Depression scorecard: Estonia

This report is based on a user guide and template that were produced by The Health Policy Partnership as part of the Words to Actions initiative. The user guide and template were initiated and funded by Janssen Pharmaceutica NV. No experts involved in the original depression scorecard work, other than The Health Policy Partnership, were paid for their time. This report for Estonia was produced by Corpore with funding from Janssen Pharmaceutica NV.

About the depression scorecard project

The aim of this research is to assess the current level of performance in key areas of healthcare services for people with depression in Estonia. The framework that underpins this scorecard report was developed based on an international literature review and consultation with an expert advisory group.

The idea for the depression scorecard came from collaborative discussions between The Health Policy Partnership and Janssen Pharmaceutica NV as part of the Words to Actions initiative. For more information about the Words to Actions initiative, please visit wordstoaction.eu/about. Janssen Pharmaceutica NV and The Health Policy Partnership were not involved in the research and the preparation of this scorecard report and bear no responsibility for its content.

The scorecard framework was developed and applied initially by The Health Policy Partnership, in collaboration with experts, to four countries: Belgium, France, Italy and Romania, with findings summarized in individual scorecard reports. National-level findings were developed based on in-depth literature review and interviews with leading national experts on depression. The scorecard framework has now been made publicly available for advocates to use in their own countries, following the template and instructions provided in an accompanying user guide. The methodology used in this research will be published on www.Depressioncare.eu and on The Health Policy Partnership website.

This scorecard report is based on the same framework to assess depression care in Estonia.

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Depression: why it matters

Depression is currently the most prevalent mental illness, according to the World Health Organization (WHO).[1] It has far-reaching consequences and an impact on the lives of people living with the disease, their families and society. Depression is associated with several negative impacts on a person's life, including work performance, financial situation, chronic diseases, deterioration of quality of life or higher chance of to death. [2] [3]

The WHO report of January 2022 states that mental illness affects up to 1 billion people worldwide. Within this one billion, 5% of the adult population suffers from depression.[4] According to WHO data, depression is the most common cause of suicide and is attributed to up to 60% of suicides in the world.[5] The stigma associated with depression can exacerbate suffering and prevent people from seeking quality healthcare.[6] Depression causes a significant emotional burden for patients and their loved ones, but also an economic burden on society. The costs associated with mental illness in the EU amount to an estimated €607 billion per year.[7]

In 2019, up to 7.2% of people in the EU suffered from chronic depression, while the overall incidence of depression remains poorly documented in many European countries. According to the OECD, up to half of serious depressive disorders remain untreated.[8] Therefore, experts from all over the world are calling for improved access to treatment for people with depression, reducing the stigma of mental illness and reducing the global burden; caused by depression.[9]

The use of the term depression in the Depression Score: Estonia report includes diagnoses of depressive episode (International Classification of Diseases Code - F32) and recurrent depressive disorder (F33).

4%

of people are estimated to be living with depression in Estonia[6]

16

psychiatrists per 100,000 inhabitants in Estonia (2019)[11]

15.57 per 100,000

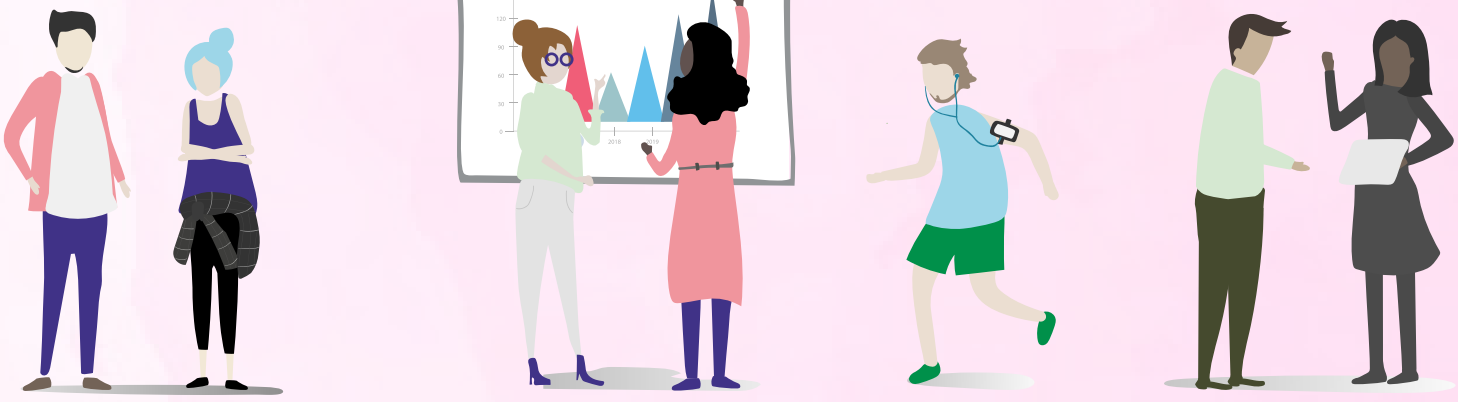
inhabitants in Estonia died from suicide or self-harm.[10] Global estimates indicate depression may have contributed to up to 60% of these deaths[1]

