profound mental disability in movement and in activities, which they cannot cope

[17] Upon the compilation of this subsection, materials, published on the website of the Ministry of Social Affairs, have been used.

with on their own. A personal assistant is also the helper of visually impaired children with severe or profound disability and/or children with severe or profound physical disability and who attend regular schools and who have difficulties with going to school, moving at school, coping in everyday life and maintaining personal hygiene without assistance.

Local governments administer the provision of the service of personal assistance. The corresponding committee of a local government body decides the necessity and volume of the service. The service is partly paid by the clients; the local government and the client using the service both pay for it. A written application, by the person or his or her legal representative, is required for using the service.

3.2.1.3. Day Care

Day care is intended for adults with profound or multiple disability, elderly people with dementia. Local governments administer the provision of the service. A local government authority or a legal person governed by private law may be the service provider. In order to be provided with the service, addressing a social worker of the local government or the service provider is required.

In general, the local government pays for the service whereas the client (or his or her family) pays for catering only. The client, his or her legal representative or close ones shall also arrange transport to and from the place where the service is provided and make sure that necessary medicinal products are available.

3.2.1.4. Supported Living

Supported living is a service intended for persons with mental special needs and moderate or severe disability:

- Who have at least 10% loss of capacity of work;
- Who have no housing or other supporting services at the place where he or she lives;
- Who are not able to work on his or her current position or who are predicted to lose their job;
- Who are job seekers or unemployed.

Care, catering and monitoring are not included in the service. Completion of a cycle of rehabilitation is the precondition for being provided with the service of supported living. A person or his or her representative must address either a social worker of the local government or a case manager of the Pension Board. The case manager refers the person to rehabilitation where the rehabilitation team assesses his or her need for assistance and drafts a rehabilitation plan. Referral of the person to the service is based on the rehabilitation team and the medical expert's assessments in the rehabilitation plan.

Operational expenditure associated with the provision of the service of supported living (including maintenance of dwellings) is paid from the state budget. The person bears the housing expenses.

3.2.1.5. Living in a Community

The service of living in a community is intended for persons with moderate or severe disability at their productive age:

- Who have at least 10% loss of capacity for work;
- Who have no housing or other supporting services at the place where he or she lives;
- Who are not able to work on his or her current position or who are predicted to lose their job;
- Who are job seekers or unemployed.

Completion of a cycle of rehabilitation, in the course of which a rehabilitation plan is drafted, is the precondition for being provided with the service. Either a social worker of the local government or a case manager of the Pension Board must be addressed in order to be provided with the service. The case manager at the Pension Board refers the person to rehabilitation at the rehabilitation institution. Referral of the person to the service is based on the assessments of the rehabilitation team and the medical expert.
Operational expenditure associated with the provision of the service (including maintenance of dwellings) is paid from the state budget. The person bears the housing expenses.

3.2.1.6. Supported Employment

The service is intended for persons, at their productive age, with special mental needs with moderate or severe disability:

- Who have at least 40% loss of capacity for work;
- Who are not able to work in his or her current position or who are predicted to lose their job;
- Who are job seekers or unemployed;
- Who are not working in a post for which the employer is paid an employment subsidy through the employment office with a view to employing unemployed persons with lower competitiveness.

Either a social worker of the local government, or a case manager of the Pension Board, must be addressed in order to be provided with the service. Referral of the person to the service is based on the assessments of the rehabilitation team and the medical expert. Catering is not included in the service.

Subsidies are paid from the state budget to the employer or the organisation providing the service.

3.2.1.7. Rehabilitation

The purpose of rehabilitation is to increase the level of a person's ability to cope in the course of which the person's abilities and skills for coping without assistance

are improved, the environment supporting coping without assistance is designed and the person is assisted in accessing general public services.

The rehabilitation of a person with special mental needs may last up to six months. The service may be provided on an inpatient basis in a rehabilitation institution or outside subject to the client and his or her needs.

A more detailed description of the service is available in subsection 3.2.4.

3.2.1.8. Primary Health Care

Any health-insured person has a family physician he or she has either chosen or who has been appointed to him or her by the county governor. In the event of illness the family physician is the patient's first contact person. He or she provides general medical care, advises all the people on his or her list on issues related to activities preventing illnesses, injuries or intoxications. In case of need the family physician refers his or her patient to an appropriate medical specialist for consulting or to hospital.

The family physician is also the first person to diagnose mental disorders, a person who treats more prevalent minor disabilities and in case of need the one who refers his or her patient to a psychiatrist's consultation or psychiatric treatment. A family physician is the one who first diagnoses mental disorders, treats more prevalent minor mental disorders and in case of need refers his or her patient to a psychiatrist for consultation or for psychiatric treatment. Family physicians continue the treatment in the events when further treatment does not necessarily require continuous monitoring by a medical specialist[18].

3.2.1.9. Outpatient Psychiatric Care

If possible, the removal of persons from familiar surroundings is avoided in the provision of psychiatric care. The percentage of outpatient psychiatric treatment is increasing in Estonia year by year. Private practices have developed vigorously, therefore giving the patient a better option.

A more detailed description of the outpatient psychiatric care with inpatient psychiatric care is available in chapter 3.2.2.4. In case of insured patients the Health Insurance Fund pays for the inpatient psychiatric care. Patients not covered by health insurance pay themselves for the care provided.

3.2.1.10. Inpatient Psychiatric Care

Inpatient psychiatric care is provided as a community service in central and general hospitals (see Annex 2). A more detailed description of the service is available in chapter 3.2.2.4. In case of insured patients, the Health Insurance Fund pays for the inpatient psychiatric care. Patients not covered by health insurance pay themselves for the care provided.

[18] Development plan of the speciality of psychiatry, www.sm.ee

All persons in the territory of Estonia are provided with inpatient emergency psychiatric care (similar to other emergency care), and emergency care provided to a person not covered by health insurance is paid for out of the funds prescribed for such purpose in the state budget.

3.2.1.11. Psychiatric Day Care

Three health care institutions provide psychiatric day care service in Estonia. This is psychiatric care during the provision of which the patient is at the health care institution in the daytime only.

In case of insured patients the Health Insurance Fund pays for the psychiatric day care service. Patients not covered by health insurance pay themselves for the care provided.

3.2.2. Non-community Based Inpatient Services

3.2.2.1. 24-hour Care in a Welfare Institution

The service is intended for persons, at their productive age, with special mental needs, with severe or profound disability and at least 80% loss of capacity for work.

Completion of a cycle of rehabilitation is the precondition for being provided with the service. A person or his or her representative must address either a social worker of the local government or a case manager of the Pension Board. The case manager refers the person to rehabilitation where the rehabilitation team assesses his or her need for assistance and drafts a rehabilitation plan. Referral of the person to the service is based on the rehabilitation team and the medical expert's assessments in the rehabilitation plan. A person is referred to a service of 24-hour care in a social welfare institution by the county governor on the basis of a referral from the case manager of the Pension Board.

Operational expenditure associated with the provision of the service (including maintenance of dwellings) is paid from the state budget. The person bears the catering and housing expenses.

3.2.2.2. 24-hour Care with Intensified Support

The service is intended for persons with special mental needs with profound multiple disability or for persons with mental disorder and unstable remission and at least 90% loss of capacity for work.

Completion of a cycle of rehabilitation is the precondition for being provided with the service of supported living. A person or his or her representative must address either a social worker of the local government or a case manager of the Pension Board. The case manager refers the person to rehabilitation where the rehabilitation team assesses his or her need for assistance and drafts a

rehabilitation plan. Referral of the person to the service is based on the rehabilitation team and the medical expert's assessments in the rehabilitation plan. A person is referred to a service of 24-hour care, with intensified support in a social welfare institution, by the county governor on the basis of a referral from the case manager of the Pension Board.

Operational expenditure associated with the provision of the service (including maintenance of dwellings) is paid from the state budget. The person shall bear the housing expenses.

3.2.2.3. Temporary Care (Interval Care)

The service is intended for elderly people, persons with dementia and disabled persons (including those with mental disability).

Local governments administer the provision of the service. Both local government authorities and private bodies, which the local governments buy the service from, may be the service providers. In order to be provided with the service, addressing a social worker of the local government or the service provider is required. If the client or his or her family pays for the service in full, addressing to a social worker of the local government is not required.

Clients must pay for the service either partly or in full.

3.2.2.4. Inpatient Psychiatric Care

A person is placed in inpatient psychiatric treatment if outpatient care is not sufficiently effective due to the state of health of the person or if the person becomes dangerous to himself or herself or others due to his or her mental disorder.

Psychiatric care means diagnosis of mental disorders, treatment and rehabilitation of persons with mental disorders and activities done for the prevention of mental disorders. Treatment setting means activities related to the assessment, diagnosis, treatment and rehabilitation of persons, which includes relationships between patients and doctors and other persons, health care institutions and the health insurance fund involved in the treatment.

Psychiatric care is provided on a voluntary basis, that is, at the request or with the informed consent of a person. Psychiatric care is provided for a person with restricted active legal capacity at the request or with the consent of his or her legal representative. The treatment of a person with a mental disorder, without his or her informed consent or the consent of his or her legal representative, is permitted only in the event of emergency psychiatric care regardless of his or her wish and in the event of coercive psychiatric treatment ordered by the courts.

