

Care Work with Mental Health and Substance Misuse Clients in Estonia

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Introduction

Dear Student

◆ Welcome to Estonia! We are very pleased to have you here doing your practical study placement and hope it proves to be a productive and pleasant experience for you.

The population of Estonia is approximately 1,300,000 and the capital city is Tallinn. The highest point in Estonia is Mountain Suur Munamägi (318 m), which is located in the middle part of Haanja uplands.

The other major cities in Estonia are Tartu, Pärnu, and Narva. Our flag is the blue, black and white and our independence day is on 24th of February (from 1918). Our currency is the Estonian kroon, our country's anthem is My Fatherland, My Happiness and Joy.



The purpose of this handbook is to give you an overall view and understanding of the care, support and help which is available for those individuals who are experiencing mental health problems including those individuals who do so as a direct result of substance misuse. Substance misuse has focussed on drug and alcohol within this pack. Tobacco misuse has not

been highlighted within this booklet but is another serious concern for the Estonian people. The pack has not made specific reference to children's mental health service provision because it is unlikely that a work placement would be available in this specialised area. It must be remembered that with any care provision it is constantly evolving to meet the needs of the individual. Changes also occur in response to government targets and initiatives to support health in its widest sense. The Government of Estonia acts towards the direction of setting mental health and the promotion of

mental health for the Estonian people as a priority, and as a result many new initiatives are being implemented throughout the country. Whilst every effort has been made to include up to date information which is accurate at the time of publication you may be introduced to new initiatives as a direct result of legislation and policy which has taken place since publication of this booklet.

At present the specializing in nursing is under way, presently the patients with mental health disorders are being treated by general nurses. General nurses also act as mentors for students in the practical training base. The practical training for mental health nursing takes place in third year for the period of 4 weeks. During practical training there is no theoretical studying in college. Every student has his / her personal mentor during the practical training period.

A case study of a family has been included in section 6.5. which will illustrate the type of service provision available for this family in Estonia.

Depending on where your placement is you may be working with individuals in a Statutory or Non Statutory organisation in either a Health or Social Care placement.

This booklet does contain a lot of information and it is hoped you will use it as an information guide prior to coming to Estonia and to provide additional information when you are undertaking your work experience. The contents page will allow you to locate the information you require with greater ease.

A glossary of terms in relation to Mental Health and substance misuse has been included to provide additional information for any terms which you may require additional clarification with.

We hope you enjoy your visit to Estonia and that this booklet assists in your learning experience.

1. History

1.1 History and Development of Mental Health Care

◆ The history of hospitals for stationary patients begins with the opening of section for mentally ill patients at Estonian Caring Council's Hospital in 1796. In 1814, Ernst von Baer stated in his dissertation that two major species of diseases – cramps and mental illnesses – are very rare among Estonians; but during the 1881 Estonian Province census it was clarified that 4,3 % of people in the province are mentally ill. The treating department had no speciality doctors, patients were only being detained and not treated. In 1867, an asylum for demented and idiots was opened at the Tallinn Deaconesses Hospital primarily meant for Germans, where nurses took care of the patients.

The enrichment of the Knighthood of Estonian Province laid the groundwork for charity, which generated the idea among the nobility to found an organization for taking care of mentally ill people. Mentally Ill was founded. In 1898, Baroness Maria Girard de Soucanton gifted 65 dessiatines of land together with her summer manor Seewald to Estonian Province's Society for Caring Mentally Ill; additionally the society took a loan for building the hospital. The opening ceremony of the

hospital took place in 1903. Initially there was only one doctor, in 1903 one doctor was added and in 1905 a third doctor was added – all of them being medical doctors. The first position of a nurse is dating back to 1912, in 1925 there were 3 nurses and in 1941 there were eight nurses.

In 1913, Seewald Hospital received an honorary-diploma on Trans-Russian health care review; hospital's work-organization had changed: the windows had no visible bars any more, the principle of opened doors was applied. The main and general principle of treating mentally ill in Estonia during that period was the saving of the patient's psychic, the psychotherapeutic environment was also considered important. The Seewald Hospital had its own library and the staff, the patients practiced amateur art.

After the end of World War I an independent University of Tartu's Neurology Clinic was opened in independent Estonia that concentrated only on diagnostics and treatment of psychiatric disorders; the development of out-of-hospital psychiatric aid was considered important because thus the patients would not stay socially passive. In 1928, insulin-treatment and electric cramp treatment were the new medical innovations, a clinical laboratory and hospital's drugstore were opened in Tallinn.



Seewald – a location with thrilling history and exciting architecture in Tallinn, familiar to many among us...

After the end of World War II in 1946, when Estonia was already a part of Soviet Union, Tallinn's Republic Psycho-Neurological Clinic was opened and a clinic was also opened in Tartu. In 1950, forensic psychiatry department and a clinic's diagnostical stationary with 50 places were opened in Tallinn, a therapist and pathoanatomist were hired. In 1952, the Leningrad Scientific Research Institute agreed to render systematic consulting and methodological assistance to clinics. In 1957, a laboratory for higher nervous system research was founded. In 1959, a hypnosis-session was conducted by two doctors in dispensary department, a recorded autosuggestion on tape was used, psychopharmacoons were taken into use in the treatment of alcoholics. A narcology cabinet was opened in 1960. In Tartu, a sociotherapeutic community of alcoholics, Anti-Backhos,

started in 1969 under the guidance of narcology cabinet.

During 1970's an Anti-Bachos club was opened at narcology cabinet of Tallinn's Republic Psycho-Neurological Dispensary and a sexologist position was created; a stationary

narcology department was opened and electric sleep treatment was taken into use. Over 5000 patients were registered during one year. The board of the Health Care Ministry of the Soviet Social Republic of Estonia decided that an additional psycho-neurological hospital must be created in Tallinn and some of the patients must be transported to nursing homes. As the result of this particular decision there were no problems with bed places; also a dispensaric narcology department, emergency room and psychology cabinet were opened. After Tallinn and Tartu, psycho-neurological cabinets were also opened in other towns of Estonia. In 1976 a building for treatment work-shops was opened that significantly broadened the possibilities of rehabilitation treatment of ambulatory and stationary patients; in 1977 two narcology departments were opened for treating alcoholics.

In 1980's, a new stationary narcology cabinet was opened in Laitse, in addition a psychotherapy cabinet and an acupuncture cabinet were opened; the first occupational therapist started

practicing. In 1984 the highest number of ambulatory receptions was registered – 104 379, 6969 patients were taken into hospital during one year, being the highest figure ever. The next year an independent Tallinn Republican Narcology Dispensary was organized; all the department executives and matron nurses were obliged to join with Non-drinkers Society.

During 1990's, after Estonia had regained independence, the number of bed places for patients with mental disorders and dependency patients was reduced by 15% and the transportation of Estonian citizens receiving compulsory treatment from Russia to Tallinn Psychiatric Hospital was terminated. The servicing structure of dispensaries was modified by adding medical stations. In 1999 the following departments were opened: a department for integrative treatment of primary psychosis with 25 beds, psychogeriatric department with 40 beds and chargeable stationary department. The nurses of ambulatory network were ordered to start the independent reception of patients. During psychiatric consultation the participation of nurses was disallowed. Selection of psychopharmacoons broadened significantly. Thanks to international contacts, more personal and research contacts were made by psychiatrists with colleagues abroad, thus helping to develop diagnostics and treatment of diseases. The combining of somatherapy instruments with

appliances of different psychotherapy versions increased in Tartu. Specializing courses for people acting in the area of psychiatry were organized, but the securing of psychiatric aid and the development of speciality was turned more problematic by the health care policy after restoring independence.

1.2 History and Development of Substance Misuse

1.2.1 Alcohol

Written reports of alcohol usage in Estonia date back to 1284, when the bishop of Saaremaa demanded beer tribute from local people. Thus it can be concluded that beer usage was widely spread. After the usurpation of land Estonians were lacking a variety of rights, including brewing beer, the activity being concentrated to cities and to the subordination of manor lords. Working in manor kitchen was exhausting and causing alcoholism. Brewing companies were established during the 14th century, the members of which being mostly Germans.

Reports from 15th century claim that beer was a daily beverage used with food in Estonian cities and castles, and it was not used for dinner parties. Beer was also used for paying wages and fines, extremely popular being quality peasant beer. It is also known from

that time period that alcohol usage was sometimes exaggerated; there are descriptions of beer orgies at chapels, churches and monasteries during holidays and weddings.

When the process of vodka-burning started during 18-19th century, vodka trains emerged and loose drinking started, and this has continued through centuries up today. At the beginning of the 19th century 1,1 pails (one bucket) of beer was drunk per 1 pail of vodka, beer and vodka started to contest with each other. The 1861 alcohol tax law allowed to continue the manufacturing of tax-free beer and the beer brewing activated again. During the process of differentiating medicine in the first period of the 19th century, psychiatry – which comprised also narcology – was separated. In 1889, the first Estonian Non-drinkers Society was established; the same year marks the organizing of the state's owned vodka monopoly. The producing of spirit grew during the second part of the 19th century when Russian market was opened to Estonian spirit; the problems of alcohol usage increased continuously.



In the beginning of World War I, general alcohol usage and manufacturing was slowed down by alcohol prohibition law that came together with war; although a remarkable decrease of alcohol usage was gained, domestic distilling and usage of technical spirit and other toxic fluids emerged instead. During post-war years, beer brewing and spirit manufacturing livened again and this also lifted up the usage of alcohol.

Alcohol consumption was a problem of great concern in the Estonian Soviet Socialist Republic. Alcohol selling grew 2,2 times during 1940-1965. In the Soviet Union Communist Party XXIV congress it was stated that the primary goal of the party must be the growing of a new man, whose moral and political qualities will shape in constant battle against the relics from the past, one of them being drinking alcohol. In 1961 a commission for directing people to compulsory alcoholism treatment was established. In 1962 a commission was organized for directing asocial alcoholics to treatment and work prophylactics. In 1970's a law was adopted that established limits to selling alcohol. In 1980's the legislature of alcohol usage was even more amended and toughened. The end of soviet era is known with Gorbachev's 'dry law'.

In independent Estonia alcohol usage is a continuous problem, over 10 litres of strong alcohol per person is being drunk in one year. The availability



of alcohol, problems relating with shaping alcohol politics, treatment and forestalling are objects of discussion of Estonian politicians.

1.2.2 Drugs

Misusing of drugs is quite a new phenomenon in Estonia, growing into a problem in Estonian society at the end of the 20th century that needed fast solving. During the 1990's, especially in the second half, a favouring attitude spread towards the usage and dealing of narcotic and psychotropic substances, thus endangering people's health and safe living environment.

It is possible to talk about the usage of illegal drugs starting from Estonia's independence, although illegal drugs were used to a small extent also during soviet times – exact data concerning this is missing. It is known that

smaller dosages of cannabis was used in Estonian prisons already in 1960's; when sporting doctors came to study to university of Tartu from all over Soviet Union at the end of 1960's, a tradition of cannabis group smoking emerged in the dormitories. A second wave of cannabis smoking emerged when in the beginning of the 1980's men who had fought in Afghanistan began to return to Estonia.



It is said that a little bit of cannabis would not hurt anybody; a little bit – yes, but Estonians do not feel any limits.

In the early years of independent Estonia the usage of illegal drugs was influenced by club-culture, reaching Estonia in the early 1990's. Electronical music parties were attended mostly by youth with intellectual interests, and already then drugs were used in

some extent; getting drugs was difficult and the selection was limited. Only a few could afford themselves cannabis, amphetamine and ecstasy. Drugs were used by a smaller group of people and it was regarded as elite culture's and society's refined entertainment. Club culture made illegal drugs attractive for the youth.

In the mid 1990's the club culture did not consist of a society with common behaviour any more; at that time ecstasy entered the Estonian market, amphetamine and cannabis usage grew, drug addicts of that period felt themselves as part of western life-style and youth culture that distinguished them from older generation. During that period drug usage broadened outside of club culture.

Regardless of Estonia's compactness, there are still regional differentials: for example the usage of amphetamine spread in Tartu already in the mid 1990's because it was easy to get it and the attitude towards it was positive. According to some sources, amphetamine was produced near Tartu in huge amounts already in the first half of 1990's. The fact that Tartu is a university-town with lots of youth who were free of parent's inspection also affected drug abusing. As the use of amphetamine was quite common among Tartu's youth community, due to this fact some younger experimenters became problematic users.



Heroin reached Estonia during 1997-1998, but self-made poppy-liquid was used already earlier. Opiate-users belong mostly among Russian-speaking population. As the self-made poppy-liquid was used already during soviet era, it became a real problem after gaining independence when drug addiction was defined as social problem.

Experience of a 29 year old youngster: "We gathered, we boiled. All other drug addicts were older than me. I was 21, but they were 28 and older. They asked me if I wanted to try. They weren't my real friends, I guess they needed money, they were short of money. They asked me if I wanted. So what did I answer them? I said – give me some. And that's how it started."

2. The European Union's Policy on Mental Health And Intoxicant Misuse

◆ Public health is a major concern within European Union. Therefore health reducing and damaging factors have already been recognised when establishing The European Community. Thus the basis for European level co-operation and promotion of mental health and initiatives and measures to reduce health damages related to intoxicants lays with The Treaty establishing The European Community (in paragraphs 1-2, article 152 dealing with public health):

“Community policies and activities complement and support national policies that aim to improve public health and prevent illnesses and diseases. These policies and activities include actions in both prevention and reduction of drugs-related health damage. Member States are encouraged to co-operate to reach stated goals. The Commission will support such efforts via different policies, initiatives and programmes.” (a)

Extract of the Article 152 of the Amsterdam Treaty:

“A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall

be directed towards improving public health, preventing human illness and disease, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.”

The need for common programmes and policies promoting mental health derives from challenging situation. Approximately 25% of EU's population suffers from some form of mental ill health, most common ones being anxiety disorders and depression. Mental ill health on social level causes also significant economic and social losses, causes far too often stigmatisation and discrimination for people suffering from them. Furthermore their human rights and dignity are neither respected in acceptable manner. Thus Commission outlined launching of common strategy on mental health called **Green Paper: “Promoting the mental health of the population. Towards a strategy on mental health for the EU”**.