EUR 572 million or 2.18%

of Estonia's GDP[7], are the estimated costs of mental health (direct and indirect) annually in Estonia (2015).[7]

0.7%

of the healthcare budget is spent annually on health and social care for depressive disorders in Estonia (2020)[6]



Depression in Estonia

The prevalence of depression in the Estonian population in 2020 was about 4%, which is below the European Union average (4.3%).[6] Between 2005 and 2020, the prevalence of depression has declined slightly, especially between 2012 and 2015. According to the data of the Estonian Health Insurance Fund's epidemiological study conducted in 2020, contrary to the general trend, the prevalence of depression among women aged about 20 (to a lesser extent also men) has increased sharply in 2015-2019 (2% -> 5%). 7% of working people with depression have also taken a certificate of incapacity for work due to depression.[6]

The number of psychiatrists in Estonia is marginally below the European average but their distribution and age makeup points to likely decrease in availability of quality treatment for people suffering from depression. There are a total of 228 psychiatrists in Estonia, accounting for 16 psychiatrists per 100 000 inhabitants (2019), while the EU average is 17. According to Estonian Psychiatric Society, the optimal number of psychiatrists (incl. Child psychiatrists) in Estonia is 260, considering the needs of both outpatient and inpatient medical care. In addition, of the 228 psychiatrists only 24 are specialized in child psychiatry, but 38 would be optimal in relation to the population.[12] It should be also noted that a substantial proportion of psychiatrists are already of retirement age or about to reach it (122 psychiatrists are aged 55+). Due to this a shortage of psychiatrists may evolve in the near future.[11]

At the same time, the country also lacks a sufficient number of psychotherapists, mainly due to systemic obstacles, which are causing excess waiting times. The distribution of psychiatric outpatient clinics across the country is uneven, making adequate treatment less available to patients from some regions. The average waiting time for examination by a psychiatrist in Estonia is within 42 days, although in recent years the share of patients who have to wait for even longer is growing.[11]

Each year about 0.2-0.3% of depression patients commit suicide.[10] According to recent study by Centar the total number of suicides possibly related to an earlier depression diagnose in victim's medical history was 347 during the period of 2009-2019 – this is 13,5% out of all suicides during that same period.[10]

Treatment of depression (medical services, discounted medicines, and incapacity benefits) accounted for 0.7% of the Estonian Health Insurance Fund's (EHIF) healthcare expenditure in 2020, of which about 1/3 is the cost of incapacity benefits. The total amount of treatment costs for depression and, to a lesser extent, the share of health care costs has risen from 0.6% to 0.7% since 2014. Over the years, 15% of the psychiatric specialty care budget and 10% of the general practitioner's therapy fund are spent on treating depression.[6]

Research has shown that depression, and in particular treatment-resistant depression, has significant costs. In terms of increased spending and lost taxes, the cost to the state of a patient with common treatment-resistant depression is around € 5,000 per year of which about a third is lost tax revenue and two-thirds higher. The cost for patients who have received acute psychiatric treatment or treatment for self-harm is even higher, at over € 7,000. Almost 60% of this expenditure is due to higher expenditure on medical care and incapacity benefits, and particularly on inpatient specialist care.[10]

The average incidence of treatment-resistant depression of patients who receive regular treatment is 4-5%. Although there are no significant differences between the sexes, there is a clear link between patient age and treatment-resistant depression as younger people are significantly more prone to it.[10]

Until 2019, Estonia was one of the few European countries that did not have a national mental health policy framework document. The Action Program of the Government of the Republic for 2021–2023, prioritized the improvement of the organization, availability, and quality of mental health services.[13] To achieve these goals, in April 2021 the Government approved a Green Paper on cross-sectoral mental health policy, which aims to support mental health, enhance prevention, and improve treatment processes and accessibility.

Active and in-depth cooperation between the healthcare and social systems in Estonia has so far been hindered when it comes to mental health but wider interdepartmental cooperation is expected to evolve with the establishment of an official mental health department and task force at the Ministry of Social Affairs.[14]

In Estonia, several active NGO engage in depression-related issues such as prevention, patient support and also supporting the relatives and close ones of depression patients Those groups are partly involved in the planning of national mental health programs and policymaking. Various organizations also specialize on mental health related issues of particular target groups such as children and adolescents, workers, seniors, or victims of violence.[15]

Assessing depression management: the scorecard

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Estonia. It is our hope that this document may galvanise policymakers to work in close partnership with all stakeholders to reverse the course of depression in Estonia, taking a comprehensive and preventive approach to address it in all its complexity.