A person has the right to refuse or discontinue psychiatric assessment or treatment except in the event of emergency psychiatric care and coercive psychiatric treatment ordered by the courts.

If possible, the removal of persons from familiar surroundings is avoided in the provision of psychiatric care.

In case of insured patients the Health Insurance Fund pays for the inpatient psychiatric care. Patients not covered by health insurance must pay themselves.

3.2.2.5. Emergency Psychiatric Care

All persons in the territory of Estonia are provided with emergency psychiatric care. Persons with mental disorders receive emergency psychiatric care on a voluntary basis, except in the case of emergency psychiatric care regardless of his or her wish.

Emergency psychiatric care is provided in the case of mental disorders where failure to provide care endangers the life of the person and it is provided according to the state of health of a person through emergency medical aid, outpatient care or inpatient care. Emergency psychiatric care must often be provided in hospital, which is why this subject is covered in this chapter.

Care provided to a person not covered by health insurance is paid for out of the funds prescribed for such a purpose in the state budget.

3.2.3. Services in Mental Hospitals and Care Homes d

At the moment, there are two psychiatric special hospitals in Estonia (AS Wismari Haigla (Wismari Hospital) and SA Ahtme Haigla (Ahtme Hospital)) but in the context of this document, also the psychiatric clinics of regional hospitals (SA Põhja-Eesti Regionaalhaigla (North Estonian Regional Hospital) and SA Tartu Ülikooli Kliinikum (Tartu University Clinics)) and the psychiatric clinic of SA Viljandi Haigla (Viljandi Hospital) are deemed to be psychiatric hospitals.

In the aforementioned institutions, both outpatient and inpatient psychiatric services are provided for children and adults pursuant to activity licences issued by the Health Care Board. Special care homes where services are provided on a 24-hour basis total 24.

3.2.4. Non-Voluntary Services

The procedures of institutionalisation will change as of 01.01.2006 (see 2.2.5). The descriptions below shall apply until 31.12.2005.

3.2.4.1. 24-hour Care with Intensified Support

The service is intended for adults with special mental needs with severe or profound disability or increased state of being dangerous to himself or herself or

others. This is deemed to be care regardless of a person's wishes (without his or her consent) in a so-called "closed" ward of a social welfare institution. Referral to the service may be conducted only on the basis of court judgments.

Operational expenditure associated with the provision of the service (including maintenance of dwellings) is paid from the state budget. The person bears housing expenses.

3.2.4.2. Involuntary Emergency 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 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 inpatient 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.

Persons in involuntary treatment shall not be subjected to clinical trials, testing of new medicinal products or treatment methods. The Health Care Board exercises supervision over involuntary treatment.

3.2.4.3. Court-ordered Coercive Psychiatric Treatment

Coercive psychiatric treatment is ordered by courts pursuant to the Penal Code. For the administration of inpatient coercive psychiatric treatment in psychiatric hospitals, ordered by the courts, a person is hospitalised in the ward of coercive psychiatric treatment of the psychiatric clinic of SA Viljandi Hospital (hereinafter "ward of coercive psychiatric treatment") and placed under supervision under the conditions, which prevent the commitment of dangerous acts. Delivery of a person for whom coercive psychiatric treatment in psychiatric hospitals has been ordered by a court, to the ward of coercive psychiatric treatment, falls under the jurisdiction of a court.

Conditions and organisation of work of regular and intensified monitoring must be ensured in the ward of coercive psychiatric treatment. Supervision over the organisation and quality of coercive psychiatric treatment is exercised by the Health Care Board.

3.2.5. Multidisciplinary Services (rehabilitation)

Rehabilitation service is a service provided with a view to favouring the ability of a person to cope independently, his or her ability of social integration and to commence work, in the framework of which:

- A rehabilitation plan with the validity of six months to three years is drafted for the person;
- Services specified in the rehabilitation plan are provided;
- The person is guided how to carry out the activities described in the rehabilitation plan.

The rehabilitation service may be provided by a self-employed person, a legal person, a local government authority or an institution administered by a government agency and which has been registered as a rehabilitation service provider in the register of economic activities.

The provider of the rehabilitation service forms a team, which comprises at least five specialists in different areas. The rehabilitation team collegially drafts in his or her presence, or if needed, the presence of his or her legal representative, a rehabilitation plan for the person.

Amongst others, persons with mental disorder, aged 16 to the age of retirement, with at least 40% loss of capacity of work have the right to be provided with the state-financed rehabilitation service.

The provision of the rehabilitation service is ensured by the Social Insurance Board.

3.3. Examples of Best Practice

Some examples of best practice concerning mental health services are given below.

3.3.1. Supported Employment – Non-profit Association Iseseisev Elu (Independent Life) [19]

NPA Iseseisev Elu was founded by four mental health specialists in Tartu in February 1997 with a purpose to promote services that improve the quality of life of people with persistent mental disorders.

The principle of the provision of the service is - as little as possible, as much as necessary.
The association has been operating for eight years now and has developed into an organisation offering three different services for more than 150 people. They have managed to create new and enhance the existing jobs, dwellings, support centres; sheltered workplaces have been created. The service of supported employment has been provided to clients since 1997. Since 2001, the association has had a possibility of providing the service of supported life in seven dwelling units. The service of supporting everyday life has been provided since 2002.

3.3.2. Day Care – SA Tartu Vaimse Tervise Hooldekeskus (Tartu Mental Health Care Centre) [20]

The foundation Tartu Vaimse Tervise Hooldekeskus (Tartu Mental Health Care Centre) is the legal successor of the institution Vaimse Tervise Hooldekeskus (Mental Health Care Centre) administered by the local government. The decision regarding the establishment of the foundation was made by Tartu city council in 2003. The Mental Health Care Centre was founded already at the beginning of the 1990s.

The target group comprises persons at their productive age with a mental disorder and elderly people. The mission of the care centre is to enable people with mental special needs to maintain or improve their ability to cope in everyday life in a way that they are successful and satisfied in the surroundings, which they have chosen and with as little professional intervention as possible.

The target group of the day care centre (day care) comprises persons with decreased memory and intellectual power and reduced handy skills, and whose families no longer manage to take care of them at home. The provision of the service is one possible solution in order to prevent their placement in care homes or homes for the aged and it exempts the family members from the obligation of

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[19] Upon the compilation of the subsection, materials from the home page of the NPA Iseseisev Elu www.iseseisev-elu.ee have been used.
[20] Upon the compilation of the subsection, materials from the home page of the Tartu Mental Health Care Centre www.tartuvthk.ee have been used.

supervision and care, which have often become mentally and physically too burdensome.

The client pays for catering expenses and transport costs for being transported to the centre and back home. Families, who cannot use their own transport for delivering the client, are provided with support by the local government. The rest of the expenses are covered out of the budget of the referring local government.

3.3.3. Haabersti Club House[21]

Haabersti Club House (with its original name Haabersti Centre of Psychosocial Rehabilitation) was founded as a municipal agency within the framework of a project of mental health, in co-operation with Canada, in Tallinn in 1996. In the district of Haabersti (45,000 inhabitants), a pilot programme was initiated, which underlined the necessity of rehabilitation services, outpatient psychiatric care and a training programme for the family members of the sick. Originally, the centre was primarily intended for the inhabitants of the district of Haabersti but now their members come from all of Tallinn. Since 2001, they operate in the framework of Tallinn Mental Health Centre. The day centre service on the basis of the Club House model is offered for people with mental disorders and who reside in Tallinn.

This is a social invention, a model of special psychosocial rehabilitation, which is spread in 28 countries. Haabersti Club House is the first of its kind in Estonia and the Baltic States.

The Club House promotes the philosophy of the Fountain House, which came into existence in New York in 1948. Mentally sick people are believed to have the right for meaningful work, supporting society, acquiring education, and a worthy possibility to rest. They are welcome to the clubhouse, where they are the most important members with their wishes, fears and dreams. The clubhouse offers the possibility of working on a daily basis in different units, transitional work on the open labour market, social counselling, a possibility of restoring his or her forgotten social skills or acquiring new ones.

The clubhouse carries four very important messages for every person who decides to join this programme. These messages – to be a member, to be welcome, to be wanted and to be needed – form the core and the most important part of the clubhouse.

The programme of the clubhouse model consist of the following parts: pre-vocational day programme, programme of transitional work, evening and week-end programmes (7 days a week), residential space programme, feedback programme, saving shop programme, clubhouse's newspapers, clubhouse's name, counselling

[21] In the compilation of the subsection, materials from the home page of Haabersti Club House www.hot.ee/vaimsetervisetugigrupid/TallinnHaabersti.html have been used.

and health, assessment and responsibility. Haabersti Club House has 80 members; its daily number of guests totals 25 – 30.

All over the world, clubhouses form an integrated network in the continuous co-operation of the members of which – clubhouses operating all over the world – the model of the clubhouse is developing and improving. Haabersti Club House has been a member of the International Development Centre since 1998.