Importance of mental health in Green Paper is crystallised in following key lines:

- ◆ good mental health is a resource for individuals and society – without it nor individuals or society as a whole can be considered well-being. Ill mental health prevents individuals to fulfill their intellectual and emotional potential to full and reducing quality of life – resulting also on social level to lesser social and economical welfare. Mental and physical health are also inter-related: e.g. depression is a risk factor for heart diseases.
- ◆ Ill mental health has significant economic and social effects: mental disorders are a leading cause of early retirement and disability pensions – and depression is expected to be the second most common cause of disability in the developed world by year 2020. Unfortunately social exclusion, stigmatisation and discrimination of the mentally ill are still a reality within the Member States.
- ◆ Currently, in the European Union app. 58,000 citizens die from suicide every year and there seems to be close connection to mental health as up to 90% of suicide cases are preceded by a history of mental ill health, often depression.

In accordance to Green Paper WHO European Ministerial Conference on Mental Health (Helsinki 2005) announce following priorities:

It is necessary to build on the platform of reform and modernization in the WHO European Region, learn from our shared experiences and be aware of the unique characteristics of individual countries. We believe that the main priorities for the next decade are to:

- a) foster awareness of the importance of mental well-being;
- b) collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
- c) design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
- d) address the need for a competent workforce, effective in all these areas;
- e) recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

(WHO European Ministerial Conference on Mental Health. Facing the Challenges, Building Solutions Helsinki, Finland, 12–15 January 2005)

The EU-Public Health Programme 2003-2008 constitutes the current instrument for action at Community level in the field of mental health and includes Green Paper's strategic aims. Member States outline their national policies in accordance of EU-level strategies and policies.

The Council of European Union set in 2005 “**EU Drugs Action Plan for years 2005-2008**”.

The drugs phenomenon was considered as one of major concerns of the citizens of Europe and as a major threat to the security and health of European society. The Action Plan was based on EU Drug Strategy (2005-2012).

From social and health care –viewpoint one of Strategy’s major aims is “to achieve a high level of health protection, well-being and social cohesion by complementing the Member States’ action in preventing and reducing drug use, dependence and drug-related harms to health and society.”

From social viewpoint emphasis is laid on prevention programmers: on reducing demand and also on improving methods of early detection of risk factors of potential intoxicant abusers. Furthermore one important result to be achieved in combating drug abuse is to “ensure the availability of and access to targeted and diversified treatment and rehabilitation programmes, referring to services and treatment available for people facing the problem.

3. Present Situation and Challenges for the Future

3.1 Most Common Mental Health Problems

◆ Major problems among Estonian population are the general psychological stress and also the increase of mood disorders like depression and anxiety disorders. Depression (especially together with alcohol abuse) is the main reason for suicides. The amount of people with stress in Estonia is 87%, 70% of people experience hard intensive stress once a year, 14% are in constant intensive stress, working environment causes stress to 38% of the population. Psychological stress is mainly connected to low incomes, intensity at work or fears of losing one's job. Primary source for stress is the economic situation of families. Beside that important role is also performing the concerns towards the well-being of family-members. Related with long-term increase of unemployment, the number of mental health problems has increased among the unemployed, many of whom belong to the 6,1% without medical insurance. In the list of factors causing working disability, mental and behavioural disorders are on second position. Problems of other nationalities are similar, fears of becoming jobless and it's consequences are even bigger.

According to 2006 data from Ministry of Social Affairs, major problems among ambulatory patients were neurotical, stress-related and somatoformal disorders, mood problems were on second position; mental and behavioural disorders caused from the use of psycho-active substances on third position. Neurotical, stress-related and somatoformal disorders occurred more frequently among women; mental and behavioural disorders caused from using psychoactive substances occurred more frequently among men. The occurring frequencies of mental disorders among ambulatory reception patients during 2006 are in the table below (table 1, pages 15 and 16).

Getting ill with mental disorders is continuously growing and despite of noticeable decreasing population, the need for psychiatric services during the past ten years has continuously grown; the occurring frequency of mood and anxiety disorders has also been significantly growing. The frequency of complex mental disorders requiring inevitable stationary caring such as alco-psychosis and aversion-delirium, and spreading of drug-addiction has been increasing. Assuming that the socio-economic condition in Estonia is getting better, stabilization of getting ill rate can be deduced for the next ten years;

Table 1. Most common Mental Problems in Estonia (The amount of people consulted ambulantlly by psychiatrist, 2006). *Source: Ministry of Social Affairs.*

Profile	RHK-10 code	Amount of people consulted during 1 year		Of them				Of them first-time cases				Of them with mental disorder disability	
		M	F	children		Youth and adults		Total	children		Youth and adults		
				M	F	M	F		M	F	M		F
TOTAL		128	6	3	52	66 256	35 927	2	1	15 282	16 093	11 866	
Mental and behavioural disorders	F00-F98	686	821	395	214			952	600				
		116	6	3	4609	60884	28543	2780	1	11 268	13 045	11 612	
		536	459	097	6			450					
Nervous-system diseases	G00-G99	3 911	190	166	1	1 851	1 363	31	34	619	679	152	
MENTAL AND BEHAVIORAL DISORDERS:		0			704		0						
Organic – incl. symptomatic mental disorders	F00-F09	17 809	72	31	7	10 536	2 575	22	12	1 029	1 512	2 014	
					170								
Mental and behavioural disorders originating from	F10-F19	17 876	15	10	13	3 942	5 582	10	2	4 521	1 049	500	
					909								

indications for this are the slowing coefficient of medical cases and the decrease of suicide coefficient during recent years. The number of stationary medical cases has constantly increased, the probable reason for this being the repeatable number of hospitalizations. The frequency of psychotic disorders caused by alcohol, and the frequency of complex depressions has grown.

3.2 Facts and Figures Relating to the Use and Misuse of Alcohol and Drugs

◆ According to scientists, the consuming of more than 6 litres of absolute alcohol per one inhabitant yearly changes population's value judgements, health, genetical fund and the functioning of whole society. In Estonia the rate was 10 litres already years ago. Temperance movements have been created in order to activate people towards healthier life-style and the renewal of alcohol policy has been launched in order to decrease the spreading of alcohol.

Estonian Health Education Centre carried out a survey on health behaviour of Estonian population. Main objective was to have information about population's mentality on health, value judgements, about the directions of changes in attitudes and health

behaviour. Target group was in the age of 16-64 year old. This kind of survey is being carried out since 1990 on even year numbers. The survey showed that in 2002 vodka or other strong alcohol was consumed at least once a week by 26% of men and 5% of women. Compared with earlier years, a dropping tendency appeared in the consumption frequency of strong alcohol among men and women (Figure 2, page 18).

A slight decrease appeared also in the consumption of wine and beer. In 2002, wine had been consumed at least once a week by 9% of men and 8% of women (in 2000 respectively 13% and 13%). Most popular beverage, beer, was consumed by 52% of men and 10% of women (in 2000 respectively 54% and 14%). During recent years the popularity of long-drink type of alcoholic beverages has decreased in stable rate; in 2002 those beverages were consumed at least once a week by 3,5% of men and 1,5% of women. In quantity the consuming of all types of alcoholic beverages has also decreased (figure 3, page 18).

More than every tenth adult experiences misuse of alcohol in Estonia. Spendings on health problems caused from alcohol abuse increase every year. During 2003 alcoholic beverages were consumed in quantity that equals 13,1 litres of absolute alcohol per grown up according to Estonian Institute of Economic Research, and in 2003 the manufacturing of alcoholic beverages increased 5%.

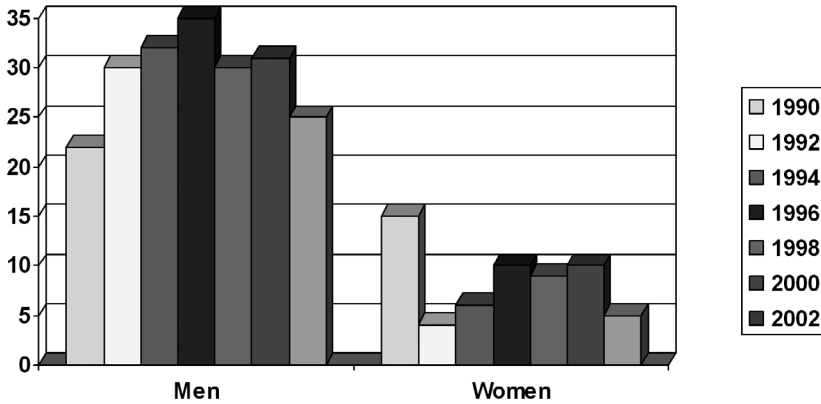


Figure 2. Consumption of strong alcohol in Estonia during 1990 – 2002.

Source: Estonian Centre of Health Education

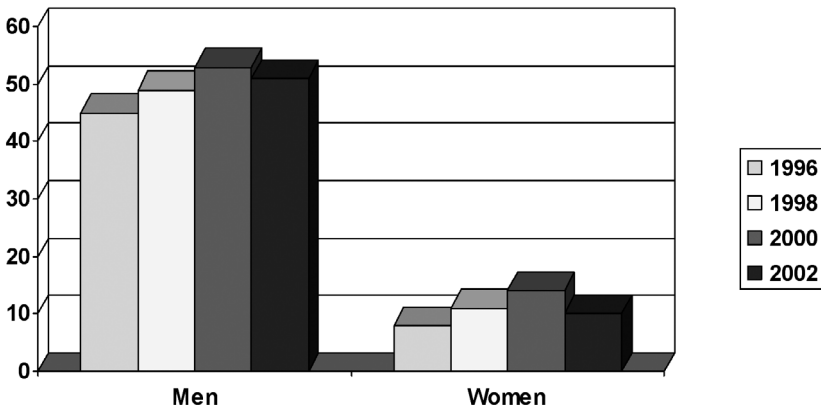


Figure 3. Beer consumption (%) at least once a week by gender, 1996 – 2002.

Source: Estonian Centre of Health Education

According to surveys on health behaviour of Estonian adult population, the consumption spreading of vodka, wine and beer has been increasing constantly during the past 10 years, a small decrease tendency appearing only in 2002. The alcoholization of

society and the health and economical damage caused by it slow down the development of society.

Estonian Institute of Economic Research carried out a research aiming to find out the alcohol consuming habits of

Estonian population, and their attitude towards state alcohol policy. Inhabitants of Estonia aged 18 – 75 were questioned. Similar surveys have been carried out since 1998 every year. According to the opinions of Estonian people as demonstrated by research results (Figure 4, page 20), alcohol is being consumed too heavily (answered by every second respondent) and according to every third respondent alcohol is being malconsumed; only 10% considered consumption as normal. The problem is most critically being felt by rural inhabitants, 43% of whom considered that alcohol is being over consumed in Estonia. Opinions like these show that the trend of alcohol consuming needs to be changed and more attention must be drawn on this issue.

The availability and the limitation of alcohol have been an object of discussion during previous years in Estonia, the result of which being the restriction of alcohol selling in kiosks and selling limitations imposed by local authorities. The survey also asked the alcohol consuming respondents to evaluate the availability of alcohol in the region of their residence. Results show that in relation of the increasing alcohol consuming and problems resulting from this fact, approximately 1/3 of alcohol consumers still consider that alcohol is much too available in their dwelling region. In this respect we can speak about the multitude of selling locations, as well as the selling hours because alcohol is often available.

According to section 42 of Alcohol Act, the council of local government may impose restrictions to assortment, selling locations and selling forms of alcoholic beverage, and also limit selling time. Many local governments have used these rights, most propagated measure being the restriction of selling light or strong alcoholic beverages during night time (for example in Haapsalu, Pärnu etc).

Most popular alcohol selling restrictions among respondents were restriction of night-time selling; second position was occupied by the selling restriction during entertainment events (51% and 28% respectfully). It was also suggested to reduce selling locations (8% of respondents), restriction of selling alcohol at gas stations and grocery stores. Alternatively to reducing selling locations, it was suggested to change selling locations, for example to sell alcohol (foremost strong alcoholic beverages) only in special alcohol stores (figure 5, page 20).

At the time being there are two laws being processed in Riigikogu (the Parliament of Estonia): Advertising Act and Alcohol Act. The general objective of Alcohol Act is the restriction of night-time alcohol selling on the whole of Estonian territory. The project of Advertising Act suggests restricting any kind of alcohol advertising before ten o'clock in domestic tv-channels.

Using of drugs became a problem in Estonia around the midst of 1990's,

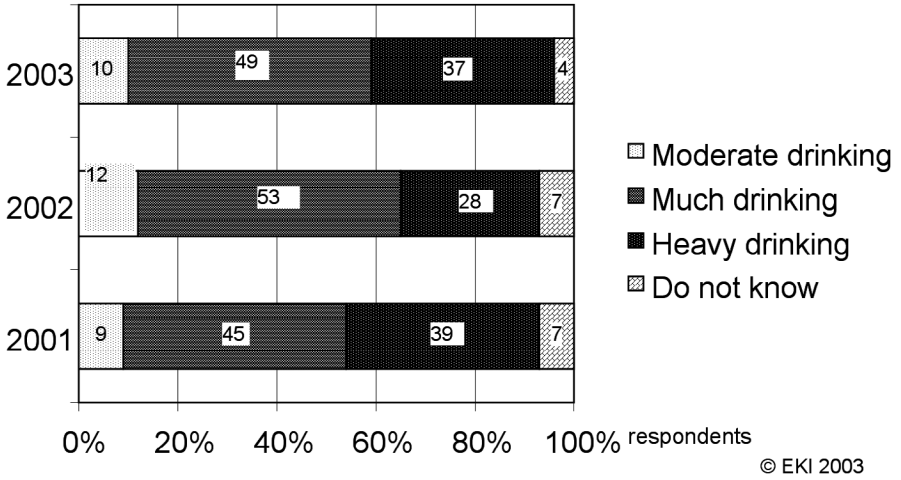


Figure 4. Evaluation on alcohol consuming in Estonia.