The scorecard focuses on four key areas, identified as priorities for improvement:

1

Joined-up and comprehensive depression services

Integrated care – that is, a patient-centred system that supports the person with depression throughout their lifetime and with continuity across the health system – is essential to delivering adequate support and treatment. Integrating mental health services into wider health and social care services is convenient and can increase treatment rates, improve comprehensiveness of care and reduce overall costs.[16]

2

Data to drive improvements in depression care

Collecting and analysing robust and up-to-date data on depression is essential for ensuring the right services are available for everyone who needs them. Monitoring patient outcomes helps to identify and inform good practice, and may give hope to service users that their mental health can improve.[16] Data on services can support clinicians, policymakers and people with depression to better understand what treatment options are available and accessible. More transparent data will also facilitate shared learning across all domains of depression care. New digital tools may have the potential to facilitate documentation for transparency and research purposes while retaining the anonymity of the user.[16]

3

Engaging and empowering people with depression

It is essential that people with depression – along with their families, friends and carers – are actively empowered to participate in depression care plans at all stages. Empowerment involves a person gaining information and control over their own life as well as their capacity to act on what they find important, which in turn will allow them to more optimally manage their depression.[17] Peer support, whereby a person who has previously experienced depression offers empathy and hope to others in the same position, can assist both people with depression and their peer supporter in their recovery.[18] Social systems, patient advocacy groups and other civil society organisations with access to underserved communities are critical in ensuring that mental health services reach everyone, including those who have 'slipped through the net.'[16]

4

Harnessing technology to improve access to care

Digital platforms such as those which facilitate remote therapy sessions and online prescription requests, as well as other depression-focused software, smartphone applications and virtual platforms, can allow greater choices of treatment for people with depression while supporting them to take more control of self-managing their condition. While virtual sessions cannot replace in-person therapy, they may be a flexible option to support people with depression between regularly scheduled visits. Health and social services may also use digital tools to facilitate data collection and monitor care.[19] [20] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[21]

Summary scorecard for Estonia

Joined-up and comprehensive depression services

Is depression included in either the national health plan or a specific plan for mental health?

Is there a government lead on mental health, with cross-ministerial responsibility to support a 'mental health in all plans' approach?

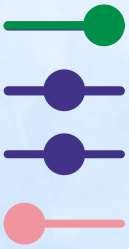
Is collaboration between primary care and mental health services supported and incentivised/encouraged/facilitated?

Are there guidelines on depression care developed jointly by primary care and psychiatry?

Is a range of therapeutic options reimbursed and available to people with depression, such as psychotherapy, counselling and cognitive behavioural therapy?

Are depression services available and tailored for at-risk groups?

- Young people
- Older people
- People in the workplace
- Homeless people

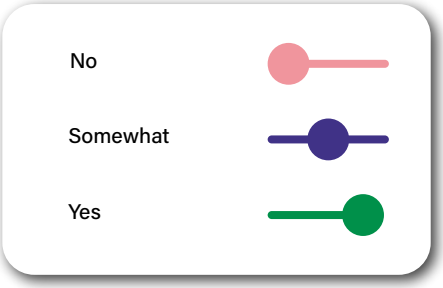


Data to drive improvements in depression care

Are data on people with depression systematically collected by the health system?

Are data on mental health services being used for planning?

Are patient-reported outcomes being measured systematically?



Engaging and empowering people with depression

Do guidelines or care pathways for depression recognise the importance of patient empowerment?

Were patient and carer representatives involved in the most recent national plan or strategy covering depression?

Is peer support recommended in depression care guidelines?

Do guidelines on depression recognise the role of families and carers in making decisions on the planning and delivery of care?

Do carers have access to financial aid to help them support their loved ones with depression?

Are peer support roles reimbursed?

Are there national associations advocating for the rights of:

- people living with depression?
- carers of people living with depression?

Harnessing technology to improve access to care

Can patients access depression support remotely (via telephone or the internet) in addition to services delivered face-to-face?

Do professional societies or guidelines recommend the use of remote services alongside face-to-face services?

Is remote support for depression reimbursed?

Are people with depression able to use telephone or online platforms that allow them to renew their prescriptions from home?

Joined-up and comprehensive depression services

Mental health is becoming a priority topic in health care

One of the positive effects of the COVID-19 crisis in Estonia is that mental health related issues have finally entered the agenda of mainstream politics. There are now favorable winds to bring depression treatment to a satisfactory and then hopefully exemplary levels in the coming years. The structure with one central financier, the Estonian Heath Insurance Fund (EHIF) helps, although in the case of mental and behavioral disorders (including depression), however there's an increasingly robust private healthcare system to support it.