3.3.4. DBSA Tallinn City Youth Support Group

The youth support group was established with a view to offer human support especially to young people with the experience of first psychosis. The support group aims at growing positive faith and hope in the youth that full recovery is possible. The group leader has a long-term experience of being sick.

The group has also its own professional counsellors. The main rule of the youth support group is: "All that we talk about here will remain between us!" The group works on the basis of a model that has been elaborated by an association Depression and Bipolar Support Alliance (DBSA), which operates in America.

The five main rules of the DBSA are: trustfulness, kindness and support, complaisance, right of participation, and counselling.

The group consists of twelve people and meets on a regular basis once a week (on Wednesdays), and the session lasts for 2 hours. Participation is free of charge for the members of the group. Since January 2005, the Youth Support Group has been officially recognised as a full and equal member of the association, and the group operates in Estonia as the first self-aid group, which follows the model of the DBSA.

3.3.5. Psychiatric Care Closer to Patients, Taking OÜ Jaanson & Lääne as an Example

OÜ Jaanson & Lääne provides psychiatric services at seven different locations: in Elva, Otepää, Tartu, Tõrva, Valga, Võru and Põlva. According to the psychiatrists, who work at the private limited company, they could be compared to family physicians, located as near as possible to their patients. This is the provision of specialised medical care outside the centres.

From Tartu, they introduced the service to other regions in 2003. The reason being that there were very few psychiatrists in the region in question, which impaired the availability of care. This, in turn, gave rise to more frequent need for hospitalisation. At the present moment, there is also a lack of professionals in regions, however, the service of psychiatric care is more available.

PLC Jaanson & Lääne has approximately 8,000 patients; about 15-16,000 home calls are made per year. The care homes of Erastvere, Paju, Valga and Kodijärve, where clients with persistent and severe mental disorders live are located within the area. Regarding diagnoses, all mental disorders are represented, however, depressive and depressive anxiety disorders occur to be prevalent, but there are also a lot of patients with psychotic disorders.

Psychiatrists and psychologists are employed at the OÜ Jaanson & Lääne. Rehabilitation service is not provided but co-operation with family physicians, social workers and local hospitals is close and is improving each year.

3.3.6. Psychiatric Day Care Service in the Psychiatric Clinic of SA Pärnu Haigla (SA Pärnu Hospital)

The specificness of the psychiatric clinic of SA Pärnu Hospital is the use of the techniques of integrative psychiatry. The clinic comprises the following units:

- An inpatient unit, acute ward, general ward and depression ward;
- Outpatient unit - consultations of psychiatrists, (including a children's psychiatrist) - a two-bed inpatient day unit for drug addicts, psychologists' consultations;
- Inpatient day unit;
- Rehabilitation unit.

Psychiatric care, provided as a day service, is particularly suitable for patients with certain disorders, such as psychotic and eating disorders. Such care helps to decrease the necessity for hospital beds without lowering the quality. This form of care is also suitable for the reason that patients can continue living in a rhythm as similar to the usual one as possible and do not have to spend the night in hospital.

3.4. Financing of Mental Health[22]

This chapter covers the financing of mental health, whereas a more detailed description is given regarding costs on the benefits of health care services, drug reimbursement and expenses on welfare services.

94% of the whole population of Estonia is covered by health insurance, which is administered by the Estonian Health Insurance Fund (hereinafter health insurance fund).

The resources for health insurance are collected from all the regions of the health insurance fund into an integrated budget. The resources are allocated back to the regions according to the number of the insured in the region, which means that the availability of resources is ensured also in poorer regions. The allocation of resources to medical institutions and specialities is conducted on the basis of the historical use of health service (also regions of insurance and providers are compared) and the waiting list.

This chapter does not cover amounts spent on first aid, emergency care, prevention and promotion. Expenses related to incapacity for work in the case of mental disorders may be significantly high but this subject is not treated in this chapter. The payments of temporary incapacity of work come from the health insurance budget but they are not directly associated with the diagnosis of a person, which would help to differentiate disease contraction due to mental disorders and thereby absence from work and the expenses of the benefits payable. Neither are long-term incapacity for work and disability – a part of the social security system – thoroughly treated in this chapter.

Additionally, the overview does not cover the persons' expenditure for consulting privately outside the health insurance system, such as addressing a private physician or psychologist, and neither are assessed the expenses on medicinal products not subject to medical prescription and medicinal products subject to discount.

3.4.1. Benefits of Health Care Services

The procedure of payment for health care services is further specified by the Health Insurance Act and other legislation established on the basis of this act. The total budget of health insurance in 2005 is 6,749 million kroons, whereas 4,683 million kroons (69% of the budget of health insurance benefit) is prescribed for health care services in the budget; 893 million kroons (13% of the budget of health insurance benefit) is prescribed for medicinal products and 1,248 million kroons (18,5% of the budget of health insurance benefit) for temporary incapacity for work . The expenses of the health insurance benefits have significantly increased over the

[22] The chapter is based on "Financing of mental health in Estonia" (2003) published by Triin Habicht and Maie Thetloff ; the text for this document has been adapted and edited by Aive Sarjas.

years but at the same time benefits for medicinal products have increased the most (by more than six times in 1996-2005).

The financing of the providers of health care services, out of the budget of health insurance benefits, is conducted through the contracts for financing medical treatment. The contracts for financing medical treatment are entered into with the service providers by the Health Insurance Fund. The contract lays down the volume of the resources obtained from the budget of health insurance for the next year and, additionally, the cost of an average case of treatment and the number of the cases of treatment by specialities are agreed upon. Payment for each case of treatment is executed by electronic means, on the basis of submitted invoices. The services provided to the patient, on the basis of the practice list of health care services, prescribing the maximum fees chargeable, are specified on the invoice for treatment.

The list of health care services comprises different forms of payment, such as examinations, inpatient days, (by different specialities), complex fees, outpatient visits, etc. The total number of different positions on the practice list is ca 1,800. The Health Insurance Fund takes over the obligation to pay a fee only for the persons who are covered with health insurance and only within the scope of the services that are specified on the list of health care services.

An important change, as of the end of 2002, has been the provision of the extent of cost sharing by an insured person, stipulated by the Health Insurance Act. Since the Act specifies the possibilities for visit fees and inpatient fees, several medical institutions have used this possibility with the view to acquiring additional resources. In 2005, the maximum rate of visiting a medical specialist is 50 kroons and that of the inpatient fee – 25 kroons per day for up to ten consecutive days in the event of one treatment case. The amount of the cash flow to psychiatric care, added as a result of this, has not been assessed, since institutions have used the possibilities in different ways.

The persons who are not covered by health insurance must pay themselves for the health care services provided for them. Payment of the treatment costs of the persons, who are not covered by health insurance, is theoretically possible but is decided by each local government. The expenses of the emergency care of persons, not covered by health insurance, are covered from the state budget.

3.4.1.1. Primary Health Care

In Estonia, the primary health care is financed on the basis of a system of capitation fees, which is combined with other fees. The other fees are:

Basic funds intended for the procurement of equipment necessary for a family physician's work and for training;
Additional distance fee, if the nearest family physician's practice is located at the distance of 40 km;
Additional fee, to the extent of 18,4% of the capitation fee, for the conduction of analyses and procedures not included in the capitation fee.

Therefore, family physicians do not receive separate additional payments for the services referred to psychiatric care, instead, they are financed on the basis of the aforementioned fees. Due to the financing system, the treatment costs of mental disorders within the primary health care system, can only be referred to on an estimated basis – pursuant to the ICD-10 (international classification of diseases), the number of the consultations of patients with the F00-F99 diagnosis and the average consultation cost. The average consultation cost of a family physician in 2002 was 88 kroons, which was obtained by dividing the total expenditure of the primary health care (except for the benefit for analyses) with the number of all consultations. According to this calculation, the consultation costs of primary health care of patients with mental disorders totalled approximately 9 million kroons. The average consultation cost, per one person covered by health insurance, varies by the regions of the Health Insurance Fund and may thus vary by approximately 2.5 times. The expenditure on the primary health care of mental disorders amongst the persons of the department of Ida-Viru County, who are covered by health insurance is conspicuously low – 3.7 kroons per one insured person. The highest expenses were in the regions of Pärnu and Rakvere (9.3 and 9.2 kroons per one insured person, respectively).

The majority of expenses (nearly 80%) of the primary health care (or family physicians) are associated with the treatment cases belonging to the diagnosis groups of F3 (mood disorders, 38 kroons per a person who has attended the consultation) and F4 (neurotic disorders associated with stress and somatoform disorders, 41 kroons per a person who has attended the consultation). The percentage of the rest of the disease groups, at primary health care level, is significantly lower (F2 – schizophrenia, schizotypic and delusional disorders – 5 kroons per a person who has attended the consultation).

3.4.1.2. Specialised Medical Care

Persons Covered by Health Insurance

In the psychiatric specialised medical care, the providers of inpatient services is providers are paid mainly on the basis of the days of inpatient care.