Source: Estonian Institute of Economic Research

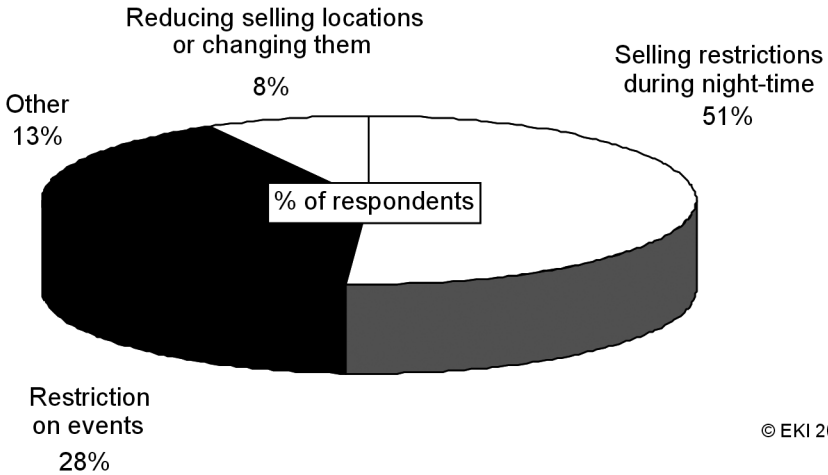


Figure 5. Suggestions from Estonian population for limiting the availability of alcohol.

Source: Estonian Institute of Economic Research

when new substances entered Estonian drug markets and drug usage increased rapidly. Resulting from this, drug addiction was regarded as a social problem worth for research.

Population surveys held in Estonia (NORBALT 1994, Population Survey 1998) refer to the consistent increase of drug usage among adults. When in 1994 1,4% of adult population had tested illegal drugs, the same number in 1998 had increased to 6,3%. Using drugs and experimenting them was more characteristic to younger generations. This can partly be explained by a fact from the survey that foremost the drugs are too available to youth. In 1998, drugs had already been offered to 36% of youth aged 18-24. Drug usage among men is more frequent than among women, drug usage among Russian population is higher than among Estonian population (Population Survey 1998; NORBALT 1994).

According to section 11 of Narcotic Drugs and Psychotropic Substances Act, drug addiction is being treated on the basis of person's free will, following the regulations in Mental Health Act. In 1999, Drug Addiction Treatment Database was founded, the authorized processor being Estonian Foundation of Drug Prevention. Since 2002, systematic data about persons getting drug addiction treatment is no longer being collected as the agreement of data collection ended.

Compared to 1999, the number of persons applying for drug addiction treatment increased 2,5 times in 2001. When in 1999 there were 812 applicants for treatment, in 2001 there were already 2034. Majority of applicants lived in Tallinn (1999 – 63,5%; 2000 – 54,4%; 2001 – 57,5%), Narva (1999 – 7,1%; 2000 – 20,3%; 2001 – 18,3%) and Kohtla-Järve (1999 – 12%; 2000 – 9,7%; 2001 – 7,8%). The proportion of treatment applicants increased significantly in Narva (1999: 7,1%; 2000: 20,3%; 2001: 18,3%). The reason for this was probably the general rise of drug users. As in previous years, the majority of persons in 2001 applied for treatment due to the use of opiates (heroin and domestic poppy liquid). Compared with previous years, the proportion of treatment applicants due to the use of stimulants (amphetamine / methamphetamine, cocaine) in 2001 increased 2,7 times (2000 – 6,8%; 2001 – 18,6%). Majority of applicants had injected drugs during last month (1999 – 78,6%; 2000 – 84,4%; 2001 – 83,8%). Basing on drug addiction treatment demand-index of the last three years it can be concluded, that during last month the proportion of common syringe users had increased (1999: 7.9%; 2000: 22.4%; 2001: 26.2%), which indicates for the necessity to stimulate the HIV/AIDS prevention work among vein-injecting drug addicts (table 2, page 22).

Medicine and police statistic indicates the drastic rise of drug usage during

recent years foremost among children and youth. The consequences of using heroin, amphetamine and other drugs is not only the health and social damages caused from using them, but also the rising rate of criminality and spreading of B-, C-hepatitis, HIV that is directly related with drug addiction problem. The figure below (figure 6, page 23) shows number of expertises of major narcotic substances in 1995-2004.

Characteristic to Estonia:

- ◆ constant rise in the usage of addictive substances (tobacco, alcohol, drugs) among children and youth;
- ◆ constant decrease in the age of first-time drug users;
- ◆ high level of inside-vein drug-users;
- ◆ rapid spreading of HIV (foremost among inside-vein drug-addicts).

	1999(%)	2000(%)	2001(%)
Nationality			
Russian	80.3	82.6	81.6
Estonian	13.8	11.3	12.0
Citizenship			
Estonian citizenship	35	39.4	40.7
Russian citizenship	6.0	8.7	9.2
No citizenship	19.3	28.3	26.0
Age			
Aged 15– 19	30	35.7	32
Aged 20– 24	39	37.1	39
Residence			
Tallinn	63.5	54.4	57.7
Narva	7.1	20.3	18.4
Kohtla – Järve	12.8	9.7	7.8
Job status			
Jobless	53.7	50.8	51.7
With permanent job	20.9	24.2	28.8
Usage of first drug			
Heroin (incl. domestically made opiates; morphine)	53.8	69.9	53.8
Stimulants	11.8	6.8	18.6
Treated earlier	39.2	42.2	48.5
Using of common syringe during last month	7.9	22.4	26.5
Current injections	78.6	84.4	83.8
Having injected drugs during life-time	57.1	53.8	53.8

3.3 Interaction between Mental Health and Substance Misuse

- ◆ In case of schizophrenia, mental health disorders resulting from alcohol consumption and the use of psychoactive

Table 2. Overview of persons applying for treatment 1999-2001.

Source: Drug Addiction Treatment Database

The number of expertises of major narcotic substances

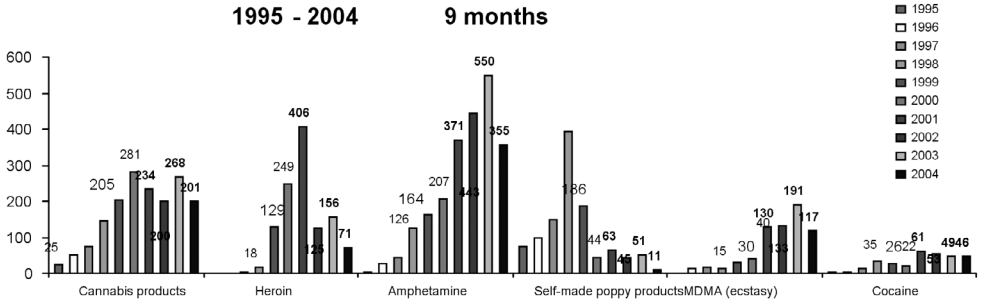


Figure 6. The number of expertises of major narcotic substances in 1995-2004.

Source: Statistics Estonia

substances are very common in Estonia (up to 80% during life-time, currently the rate is approx. 25%). Usually several different substances have been used, and in most cases it is related with moderate functional recovering, high suicidal and violence rate. If there has been a misuse of substances, the case diagnosis could be residual symptomatics of psychosis, or the self-treating attempts of by-effects of anti-psychotic treatment. Alcohol, cannabis and amphetamines are considered as commonly used substances, but recipe-free anti-histamine drugs and pain-killers are also being used.

In the co-existence of alcoholism and depression, depression is primary to 66% of women with alcohol-addiction and to 22-41% of men. Due to this the treating of alcohol addiction requires careful evaluation of accompanying disorders and treatment planning. If depression is assessed

as primary disorder, it also requires specific treatment. If being secondary, depression can withdraw spontaneously together with decreasing addiction problems.

Women experience additional psychological disorders related with alcohol problems more frequently than men. Related disorders can be mood disorders, anxiety disorders, eating disorders and post-traumatic stress-disorder which is often related with sexual abuse. Men experience more often residual activity and attention disorder, dissociative personality disorder and pathological gambling.

According to the data from Ministry of Social Affairs from 2006, the primary cause for mental disorders in Estonia is misusing alcohol, misuse of opioids being on second position, and overdose of tranquilizers and sedatives on third position (table 3, page 24).

Table 3. Mental and behavioural disorders resulting from use of psycho-active substances, 2006 (persons from ambulant reception or stationary treatment). *Source: Ministry of Social Affairs*

Mental and behavioural disorders resulting from use of psycho-active substances	RHK-10 code	Intoxication	Misuse	Dependency	Aversion situation	Aversion delirium	Other psychosis	Other permanent disorders	Total	Per 100 000 people
		X=0	X=1	X=2	X=3	X=4	X=5	X=6,7		
TOTAL	F10.X- F19.X	339	1606	9141	4291	493	723	989	17582	1306
Incl. from alcohol	F10.X	273	1384	5723	3004	489	674	881	12428	923
From opioids	F11.X	4	43	2576	1169	0	7	57	3856	286
From cannabinoids	F12.X	2	39	23	5	0	3	1	73	5
From tranquilizers or sedatives	F13.X	6	21	583	5	0	1	6	622	46
From cocaine	F14.X	1	3	1	1	0	0	0	6	0
From other stimulators	F15.X	10	78	40	13	0	14	20	175	13
From hallucinogens	F16.X	0	2	2	1	0	0	1	6	0
From tobacco	F17.X	0	0	15	0	0	0	0	15	1
From volatile dissolvents	F18.X	3	3	2	2	0	2	2	14	1
From multi or other	F19.X	40	33	176	91	4	22	21	387	29

Estonia is a country of high suicidal risk. The rate of suicides has remained on high stable level (over 30-40 cases per 100 000 inhabitants in 1 year). Estonia was on 3rd position in Europe with the number of suicides, approximately a third of suicide cases related with alcohol, and 5-10% of alcoholics ending their life with suicide. In case of people with suicidal behaviour, the problem could also be the misuse of drugs (toxicomania, drug addiction). There are more suicides among men than among women, more in rural areas than in towns. Suicides are related with untreated depression, alcoholism and misuse of drugs. 5000 people lost their lives through suicide in 1991-1999.

3.4 Preventative Work

◆ In 2003 the government of Estonia approved the basic document for mental health policy. Tempo decreased after primary governmental support because government changed after parliamentary elections and the original co-ordinated plan basing on state funding was left out of government primary priorities. A document concerning state policy is being completed in the Ministry of Social Affairs. In search of the solutions it is necessary to have a general and systematic approach – there is no concrete solution to every problem. But a solution for one target group may also help another target group. Resulting

from this the following main solutions have been worked out:

Informing people: most important activities of developing and prevention work related with mental health:

- ◆ Starting the creation of help-providers database by Ministry of Social Affairs in cooperation with state and local authorities for centralizing and administering data about help-providers, aiming to develop co-operation networks between different sectors and to increase the availability of help through the availability of data
- ◆ Ministry of Education in co-operation with Ministry of Social Affairs: to work out criteria for ensuring mentally and physically secure school environment, and guidelines for handling problematic situations
- ◆ Ministry of Social Affairs in co-operation with relevant partners: to work out info-materials and to launch wide media-program for informing people about mental health issues (starting from people's basic rights up to self-aid and increasing the coping with every-day life), with the objective to increase people's coping and to prevent mental health problems in different age and social groups
- ◆ Ministry of Social Affairs in co-operation with relevant ministries: to launch a re-evaluation of current activities and the planning of relevant activities with the aim to make drug and alcohol policy more severe

- ◆ schools in co-operation with local governments: to find possibilities and to re-evaluate priorities for creating a supporting and mentally healthy environment for children in order to prevent and discover children's mental problems in an early stage
- ◆ local governments: to review their development plans and programs and to improve them according to mental health basic document
- ◆ Ministry of Social Affairs: to review, improve and harmonize existing state programmes and development plans, and to make suggestions to other ministries to improve and connect the programmes and development plans in their subordination with mental health basic document
- ◆ Ministry of Education: to bring into consciousness and to find resources for teaching coping skills in secondary schools with the aim to prevent mental health problems
- ◆ Ministry of Social Affairs: to work out and launch state program for preventing suicides.
- ◆ Ministry of Social Affairs in cooperation with the Association of Estonian Psychiatrists has to plan a refresher programme for family doctors, social workers, teachers and other help providers in order to discover mental health problems in early stages in different target groups
- ◆ Ministry of Social Affairs together with other ministries and professional associations has to plan and calculate the actual need for different specialists for the next 20 years considering the demographical situation and health trends in Estonia.
- ◆ Ministry of Social Affairs in cooperation with other ministries has to draw up an action plan and solutions for employing specialists and create preconditions for private sector development in these areas
- ◆ Ministry of Social Affairs in cooperation with other ministries has to plan and start a supervision system of help providers.

Raising the speciality level of help-providers: training, job consulting and motivation, the most important activities of this course of activities are:

- ◆ Ministry of Social Affairs in cooperation with the Ministry of Education, Ministry of Justice and Ministry of Interior has to develop for specialists belonging to the team of help-providers professional and cooperation training programmes that are based on integral principles

Creating an integral network of services

- ◆ Local governments in cooperation with relevant ministries have to create possibilities for starting the self-help groups
- ◆ Ministry of Social Affairs has to develop a plan for connecting and adequately financing the family doctor and psychiatry system
- ◆ Local governments have to find possibilities for starting a sufficient network of counselling services by creating preconditions for this through financial schemes

- ◆ Ministry of Social Affairs has to develop an action plan of open care system reevaluating the financing schemes and promoting private sector participation
- ◆ Ministry of Social Affairs has to elaborate an improved development plan of treatment, care and rehabilitation system of people with special needs
- ◆ In order to implement the above-mentioned development plans the Ministry of Social Affairs has to describe the transitional stages

Flexible cooperation with clear responsibility, adaptation of legislation and quality assurance

- ◆ Education: School curricula should contain mental health education, educational special needs and guarantees have been thorally discussed.
- ◆ Employment: Estonia has joined with different employment standards that involve employees, mental health and working environment.
- ◆ Living environment: development of carefully planned social policy; it is necessary to guarantee through an integral environmental policy the physical and mentally safe living environment and the availability of mental health services both in the urban and rural areas.
- ◆ Equality and lack of discrimination: possibilities to take care of one's mental health must be available for all members of the society.