In February of 2021, the Government of the Republic approved the Action Program of the Government of the Republic for 2021–2023, which sets out to increase the organization, availability, and quality of mental health services. To achieve these goals, a Green Paper on cross-sectoral mental health policy was approved to support the development of mental health, enhance prevention, and to improve treatment processes.[11] According to the Green Book the government intends to:

- Develop mental health indicators to help identify areas for intervention in mental health, set targets and monitor their achievement and agree on how the effectiveness and quality of activities will be assessed. With the goal of having a comprehensive overview of the incidence, prevalence and trends of mental disorders, the objectives, availability and quality of services, the profile of users, etc. at different service levels.

- Develop a suicide prevention action plan based on the recommendations of the World Health Organization.

- Develop, in collaboration with relevant ministries, a mental health support guide for first responders and frontline staff, with assessment indicators and training to support its implementation.

- Strengthen mental health services at the community level and in health care through a range of interventions and measures to ensure close, timely and high-quality healthcare for people suffering mental health problems.

In the second half of 2021, a parliamentary mental health support group was established aiming to raise the awareness of mental health related issues at the level of the Riigikogu (National Parliament) and to function as a cooperation platform between the legislative body, the ministries, and all other direct and indirect stakeholders active in the field of mental health.[22]

To ensure better access to healthcare services, the Ministry of Social Affairs has convened a dedicated permanent department and supportive task group to help to improve access to healthcare services for patients suffering mental health problems. An additional 2.85 million euros will be allocated from the supplementary budget to mental health services and 15 million euros to the provision of support services to local governments.[14]

Additionally, in September 2021 the government approved conditions for support measures to increase access to mental health services at the primary level. The new measures will give local governments the opportunity to apply for funds to expand the provision of mental health services and the salary or mentoring of a community psychologist for a total fund of half a million euros. The funding was increased in February of 2022.[23]

Interdepartmental cooperation in the field of mental health is improving

As of 2021 the Governmental Green Book on Mental Health aims to provide the framework to support the interdepartmental cooperation between ministries, government agencies and local governments as well as community organizations.[11]

In March 2021, the newly appointed Minister of Social Protection also convened the Mental Health Staff and Think Tank, two different but very closely linked task groups/units that cooperated in the Ministry of Social Affairs and led and/or supported developments in the field.[14] The task groups did a lot of mapping and consultations with experts to determine and identify needs and bottlenecks in the field of mental health, and also took direct measures to mitigate the negative effects emerging from the COVID-19 crisis.

In addition, from January 2022 a new mental health department has been established in the Ministry of Social Affairs to develop and implement mental health policy. Previous 0,5 FTE in MOSA that was allocated for mental health has not been enough to drive the mental health policy.

Psychiatrists are unevenly distributed, and general practitioners are not sufficiently involved in caring for depressed patients

The accessibility of healthcare for people suffering depression in Estonia has several fundamental limitations. Although the total number of psychiatrists per capita is only slightly below the European Union average, psychiatric outpatient clinics are unevenly distributed across the country, and although waiting times for psychiatric examination mostly remain within the government's aim of 42 days, these waiting times have begun to rise. [11] [18] Patients are therefore often forced to seek therapies provided outside of the coverage of the EHIF. However, these are financially inaccessible to many of them and therefore they cannot afford the necessary follow-up care.

When moving between different professionals and services, a person does not receive steadfast support from the system. There is a lack of case managers/coordinators, which makes it often difficult and difficult to navigate and progress successfully.[6]

Often, in the case of mental health issues, the care is not initiated by a family doctor, but by a specialist. Psychiatrists are often involved in the initial treatment phase too early, which puts them in a situation where they need additional support from primary care counseling.[6]

From 2017, general practitioners have the opportunity to use an e-consultation with a psychiatrist through the health information system to clarify their patient's diagnosis and prescribe treatment. According to the Estonian Health Insurance Fund, in the first nine months of 2019, this opportunity was used 246 times. In 2020, an e-consultation option for child psychiatry was added.[11]

The capability of primary care professionals to assist people with mental health problems is not uniform across the country. GPs do not always consult a psychiatrist before referring patients to them. Professionals also have different perceptions of the optimal amount and form of mental health data. Tasks and responsibilities are not clearly divided between the parties involved. The lack of a timely and coordinated action plan is also reflected in poorer

treatment outcomes. Different service providers participating at the care plan do not work together as a team.[6]

Often, the service provider does not know what will happen to the person after receiving care, there is no unified feedback and quality monitoring system. The quality of communication between service providers varies.[6]