A change concerning inpatient fees occurred at the beginning of 2003 when the maximum allowed number of days of inpatient medical treatment (i.e. the number of days in the limit of which the Health Insurance Fund takes on the obligation to pay the fee) was reduced, and, at the same time, the service of the days of inpatient medical treatment of acute psychiatry, was introduced. The maximum fees chargeable for both services increased in comparison with the earlier ones. Currently, the main possibility for paying for inpatient medical treatment is the hospital day of inpatient medical psychiatric care, in the case of which, the maximum number allowed for the days of inpatient medical treatment is 20 (previously 35 days) and the maximum fee chargeable is 674 kroons. In the event of acute psychiatry, used in the event of involuntary treatment, payment for up to 14 days is allowed whereas the fee chargeable for one day of inpatient medical

treatment is 872 kroons[23]. Such amendment on the list of health care services has been introduced with a view to making the service providers treat patients with less severe disease conditions rather on an outpatient basis and hospitalise mainly those patients with more severe conditions (that gives rise to the increase of the average fee per day).

In outpatient psychiatry, the main form of payment for the provider of the health care service is a visit (consultation) fee. The consultation of a psychiatrist (price – 149 kroons), the consultation of a psychologist (price – 121 kroons) and the consultation of a team of psychiatric care (price – 178 kroons) are specified in the list of health care services. The latter was added as a new service in 2003 and this refers to a consultation by two specialists, giving an additional possibility for the psychiatric care to be improved.

The expenses of specialised medical care for the treatment of people with mental disorders can be assessed in two ways: considering the medical treatment expenses of persons with F-diagnosis (notwithstanding the speciality of the specialist who has provided the invoice of the respective main diagnosis) or those of the speciality of psychiatry (it may also comprise patients with different main diagnoses). The medical treatment expenses are mainly (99%) associated with the treatment cases, in the event of which the main diagnosis is a psychiatric disorder. The cost of the speciality of psychiatry per one person covered by health insurance varied a lot in different regions of Estonia in 2002. It was the lowest in Ida-Viru county (3.7 kroons), 11% of which was outpatient specialised medical care. In all other regions, the proportion of outpatient specialised medical care was more than 10% higher, forming 21-23% of total costs.

Observing expenses on cases of treatment, where the main diagnosis falls under mental disorders (F00 – F99), allows a more detailed coverage of mental disorders, which involve different specialities. The cases of treatment where the main diagnosis is a mental disorder have been taken into consideration. Regarding the treatment expenses of mental disorders, 87% were covered from the contractual volumes of psychiatry, 4% from these of paediatrics, 3% of therapy, 2% of neurology and the rest of 4% - from the contractual volumes of other specialities.

In 2003, the total costs of the whole of outpatient specialised medical care amounted 794 million kroons, 4.4% of which was the medical treatment of mental disorders. The total costs of the whole of inpatient specialised medical care amounted 1,915 million kroons and 4% thereof was spent on the treatment of mental diseases. In 2003, the amount, which was spent on the cases of treatment with F-diagnosis totalled 121 million kroons, including 30 million on outpatient treatment, which forms 25% of the expenses of specialised medical care. The comparison of different regions shows that the percentage of outpatient medical care is significantly lower in Ida-Viru county than in the other regions. At the same time, the expenses of inpatient care are the highest in Ida-Viru county.

[23] List of health care services, www.haigekassa.ee

The expenses of outpatient and inpatient specialised medical care can also be presented according to different mental disorders. The highest outpatient expenses are associated with group F4 (neurotic, stress related and somatoform disorders), forming a quarter of the outpatient expenses of medical treatment of mental disorders. The second highest outpatient expenses are associated with diagnoses groups F3 (mood disorders) and F2 (schizophrenia, schizotypic and delusional disorders). The highest expenses of inpatient medical treatment (41%) are associated with the diagnosis group F2 (schizophrenia, schizotypic and delusional disorders). Regarding inpatient medical treatment expenses, 17% are associated with diagnosis group F3 (mood disorders) and 15% - with group F0 (organic mental disorders).

Persons Not Covered by Insurance

Since 2002, it has been possible to observe the medical treatment expenses of specialised medical care of persons not covered by insurance, through the database of the Health Insurance Fund. In 2002, the treatment expenses of persons, not covered by insurance, totalled 61 million kroons, with 2.5 million (i.e. 4%) being the treatment expenses of mental disorders. The percentage of outpatient care, regarding the treatment expenses of mental disorders of persons not covered by insurance, was low, constituting only 5%.

Expenses per persons not covered by health insurance totalled 165 kroons, in the case of outpatient specialised medical care, and 3024 kroons in inpatient care. Concerning insured persons, these amounts totalled 376 and 8,738 kroons, respectively. A multiple difference proceeds from the fact that the persons not covered by health insurance are only provided with emergency care.

The majority of the persons not covered by insurance and the biggest portion of the money are related to the treatment of mental disorders caused by the use of psychoactive substances, for which 44% of the money of inpatient care (in the case of insured persons, the percentage was only 7%) and 54% of the money of outpatient emergency care (in the case of persons covered by insurance the respective percentage totalled only 17%) is spent. 36% of the inpatient treatment expenses is spent on the treatment of schizophrenia, schizotypic and delusional disorders (in the case of persons covered by insurance, the respective percentage was 41%).

3.4.1.3. Long-term Care

In addition to specialised medical care, there is another extremely important type of medical care – long-term nursing care – the importance of which is growing in Estonia. In 2002 the long-term nursing care budget formed ca 2% of the budget of specialised medical care. 2.3 million EEK was spent on the long-term nursing care of patients with mental disorders, which is approximately 2% of the expenses of specialised medical care spent on mental disorders. The distribution of treatment expenses between the regions of health insurance is extremely uneven, being the highest, 3.6 EEK per one insured person, in Tartu region and the lowest, 0.7 EEK, in the Ida-Viru region. The difference is five-fold and is probably caused by the fact

that the service of long-term care has been financed in the case of a very small number of people.
In the same way, the treatment expenses of patients, in different regions, are also very distinguished – 22.5 thousand EEK in the Tartu region and 2.5 thousand in the Western region (here the difference is already nine-fold). Here, consideration should be given to the fact that the possibilities of long-term care differ by regions.

More than 70% of the people, who have been provided with long-term nursing care, are older than 65 years of age and therefore it is completely probable that the main part of treatment expenses (i.e. 59%) is associated with the treatment of organic mental disorders. As to the expenses, the second significant disease group comprises schizophrenia, schizotypic and delusional disorders, utilising 30% of the expenses of long-term nursing care.

3.4.2. Compensations for Medicinal Products

Reimbursement of medicinal products in Estonia has been organised through the list of medicinal products subjected to discount, to which the rates of 50%, 75%, 90% and 100% may apply. The Health Insurance Fund only compensates for the medicinal products if the relevant preparation has been entered into the list of compensated medicinal products together with the rate of discount. There are separate lists for medicinal products with the discount of 75% and 100%, which include the descriptions of disease condition, medicinal product and the persons who have the right to issue the relevant prescription. In the case of most diagnoses of mental and behavioural disorders, the permitted discount rate is 100%, i.e. the cost sharing by a patient is 20 EEK and the remaining part is covered by health insurance. There is a restriction according to which only psychiatrists and, in the case of some medicinal products, neurologists are qualified to prescribe medicinal products subjected to a 100% discount.

The calculation of the expenses of medicinal products subjected to discount and used in the case of mental disorders out of the health insurance resources is based on the benefits of psychotropic medicinal products bought on the basis of a prescription by patients with mental disorders (diagnosis F00-F99). Medicinal products, not compensated from health insurance resources, have not been taken into consideration. In 2002, the respective amount of benefits totalled 33.6 million EEK, mainly formed by 100% and 50% benefits and to a lesser extent also 75% and 90% benefits. In total, this is nearly 4% of the amounts of all the benefits for medicinal products in 2002.

Medicinal products prescribed by family physicians in the event of mental disorders have been compensated in the amount of 10 million EEK, which forms 30% of the total costs of the benefits of medicinal products for mental disorders.

Accordingly, the health insurance expenses based on the division of the ICD-10 (classification of benefits for medicinal products), more resources have been spent on benefits for medicinal products for schizophrenia, schizotypic and delusional disorders and mood disorders. The expenses of the two disease groups form

together nearly 74% of the total volume of the benefits for medicinal products. A different rate of total cost-sharing can be observed according to separate disease conditions, varying from 14% in the case of schizophrenia, schizotypic and delusional disorders to 70% in the case of eating disorders, sleeping disorders, and sexual dysfunctions.
Most of the persons' cost-sharing payments, for medicinal products of psychiatric care, is used for the treatment of mood disorders, forming 57% of the total amount of cost sharing. While considering both the health insurance expenses and the cost sharing, it becomes evident that 87% of the funds are allocated for the treatment of three disease groups (F2, F3 and F4).

3.4.3. Financing of Social Servises

In Estonia, social services are financed from the state budget, the budgets of local governments and by households. Services intended for adults of productive age, with special mental needs, primarily for clients with a severe and long-term mental disorder (including those with mental disability) are financed from the state budget through the Ministry of Social Affairs and Social Insurance Board – an agency administered by the Ministry of Social Affairs. Services intended for children with severe mental disability are also largely financed from the state budget but also through county governments and the Social Insurance Board.

Clients with less severe mental disorders use general public services (including social services, which are intended for the entire population), for which, as a rule, payments are made from the rural municipality budgets or city budgets.