- ◆ Quality: representations of patients must be involved in the making of decisions that concern psychiatry and social welfare.
- ◆ Legislation: Laws must be in accordance with generally acknowledged human rights principles; laws are used to regulate the services, rights and social benefits that are guaranteed to people with mental disorders; in addition to professionals also the consumers of services are involved into the preparation of draft laws; in the development of each law it's impact on mental health must be taken into consideration.

Since 1997 the prevention activities for alcoholism and drug addiction have been mainly financed from "National program for preventing alcoholism and drug addiction for 1997-2007". According to the Regulation no 7 of the Minister of Social Affairs from Dec 28th, 2000 "Regulation of applying national health care programs", parts of the program were applied by The Estonian Health Education Centre, acting as a state enterprise in the jurisdiction of Ministry of Social Affairs. Starting from May 1st, 2003 the program's leading organization is the Institute of Health Education.

Today, "National drug addiction prevention strategy until 2012" has been worked out in Estonia. It is a national multidisciplinary long-term strategy on combating narcotic drugs, drafted

as a result of the cooperation between the Ministry of Social Affairs, Ministry of Internal Affairs, Ministry of Justice, Ministry of Education and Research and other relevant institutions. The national drug strategy is in correspondence with the European Union acquis of the drug field and incorporates 6 areas: prevention, treatment-rehabilitation, reduction of damages, decrease of supply, drugs in prisons and monitoring of drug situation. National drug addiction prevention strategy focuses on illegal drugs and the general objectives are: decreased supply and demand of drugs, a functioning social network aimed at the reduction of damage caused by drug use.

In terms of the prevention of drug use a declining tendency must be achieved with respect to the number of cases of primary drug use and an increasing tendency with respect to the age of primary drug users by the year 2012 through the development of the activities of drug use prevention; also, ensuring provision of regular support thereto and continuity thereof. The use of drugs is often preceded by use of alcohol; the aforementioned substances are also used together with illegal drugs, thus the prevention of drug addiction should be aimed also to prevention of alcohol addiction.

In the field of treatment and rehabilitation of drug-addicted persons a contemporary, professional and available network of health care and social assistance services of advanced

level must be developed by the year 2012. In case of drug addiction effective assistance will be provided to children as well as adults. Treatment-rehabilitation centres with different work organization for children and adults with addiction or personality disorders with different level of severity will be fully operational.

Main elements of the network for special treatment and rehabilitation of drug addicts for the year 2012 are treatment centre, social care system's daily-centre and 24 hour centre, including treatment commune and nursing home. The task of addiction-psychiatric treatment centre is to provide ambulatory and stationary special health care, and to supervise the activities of other providers of health care services, social care daily-centres and treatment communes in their area. A treatment centre may be a separated special hospital, central hospital or a centre belonging to psychiatric service of regional hospital.

Harm reduction measures are targeted at reducing the adverse psychological, social and physical consequences and side effects of drug use on the individual and society. By the year 2012 constant decrease must be achieved with respect to harm caused by the use of drugs.

In the field of supply reduction, enhancement of cooperation between different law enforcement activities is

of major importance. By the year 2012 fight against the supply of narcotic substances must be well coordinated between competent authorities; training and technical equipment have to be modern and correspond to the necessary requirements.

Drugs in prison comprise: drug prevention, treatment and rehabilitation in Estonian prisons. Establishment of a functioning control system, ensuring access to regular treatment and provision of drug addicts with rehabilitation possibilities in prison have been set as objectives of this field. By the year 2012, “drug-free” departments must be established in prisons and comprehensive measures applied to motivate inmates to lead drug-free life.

In the field of monitoring and evaluation compliance of the Estonian system of drug monitoring to the requirements provided by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) must be ensured by the year 2012. On the national level all key fields must be covered with databases of good quality.

The productiveness indicators of drug use prevention work for the year 2012 are:

- ◆ the possibility of joining harm reduction programs is guaranteed for 100% of drug addicts not wanting or not being able to give up drugs by 2012;
- ◆ at least 60% of all injecting drug addicts are covered with syringe swoping programs;

- ◆ 100% of health care staff providing replacement treatment services have passed a relevant training by 2012;
- ◆ reusing of syringes has decreased at least by 30%;
- ◆ decrease of deaths related with drugs by 50%;
- ◆ decrease in the occurrence of infection diseases caused of drug using by 40%;
- ◆ decrease of registered law offences by 20%.

Aiming to prevent damages related with alcohol abuse, on Nov 25th, 1997 the government of Estonia adopted the national program for preventing alcoholism and drug addiction for 1997-2007. With this document the government, aiming to reduce damages caused from consuming alcohol, set the objective to work out alcohol policy basing on programs and other national documents. From Jan. 1st 2005, “The national program for preventing alcoholism and drug addiction” was changed into Narcotic substances strategy. In the national budget for 2005 no finances were foreseen for prevention of alcoholism, at the time being majority of sums is used for applying the strategies of HIV and drug addiction prevention. Still we cannot talk about the solving of problems related with alcohol in the society. People’s problems with alcohol have emerged to the top and the state has somehow given up dealing with this topic. Following the world’s most successful practice in the area of

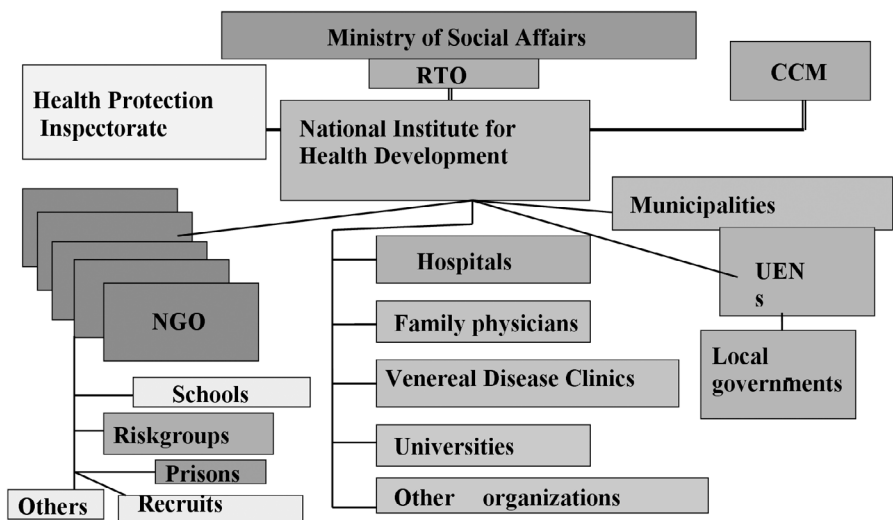


Figure 7. Horizontal and vertical cooperation in the area of mental health, drug addiction, alcoholism. *Source: Ministry of Social Affairs*

reducing the spread of alcohol, Ministry of Social Affairs recommended some proposals for talks and for gaining consensus:

- ◆ selling restriction of alcoholic beverages in stores during evenings and night-time,
- ◆ separation of alcoholic beverages in the selling area from other articles into a private section,
- ◆ prohibition of public alcohol advertising similarly to tobacco advertising,
- ◆ prohibition of sponsoring with alcoholic beverages and consumer campaigns, including the enhancing of selling, similarly to tobacco advertising,
- ◆ limiting the number of selling locations on certain territories and

prohibiting selling at certain time or locations,

- ◆ raising the age-limit allowing to sell and consume alcohol,
- ◆ correcting the effectiveness of taxation policy of alcoholic beverages,
- ◆ to intensify state monitoring,
- ◆ changing people's value judgements and attitudes.

4. Legislation

4.1. Legislation for Mental Health

◆ 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 Organization 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).

Below a more detailed overview of more important legal acts regulating mental health.

Forensic Examination Act was adopted on May 30th, 2001 and it took effect on Jan. 1st, 2002. Last time the act was amended in 2005. Forensic Examination Act states legal statuses of forensic expert, state's examination institution and nationally recognized expert, the origination of expert's rights and obligations in proceedings of criminal, civil and administrative court and the proceedings of administrative offences. Among others the act also regulates the performing of forensic psychiatry expertises.

Family Law Act was adopted on Oct. 12th, 1994 and it took effect on Jan. 1st, 1995. Last time the act was amended in 2005. In addition to other important regulations in family law the act states the arrangement of guardianship and curatorship. In the context of mental health it is remarkable the establishment of guardianship for the protection of proprietary and personal rights and interests of an adult with restricted active legal capacity.

Mental Health Act was adopted on Feb. 12th, 1997 and it took effect on

March. 16th, 1997. Last time the act was amended in 2002. The act regulates the procedure and conditions for provision of psychiatric care and the relationships with health care institutions which arise from the provision of psychiatric care, provides the duties of the state and local governments in the organization of psychiatric care, and provides the rights of persons in receiving psychiatric care. The act consists of five chapters: general provisions (scope of regulation of act, definitions, voluntary nature of psychiatric care, rights of person while receiving psychiatric care, diagnosis of mental disorders and treatment of persons with mental disorders), organization of psychiatric care, emergency psychiatric care, psychiatric examinations and psychiatric treatment of persons placed in psychiatric hospital by court, financing.

Public Health Act was adopted on June 14th, 1995 and it took effect on July 21st, 1995. Last time the act was amended in 2004. The purpose of the act is to protect human health, prevent disease and promote health, which is to be achieved through the performance of duties by the state, local governments, legal persons in public law, legal persons in private law and natural persons, and through national and local measures. The act consists of four chapters, mental health being indirectly treated in all of these chapters, but the most important being sections 5 and 6, that state the instruments of disease prevention and health promotion.

Social Welfare Act was adopted on Feb 8th, 1995 and it took effect on Apr 1st, 1995. Last time the act was amended in 2005. Social Welfare Act is among one of those acts that has been amended by the Supreme Court's Constitutional Review Chamber ruling (concerning dwelling expenses that are counted when paying subsistence benefits). Social Welfare Act provides the organizational, economic and legal bases of social welfare, and regulates the relations relating to social welfare. The act consists of seven chapters, of most important in the context of mental health being the chapter regulating social services. Social services are counselling, rehabilitation service, provision of prosthetic, orthopaedic and other appliances, domestic services, housing services, foster care, care and rehabilitation in social welfare institutions, other social services needed for coping. Most important of them being the rehabilitation service added in 2005, provided to support the ability of persons to cope independently, their social integration and employment. At the same time sections 19 (care without consent of the person) and 20 (restriction of rights of persons staying in social welfare institutions) are also important

Health Services Organization Act was adopted on May 9th, 2001 and it took effect partially on Jan. 1st 2002, Jan. 1st 2003 and Jan. 1st 2005. Last time the act was amended in 2005. The act provides the organization of

and the requirements for the provision of health services, and the procedure for the management, financing and supervision of health care. The Health Services Organization Act consists of six chapters: general provisions (scope of application of act, health service, health care professional, health care providers), Organization of Provision of Health Services (Emergency Care, General Medical Care, Emergency Medical Care, Specialized Medical Care, Nursing), Requirements for Provision of Health Services, Financing of Health care, Management of Health care, Supervision. Generally, in the context of mental health all of them are important.

Code of Civil Procedure. The redaction of the code that took effect in 2006, was adopted on Apr. 20th, 2005 and entered into force on Jan. 1st, 2006. The code is very voluminous, regulating among others the establishment of guardianship to a person with restricted active legal capacity and placement of persons in closed institutions. The act changes significantly the existing regulations of establishing guardianship and placement of persons in institutions against one's will.

Chapter 54 of the Code of Civil Procedure states a regulation, after which the court shall conduct proceedings in the following matters based on a petition by the rural municipality or city government of the residence of the person: placement of

a mentally ill person in a psychiatric hospital or a social welfare institution against his/her will together with deprivation of the liberty of the person; hospitalization of a person suffering from a communicable disease without his/her consent and application of inpatient treatment to the person if this is necessary for the prevention of the spread of an especially dangerous infectious disease; other matters of placement of a person in a closed institution provided by law.

General Part of the Civil Code Act was adopted on March 27th, 2002 and entered into force on July 1st 2002. Last time the act was amended in 2003.

The act is very voluminous, consisting of eight parts. In the context of mental health the most important of them being Part II, chapter 1, division 1, which regulates natural person's passive legal capacity and active legal capacity.

Law of Obligations Act was adopted on Sept. 26th, 2001 and entered into force on July 1st 2002. Last time the act was amended in 2005. The act is implemented to all obligational relations and therefore it is very voluminous. An obligation is a legal relationship which gives rise to the obligation of one person (obligated person or obligor) to perform an act or omission (perform an obligation) for the benefit of another person (entitled person or obligee), and to the right of the obligee to demand that the obligor perform the obligation. Chapter 41 of

the act deals with contract for provision of health care services. By a contract for the provision of health care services, one person (the provider of health care services) undertakes, in the professional activities thereof, to provide health care services to another person (the patient), particularly by examining the patient in the interests of his or her health and observing the rules of medicine, by consulting and treating the patient and by informing the patient of his or her state of health and the progress and results of his or her treatment.

4.2 Legislation for Substance Misuse

◆ The shaping of Estonian narcotic substances policy began in 1997 when the Government of the Republic adopted two vital documents that stated the political, legislative and institutional framework for fighting drugs: The principles of preventing drug addiction and combating criminality connected with narcotic drugs (Drug Policy) for 1997-2007; and The program of preventing alcoholism and drug addiction for 1997-2007.

Legislative basis for producing alcohol was created already after Estonia's regaining of independence and moving to free-market economy. The priorities of alcohol policy are: people's health, alcohol that is allowed for manufacturing, alcohol merchandising, alcohol advertising, taxation and

monitoring. The area of people's health deals with the reducing of damages caused by alcohol consuming, with the main emphasis laying on raising awareness of growing generations about health risks caused by alcohol usage.

Public Health Act was adopted by Riigikogu in 1995. The purpose of the act is to protect human health, prevent diseases and promote health, which is to be achieved through the performance of duties by the state, local governments, legal persons in public law, legal persons in private law and natural persons, and through national and local measures. The act forms the basis for activities in national health care programs.

Act on Narcotic Drugs and Psychotropic Substances was adopted in 1997. The act regulates the procedures for handling, inspection, identification of narcotic drugs, psychotropic substances and precursors; the procedure regarding information and reporting on aforementioned substances and the procedure for prevention of the spread of drug addiction, and treatment and rehabilitation of drug addicts.