Healthcare providers do not always consider the patient as part of the treatment team and thus fail to share information accordingly – yet still expect the patient to take more responsibility for their treatment progress and results. The involvement of relatives of mental health patients in need of more social support due to their condition is low.[6]

Estonia has a shortage of clinical psychologists and mental health nurses

According to the Green Book on Mental Health the need for clinical psychologists in Estonia has not been reliably assessed. Assuming that the need for clinical psychologists in specialist care is equivalent to the need for mental health nurses, i.e., one clinical psychologist per psychiatrist, the level of specialist care would require 210-260 clinical psychologists. Assuming the widespread use of clinical psychologists at the primary level, with one clinical psychologist on five or six lists, there is an additional need for 130-160 clinical psychologists at the primary level in Estonia.[11]

A mental health nurse is a specialist nurse who provides nursing care but also assesses the need for help of people with possible or diagnosed mental health problems and mental disorders and also the needs of their families. The mental health nurse has a special skillset, training, and knowledge for working with people with mental disorders and prevention, as well as promoting the mental health of the population. In practice, the mental health nurse provides independent reception and group psychotherapy, for example, with EHIF funding.

Considering the optimal ratio of one mental health nurse per psychiatrist, the specialized care level would require at least 210-260 mental health nurses. Additional implementation of mental health nurses in primary care centers would have an added minimum need of 60-70 mental health nurses. Currently, there are 137 nurses specializing in mental health in Estonia.[11]

About 20% of people with depression diagnosed by a psychiatrist receive psychotherapy services and about 10% visit a clinical psychologist as well as a mental health nurse. About 20% of these people see a GP for four years, usually more than a few months after the onset of a depressive episode.[6]

In May of 2022 Riigikogu, the legislative branch of the Estonian government, passed a first reading of amendments to the law that would allow the EHIF to enter into direct agreements with psychological practices to finance psychotherapy and thereby help improve access to mental health care.[24]

The amendments proposed in the first reading of the Psychiatric Care Act and the Bill on the Organization of Health Care Services are necessary to change the current financing scheme for psychotherapy. The Health Care Services Organization Act adds psychological treatment as a new type of healthcare service, sets rules for an activity license requirement for providers of psychological treatment, and considers clinical psychologists to be equated with healthcare professionals. In this way, private providers of clinical psychologists looking to operate without a doctor can obtain a license to provide psychological treatment independently, based on a doctor's referral. Clinical psychologists will also have the capability to send data to the health information system.

So far, the EHIF has financed psychotherapy, but at the primary level and only through the general practitioner's therapy fund. The amendments to the law will enable the EHIF to enter into direct agreements with psychological practices to finance psychotherapy in the future.

The changes are scheduled to be enforced in July 2022, but a transitional period is provided for several implementing provisions. The Health Board will start accepting applications for activity licenses from August 2022, and all those wishing to provide psychological treatment independently must meet the new requirements by January 2023.

Some of the most severe risk-groups of depression don't have sufficient support

The shortage of qualified doctors is also reflected in the necessary medical specializations. In Estonia, just 21 child psychiatrists were registered in 2019. 11 This is mainly due to the low attractiveness of specialization in this field. There are currently 4 stationary clinics with competency in child psychiatry in Estonia.

In Estonia, there are school psychologists and sometimes school nurses who should be involved in mental health screening and detection. On paper these specialists should be able to spot students with depressive symptoms quickly. In practice, however, schools vary, as do the schools' own practices, even if they have the designated staff available.

The necessity to increase the number of school psychologists has been debated for a long time. One of the main challenges for the provision of these services remains to be funding. To date, national government and municipalities haven't agreed on the responsibilities of such additional expenses. Thus, prevention and support in the field of mental health of children and young people is sought by various non-profit associations (e.g., MTÜ Peaasjad, Estonian Association of School Psychologists, Youth Mental Health Movement, Estonian Association of Social Educators), which operate free helplines or organize outreach events.

There are few experts in geriatric psychiatry and this specialization cannot be obtained in Estonia at the moment. In the case of the elderly, if a disability is identified, it is possible to receive additional assistance through the rehabilitation services of the Social Insurance Board.