Almost all the services that are intended for persons with special mental needs pre-necessitate the payment out of the households' expenses. The grounds for this is provided by the Social Welfare Act according to which a fee, which depends on the extent and cost of the service and the financial situation of the person and family receiving the service, may be collected from a person for the social services provided. The prices of social services are determined by the agency, which provides the service or pays for the service.

In the state budget of 2005, 150.6 million kroons has been planned for the welfare services of people with special mental needs; 117.5 million of it as allocations (to county governments) and 33.1 million as returns from economic activities (from the clients' contributions).

In the state budget of 2005, 21.7 million kroons has been planned to be allocated to the budget of the Ministry of Social Affairs for the rehabilitation of people with special mental needs (including people with mental disorders).

The funds allocated for state-provided social welfare of people with special mental needs, are used to compensate for the expenses of such welfare services, which also meet the established requirements. The expense of a social welfare service is compensated for on the basis of the established rate and unit of account.

Table 3. Rates for the compensation of the expenses of state social services of people with special mental needs 2005

Service	Unit of account	Value in kroons
Supporting everyday life	per person per month	850.–
Supported living	per person per month	1300.–
Living in community	per person per month	2450.–
Supported employment	per person per month	735.–
24-hour care	per person per month	3130.–
24-hour care with intensified support	per person per month	5050.–
24-hour care with intensified monitoring	per person per month	4350.–

Source: Riigi Teataja (State Gazette)

In the case of 24-hour care, a county governor establishes the limits for the value of the expenses on accommodation and catering.

Resources are allocated on the basis of the actual number of people in a county as of 1 January 2005 with a view to compensating for the expenses of the services of people with special mental needs. The county governor allocates the resources for the compensation of the expenses to the service provider and, in order to compensate for the expenses, enters into a contract with a legal person governed by private law or a local government authority.

3.4.4. Expenses of Self-aid Groups and Organisations

It is not possible to assess the expenses of self-aid groups and organisations, since their financing sources are unstable, their activities are mainly project-based and no statistical data thereof is collected.

3.5. Quality Monitoring and Appealing Systems

3.5.1. Health Care Services[24]

Quality requirements for health care services were specified in the Health Services Organisation Act adopted in 2001. Pursuant to this Act, the Minister of Social Affairs establishes the requirements for the quality and availability of health care services. Additionally, the minimum requirements for health care professionals and providers of health care services were established. All health care professionals and providers of health care services were given three years (i.e. until 31 December 2004) to bring their activities into conformity with the requirements in force.

Pursuant to the Health Services Organisation Act, all health service providers are persons governed by private law (both legal and natural persons), and this has given rise to additional requirements for the development of the quality of management.

The assurance of the quality of health care services may be divided into three spheres:

- The assurance of the quality of the structure, i.e. requirements set for service providers (people, buildings, premises, equipment) is mostly provided by legislation;
- The assurance of the quality of process, i.e. requirements set for the method of the provision of services (diagnostics, medical treatment, nursing activities, rehabilitation, prevention) is mostly regulated by instructions and observance of good practice. Legislation is seldom implemented in the assurance of the quality of the process;
- The quality of the results is generally not stipulated by legislation. The quality of the results in health care services is mostly provided for in the agreements between a health care service provider and a buyer.

The Minister of Social Affairs has issued, on the basis and for the implementation of the Act, the following quality assuring regulations essential in the context of mental health.

Supervision over compliance with the requirements imposed on health care providers in the Health Services Organisation Act is exercised by county governors and officials authorised therefor. A county governor exercises supervision over the activities of family physicians practising in the county on the basis of practice lists of the family physicians. Supervision over the activities of family physicians, providers of emergency medical care, providers of specialised medical care and independent providers of nursing is exercised by the officials of the Health Care

[24] Upon the compilation of the subsection, the document "Assurance of health care services in Estonia", (2005) issued by the Ministry of Social Affairs has been used, www.sm.ee

Board authorised therefor. The Minister of Social Affairs exercises supervision over health care services provided in prisons.

A permanent expert advisory committee, the activities of which are aimed at giving an independent expert assessment with regard to the quality of health care services provided for patients, has been formed at the Health Care board on the basis of a regulation of the Minister of Social Affairs.

The possibility and procedure of obtaining a second opinion is provided for in the Health Insurance Act, pursuant to which the health insurance fund makes a one-time payment for the expenses related to obtaining a second opinion (also in case if addressing to a foreign country is needed for the second opinion to be obtained).

3.5.2. Social Services

Requirements set for social services, and social service providers, must be stipulated by law, unless otherwise legally provided. So far, the requirements for the providers and the provision of several services (e.g. social services intended for people with special mental needs) have been established by a regulation of the Minister of Social Affairs but since the Social Welfare Act fails to provide a direct authorisation form for the Minister of Social Affairs and since the Chancellor of Justice has also pointed out the respective inconsistency, the Ministry of Social Affairs is preparing the Social Welfare Act Amendment Act for autumn 2005.

The rehabilitation service is the only service in the context of mental health, the requirements for which are established by the Social Welfare Act (see 3.2.4).

There is no universal system for the resolution of appeals regarding social services. At the same time, there are different institutions which can be addressed by clients or their representatives in case of dissatisfaction. A person who finds that his or her rights are violated, or his or her freedoms are restricted in the course of administrative proceedings executed by the rehabilitation service provider or by an administrative act, has the right to file a challenge with the state dispute committee formed at the Social Welfare Board pursuant to the State Pension Insurance Act, within thirty days as of the day when a person becomes or should become aware of the challenged measure or administrative act.

In the case of other social services, if the client is not satisfied with the service provided, he or she has the right to address the county governor in whose administrative jurisdiction the respective service was provided. Pursuant to the Social Welfare Act, the county governor, or a person authorised by him or her, is required to monitor the quality of the social services, emergency social assistance and other assistance provided within his or her administrative area and exercise supervision over the use of financial resources for intended purposes allocated by the state for social welfare services. A corresponding written report shall be submitted to the Government of the Republic at least once a year.

If deficiencies become evident as the result of the review of a complaint, a county governor may propose that the deficiencies be eliminated by the service provider. The Minister of Social Affairs exercises professional supervision over the services provided in prison.

In the case where a competent organisation dealing with points of dispute cannot be ascertained, the client may have recourse to an administrative court to protect his or her rights.

4. Users of Mental Health Service

4.1. Main User Groups[25]

Exact state statistics concerning the occurrence and prevalence of mental disorders and the people with special mental needs and the number thereof is not kept in Estonia (likewise in many other countries). Therefore, the formation of a general background may be based on more or less accurate data found from different sources, as well as derived data. A possible selection with the corresponding content is given in the following table.

Table 4. Possible number of people with mental disorders in Estonia

	Indicator	**Number**
1.	Number of people who have consulted a psychiatrist	~ 35 000
2.	Cases of incidences of schizophrenia per year	400-500
3.	Annual number of persons declared disabled on the basis of mental and behavioural disorders	900-1100
4.	Total of disabled persons with mental and behavioural disorders	~ 6 500
5.	Referred to 24-hour care in care homes per year	150-250

The numbers concerning the incidences (rows 1-3; total of incidences, incidence of schizophrenia, declaration of disability) given in the table may be considered relatively exact, since certain national data thereof is gathered and systemised. The total number of disabled persons with mental and behavioural disorders (row 4) has been derived from the overall statistics of the state pension insurance, which is why it is certainly a rough estimation. The number of the people who have been referred to a care home for 24-hour care (row 5) is based on the welfare register but given the current practice of referral to care, it should only be taken as a benchmark.

The number given in the first row of the table is slightly bigger than the total number of the first-time outpatient psychiatric patients given above, since it contains also cases of simply consulting a psychiatrist (e.g. upon application for a weapons permit), which in most cases are not driven by a diagnosed mental disorder. Nevertheless, all the people who have been diagnosed with a mental

[25] The chapter is taken from the handbook "Welfare services for people with special mental needs in Estonia". V. Paavel, J. Kõrgesaar, A. Sarjas, S. Sõmer. V. Vasar. (2000/2001)

disorder cannot be classified as persons with special mental needs, as the disorders of the majority of them are relatively mild or short-term (transient).

There is a reason for persons with special needs, caused by severe and/or persistent mental disorder, to be treated as people with special mental needs. Given Estonia's current practice, including the criteria of affiliation to disability groups (and determination of the degree of severity of disability – *A. Sarjas*), the number of the persons who have been declared to belong to a certain group of disability on the basis of mental or behavioural disorders (or to whom a degree of severity of a certain disability has been determined – *A. Sarjas*) could be considered the reference figures of this group. Thus, the number of people with special mental needs ranges with great probability from 6,000 – 7,000 in Estonia. It is possible that the current third disability group could be interpreted as a more problematic one, to some extent, but even if they were excluded, the respective group would still comprise approximately 5,000 people.

These, no less than 5,000 persons are those who, according to the disability classification system, will be diagnosed, with high probability, with either severe or profound disability, which, according to the stipulations of the Social Benefits for Disabled Persons Act, means that a person needs personal assistance, guidance or supervision on a daily basis. According to the table, at least 700 people of whom 60 – 70% are at their productive age, are added to this group each year, pursuant to derived data.