Penal Code was adopted by the decision of Riigikogu on June 6th, 2001. Starting from Sept. 1st, 2002 Penal Code determines acts that are penalized in criminal or in administrative means and the sanctions. Acts that are penalized: unlawful handling of small quantities

of narcotic drugs or psychotropic substances, unlawful handling of large quantities; providing of narcotic drugs or psychotropic substances to persons of less than 18 years of age; inducing person to engage in illegal use of narcotic drugs or psychotropic substances; inducing minors to illegally consume narcotic drugs or psychotropic substances or other narcotic substances; illegal cultivation of opium poppy, cannabis or coca shrubs; preparation for distribution of narcotic drugs or psychotropic substances; violation of requirements for handling narcotic drugs or psychotropic substances or precursors thereof or of requirements for related recording keeping or reporting; illegal providing of narcotic drugs or psychotropic substances at prisons etc.

Alcohol Act was adopted on Dec. 19th, 2001 by the decision of Riigikogu. The act prescribes features of alcohol and regulates handling of alcohol (manufacturing, processing, bottling, import, export, retail and wholesale trade, possession, storage or distribution for commercial purposes), restrictions for handling and responsibility for violation of regulations. Section 42 prescribes that in its administrative territory, a local government council may establish restrictions concerning the selection, places of sale and forms of sale in retail trade in alcoholic beverages, and restrict the time for trade in alcoholic beverages.

Advertising Act was adopted on June 11th, 2001. Among others the act regulates the advertising of health care services, advertising of light and strong alcohol and prescribes limitations and special conditions.

Other relevant legal acts:

- ◆ Regulations on applying limitations at caring institutions (May 30, 2002)
- ◆ Procedure for identifying intoxication, determining the level of intoxication and protesting the determination of intoxication (Apr. 2nd, 2001)
- ◆ Applying the Act on Narcotic Drugs and Psychotropic Substances: The procedures for registering and preserving the handing over of narcotic or psychotropic substances; Procedures for preserving and neutralizing narcotic or psychotropic substance that is evidence or is subject to special confiscation in Forensic Expertise and Criminality Bureau (Oct 24, 1997).
- ◆ Establishment of small and large quantities of narcotic or psychotropic substances (Nov 27th, 1997).
- ◆ Border Guard Act (June 30, 1994, last amendment from May 8th, 2002)
- ◆ Police Act (Sept. 20th, 1990).
- ◆ Procedures of handling opium poppy and cannabis for purposes of agricultural manufacturing (Apr. 28th, 1997).
- ◆ Money Laundering Prevention Act (Dec. 15th, 2007).
- ◆ Establishment of procedures for import and export of medicals (Apr. 9th, 1998) Customs Code (Oct. 17th, 2001).

5. Service Provision

5.1 Service Provision for Mental Health Clients

◆ A relevant of changes in the provision of special medical care during 1990 – 2000 period are the reforms in psychiatry. The Act of Psychiatric Care was enforced in 1997 and since then society has full control and transparent rules in the use of non-voluntary institutional psychiatric care for the treatment of serious mental disorders in Estonia. The principles of care of mental disorders have radically changed.

In spite of the positive changes in the treatment of mental disorders, there are a lot of problems unsolved in Estonia when compared with soviet times. The general problem of mental health services is its underestimation, lack of availability, lack of alternatives and deficient information about the possibilities of services. It is not possible to guarantee the quality of services as there are not enough help providers. At present there are not enough possibilities for training psychiatrists and psychiatric nurses and creating jobs for them. In the area of social caring there are not enough specialists for integrating people with special needs to society. Ineffective and low quality service is often related with wrong working principles and burned-out staff.

Problems related to treating patients with unstable expenses and first-time psychoses are not solved. Guaranteeing the correct treatment to first-time patients prevents further and indirect expenses. Positive is the reintegrating of people with special needs from caring homes to everyday living environment. There is a lack of services for living outside the caring-home – the inside-institution services are prevailing. Foremost there are lacking supported possibilities for living, working and also learning. With the supporting of people with special needs it is possible to prevent their falling out of the quota of those having obtained education or speciality; and also paying social benefits to them. Compared with other European states, Estonian elderly are characterized with high appearance rate of dementiality and depression, but the treatment and caring possibilities for these patients have not been developed.

General Health Care. 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.

Specialized 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.

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.

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 staff 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.

Social Protection and Social Care.

In Estonia, a principle that the state provides its 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.

Psychological Counselling and Crisis Aid.

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 nationwide 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.

Citizen Initiative. There are not many non-governmental organizations 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 organizations, 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 organizations supporting mentally disabled people, founded in 1990. The mission of the support association is to improve the position of mentally disabled people in society. The support association represents an organization dealing with mentally disabled people in several international and national organizations: Inclusion International, Inclusion Europe, The Estonian Chamber of Disabled People, Network of Estonian Non-profit Organizations, Estonian Non-formal Adult Education. Self-aid groups and mental health support groups constituted by people with mental disorders are mostly located in bigger cities see e.g. at Merimetsa Support Centre and Tallinn Mental Health Centre; a citizen's association "Davy" is operating in Tartu.

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).

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.

Services referred to people with mental disorders in the context of general public services are described in the table below (table 4, page 39).

As at the end of 2002 there were 3899 adults with psychological needs in caring institutions, the number at the end of 2003 was already 4118. It is important to remember that part of the consumers used several caring services and thus, if summarizing the number of persons using several services at the end of the reporting year we receive a bigger sum than the total number of service users at the end of the year. An overview of persons using different caring services in 2002-2003 and about the mobility of people in 2003 can be found from table 5, page 40.

Table 4. Services referred to people with mental disorders in the context of general public services. *Source: Ministry of Social Affaires*

	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)

Table 5. Number of people subjected to services and movement of people in Estonia 2002–2003. Ministry of Social Affairs

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 100,000 inhabitants as of the end of 2003
Supporting every-day 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

5.2 Service Provision for Substance Misuse Clients

◆ The number of drug and psychotropic substance users has increased rapidly during past years; therefore the increase in the demand for treatment will be expected during the years to come. At the same time the number of institutions providing treatment service for drug addicts has barely increased. Only a few projects in Estonia are oriented to systematic and active sorting out, consulting and treatment of people with addiction problems. Health care services have been offered to opioid addicts for fast detoxification and easing their condition, there is a lack of long-term treatment and alternative treatment programs at the moment.

In first-level medical help, the load of emergency care has significantly increased during recent years related with overdoses of drug addicts, difficult aversion symptoms and the increasing number of psychosis.

Family physicians have more cases with drug problems. At the same time the system of family physicians has hardly been included into the treatment of drug addicts. The treatment of drug addicts takes place in medical centres that possess permit for operating in psychiatric area. The system of

rehabilitation is currently in the shaping process and can not satisfy the demand for rehabilitation.

At present there are no specialized ambulatory or stationary care-institutions that provide emergency care for the treatment of drug addicts. In 2002 there were 1,18 psychiatrists for 10000 inhabitants, the psychiatric care development plan for the years up to 2015 forecasts the demand of 2,0 psychiatrists per 10 000 inhabitants. A family physician's referral letter is not necessary for attending the psychiatrist's reception. The treatment of drug addiction does not belong to the first priority group in psychiatry, the pre-training of psychiatrists in this specific area is not sufficient and doctors are not enough motivated for working with these patients.

At the time being stationary emergency care consists of short-term (1-3 weeks) treatment of acute state of aversion and detoxification. The number of locations where a person can go through aversion therapy is limited and their availability and quality do not respond to real demands. A motivating psycho-therapeutic after-treatment in stationary conditions is missing. There are no middle and long-term institutional treatment wards also.

All drug-addiction patients having passed ambulatory or stationary aversion treatment need ambulatory psychiatric after-treatment, but at

present there is lacking a consistent rehabilitation system for drug addicts in Estonia and also an overview of how many drug addicts would like to participate in rehabilitation-programs and how efficient have those been. The centres that have been developed on the basis of pilot-projects can not guarantee the sustainable development of their activities and can not cover the growing demand for rehabilitation services. No places for women have been created in rehabilitation institutions and there is a lack of rehabilitation centres that are oriented to children. The work methodology is still developing in rehabilitation units that have been established during recent 2-3 years. The obstruction for getting good results is the system of resocialising and integrating the drug addicts finishing the rehabilitation back to society, including the lack of exiting programs (supported apartment; supported job openings). In 2002 the only rehabilitation centre started operating (Vihmari farm) with HIV-positive drug addicts. Main reasons in the lack of common rehabilitation system are the missing of motivation and special qualification of the potential service providers, lack of common rehabilitation conception, lack of instructions for service provision and model for financing the activities.

During recent years the demand for dependency treatment has increased and it's availability in health care system is not sufficient. During health

care reforms in Estonia the system of dependency psychiatry (narcology) was almost liquidated. In the health care system of Soviet Socialist Republic of Estonia there were almost 700 beds in narcology wards for treating alcoholism. At the time being there are 25 beds at Wismari Hospital for treating addiction situations. The state and the health insurance fund guarantee only short-term unavoidable care of acute conditions at regional psychiatry hospitals. Ambulatory

Aversion therapy is more accessible, but mainly as chargeable service. Only two institutions in Estonia deal with the treatment of addiction condition: Wismari Hospital (North-Estonian Regional Hospital) in Tallinn and A-Kliinik in Tartu.

In 1990 the first AA group started it's activities in Estonia. There is a circle of friends for women and men who share their experiences, strength and hope in the quarters of Wismari Hospital, where AA is also operating. The goal is to solve a common problem – recovering from alcohol – and also to help other people with solving this problem. The only condition for being a member is the wish to quit drinking. For today AA operates in fifteen different towns and the oldest members have stayed sober since the first year of operating. During these years hundreds of people have joined the AA, having recovered from alcoholism and gained permanent soberness.

5.3 Service Provision for Dual Diagnoses Clients

◆ There is no specially organized system of health care services for patients having problems both with mental health and addiction. If a patient with mental health problems experiences complicated state of aversion as a result of addictive substances, the patient is hospitalized for stationary treatment in a state of unavoidable aid, the rest of the treatment is ambulatory and based on patient's wish. The treatment and rehabilitation of mental health problem of a patient who also suffers from addiction problems takes place the same way as of all other patients with mental health disorders and addiction problems.

6. Working with Clients

6.1 Principles of Working with Clients

◆ Mental Health Act regulates the procedure and conditions for the provision of psychiatric care and the relationships with health care institutions which arise from the provision of psychiatric care. Section 1 of the act provides the duties of the state and local governments in organising psychiatric care, and provides the rights of persons in receiving psychiatric care.

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 to a person with restricted active legal capacity at the request or with the consent of his or her legal representative.

A person is admitted to the psychiatric ward 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; and
- ◆ other psychiatric care is not sufficient.

Involuntary emergency psychiatric care can only be applied on the basis of court order; without a court order it can be applied if it is inevitable for the protection of the person or society, and if it is not possible to urgently receive the court order. The decision of applying involuntary emergency psychiatric care without court order is made by a psychiatrist of the psychiatric ward after the person has arrived to the ward, or on the basis of person's free will application if the need of applying involuntary emergency psychiatric care occurs after a medical assessment.

Involuntary emergency psychiatric care may be applied during 48 hours starting from the commencing of hospital care; the person being treated cannot disrupt the examination, treatment or leave the psychiatric ward of the hospital. In case of involuntary emergency psychiatric care the least restricting methods must be applied that will guarantee the safety of the person being treated and other persons.

When dealing with patients with mental health and addiction problems, who are in need of treatment and caring, the following principles must be observed by the staff:

- ◆ patients with mental health problems must be guaranteed treatment and nursing on equal grounds with other patients;
- ◆ patient must receive information on his or her mental disorder, methods of treatment and diagnosis being used, and review his or her medical file, except if this may be harmful to his or her mental health or the safety of others.
- ◆ Patient has the right to refuse or discontinue psychiatric assessment or treatment, except in the cases of involuntary emergency treatment and care.
- ◆ Patient must receive compensation for damage caused by errors in treatment or nursing.
- ◆ Physicians must be independent in the diagnosis of mental disorders and provision of psychiatric care, and are guided by medical science, the medical code of ethics, laws and other legislation.
- ◆ Information concerning psychiatric treatment and diagnosis is confidential information and disclosure thereof outside the treatment setting is permitted only with the written consent of the person or his or her legal representative, or at the request, pursuant to law, of an investigative body, the police, the Prosecutor's Office or the courts; presenting data for the drug addiction database that is created by the Act on Narcotic Drugs and Psychotropic Substances and Precursors thereof, or on the demand of Estonian Health

Insurance Fund for the functions imposed by law;

- ◆ The attending treatment staff of a person with a mental disorder is not required to make any statements to any person regarding confidential information of which the staff becomes aware in the course of their duties.

There are twenty-four hour welfare institutions meant for children, elderly, mentally ill, mentally handicapped adults and other socially not managing persons. If needed local municipalities may create mixed type of twenty-four hour welfare institutions, where separate wards can be created for persons needing different type of caring. Basing on court order, a person is placed in a social welfare institution without his or her consent or the consent of his or her legal representative upon the concurrent presence of the following circumstances:

- ◆ the person has a severe mental disorder which restricts his or her ability to understand or control his or her behaviour;
- ◆ if upon failure to place the person in a social welfare institution the person poses a danger to himself or herself or to others;
- ◆ the application of earlier measures has not been sufficient or the use of other measures is not possible.