The promotion of the employee mental health in Estonia is mostly in the hands of employers themselves, NGOs or educational institutions. Employers with at least 50 employees offer mental health-related training or services in 88% of organizations and only 57% in organizations with up to 49 employees.[25]

As a result of the amendment to the Occupational Health and Safety Act of 2019, the concept of psychosocial risk factors was expanded and in addition to psychological aspects, the law also included social aspects that must be assessed in the work environment and the mitigation of relevant risks. 5–11% of Estonian companies use the services of an occupational psychologist as an occupational health service, while the aggregate indicator of European countries is 15–74%. [26]

At present, the service of a clinical psychologist provided by an employer is tax-exempted as a special benefit in the amount of EUR 100 per employee per quarter, provided that this service is accessible to all employees.[27]

In 2022, the "Action Plan on Mental Health" is being prepared by the Ministry of Social Affairs together with its partners and could be completed by the end of the year. That would provide further action plans with funding, not just a vision, to implement sectoral policies. At present, the "Action Plan for Suicide Prevention" prepared by the Ministry of Social Affairs should have been in progress, the schedule of which was postponed due to the intention to prepare it in international cooperation. Other action plans are not specific to mental health.

In the case of the elderly, if a disability is identified, it is possible to receive additional assistance through the rehabilitation services of the Social Insurance Board.

Data to drive improvements in depression care

There is a lack of sufficient data for a realistic overview of the incidence of depression in Estonia

Systematic collection of health data in Estonia is provided by the National Institute for Health Development (TAI). Among other things, the TAI regularly publishes data on mental illness on an annual basis. There is no central database or national depression register. However, certain registries exist for other health issues, such as the cancer, tuberculosis, and drug addiction treatment registries.[28] A population-wide mental health survey has been launched, funded by the Ministry of Social Affairs, and carried out by the Institute for Health Development together with the University of Tartu.[29]

In Estonia, each healthcare provider collects its own data based on interactions with the patients and periodically passes it on to the EHIF. This is how the payment system for the healthcare services is set up. To report or summarize, and plan national services and measures, the Institute for Health Development (TAI) also conducts surveys of the occurrence of psychiatric disorders, cases, admissions and more. In other words, TAI processes the same EHIF data separately in order to make certain generalizations, policy suggestions and prevention plans.

Data on disability, incapacity for work certificates, use of assistive devices, etc. are also collected by designated national agencies. In conclusion there are plenty of registers and means to collect massive amounts of patient data, yet the data remains in separate silos, which do not interact very effectively.

The focus on mental health is increasing, but there is a lack of feedback from patients and the implementation of plans

The latest OECD analysis on mental health highlights the importance of measuring and evaluating patient experience in the healthcare system. 30 Just as data on the prevalence of mental illness is not systematically collected in Estonia, often mental health service providers do not know what will happens to their patients after receiving initial help, because there is no unified feedback and quality monitoring system. The quality of communication between service providers also varies.[6]

The current service design unfortunately does not provide healthcare services that would sufficiently address the individual needs of patients. This is partly why some patients receive healthcare too early, too late, or not at all. During the period between receiving different healthcare services, people need additional supportive services - people's assistance needs and levels of independence are very different, but the current counseling system setup does not support patients to the necessary extent.[6]

The current oral and written communication between the healthcare system and the patient is complicated, text-intensive, too general and does not reflect information related to the treatment course of a particular person/individual case. Thus, many people end up confused, which often may lead to the search of additional alternative services and independent information.[6]

Engaging and empowering people with depression

People with depression participate in healthcare decision-making, but their involvement needs to be increased

The current framework document – the Green Book on Mental Health recognizes the need to involve patients with mental illness and their relatives or guardians in the planning, implementation, and evaluation of treatment processes. This includes patients, caregivers, and guardians of patients accordingly. The document also highlights that there is no particular organization in Estonia that would bring together and represent people with mental disorders and their relatives.[11]

The Estonian Coalition for Mental Health and Welfare (VATEK) is a public interest association that unites majority of organizations active in the field of mental health in Estonia. VATEK's main goal is to protect the wider interests of the Estonian population through the promotion of mental health and well-being and the development of mental health and well-being policy.[31]

Under the leadership and support of MTÜ Peaasjad, the Estonian Youth Mental Health Movement (ENVTL) started in 2017, focused on mental health awareness and advocacy for young people. The members of the ENVTL are primarily representatives of a vulnerable target group.[32] The ENVTL is the closest analogue to a representative organization of experience experts or patients, but they only represent young people.

In 2016, MTÜ Elu Dementsusega (Life with Dementia) was founded, the members of which are united by the mission to support dementia patients and their relatives in Estonia.[33]

Organizations bringing together adult mental health patients and their relatives that meet the criteria for an advocacy organization do not exist in Estonia. To improve the situation the government aims to agree on clear expectations and principles for the effective implementation of mental health strategies between mental health organizations and the state and the involvement of mental health patients at different levels of decision-making, building on the best practices of inclusion.[11]

Family members and guardians of people suffering from depression are also in a difficult situation. Today, there is no systemic state financial support in Estonia for caretakers of depression patients. Financial assistance is only available for caregivers of people with severe disabilities. Reducing the burden by supporting the caretakers of patients suffering severe mental disorders is an issue that still needs to be modelled separately in Estonia. According to experts there are no good models on the table yet and the topic still needs initial analysis.