The assessment (determination) of the existence of a special need and the nature (content) thereof belongs primarily and altogether to the field of professional expert assessment. The main problem thereat is which problem it is:

- Is it one or are there several specialities?
- If one, then which speciality?
- If several, then which specialities?

According to the current practice of Estonia, the determination of disability (and the special needs conditional thereupon) has belonged to the sphere of medical assessment. Unfortunately, given the bio-psycho-social nature of a person, it must be considered one-sided, since there is no way clinical and medical competence could cover all the spheres of life and activities of a person, in an adequate manner. Assessing adequately a person's condition and the special need resulting therefrom is only possible in an interdisciplinary approach.

4.2. Morbidity

Incidence of mental disorders has been continuously increasing and despite obvious decrease in the population, the necessity for psychiatric services, especially with regard to mood and anxiety disorders, has been continuously increasing over the past ten years. The frequency of severe mental disorders, such as alcohol psychoses and delirium tremens and the prevalence of drug addiction, which are caused by alcohol and need emergency inpatient care, have increased. Presuming that the socio-economic situation will improve in Estonia, the stabilisation of the incidence rate within the next 10 years may be predicted, to which the slowdown of the coefficient of the increase of incidents and the increase in the suicide coefficient over the last years also refers.

The number of hospitalisations has been continuously increasing, probably partly on the account of repeated hospitalisations. The frequency of alcohol-caused psychotic disorders, as well as the frequency of severe depressions, has increased[26].

In 1992-1996, children under 14 years of age committed as many suicides in Estonia as during the previous 20 years. Suicide is the main cause of death among young people aged 15-29 in Estonia. Men commit more suicides than women do and more suicides are committed in the country than in towns. According to expert assessments, the number of suicide attempts is 10-30 times bigger than the number of suicides, and the ratio of suicidal intentions against suicides is 200-folded. Suicides are associated with incurable depression, alcoholism and also with the learned helplessness syndrome. Alcohol consumption is considered a natural means for alleviation of stress and relaxation. The consumption of alcohol and narcotic drugs has become a part of the youth culture and recreational activities[27].

[26] The report of the Speciality Committee of Psychiatry on the problems of the speciality as of 2004. (2005).

[27] Source document of the mental health policy, www.praxis.ee

4.3. Self-aid Groups and Organisations

There are few non-governmental organisations constituted by people with mental disorders or in the support thereof, which is why the role of self-aid groups in influencing the policy of mental health has not been very big. Similarly to the trends in the rest of the world, the organisations, the activity of which is aimed at mentally handicapped people, started to develop earlier in time also in Estonia.

The umbrella organisation of people with mental disability and their support organisations is the Eesti Vaimupuudega Inimeste Tugiliit (EVPIT) (Estonian Mentally Disabled People Support Organisation (EMDPSO)), which has 22 membership organisations (see 1.2.4).

The number of self-aid groups and mental health support groups, created by people with mental disorders, is small and they are concentrated in bigger cities (see 1.2.4).

4.3.1. Patients Advocacy, Protection of Human Rights and Legal Assistance of Service Users [28]

In 1994, the Psühhiaatriliste Patsientide Esindusühing (PPE) (Psychiatric Patients' Advocacy Association (PPAA)) was registered as a non-profit association. The field of activities of the association has extended by now. In addition to patients with mental disorders, other users of health care and welfare services are also advocated. The association is called the Eesti Patsientide Esindusühing (EPE) (Estonian Patients' Advocacy Association (EPAA)) and the objective of its activities is to help the people who are using medical treatment and welfare services to enjoy the rights provided for in the Constitution and by other legislation. The association has four offices – in Tallinn, Tartu, Pärnu and Viljandi (see also 1.2.4).

The number of client cases is associated with the number of the offices of the EPAA and the financing volume. In 1994, the number of client cases was 254 and that of the clients was 188; in 2004 the respective figures were 1,800 and 2,350. Approximately 30% of the serviced clients and cases are connected with mental disorders.

Employees of the EPAA work independently from health care institutions, helping their clients to find the best solutions, considering the rights necessities, the best solution. The EPAA informs the patients of their rights and helps the clients who have addressed the association to exercise their rights. Systematic work – raising the problems occurring in agencies providing welfare and health cares services and contribution to solutions – holds an important place in the activities of the EPAA.

[28] The materials published on the homepage of the EPAA, www.epey.ee have been used in the compilation of the subsection.

The activities of the EPAA in the provision of the patient advocating service have been financed from the state budget and regulated on the basis of the contracts entered into with the Ministry of Social Affairs in 1995-2002. In 2003, the service was funded by the Gambling Tax Council out of the funds collected pursuant to the Gambling Tax Act (also from the state budget) and in 2004, the service of patients' advocacy was partly financed through the budget of the Ministry of Social Affairs.

In the framework of the project of legal aid, "Equality for everybody", which was financed in 2000 by the Open Society Institute, SA Õigusteenuste Büroo (Bureau of Legal Services) was founded in Tallinn. Clients are offered help by three full-time lawyers and the bureau provides services for a very low service charge.

Nevertheless, providing the least privileged, often also comprising people with mental disorders, with legal aid free of charge, is a problem. The EPAA is carrying out lobby-work with the aim to solve this. In addition to the provision of the state legal aid, The State Legal Aid Act also regulates the support of the non-profit legal persons, which provide legal services. It means that associations providing persons with legal aid free of charge are also supported from the state budget. Within the limits of the funds prescribed in the state budget, the state supports non-profit associations or foundations entered in the list of non-profit associations and foundations benefiting from income tax incentives or deemed to be equal thereto if their activities are important to improve the accessibility of general legal counselling and they can ensure the grant of quality legal aid to persons requiring help.

5. Human Resources – Existence and Need

5.1. Health Care Specialists [29]

Training of health cares specialists in conformity with contemporary requirements is the precondition for ensuring the competence of health care service providers. In Estonia, the training of doctors and dentists is carried out in the Faculty of Medicine of the University of Tartu. The requirements for health care professionals are provided for in legislation. The standard for higher education applies to all levels and forms of study in higher education, regardless of the legal status of the institution of higher education. The training of nurses is regulated by the Institutions of Professional Higher Education Act.

Pursuant to the Universities Act, medical and dentistry training is instruction based on the integrated curricula of Bachelor's and Master's studies. The standard period of medical training is six and the standard period of dentistry training is five years. The clinical instruction of medical training is carried out at Tartu University Hospital; medical training and dentistry training is followed by residency in a medical or dentistry speciality with a duration of three to five years. The standard period of study in obstetrics is 4.5 years and the standard period of nursing training is 3.5 years, upon supplementary specialisation, 4.5 years. In 1997, the curricula of medical science and dentistry of the faculty of medicine and in 1996, the curricula of nurses and obstetrics were brought into conformity with the EU directives regulating the study content.

A working group, called together by the Ministry of Social Affairs, worked out - The Principles of Professional Training of Nurses in 2003.

The Health Care Board, as the representative of the state, grants a health care professional the right to provide health services in a speciality set out in the document certifying his or her qualifications and the certificate issued upon registration. Registration is based on the regulations, which take into account the basic training of health care professionals, proficiency in their speciality, their evaluation and work experience in order to ensure the entry of only qualified specialists in the register. The list of specialities has been approved by a regulation of the Minister of Social Affairs.

Pursuant to the Health Care Services Organisation Act doctors, dentists, nurses and obstetricians are health care professionals. The qualification requirements of the representatives of all other professions are provided for in the Professions Act. The Estonian Qualification Authority, one of the purposes of which is also the development of the professional standards of the specialists who work in the health care system (e.g. physiotherapists, speech therapists, optometrists), has been established on the basis of the Professions Act.

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[29] Upon the compilation of the subsection, the document, "Assurance of the quality of health care services in Estonia", has been used. (2005)

In order to ensure structure and quality, the principles of the assessment of the competence of health care workers have been worked out. The state authorised speciality and professional associations to carry out periodic assessment of the competency of health care professionals, as of 1 January 2002. In 2002, The Principles And System Of The Assessment Of Competency Of Medical Specialists and in 2003, The Principles And System Of The Assessment Of The Competency Of Nurses And Obstetricians were elaborated. Competence assessment is voluntary for health care professionals.

The assessment of the competence of medical specialists is arranged by professional associations. By the end of 2004, the certification of the Estonian Association of Psychiatrists had not yet been arranged. The assessment of the competence of nurses is arranged by the Estonian Nurses Union.

Based on optimal workload standards and the model of the prediction of the training of health care professionals, worked out in the Ministry of Social Affairs, the optimal number of psychiatrists in 2015 should be 260. The model takes into account the need for doctors, the working time, training sessions, vacations, the number of patients of doctors, the number of incidences, the age, potential migration of currently working doctors, and other relevant indicators. The Ministry of Social Affairs submits a government order for the admission of at least eight psychiatry residents (including one resident of children's psychiatry).