A court may give permission for care of a person in a social welfare institution without the consent of the person

for a period of up to one year. If the aforementioned circumstances have not ceased to exist at the end of such term, the court may give permission to extend the term of the person's care in a social welfare institution without his or her consent at the request of the local government of the person's residence for one year at a time. The application of care will be terminated if one of above mentioned circumstances that caused the application of care has been eliminated. During the staying period in the welfare institution the staff must guarantee the inviolability of the private life of persons staying in the institution, with the following exceptions:

- ◆ a person staying in a social welfare institution shall not possess narcotic substances, devices related to their use or other substances or devices which endanger life or health. Upon discovery of such substances or devices, employees of the social welfare institution are required to remove them from the person's possession;
- ◆ if it becomes known that a person staying in a social welfare institution possesses or that mail or some other parcel addressed to him or her contains the unprohibited substances or devices related to their use, the person or the mail or other parcel addressed to him or her shall be searched with the permission of the head of the social welfare institution;
- ◆ the right to move freely may be restricted on the basis of a decision of the head of the social welfare

institution or his or her substitute only so far as this is necessary to prevent leaving a person without supervision and to protect the rights and freedoms of other persons;

- ◆ a person staying in a social welfare institution may, on the basis of a decision of the head of the social welfare institution or his or her substitute, be isolated from other persons staying in the institution if the person is dangerous to himself or herself or to others, but for not longer than twenty-four hours. The isolated person must be under the constant supervision of the employees of the social welfare institution.

Every discerning patient has the right to decide about his or her treatment; choose possible medicine, treatment methods or also cancelling treatment, decline from treatment, leave the hospital, choose doctor and treatment institution, and accepting one's earlier statements that were made in the condition of unable to make decisions and that were accepted by service provider. For medical intervention into patient's bodily integrity it is required to have patient's informed consent. The patient can withdraw from his/her consent at any time.

If a treatment institution chosen by the patient can not offer a quality service, the patient has the right to apply for a place in another treating institution where the required standards are guaranteed. In some cases this could

mean that the patient will be directed abroad if it is not possible to provide a service with required quality in Estonia. Every discerning patient has the right to decline treatment or from any kind of medical intervention.

All patients using treatment services or their representatives (lawyers appointed by state), have the right to submit complaints. Information gained from the complaints is necessary for developing better treatment services raising the quality of treatment organization. Complaints may be submitted directly to treatment institution or to Estonian Patient Advocacy Association if the result was not achieved.

6.2 Multidisciplinary Team

◆ The results will be better if the treatment is multi-professional and complex. In the process of treatment there should be experts of different speciality working under the supervision of the psychiatrist – psychologist, psychiatric nurse, social worker and other members of multidisciplinary team. The work of multidisciplinary team can be identified as the cooperation of a group of people aspiring for a common goal with each other's support. Team work provides an opportunity to reach for goals that would be unachievable for the team members if working alone. In Estonia

the multidisciplinary team dealing with mental health and addiction problems consists of family physician, psychiatrist, psychologist, social worker, psychiatry nurse, case organizer, domestic nurse, occupational therapist, special pedagogue and social care worker (table 6, pages 48 and 49). When compared with other multidisciplinary team members, the family physician and domestic nurse have less been included into the prevention, treatment and coping improvement of patients with mental health and addiction problems in Estonia.

6.3 Ethical Codes and Questions

◆ Ethics as part of philosophy is a way of thinking that helps us to deal with the questions related with human behaviour. For those whose profession is related with health care, ethics comprises the following questions: what would be right or how to act in situations that arise during the making of moral decisions concerning the clients. For example, for a nurse the patient study could turn into a constant solving of ethical dilemmas. But if a nurse remembers that her main responsibility lies upon the patient and her profession, and after that the responsibility upon doctor and institution are followed, the right decision is emerging spontaneously. For example, in patient-study it would be considered “correct” if a patient is

Table 6. Multidisciplinary team dealing with mental health and addiction problems

<i>Multidisciplinary team member</i>	<i>Function of multidisciplinary team member</i>
Family physician	The role of the family physician is to prevent and discover mental health problems in early stage of different target groups. A family physician's reference letter is not necessary for attending psychiatrist consulting.
Psychiatrist	A specially trained doctor whose task is to diagnose mental disorders, the treatment and rehabilitation supporting of patient with mental disorders and activities for preventing mental disorders.
Psychologist	A doctor with psychology education, whose speciality is psychological consulting and the appliance of different therapies for improving patient's health and well-being.
Social worker	Specialist in social work who assists hospital patients in solving domestic hardships and consults signed-out ex-patients in social problems (apartment, job etc).
Psychiatry nurse	A nurse, who provides nursing-aid service for patients suffering from mental health and addiction problems. Psychiatry nurse provides the services independently or with special doctor, possesses know-how for working with patients with mental disorders, and for promotion and prevention work.
Case organizer	In case of well-organized work-arrangements the case organizer has had a special training (a qualified nurse or social worker). The case organizer has a number of patients who she/he is responsible and with whom she/he cooperates for achieving the goals that were set, following a certain plan.

<i>Multidisciplinary team member</i>	<i>Function of multidisciplinary team member</i>
Domestic nurse	A qualified nurse who provides caring aid to patients with illness in recovering stage, chronic illness or with limited functional capability treatment requirement (on doctors prescription), and helps the patient to manage in domestic environment.
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. Works with patients at hospital or in supported living. Teaches practical domestic work, communication with state offices etc, helps them with different skills and coping techniques in order to help the person in improving and managing.
Special pedagogue	A specialist with higher education, who knows the essence of different deflections and helps to rehabilitate people with various problems and ages back to full-value life. The special pedagogue's main activity is to guide the development of people with special educational needs, aiming to enhance psychic processes and the development of personality towards the age-proper norm; overcoming / reducing primary disability and avoiding secondary disabilities with pedagogical means.
Social care worker	Social care worker is a first-level worker in social care. Her / his goal is to assist the client with organizing decent life and the gaining of possibly high life standard. Social care worker takes care of client's physical and psychosocial needs, instructs and supports them. Social care worker may work in open-care or caring-institution.

recommended to take continuously pills, uninforming him/her about the side-effects that might lead to changing of life-style – in that respect this kind of activity is not “correct”.

Respecting human life, human dignity and human rights is characteristic for nurse’s activities. Nurse’s job does not depend of the nationality, race or religion, skin colour, age or gender, political or social status. Together with other health care and social care workers, nurse applies her professional knowledge and skills for the service of private person, family and whole society, and for providing them help. In nurse’s profession it is often necessary to make decisions that influence patient’s health. On the 1996 congress of The Nurses’ Union the Code of Ethics for nurses was adopted, aiming to support nurses in decision-making in their every-day work. Nurse’s main activity and responsibility contain four main aspects: health promotion and preserving, prevention of diseases, restoring health, relieving complaints and suffering. A nurse carries personal responsibility for her professional activities, for constant improvement of knowledge and skills. Feeling responsible, a nurse should:

- ◆ act in a way that enhances and protects client’s / patient’s interests and well-being;
- ◆ make sure that there are no activities or omissions in her area of responsibility that would harm or jeopardize client’s/patient’s interests;

- ◆ acknowledge every gap in her knowledge, practical skills and competency, and to decline every obligation or responsibility that is not possible to fulfil safely without having skills or experiences for it;
- ◆ a nurse guarantees and preserves the quality activities in every situation;
- ◆ a nurse analyzes the work of herself and her colleagues and makes suggestions for improving their work;
- ◆ a nurse always acts in a way that will arise reliability towards her and her profession.

Today’s legal systems vary by country in their complexity and content. A professional health care and social worker must be able to make decisions in an existing legal space, starting from general human values, which can be called ethics, as agreed. In spite of the contradictions of legislature, a health care and social worker can not unreact if anybody needs help.

There are situations in which a social worker can be wounded in her / his activities and resulting from conservative fears might not react in conflict situations, damaging thus the essence and reputation of social work. The ethics committee of Estonian Association of Social Work took a responsibility to create a Code of Ethics for social care, which will supplement the legislature and will help the social worker in their hard and necessary work. The social worker’s Code of Ethics was adopted on November 30th,

2005 on the III Congress of Estonian social work. The code comprises the principles of ethical behaviour of a social worker:

- ◆ a social worker serves the interests of society, justifies client's trust and raises and preserves the reputation of one's profession;
- ◆ a social worker supports natural human values and the right to well-being and dignified treatment;
- ◆ a social worker follows and promotes the principles of social justice in the relations with society as well as with people, with whom or for whom she / he works for;
- ◆ a social worker is against discrimination and works for guarantying people's well-being irrespective of their abilities, age, culture, gender, marital status, social-economical status, political preferences, sexual orientation, beliefs, skin colour or other physical qualities;
- ◆ a social worker acknowledges and respects the ethnical and cultural diversity of her / his region of activity and considers personality, family, group and community differences;
- ◆ a social worker provides and is responsible for the distribution of resources that must take place economically, fairly and according to needs;
- ◆ a social worker undertakes to draw the attention of public, interest groups, politicians and his/her employees to situations: where people live in poverty; the distribution of

resources is degrading and unfair, or affects peoples', household's and community's ability to manage by themselves;

- ◆ a social worker will see that public and employees are aware of this document and the expected influence on the activities of social workers;
- ◆ a social worker may launch work-related ethical discussions with the aim of finding the best solution.

6.4 Professional Codes of Practice

- ◆ In Estonia only those health care workers have the right to provide health care services, who have been entered into the registry of health care workers. Since 2002, health care workers are being registered by Health Care Board which acts under the subordination of the Ministry of Social Affairs; entering into the registry is in the interests of patients – so that health care services are being offered only by specialists with relevant qualification. The objective of the state registry is to register health care workers, which in return will authorize them to provide health care services in the speciality that is affirmed in the document certifying their qualification and in the certificate issued upon registering, in order to guarantee state protection of the consumer of health care services through providing health care services by persons holding the

required qualification; also to carry out supervision upon them and to ensure the necessary data for state offices for accomplishing their tasks arising from legislature.

One of the presumptions for providing quality health care services is the competency of service provider. Only those people can act as health care workers who possess the necessary knowledge and skills for providing the services; i.e. their knowledge and skills must meet certain standards necessary for practicing on certain vocations and professions. Up to 2002 state evaluation was carried out accordingly with the directives of the Ministry of Health Care and the Ministry of Social Affairs for the evaluation of nurses. Health Services Organisation Act denounced these directives and so the right for practicing as a health care worker will be obtained after registering at Health Care Board. The right of practicing as a health care worker can only be deprived on the basis of court ruling.

In the spring of 2003 a work-group was organized with the objective to work out the principles of evaluating the competency of nurses and midwives. The following principles are being applied in the evaluation of competency of nurses:

- ◆ Practical working experience and work-analysis – job description in which the person applying for the evaluation of competency analyzes her/his work activities and self-

development according to the scheme provided.

- ◆ Professional self-improvement. Passive and active self-improvement are distinguished when dealing with professional self-improvement. Passive self-improvement stands for participation in courses, conferences etc as a listener. Active self-improvement stands for example the holding of lectures or seminars on courses, instruction of diploma thesis etc.
- ◆ Competency exam or test if needed, in case the person's practical job experience and/or professional self-improvement do not meet the requirements.

Competency evaluation is being carried out by commissions created by the Estonian Nurses' Union and the Estonian Society of Midwives.

In Estonian system of vocational qualifications the requirements for vocational qualifications are specified in five levels. The qualification levels of concrete health care and social workers vocations, including education requirements are set by the Vocational Council for Health Care and Social Work. The requirements for vocational qualifications and basic functions of Estonian nurses have been set in professional standards for nurses, approved by decision no 21 from Sept. 27th, 2005 of Vocational Council for Health Care and Social Work. According to the professional

standards for nurses, a nurse is a health care worker who applies her vocational knowledge and skills for the servicing of single person, family and society, and for providing them help. Nurse's activities are based on four basic concepts: human being, health, environment, nursing, and on four common principles: justice, equality, individuality and cooperation. Basing on nurse's professional standards, the nurse has the following basic functions:

- ◆ Providing nursing aid with the objective to preserve and enhance the health of human beings, preventing diseases, restoring health and the ability to work, and relieving pain and tension;
- ◆ Managing and organising nursing aid;
- ◆ Pedagogical work with the objective of teaching patient, family and population groups, and training members of health care team;
- ◆ Developing nursing speciality, integrating nursing science into nursing practice.

The general skills and knowledge, basic skills and knowledge, personal qualities and abilities for obtaining a social worker's vocation have been set in the new versions of social worker's professional standards III, IV and V, approved with the decision no 17 of Vocational Council for Health Care and Social Work, from Dec. 8th, 2004. According to the description of social worker's professional standard, a social worker is a person with speciality training and higher education, whose

activity is aimed for supporting the coping of individuals, families and groups, and bringing into accordance the community and society with the needs of their members. Social worker's clients are people with coping difficulties. After acquiring special skills and knowledge, a social worker may specialize on the social caring of children, elderly, disabled people or homeless and/or unemployed. The duties of social worker are:

- ◆ to help the client through direct consulting to understand his/her situation, to reach a decision and to find necessary resources;
- ◆ to inform the client about one's rights and society's possibilities, and to mediate or organize social benefits, social services and aid;
- ◆ social worker is the executioner of common work, who's duty is to use and coordinate, or if needed to create a network of specialists and to activate client's nearby network.

In one's activities, a social worker proceeds from human rights, vocation-ethics and confidentiality requirements. The objective is to ensure the equal treatment of all members of the society, considering their national, religious and cultural differentialities. In case the client's rights have not been protected or the needs have not been considered in society, the social worker then acts as the client's representative. Social workers are presumed to have tolerance and commitment, endurance of tension and frustration,

ability for empathy, responsibility and independency in making decisions, also good communication skills, ability for cooperation and motivation.

A social worker works in state, local government, private or third sector institutions: local or city governments, hospitals, schools, children's homes, nursing homes, consulting and rehabilitation centres, prisons, shelters etc. The work of a social worker is directed to certain region and/or certain group of clients.

6.5 Working Methods

◆ There are several methods for working with psychiatric patients. Today mainly combined methods are used that comprise many highly qualified professionals. For reaching the treatment goals, the whole team's social activities and communication will be used. Patients are active participants in this process. Every member of the multidisciplinary team carries responsibility for the whole team and the activities that take place. Team members receive feedback in meetings where events and situations are being discussed. The final goal is the rehabilitation of patient in the way that she / he will cope with the independent life outside the hospital. Patient should be treated calmly and encouragingly.

Cognitive behavioural therapy – behavioural therapy deals with strictly

observed events – with connections of different situations, the human behaviour in these situations, and during therapy tries to help the person to change one's behaviour. Together with behavioural therapy the cognitive therapy was developed that focuses on thinking patterns and on the ways how thinking could cause problems: to change attitudes, irritate or bring forward anxiety situations, cause regretful behaviour. The therapy trains to evaluate oneself objectively and through this improves the person's self-esteem and coping.