Community-based care is only in its infancy

The peer support scheme for patients with depression is not sufficiently developed in Estonia. Diagnostic therapies cite community care as means to care for depressed patients, but do not offer more detailed information on this form of support.[34] Socio therapeutic support groups where patients could meet, are focused on people with drug or alcohol issues. Co-sponsors of patients are also not entitled to financial compensation for their services in Estonia. The EHIF has also noted that the involvement of relatives of those who need more social support, is relatively low In Estonia.[6]

In 2021 a measure for the provision of community psychologists and community mental health services to local governments was created.[35] In essence, local governments can use it to fund various interventions, one of them being experiential counseling. The state considers experiential counseling to be a mental health service, i.e., if a local government can justify why this service should be implemented, has previous experience with a good partner, previous good results among the population and a functioning cooperation network then experiential counseling would also receive community action funding. According to experts the problem is that experiential counseling does not have specific public funding scheme, and one of the reasons for that is the unclarity of this service and its role in the overall service ecosystem.

Dozens of nationwide mental health associations operate in Estonia. Some organizations provide support to people across the spectrum of mental illness (e.g., MTÜ Eluliin, Laste ja Noorte Kriisiprogramm MTÜ), others focus on certain at-risk groups. However, these associations often encounter a barrier such as lack of funding, which greatly limits their possibilities and impact - as non-profit organizations are reliant on limited state support, grant contributions and voluntary financial donations from the public.[15]

Harnessing technology to improve access to care

Digital therapy options are available but currently limited

Digital tools and modern technologies are increasingly penetrating the provision of healthcare. The Green Book on Mental Health highlights the need to develop new approaches to provide sustainable mental health care, such as the development of different digital solutions - online counseling, e-self-help, e-psychotherapy, etc. The framework document states that in order to ensure the quality of online counseling, it is necessary to create appropriate framework of standards and evaluate both existing and future technical solutions for telecounseling. To this extent the document recommends analysis and support for the deployment of evidence-based guided online self-help programs and assessment of what programs are needed by primary care workers and patients.[11]

For instance, the Estonian Sexual Health Association, in cooperation with partners, has created quality standards for online health counseling for young people, and under the auspices of the Estonian-Swedish Institute of Mental Health and Suicidology, counseling guidelines have been developed for online counselors.[11]

The usage of remote consultations has also increased significantly in Estonia due to the COVID-19 pandemic. In 2020, 36% of psychiatric appointments were made remotely as part of the treatment of depression.[6] This also applies to the area of mental health, where the possibilities for routine face-to-face consultations have been limited.

Nevertheless, traditional means such as telephone helplines, which offer free advice, are used to a significant extent. They are most often run by non-profit organizations. Online therapy options that allow sessions with a psychologist or psychotherapist are also available, yet to a significantly lower extent.

Frameworks for evaluating and recognizing digital tools are in development

According to experts, there is no set system of evaluating digital health solutions in Estonia. An evaluation framework is needed for digital therapy/digital therapies, i.e., various digital interventions, including, for example, various phone applications that could be used to improve or maintain mental well-being. An evaluation system would mean that any solution entering the market can go through an evaluation system and that can lead to the service being a recognized treatment on a national level. This national recognition could possibly mean that doctors could prescribe an app for the patient as part of their treatment

TalTech is currently looking to create an evaluation platform for digital health solutions. But there is currently no set standard for treating depression and the Estonian Connected Health Cluster working under the umbrella of Technopolis, is trying to set initial standard framework. There is currently no list of tools recommended for healthcare professionals.[36]

Accelerate Estonia (Innovation Program of the Ministry of Economic Affairs and Communications and Tehnopol), which is currently supporting mental health services, may be able to create, on the one hand, a funding model and, on the other hand, some accepted, subsidized digital tools, which could be used by both healthcare providers and patients, either at zero cost or with a low deductible. The whole field has great potential, but the process is still underway.[37]

E-prescriptions of medicines are fully available in Estonia, but the full potential of technologies remains untapped

e-Prescription is a centralized paperless system for issuing and handling medical prescriptions. When a doctor prescribes medicine using the system, they do it electronically via an online form. At the pharmacy, all a patient needs to do is present an ID-card. The pharmacist then retrieves the patient's information from the system and issues the medicine. Today, 99% of all prescriptions in the country are issued electronically.[38]

Because the e-Prescription system draws on data from the National Health Insurance Fund, any state medical subsidies that the patient is entitled to also appear, and the medicine is discounted automatically. Another advantage of the system is that doctor visits are no longer needed for recurrent prescriptions. A patient can contact the doctor by e-mail, Skype or phone, and the doctors can issue refills with just a few clicks.