In the opinion of the Association of Psychiatrists the need for psychiatrists is the following:

- Need for outpatient psychiatrists – 1 psychiatrist per 10,000 inhabitants;
- Children's psychiatrists – 1 child psychiatrist per 40,000 inhabitants;
- Inpatient work – the number of psychiatrists depends on the number of beds and shift circles (90-100 psychiatrists);
- Other fields – education and research, forensic psychiatry, prison psychiatry (5-10 psychiatrists).

Specification of the need for psychiatry nurses, clinical psychologists, speech therapists and other specialists is necessary[30].

According to the prediction of the Estonian Nurses Union, the necessity for nursing staff for 2005 is 750, for 2010 - 900 and for 2015 – 1,200 nurses.[31]

213 psychiatrists and 278 psychiatric nurses have been entered in the Register of Health Care Professionals of the Health Care Board as of 14.05.2005 .

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[30] Report of the Speciality Committee of Psychiatry on the problems of the speciality as of 2004 (2005).

[31] Development plan of nursing 2002-2015, www.ena.ee

5.2. Social Care Specialists

Training is provided for social work specialists both at academic institutions of higher education (University of Tartu, University of Tallinn), institutions of professional higher education (Pärnu College of Tartu University, Lääne-Virumaa Higher Vocational School, Tallinn Pedagogical College) and in vocational educational institutions. As in the case of health care professionals, the Standard of Higher Education, established by the Government of the Republic, determines the general requirements of higher education. The Standard of Higher Education applies to all levels and forms of instruction in the higher education regardless of the legal status of an educational institution. The training of some social work specialists (e.g. teachers in social pedagogy) is regulated by the Institutions of Professional Higher Education Act .

Tallinn Open Care Development Centre operates as an organisation awarding professions.

While observing the employees of special social welfare institutions by their speciality, sex and age in 1998-2001, we see that the total number of employees has dropped from 1,344 to 1,200. By the end of 2003, the number of employees had decreased to 969, consequently, it had decreased by nearly 28% in comparison with 1998. At the same time, it may have been caused by the increase in the extent of non-institutional services (it is not possible to read from statistical reports to which extent they reflect these services).

The majority of employees are women whose average age is constantly increasing. While the number of employees, older than 60, was 17 in 1998, then by the end of 2002, the respective number amounted already to 189.

According to service providers, the social welfare services, intended for people with mental disorders, are under-staffed with personnel, but the low price of the services fails to allow employing a larger number of workers. Many social workers (including those providing services for people with mental disorders) have no professional education. In connection with the aging of the population, increasing frequency of mental disorders and the transition to a case centred provision of service, there is a great necessity for the recruitment of new employees.

Based on the fact that at least one case manager is needed per 1,500 people of working age and elderly people, and one social worker per 1000 children, for the full implementation of a higher quality method of customer work and case management, approximately 550 customer employees must additionally be employed within the next five years. It is not known how many of them should work with people with mental disorders.

In 2001, the Ministry of Social Affairs launched a 260-hour in-service training programme, which contains both professional placement and the defence of final theses, for people carrying out the customer work of agencies and organisations providing services for people with special mental needs. By now, nearly 1000 people have completed the training programme.

5.3. People Working in Self-aid and Citizen-initiative Organisations

The number and qualification of people, who work in self-aid and citizen-initiative organisations, is unknown. No concrete requirements have been established for them. Given the nature of the work carried out by the organisations, this is not necessary. At the same time, the application of the so-called internal rules, which regulate the activities of an organisation, in addition to the relatively formal statutes (in case if this is a so-called registered organisation) in every organisation, should be essential.

6. Problems and Challenges

6.1. Problems that Interfere with the Development of Mental Health Services (Identified by Different Mental Health Professionals and User Groups)

Clients seldom have one-dimensional problems – the different elements, which altogether form a vicious circle of social deprivation and the accompanying psychological reactions are mostly interactive.[32]

Different mental health professionals and service users have identified a number of problems, over the past years, which according to their opinion are impediments in the development of mental health services. Solutions for the settlement of the problems have also been proposed but they are not treated in this document. Solutions for problems should be created with a larger participation of service users, in the course of the preparation of the policy of mental health.

6.1.1. Human Resource

The overall problem of the mental health service in Estonia is the understatement, scarce availability, lack of alternatives thereof and insufficient information of the different possibilities of getting help. The services differ by regions, regarding their quality and content. In different areas, the professional quality is uneven; no regular evaluation on uniform bases is carried out. At the same time, there is a positive experience regarding the implementation of the obligatory requirements for the state welfare services of people with special mental needs, worked out by the Ministry of Social Affairs; these requirements also concern the development of human resources.

The quality of the services cannot be assured, since there is a lack of aid-providers. Currently, there are no possibilities for training a necessary number of psychiatrists and psychiatry nurses and creating jobs for them. In the sphere of social welfare, there are few specialists for the integration of people with special needs into society. The lack of aid-providers is associated with low salaries in all spheres (social assistance, health care, education system), which do not motivate working. An ineffective and low quality service is often related to wrong working principles and burnt-out personnel[33].

The demand for psychiatric outpatient care has been continuously increasing in association with:

- The increase in morbidity;
- The decrease in hospital beds;

[32] Sheldon (1986). Social work, 1/2005.
[33] Source document of the development of the policy of mental health services, www.praxis.ee

- The increase of people's awareness;
- The decrease in the negative attitude towards certain mental disorders, such as depression and anxiety disorders.

Until recently, the extent of outpatient care has mainly increased on the account of the decrease in the inpatient extent and the personnel disengaged. At the same time, the availability of outpatient care in rural regions differs a lot and it is mostly depending on the number of psychiatrists and other specialists (psychiatry nurses, clinical psychologists) working in the region.

During the next 5 years, the opening of a psychiatric residency with 8-10 resident places (including children's psychiatrists) per year may be considered justified. The duration of the psychiatric residency must be extended by one year – from four to five years.[34]

According to service providers, welfare services, intended for people with mental disorders, are understaffed, whereas the amount of employees has been continuously decreasing, although probably it has partly happened on the account of the increase of the extent of extra-institutional services.

It is necessary to specify the number of different specialists needed in the welfare system and provide them with training in a respective volume. Otherwise the provision of a quality service cannot be ensured.

6.1.2. Services

Inclusion of service users in service planning and quality assessment is essential for better formation of the network of services. Representations of patients must be included in making psychiatry and social welfare related decisions. The responsibility of professional associations must increase in order to ensure that an employee who works in a concrete position meets the requirements for this job.

Supervision over a mental health service must include the planning of the service, based on development plans, and ensure a co-ordinated compilation of the development plans of different sectors, supervision over legality, service quality (audit, peer-review), availability of aid and the assessment of the satisfaction with the services and the procedures for the settlement of complaints[35].

The provision of rehabilitation services is scattered between several institutions; in certain instances, it is doubled; the administration of provision of services is ineffective, there is no quality checking or supervision system and the use of financial resources is rigid.

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[34] Report of the Speciality Committee of Psychiatry on the problems of the speciality as of 2004(2005).

[35] Source document of the development of the policy of mental health services, www.praxis.ee

The main part of the service comprises the assessment of a person's condition and needs and the assessment of his or her need for assistance – rehabilitation diagnostics. According to the concept of social welfare, rehabilitation will be a part of the process of granting benefits. Before the determination of a degree of the severity of a disability or the percentage of the loss of work capacity, the people who apply for benefits and services (benefits for disabled persons, state-financed services) must go through a rehabilitation process in the course of which their abilities and life surroundings are being developed and an attempt is made to find a suitable job for them.

Considering the fact that people have to constantly be in a waiting list in order to be provided with associated and supporting services, the extent thereof must be increased to a significant extent.

The assessment of the social efficiency of welfare policy, which should be carried out on a regular basis once per year on the initiative of the Ministry of Social Affairs and with the participation of the experts of a respective sphere, is a part of the supervision and continuous assessment of the welfare policy and programmes. In the course thereof, surveys are carried out to determine the direct and indirect impacts of concrete welfare policies. The results of the assessment form the basis for the revision and correction of the welfare policy.

Minimum requirements or standards must be established for all welfare services and the providers thereof in cooperation with users. All the organisations, which provide welfare services, should have an internal quality system, the procedure for settling complaints and disputes and methods for the collection of feedback from their clients/ service users.[36]

In addition to coercive inpatient treatment ordered by courts, legalisation of the possibility of the execution of outpatient coercive treatment is necessary. This would enable to shorten the period of coercive treatment and would make the organisation of post-hospital treatment more flexible and purposeful. In certain cases, it would be sufficient to exercise outpatient coercive treatment, which must currently be replaced by inpatient one as the only treatment possible.

Although practice guidelines are important in the implementation of contemporary principles of treatment, Estonia is still too small in order to make it possible to compile the same number of practice guidelines of the same quality as done by bigger countries, and update them quickly enough. With today's possibilities and language skills, it is possible to obtain, through the Internet, practice guidelines, which have been worked out elsewhere and could be also used in Estonia. We should find possibilities for the compilation and updating of the practice guidelines of certain mental disorders (e.g. depression, schizophrenia, bipolar disorder).