Psychotherapy – is directed to the treatment of mental health disorders and crises. Many psychological theories are used in psychotherapy. The objective of psychotherapy is to remove disorders, the soothing and explaining of crises. It can be exercised individually and also in groups and with patients in all ages. It is important to create a therapy atmosphere.

Family therapy – is being conducted by a psychologist, specially trained doctor or nurse. In family therapy, the attitude towards the family must be respective, positive resources must be found and the need for help for the whole family must be identified. The goal of the therapy is the independent coping of family and patient. Family therapy is used in the research work concerning different crisis situations in the treatment of children, youth and adult psychiatric disorders.

Gestalt therapy – it is trained to realize present situation the way a person experiences it and thus the feeling of abusing is soothed. The protection mechanisms adopted in childhood can often become obstructions as an adult. When being in contact with therapist, the patient can take risks and control whether he/she needs the old behavioural models or can these be displaced with new and more functional ones. Thus it is possible to live in more complete way and to use one's possibilities in better way.

Creative therapies – therapies that comprise music, movement, dancing, literature, poetry and art therapies. A therapy can be a short or long-term therapy. It is not required that a patient would have had a certain education. These therapy forms allow people to express themselves in multiple activities and then discuss one's feelings individually or in group.

Electro impulsive therapy – a therapy dating back to 1938. Basing on repeated stimulation of brain with electricity. Prescribed to depression patients, catatonia patients and other patients with mental health problems accordingly with doctor's prescriptions and patient's written consent. The patient must be somatically healthy and fit for anaesthetics. Duration up to 3-10 times, 2-3 times a week in a special room. A slight memory disorder could be a side effect that will be recovered.

Medicament therapy – medicaments are specific and as a rule the prescriptions are made by psychiatrist. Nowadays several depo-preparations are in use as injections and as pills. The treatment of psycho-pharmacoans can not be finished abruptly. It is recommended for the patient to always carry a paper with information about one's drugs. It is important to know the side-effects and interaction of drugs.

Psycho-social rehabilitation – focuses around one patient; a rehabilitation plan is composed, the whole team, patient and her/his close-ones participate in the implementation of the plan. Psycho-social rehabilitation is being exercised in supported accommodation, social centres and nursing homes. Patients are taught every-day skills and self-managing, the necessity of taking medicine, communication with other members of the society.

Soul care – if the patient wishes, the taking into account the patients religious beliefs can also be part of the holistic treatment process. Her / his beliefs should be respected, but the patient's religious beliefs should not disturb other patients. A solution should be found how patients can practice their religious traditions.

Before a treatment plan is composed and medicine is prescribed for a patient in addiction treatment, the following activities must be conducted:

evaluation of patient's general health condition, determination of the using period of substance and addiction's level of difficulty, finding out the social situation. Basing on prior information a suitable cure can be prescribed for the person. In easier cases an addictive person can recover oneself without medical aid, but this presumes good motivation and safe environment. The choosing of treatment tactics must always be carried out together with the patient and all the recommendations must be explained. Very different methods and schemes are used in the treatment of aversion situations. In some cases only psychological assistance, rehabilitation cure and physical medical procedures are used. Therapies that are most often used in addiction treatments:

Cognitive behavioural therapy – one of the most often used therapies among psychotherapies when preventing setbacks from addiction treatment. Majority of the methods of this therapy are also the strategies for preventing setbacks. Three stages can be separated in preventing setbacks:

- ◆ first the patients are trained to recognize the situations of high consuming risks. External risk situations (persons-locations-things) as well as internal risk situations (thoughts and imagining) must be explored. At the beginning it is reasonable to prevent situations that can be eruptive, stimulus control and distraction strategy should be used;

- ◆ skills for foreseeing risk situations and managing with them. In this stage it is important to learn the ways of coping with negative emotions, as well as social skills – for example rehearsing to decline drugs or alcohol.
- ◆ Change in the life-style form the third level. Usually it is necessary to help to change the system of relations, to increase the number of pleasant drug-free activities and to teach general skills of problem solving. Sometimes giving up drugs means also a deeper change in identity.

Group therapy – in case of addiction disorders, it is important to have a certain structure and clear objectives in group therapy. A group offers social support; it is possible to learn from experiences of others and to get feedback about oneself. It is easier to identify oneself with people having similar problem, and the received info is more influential. When preventing relapsing, it is important to have the possibility for playing through the risk situations and to practice social skills. Group therapy is a selection method in long-term treatment programs.

Family therapy – the central object in family therapy is the whole family, but also friends, colleagues and other persons who are related with the problem can be part of the network. The therapy is directed to a circular body of opposite effects, aiming the

family to find itself a necessary change in the system that will accompany the finishing of addictive substances use.

Medicament therapy – for the treatment of aversion situations caused by opioids, the treatment with agonists of opioid-receptors and the treatment with non-opiatic medicals are used. In Estonia methadone replacement treatment (opioidreceptor agonist) is used most often for the treatment of aversion situations caused by opioids. Methadone replacement treatment helps to finish the use of heroin and other opiates, helps to avoid absence symptoms and to control addiction. In replacement treatment a person addictive of opiates is being transformed from the use of opiates to using methadone.

In Estonia the state enters into an agreement with drug addict according to which a daily dosage of drugs necessary for the addict will be ensured. As the net price of methadone is low, the state's expenses for satisfying the addict's needs are low and the benefit of soothing the criminality situation is remarkable. The main objective of the treatment is to provide the addict a possibility not to waste one's money on illegal drugs and through this to provide a chance to raise one's quality of life.

Disulfiram is used for the treatment of alcoholism. The use of disulfiram for the treatment of alcoholics is based on the unpleasant interaction of disulfiram

and the alcohol (so called disgusting-treatment). Disulfiram increases the quantity of acetyl aldehyde, product of alcohol metabolism, in organism that deepens subjective discomforts: queasiness, erythema, dizziness, tachycardia, headache, lack of air. Even small alcohol dosages may cause reaction. Big alcohol dosages may cause critical breathing difficulties, falling of blood pressure and passing out. The medicine can be used once a day by mouth and can also be installed as an under-skin 'ampul' (influences for one year). The medicine is prescribed by doctor. A small operation with local anaesthesia is made for instalment under the skin. A client's health condition and possible contraindications will be checked previously.

Benzodiazepines are mostly used for the treatment of aversion statuses. Benzodiazepines have sedative and anti-spasm effect, but they also have harmful effects, specially the risk for addiction. The so-called small dosage neurolepticums are also used for curing aversion statuses, their advantage is the non-existent risk of becoming addicted.

The Case of Mrs K

Mrs K is a 46- year old married woman with secondary education.

Her family lives in a 3-room apartment in Tallinn's suburb. The region is a low-prestige city-district far from centre.

The family of Mrs K consists of her husband (46 year old) and grown-up daughter (20 year old). K has also a 27-year old son from previous marriage, who lives abroad and does not communicate with mother too often. K married in her youth and the university (Estonian philology) was left ungraduated due to child birth, the fact that is being regretted by K. She would have wanted to become a teacher of Estonian language. K has worked on different job positions: a real estate agent, salesperson and a sales assistant. At present she works as assistant in supermarket's sales-hall.

During the last 19 years K has suffered with mixed types of schizoaffective disorders. For the first time she fell ill 4 months after her daughter's birth.

K's husband has worked as an army officer his whole life. After graduating from high school he signed to soviet army, and after finishing regular military service he started serving overtime and got promoted. After Estonia regained its independence he started serving in Estonian army, where he has served since then. Due to the lack of higher education he has not been promoted for the past 10 years (higher education is required for becoming a senior officer). K's husband has consumed alcohol for years: in early years moderately on special occasions, but during past 5 years he has consumed alcohol every day (at least four 0,5 litre 5% beers every evening).

K's daughter has not continued studying after graduating from gymnasium and at present she is not working either. During secondary school she had been busy with gymnastics, ball-dancing and show-dancing and was interested in dancing career. After graduation she has worked as show dancer in night-clubs and taken part in couple of commercials. K's daughter is not interested in further studying, preferring to spend time on beauty care and shopping.

Mrs. K is worried about her husband and daughter and feels herself guilty in their unsuccess and problems. During recent times she also feels herself lonely, presuming that family members have alienated from her and do not understand her any more. K has no close friends with whom she could discuss her problems.

How could Mrs K and her family be helped?

Mrs K has had relatively good and firm contact (5 years) with her psychiatrist Dr Sepp. But recently Dr Sepp changed his working and living place and started his praxis in

another bigger town in Estonia. K has been worrying whether to change her psychiatrist or to start making visits to another town. But fortunately dr Sepp maintains part of his Tallinn praxis, retaining his reception once a week in Tallinn.

The family physician of mrs K and her husband has not dealt with the family's mental problems, being occupied with the developing of her centre of family physicians and preserving the client list. Mrs K's opinion is that the family physician has not been able to provide significant help in solving her problems.

When hearing about the development of her husband's alcohol problems, dr Sepp recommends considering to participate in the support group for the spouses of alcoholics. For now K has participated in the group a couple of times, but she is not sure whether this kind of therapy can really help her. K is quite uncertain about the common future of her and her husband; she is also uncertain whether participating in group therapy could improve her family's managing.

In order to soothe her family problems, K started using benzodiazepines about 1,5 years ago, with bigger dosages as allowed. Fortunately she admitted her problem to dr Sepp and for now her round-a-clock dosage of alprazolam (Xanax) has been lowered again to 0,75-1 mg. A year ago in the high-point of misusing Xanax K used 2,5-3 mg of Xanax daily.

The episode of misusing benzodiazepines frightened K to the extent that she became over-alerted towards other medicine as well, being afraid that she could become addictive to them also. So she finished using valproate, being frightened about its possible dangers and side-effects. But after this her illness became worse and she was taken to hospital for a month. K experienced that daily use of Orfiril is crucial for preventing the illness getting worse again.

Now K uses Orfiril, Xanax and Sertralin daily. K does not feel any side-effects of the medicines: the daily worrying and anxiety for her and her family's coping has eased, and following the recommendations of dr Sepp, K is trying to reduce the dosages of Xanax. K attends the reception of a psychiatry nurse in every two weeks, who observes the condition of her mental health, explores the affect and side-effects of medicals and makes the next appointment to dr Sepp if needed.

On a reception 3 months ago K told more openly about her worries of the existence of her family, and thus dr Sepp recommended seeing a family therapist P. For now K and her husband have attended two family-therapy sessions and she is hopeful about the future of her family.

7. A Day in the Life of a Health Care Student

◆ There are three psychiatric wards for children and youth in Estonian clinics all together: one of these has specialized on the treatment of children and youth with addiction disorders; the other two are general psychiatry wards. So a single children and youth general psychiatry ward serves approximately half of Estonia's needs. Majority of hospitalizations are planned, emergency children psychiatric care is being offered if needed. It is possible for students to carry out one's mental health nursing or pre-diploma practical training in all these wards.

A day of a student at a practical training of mental health nursing at children and youth general psychiatric ward:

The trainees stay in the ward work-days from 8.00-16.00. A practice day starts with participation in shift changing. Nurses in night shift provide an overview of children's health condition during their shift and changes in children's behaviour. The shift change is attended by nurses, ward's doctor, exercising instructor and psychologist if possible.

Next, the mentor nurse introduces the daily plan of activities to the student and discusses, which of the planned activities play an important role in achieving the student's personal goals in

practical training. The activities which the student could practice during the day are being discussed. A plan of activities is being concluded for the day.

The training instructor introduces the student an 11-year old boy, being in the hospital due to behavioural disorders. The boy is suffering from mental retardation. The student's assignment is to assist the boy with eating. The patient is able to eat by himself but needs instructing and assistance. After these activities the student will document his activities and discusses it with the mentor.

It is then possible for the student to participate in a reception of a patient into the ward. In this specific ward, the whole team is participating in the reception: psychiatrist, psychologist, occupational therapist and nurses. During reception the 9-year old girl is introduced with the ward and the team, the internal rules of the ward are discussed and the obligations of patients and the team during the hospital period are agreed.

The student has again the opportunity to assist the patients with eating during lunch. Special attention should be drawn on 8-year old autistic boy, who is very selective towards food and dining-room's environment. Finally they

succeed in convincing the boy to eat a quarter of the lunch portion. The boy's eating-diary will be reviewed together with the mentor, the calories of last days will be evaluated and it is decided that the boy needs additional food. Together they find out what kind of food the boy would prefer. The boy turns out to be in stress due to a new hospital roommate and therefore refuses from hospital food. Frozen fish-fries are the only food he agrees to eat. The mentor instructs the student how the clinic's system of ordering additional food is functioning and how the computer system works.

During the silent hour after the lunch, further activities are being discussed between student and instructor. Together it is being discussed which playing activities would be suitable today considering the peculiarities of patients in the ward. A joint game is being attended after awaking (the goal of the game is enhancing communication skills and providing feedback).

In the afternoon the student has the opportunity to participate as an observer in a group therapy session for older children (14-17 years). On this day relations with adults and possibilities of improving them are being discussed. During a session, a conflict takes place between two

patients, but luckily it is solved peacefully. After the session the student and the group therapist discuss the events of session and a joint evaluation is given to the technique used for anger management during the session.

8. Vocational Educational System

◆ Estonia has a common system of general education, meaning that the provision of instruction is carried out on the basis of common study programs on every level of education, irrespective of the language of instruction. Local municipalities have established service regions for municipal schools. The school has to guarantee places for children living in the school's region.

Pre-school education is provided by 4 types of pre-school childcare institutions: creches (for children up to 3 years of age), kindergartens (for children up to 7 years of age), kindergartens for children with special needs and kindergartens.

In pre-school childcare institutions the children acquire pre-school education, which creates the necessary requirements for successfully getting along with everyday life and at school. Both the upbringing and education are provided on the basis of the framework study curriculum of pre-school education. Pre-school child care institutions or schools have preparatory groups for children, who are not going to nursery schools; participation in those groups is voluntary. Compulsory school attendance begins when the child reaches the age of 7.