Conclusion and recommendations

In Estonia, available acute healthcare for patients with mental illness, including patients with various degrees of depression, is currently working very well. However, the provision of follow-up care and long-term management of the disease are proving to be a problem. The problems primarily stem from the service capacity, financing as well as the system itself.

Even though people in Estonia are entitled to therapeutic care from the National Health Insurance Fund, its provision is limited due to limited personnel and financial capacities within the system and beyond. Patients must wait for a long time to receive therapy and thus get the necessary treatment late or worse, they never look for help due to financial limitations. The situation is furthermore complicated by the fact that depression patients often face social stigmatization.

In addition, Estonia today still does not have a system of community centers and comprehensive integrated care. There is also a lack of integration of patients into decision-making processes, as well as in mutual assistance between the patients themselves. However, from the experience of several other countries, it is precisely the best practice of managing follow-up care that appears to be functional and effective in providing the necessary assistance for depression patients. On the positive side, both patient representatives and healthcare providers are aware of this fact and both parties are therefore seeking to adopt the necessary systemic changes in this area.

In response to the status quo, several strategy papers have been adopted along with legislative procedures in recent months, and an overseeing Council of the Government on Mental Illness and think tanks have also been set up to help improve the functionality of the existing system and cooperation between different branches of government. Although changes in the provision of healthcare for people with mental illness encounter a number of problems, e.g., with data, kick-starting the processes of change gives hope for an improvement in the status quo in the future.

Priority recommendations

Joined-up and comprehensive depression services

- Estonia is lacking prevention measures and provision of follow-up healthcare for people suffering depression. The system therefore needs to expand the provision of integrated care, e.g., through the development of community centers for patients who do not require hospitalization. The unquestionable advantage of community centers would be the provision of comprehensive health and social services, which is now noticeably lacking in the system.
- The solution to the ongoing and increasing personnel problem in the system could be to optimize qualification requirements and training durations for the provision of therapy for people with milder degrees of depression, systematical involvement of family members and relatives, but also the development of peer-to-peer assistance.
- A significant barrier to availability of follow-up care is the price of therapies. The current situation therefore requires a change in the structure of the reimbursement system from public health insurance and creation of additional financial mechanisms should be considered.
- Prevention and assistance projects for at-risk groups such as young people, seniors or marginalized groups need to be implemented. At present, such programs are practically completely absent at the national, as well as community level.
- Estonia would benefit from increasing the support for information campaigns aimed at encouraging people with depression to seek the necessary professional care early-on, as well as campaigns to destigmatize mental illnesses.

Data to drive improvements in depression care

- Estonia has a long-term data problem in the field of mental health care. The country lacks unified patient registries as well as systematic epidemiological studies. However, there is an increased pressure to improve the current system, both from inside the health system, as well as from patients. The good news is that the ongoing national mental health study could shed some new light on areas of improvement.
- The lack of relevant data makes it difficult to work on systemic changes in mental health sphere. There is a necessity for more data exchange and analysis by health insurance companies, as well as the results of expert studies or patient data on quality of life. The aim is to improve monitoring and understanding of the actual needs within the system, as well as to respond more actively to deficiencies in the treatment of depression.
- ▪ Estonia would greatly benefit from the creation of a central database, which contains information on affordable private healthcare, but also on the possibilities of comprehensive assistance for patients with depression.

Engaging and empowering people with depression

- Patients and patient organizations are now formally included in the processes aiming to reform mental health care. However, the actual opportunities of patients to actively participate and influence the processes and policy making remain somewhat limited. Their participation in defining systematical changes would contribute to more effective adjustment and improvement of the quality of healthcare provided.
- Standard medical procedures for depression and associated funding schemes have not been reviewed recently to respond to the latest therapeutic trends and don't quite include best practices from several countries where professionals with lower levels of qualifications are actively involved, as well as people with depression, their caretakers, and families in therapy. Further updates to the guidelines should cover this particular area as well.
- At present, there is no financial and material support scheme in Estonia for guardians and relatives who take care of patients suffering depression. As part of the comprehensive system reforms, it would be a desirable outcome if such support mechanisms were incorporated as well.

Harnessing technology to improve access to care

- Today, there is no national nor regional digital toolbox that healthcare providers could use within the Estonian health system. Their implementation into practice is not coordinated or financed under special grant schemes. The status quo therefore requires the introduction of standardized guidelines, the need for training to work with digital tools, as well as cybersecurity and data security.
- In view of the projected increase in the number of people with varying degrees of depression and the limited human expertise capacity, the implementation of digital tools will need to increase further. It is necessary to prepare for this in technical terms, but also from the perspective of setting up the financing model for the provision of online therapy, professional consultations, or multidisciplinary care.

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