Increasing the extent of outpatient services by up to 20% is necessary for ensuring the availability of outpatient psychiatric care in counties. According to forecasts, the extent of inpatient psychiatric care will remain at the current level. Psychiatric

[36] Concept of welfare services, www.sm.ee

inpatient day care is promising for patients with certain disorders (psychotic and eating disorders) in order to lower the necessity for hospital beds.[37]

6.1.3. Financing Issues

The financing of outpatient psychiatric care must increase by 20-30% in the perspective of the next five years, which will enable the optimisation of workload standards. At the moment they are still too intensive and fail to assure quality care in the conditions where the percentage of inpatient care has been lowered. The percentage of teamwork, as well as the time spent on dealing with patients during consultations, which is a quality indicator of work in psychiatric care, must increase. In the conditions of a continuous growth of outpatient care, the financing of psychiatric care must be reviewed in order to ensure implementation of the principles of teamwork and integrative assistance.[38]

In the case of health insurance, it is important to co-operate with public health programmes, in addition to the increase in the effectiveness of the health care system. Indirect costs related to mental disorders form approximately 80% of incidence costs. Mortality is relatively low but the beginning of morbidity is often at an early age and the majority of indirect costs are conditioned by lower productivity at work, school and home. It is possible to economise by keeping people in the work and study processes by supporting them in crisis periods and in coping with everyday life.

On the other hand, additional funds are needed for ensuring mental health services both in the systems of psychiatric care and social welfare. The WHO has suggested that 6% of health care expenses be directed to mental health, whereas most developed countries spend 10%.

The principle of regional responsibility, which is based on the system of capitation fees, must be implemented in the financing system of psychiatry. Persons who are responsible for the organisation of psychiatric care of certain regions must have the right and obligation to do this within the limits of funds they have received, whereas the same rules of the game should apply to everyone. This ensures better cooperation between psychiatrists, family physicians and social workers. Diagnosis-centred coverage of expenses is not suitable for psychiatry; the different duration of disease cases speaks against this – some of them last for the entire life, some for several years. Regarding the development of the quality of services, it would be expedient if the funds spent by the state would move together with the person and the latter could decide, which form of assistance he or she wishes to have. The role of local governments in financing mental health services, must be increased.

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[37] Report of the Speciality Committee of Psychiatry on the problems of the speciality as of 2004(2005).

[38] Report of the Speciality Committee of Psychiatry on the problems of the speciality as of 2004 (2005).

It is necessary to avoid rehabilitators' excessive interest in the so-called long-lasting rehabilitation service, on the principle that the longer the process, the more money. Both the preferences of the development of systems and the financing of services must be oriented towards services that are open and favour independent coping as much as possible. The financial resources, which are currently used for the repair and improvement of care homes, must rather be used for paying for the so-called open services.

The state must find possibilities of equal payment for the treatment expenses of both insured people and those who are not covered by health insurance.[39]

6.2. Challenges to Accept

Given the developments in the world, the main challenges in the development of the mental health system, during the forthcoming years, will concern the following: significantly more extensive involvement of service users in the planning and quality assessment of services, provision of training to a sufficient number of mental health professionals and the arrangement of the bases for financing the services.

It is necessary to systematically observe the activities of international powerful lobby organisations and develop our standpoints with respect thereto (at both governmental level and the level of professional organisations). For example, in the preparation of the UN Declaration of People with Disabilities, the European Disability Forum promotes standpoints, according to which the restriction of the active legal capacity of people with disabilities (including mental disorders) and the use of involuntary treatment (so far considered necessary, and in cases stipulated by law) are inadmissible. The same organisation's concept of disabled people, from the viewpoint of discrimination, is significantly wider than we have used to think – the concept covers practically all people with health disorders and, depending on a concrete situation, their family members as well.

[39] Source document of the development of the policy of mental health services, www.praxis.ee

7. Summary

The system of mental health services in Estonia has significantly developed over the last 10-15 years and is aimed at improving the clients' / patients' quality of life.

During the last years, several different institutions have assessed the system of mental health services and the development thereof, and drawn up overviews of changes that have taken place. Unfortunately, there is no document, which could provide a generic overview of the developments in both social and health care sectors (in the sphere of mental health). This document fulfils this task by giving an overview of both spheres (except addiction disorders) and establishing an initial basis for further, more integrated developments.

It is extremely important that the system of mental health services be guided by the clients' needs and at the same time consider society's needs and potentialities. "Integrative and multidisciplinary approach" are the key words in achieving this goal.

The document gives a general overview of the developments in the sphere of mental health during the last decade, defines the notions used, describes the legal background of the system of mental health services, provides a detailed overview of the system of services, by also giving some examples of good practice, describes the users of mental health services, the mental health professionals and the training thereof, points out problems and challenges.

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Annex 1

Definitions for Terms Used in the Document

The terms defined below are for use within the context of that document, the definitions and descriptions are not to be construed as official definitions.

Community based facility: A mental health facility outside of a mental hospital.

Community-based psychiatric inpatient unit: A psychiatric unit that provides inpatient care for the management of mental disorder with in a community-based facility. These units provide care to users with acute problems, and the period of stay is usually short (weeks to months). Excludes mental hospitals, community residential facilities, facilities that treat only persons with alcohol or substance abuse disorder.

Community residential facility: A non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve users with relatively stable mental disorders not requiring intensive medical interventions. Includes supervised housing, un-staffed group homes, group homes with some residential or visiting staff, hostels with day staff, hostels with day and night staff, hostels and homes with 24hours nursing staff, halfway houses, therapeutic communities. Excludes facilities that treat only persons with diagnosis of alcohol and substance abuse disorder, residential facilities in mental hospitals and care homes, generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind (e.g. nursing homes and rest homes for elderly people, institutions treating mainly neurological disorders or physical disability problems).

Forensic inpatient unit: Inpatients units that are exclusively maintained for the evaluation or treatment of persons with mental disorders who are involved with the criminal justice system. These units can be located in mental hospitals, general hospitals, or elsewhere.

Human rights protection of users/patients: Action related to the following issues to ensure the protection of users' human rights: least restrictive care, informed consent to treatment, confidentiality, avoidance of restraint and seclusion when possible, voluntary and involuntary admission and treatment procedures, discharge procedures, complaints and appeals processes, protection from abuse by staff, and protection of user property.

Medical doctor: A health professional with a degree in modern medicine who is authorized/licensed to practice medicine under the rules of the country.

Mental health day treatment facility: A facility that typically provides care for users during the day. The facilities are generally: (1) available to groups of users at the same time (rather than delivering services to individuals one at a time), (2) expect users to stay at the facilities beyond the periods during which they have

face-to-face contact with staff (i.e. the service is not simply based on users coming for appointments with staff and then leaving immediately after the appointment) and (3) involve attendances that last half or one full day. Includes day centres, day care centres, sheltered workshops, club houses, drop-in centres, employment/rehabilitation workshops, social firms. Excludes facilities that treat only persons with diagnosis of alcohol and substance abuse disorder, generic facilities that are important for people with mental disorder, but that are not planned with their specific needs in mind.

Mental health legislation: Legal provisions related to mental health. These provisions typically focus on issues such as: civil and human rights protection of people with mental disorders, treatment facilities, personnel, professional training and service structure.

Mental health outpatient facility: A facility that focuses on the management of mental disorder and the clinical and social problems related to it on an outpatient basis. Includes community mental health centres, mental health ambulatories, outpatient services for specific mental disorders or for specialized treatments, mental health outpatient department in general hospital, mental health policlinics, specialized NGO-clinics that have mental health staff and provide mental health outpatients care (e.g. for rape survivors or homeless people). Excludes facilities that treat only persons with alcohol and substance abuse disorder.

Mental hospital: A specialized hospital-based facility that provides inpatient care and long-stay residential services for persons with mental disorders. Usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialization varies considerably: in some cases only long-stay custodial services are offered, in others specialized and short-term services are also available (rehabilitation services, specialist units for children and elderly, etc.). Includes, both public and private non-profit and for-profit facilities, mental hospitals for children and adolescents only and mental hospitals for other specifics groups (e.g. elderIy) are also included. Excludes community-based psychiatric inpatient units, forensic inpatient units and forensic hospitals, facilities that treat only persons with alcohol and substance abuse disorder.

Nurse: A health professional having completed a formal training in nursing at a recognized, university-level school for a diploma or degree in nursing.

Occupational therapist: A health professional having completed a formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

Primary health care clinic: A clinic that often offers the first point of entry into the health care system. Primary heatlh care clinics usually provide initial assessrnent and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to the facilities with staff with a higher level of training.

Primary health care doctor: A general practitioner, family doctor or other medical doctor working in a primary care clinic.

Primary health care nurse: Nurse working in a primary health care clinic.

Psychiatrist: A medical doctor who has had at least two years of post graduate training in psychiatry at a recognized teaching institution. This period may include training in any sub-specialty of psychiatry.

Psychologist: A professional having completed a formal training in psychology at a recognized, university-level school for a diploma or degree in psychology.

Social worker: A professional having completed a formal training in social work at a recognized, university-level school for a diploma or degree in social work. WHO-AIMS asks for information only on social workers working in mental health care.

User/Consumer/Patient: A person receiving mental health care. These terms are used in different places and by different groups of practitioners and persons with mental disorders, and are used synonymously.