Basic education is minimum compulsory general education. Basic education may be acquired partially

in primary school (grades 1 to 6), basic school (grades 1 to 9) or upper secondary school, which also includes basic school grades. Basic education can be acquired on the bases of three national curricula: national curriculum for basic schools and upper secondary schools, simplified curriculum for basic education and national curriculum for students with moderate and severe learning disabilities. Basic school is divided into three stages of study: I stage of study – grades 1 to 3; II stage of study – grades 4 to 6; III stage of study – grades 7 to 9. After graduating from basic school there are several options for the acquisition of further education: to acquire general secondary education at an upper secondary school, secondary vocational education at vocational educational institution or to simply enter a profession.

General secondary education

In upper secondary schools the provision of instruction is carried out pursuant to the national curriculum, on the basis of which each school establishes its own study curriculum. During upper secondary school studies it is possible to acquire a profession taught in the school. At the end of the three-year study period students will take five final examinations, including at least three state examinations with standard questions. Acquiring general secondary education enables

to continue studies to obtain higher education or vocational education.

Vocational education: the definition of vocational education comprises all the forms of vocational, speciality and profession studying. The types of vocational studying in formal educational system are: vocational pre-training, vocational secondary education and applied higher education. Different trainings and courses are taking place outside the formal educational system. In the volume of selective courses vocational training may be offered also by the gymnasium in cooperation with the vocational educational institution. The acquiring of vocational secondary education can be started after graduating basic school or gymnasium. The graduates of vocational institutions willing to continue on higher education level have to pass state exams.

All people with secondary education have the right to apply for the curricula of higher education offered by universities, institutions of professional higher education and vocational educational institutions. It is possible to choose between two types of curricula, depending on the first level of higher education:

- ◆ theory-based curricula of Bachelor's study in order to develop practical skills on the basis of theoretical principles;

- ◆ or practice-based curricula of professional higher education in order to develop theoretical knowledge primarily based on practical needs. Practical work makes the minimum of 30% of the curriculum. Both professional higher educational study and Bachelor's study are first level studies and a person having completed the studies has the right to continue his or her studies in Master's level.

The nominal duration of Master's study is one to two years and the study load fixed in the curricula is 40–80 credit points (60 – 120 credit points in ECTS). The nominal duration of Bachelor's and Master's study is at least five years in total and the study load fixed in the curricula is 200 credit points (300 credit points in ECTS). Having completed Master's study it is possible to continue in Doctor's study.

Estonian education system is described on following figure (figure 9).

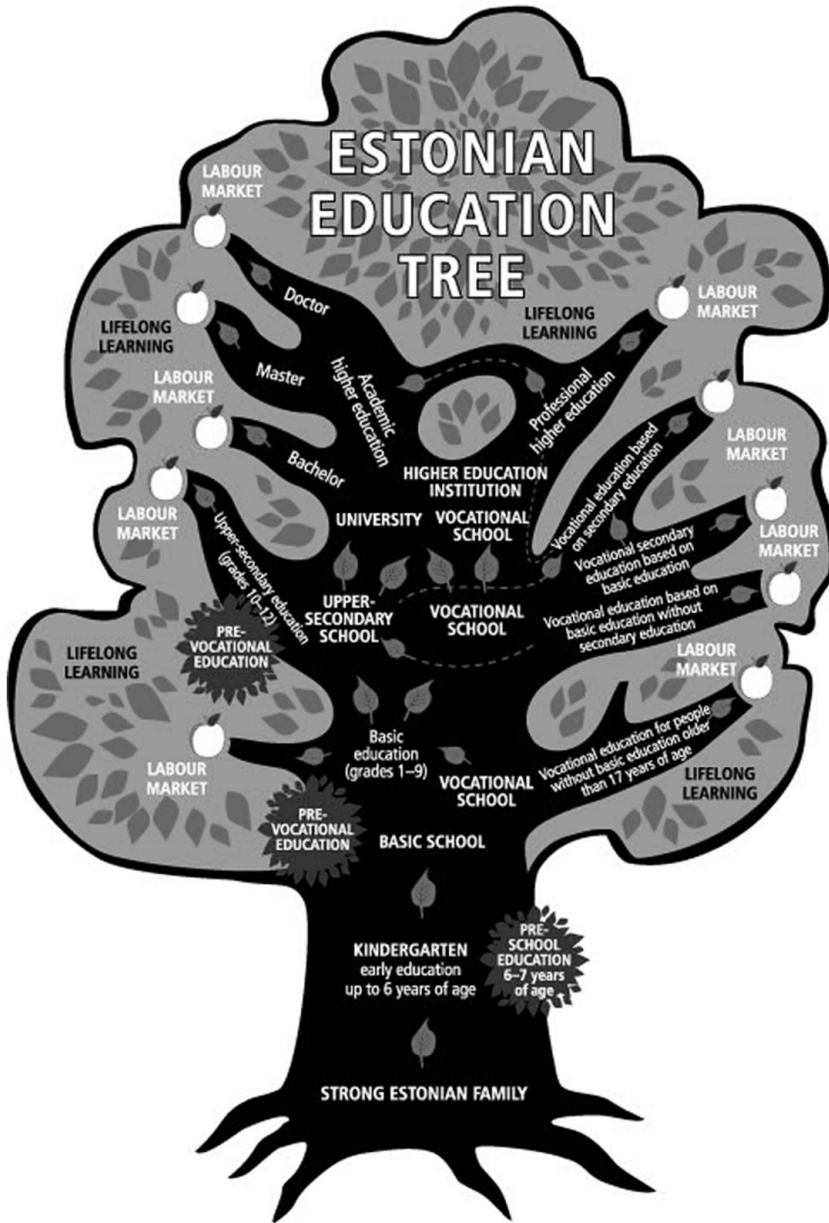


Figure 9. The Estonian Education Tree. Source: Ministry of Education of Estonia.

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Glossary

Abusing – consumption of substance during such time, status and conditions in which it could be dangerous for health or deteriorate coping with life.

Addiction – forced consuming of addictive substances that an individual cannot control and that leads to the emerging of heavy health, psychological and social problems.

Alcohol – food group formed by spirits and alcoholic beverages (Alcohol Act).

Alienation status – a bunch of symptoms with different difficulty level that emerges in case of absolute or relative abandoning of narcotic substance, if the substance has been used regularly and in big quantities.

Alternate treatment – treatment process of a person with dependency.

Amphetamine – (incl. methamphetamine) synthetic stimulant. Usually in the shape of powder and it is possible to inhale through nose, mix with a drink or inject. Causes high psychological dependency and may also cause physical dependency.

Cannabis – a plant which female plant's bruised top and parts of inflorescence are used for producing marihuana and hashish.

Coping – person's or family's physical or psychosocial ability to manage in everyday life.

Daily centre – a daily rehabilitation facility for patients who have given up drugs in the subordination of social caring. Patients having finished successfully ambulatory or stationary aversion syndrome therapy, who are motivated for further drug-free life, having home and family, but lacking study-opportunity or job.

Detoxification – a combination of medical methods aiming to treat acute aversion status

Drug – chemical substance that causes changes in human being's mental, physical and emotional condition.

Drug addict – a person who, as a result of using narcotic drugs or psychotropic substances, has a psychological or physical dependency on such substances.

Drug addiction – psychological or physical dependence which develops as a result of using narcotic drugs or psychotropic substances

Ecstasy – MDMA (methylenedioxyamphetamine) in the forms of pills used via mouth (by eating). Causes psychological dependency and could cause physical dependency.

Heroin – semi-synthetic opiate. Usually in form of white powder (the reason why sometimes called as white heroin in order to separate it from black heroin), that is mixed with liquid and injected to vein. Causes very high psychological and physical dependency.

Light alcoholic beverage – light alcoholic beverage with the content of ethanol up to 22 % per volume.

Mental disorder – a psychological status or behaving disorder that corresponds to valid international classification of psychological and behaving disorders.

Mental health – subjective situation of well-being, independence and intellectual and emotional potential that enables the individual to apply his/her abilities, cope with every-day stress and to participate in social life (WHO 2001).

Mental health daily-treatment facility: A facility that typically provides care for users during the day. The facilities are generally: Available to groups of users at the same time, expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff and involve attendances that last half or one full day.

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.

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 stand separately, 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.).

Narcotic Drugs and Psychotropic Substances – substances listed in the schedule established on the basis of subsection 31 (1) of the Act on Narcotic Drugs and Psychotropic Substances and stereoisomers, esters, ethers and salts of these substances, and medicinal products containing such.

Open Caring – a flexible health care and caring system that has grown socially from clients needs and bases on cooperation that guarantees the client/help requirer a possibility to live at home securely and as long as possible.

Opiates – many natural and synthetic substances belong to this group (incl morphine, methadone etc). Source plant is poppy.

Prevention – intervention before the formation of health problem, or during a developing but clinically not very notable disease or health problem, or before discovering of seizure

Psychiatric help – diagnostics of psychiatric disorders, rehab help and treatment of person with psychiatric disorders, and activities for the prevention of psychiatric disorders.

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.

Rehabilitation – restoring functions that were damaged during illness.

Strong alcoholic beverage – strong alcoholic beverage with ethanol content over 22 % per volume.

Treatment – eliminating disease, disorder or symptom.

Appendix (model of care plan)

◆ A 47-year old woman is being hospitalized in the psychiatric department with a diagnosis of Moderate depression without somatic symptoms (F 32.11). The patient complains about mood declining and lack of willingness. She feels that she does not cope with work and taking care of family. Worries about work duties, thoughts about coping with work are prevailing also outside work. Every day during recent weeks she had closed herself to bedroom so that she does not have to communicate with husband and children. The patient also complains about sleeping problems – she tosses and tumbles in bed for several hours before falling to sleep. During the night sleeping is fragmentary; during day-time she feels herself sleepy and uses every moment to lie down in bed. The patient feels that the situation is inescapable and she does not have any hope of getting help or support from somebody.

Nursing problem	Objection of Nursing Activities	Nursing Activities	Results
Melancholy, related with low self-esteem and ineffective coping in every-day life situations	<ul style="list-style-type: none"> Feels the improvement in state of mind; Knows how to cope with negative automatic thoughts; Fills in daily-plan and feeling diary. 	<ul style="list-style-type: none"> Create a secure and reliable relation-ship; Encourage to express your feelings, thoughts, experiences; Give instruction about keeping feeling-diary and support her in filling it; Instruct how to recognize automatic thoughts and to cope with them; Help to compose a daily-plan, explain the favourite activities and motivate to deal with them; Support patient's activeness in daily activities and in finding ways of coping; Give credit even with smallest success. 	<p>01.09. State of mind 3/10. 03.09. State of mind 4/10. 05.09. State of mind 3/10.</p> <p>Follows structured daily-plan. Expresses thoughts connected with inferiority and guilt. Fills the state of mind diary (etc. etc)</p>
Interfered sleep, expressed in difficulties of falling asleep and awakenings during night (sleeps four hours during night, passive during day-time and lies down a lot).	<ul style="list-style-type: none"> Feels relaxed – sleeps eight hours during the night. 	<ul style="list-style-type: none"> Make certain earlier sleeping habits; Explain sleeping hygiene; Explain about keeping a sleeping diary and support the filling of it; Create an appropriate environment for falling to sleep; Motivate daily activity. 	<p>01.09. Sleeping during night for 5 hours (has administered prescribed sleeping pills if necessary). Experiences daily sleepiness. 03.09. Sleeping during night for 5-6 hours, with frequent awakenings. 05.09. From doctor's orders sleeping pills changed (Stilnox to Imovan). Sleeps for approximately 7 hours. Minimal daily sleepiness.</p>
Anxiety, determined from ineffective coping and prevailing negative thoughts.	<ul style="list-style-type: none"> Knows how to cope with anxiety. 	<ul style="list-style-type: none"> Make certain earlier coping ways with anxiety/stress; Make certain the thoughts and situations that are creating anxiety; Instruct the steps of solvable problem treatment; Instruct in relaxing and breathing exercises. 	<p>01.09. Anxiety 6/10 before the discussion about negative thoughts; anxiety after the discussion 5/10. 03.09. Anxiety 4/10. Expresses signs of successful coping with anxiety; knows how to soothe anxiety through discussing about her thoughts. 05.09. Anxiety 2/10. Feels that it is possible to control anxiety.</p>

<p>Social isolation that is expressed in avoiding family and friends.</p>	<ul style="list-style-type: none"> • Participates in social communication and in activities with others (family members, friends, other patients); • Expresses content after participating in social conversations or activities. 	<ul style="list-style-type: none"> • Help to maintain and create bonds with close persons; • Explain the participation of close persons in healing process; • Make conversation with patient in interesting topics, hobbies and encourage to participate in social relations and activities; • Add short activities and communications with close ones to daily plan, e.g. phone calls, common activities, visits; • Explain treatment factors of group-therapy and engage to group-therapy. 	<p>01.09. Does not wish to meet with husband or kids, but thinks about them frequently. Avoids communication with other patients.</p> <p>03.09. Jovially communicates with hospital roommates and staff. Makes phone calls to husband and asks to visit her.</p> <p>05.09. Tight-lipped and tearful when meeting with husband. Feels happy after having seen her husband.</p>
<p>Deficiency of knowledge about the essence of depression and healing processes.</p>	<ul style="list-style-type: none"> • Is aware about the essence of depression and healing process. 	<ul style="list-style-type: none"> • Explain the symptomatics of depression; • Explain the healing process, including the symptoms of possible regression and coping with them; • Suggest reading hand-outs about depression and self-help guide books. 	<p>01.09. Reads literature and hand-outs about state-of-mind disorders and discusses about them.</p> <p>03.09. Discusses about treating depression and it's prognosis with nurse.</p> <p>05.09. Understands that treatment is possible and agrees to actively contribute to it</p>
<p>Deficiency of knowledge about the medication used.</p>	<ul style="list-style-type: none"> • Is aware of medication used. 	<ul style="list-style-type: none"> • Explain the effects of used medicine and possible side-effects; • Explain and observe the correct administering of used drugs. 	<p>01.09. Reads pharmaco-therapy literature about depression, medication fact-sheet and discusses about it with nurse.</p> <p>03.09. Discusses about individual treatment-plan and about coping with side-effects of medication.</p>

Notes

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