1 Mental health in Estonia at the beginning of the 21st century

1.0 Introduction

Mental health in Estonia at the beginning of the 21st century

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KEY MESSAGES

1. Mental health is a broader concept than the presence or absence of mental health problems. It refers to a state of well-being in which individuals can cope with the stresses of everyday life and realise their abilities.

2. Mental health problems are more widespread than commonly believed, and during the COVID-19 pandemic, they became even more prevalent. Self-report surveys show a much wider prevalence than indicated by registered cases.

3. Mental health problems can be effectively prevented and treated. Every euro invested in systemic intervention can save tens of euros in the long term.

INTRODUCTION

The World Health Organization (WHO 2001) defines mental health as 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'. This definition says something crucial: mental health is more than the absence of a disorder or of 'ill-being'; it also involves acting meaningfully within the limits of one's abilities or extending those limits.

This chapter contains five articles that discuss both positive and negative mental health. The first three articles are based on the WHO's definition of mental health cited above: the topics are life satisfaction (Ainsaar and Konstabel), stress and coping with it (Lehto et al.) and success, or realising one's abilities (Täht et al.). The fourth article looks at the occurrence of mental health problems, risk factors and protective factors (Akkermann et al.). The fifth article discusses activities and services supporting mental health in the broadest sense – from prevention to specialist medical care (Randver et al.).

Mental health is more than the absence of disorder or 'ill-being'.

> *'I'm not crazy – my mental health is fine. Don't send me these forms or I'll call the police.'*
>
> A person invited to participate in the survey who apparently only read the title and so was not aware of the positive definition of mental health or the fact that everyone invited to take the survey could opt out, even without the help of the police.

How and why should we talk about mental health?

People tend to notice and think about mental health only when something is wrong. Thinking can help fix mistakes, but it can also make things worse. At the individual level, a characteristic response is 'rumination' – thinking about a negative event over and over. This may help the person avoid similar situations in the future but mostly just prolongs feeling miserable. Looking at the mental health situation of the population, on the other hand, stigmatising a specific age group or emphasising the difficulty and hopelessness of problems can exacerbate the situation.

For example, what are we to make of the information that, based on a self-report survey at the beginning of 2021, more than 50% of 18-to-24-year-olds were at risk of depression in Estonia? One might think disaster is imminent and that to avoid it, the number of psychiatrists must be increased as soon as possible. However, this conclusion should be considered in the proper context. First, we know that during the pandemic, the prevalence of depression and anxiety also increased in other countries and age groups, and negative life events and difficult life periods often lead to symptoms that later subside. We also know that depression is less stigmatised among young people. Therefore, we can assume that younger respondents more readily recognise possible symp-

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toms of depression. Finally, the risk of depression does not automatically translate into a clinical diagnosis.

These considerations do not change the conclusion that the situation is serious and needs attention. But we must pay attention to details and how we interpret the information: we cannot expect the facts to speak for themselves. By changing the emphasis, the situation can be cast as hopeless, which is not useful and limits the possible courses of action (cf. Bandura 1997).

Measurement and research

In this chapter, we use two main sources of information on population mental health: registry data and surveys. The primary registry data we use is the Estonian Health Insurance Fund's database, where a diagnosis is recorded when services are used or medicines prescribed. These diagnosed cases provide information about mental health disorders, but with an important caveat: only services financed by the Health Insurance Fund are reflected in the database, and the in-

'How could I behave so inappropriately? What could they be thinking about me? What will happen now?'

dividual must first seek help to receive a diagnosis. Thus, if we rely solely on data about diagnosed cases, we underestimate the rate of 'ill-being' in the population and learn nothing about the rate of well-being. On the other hand, registry data has important advantages over surveys. The diagnosis is based on a thorough assessment by a specialist; the entire population can be included (not just a sample); the subjects do not have to be approached separately; and uncertainty and bias due to insufficient response rates are avoided.

The questions used in mental health surveys will always involve a degree of subjectivity and ambiguity, which is why verifying the informational value of the questionnaire is particularly important. Information indicating the quality of a questionnaire is described with the blanket term 'validity' (Goldstein et al. 2011).

Since questionnaires are a less expensive and less accurate tool than diagnoses made by a specialist, the predictions they provide are always approximate, but it is important to know their level of accuracy. One helpful way of describing accuracy is known as 'positive predictive value' (PPV): if a respondent is at risk of a disorder according to a test result, how likely is it that they actually have the disorder? For example, the EST-Q-2 depression scale used in the article by Akkermann et al. has a PPV of 0.44, which means that 44% of respondents with a

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If we want to avoid making a decision based on incomplete information, we should leave it to the 'day after doomsday'. While this approach has its merits, it can be slow. Even when our judgement is based on the best evidence, something can go wrong. Mäe Tanil, a master shipbuilder from the island of Kihnu, knew this when he said: 'If you do nothing, you get nothing wrong. Do something, and you get something wrong.' (A quote from Kihnu Museum.) Science aims to reduce any uncertainty associated with measurement, but uncertainty cannot be completely eliminated.

score exceeding the risk threshold would receive a diagnosis of depression based on the interview. That is a fairly good level of accuracy in this area.

For health and social policy planning, it is important to estimate the prevalence of disorders as accurately as possible: if we want to know the optimal number of psychologists or psychiatrists per 100,000 inhabitants, a 10% difference in the prevalence rate of the relevant disorders matters. Reliable conclusions about time trends and risk and protective factors can also be drawn from questionnaires with a less well established level of accuracy. Such conclusions are also important and can or could affect our everyday life: for example, knowing that a lack of sleep and physical activity are risk factors for depression (see Akkermann et al. in this chapter and Reile in Chapter 2).

Determinants and interventions

According to a widely cited account (Tarlov 1999), the determinants of population health can be divided into four categories: genetic and biological characteristics, health behaviour, medical care, and social and environmental factors. Tarlov emphasises that the relative importance of these factors cannot be accurately assessed. However, Tarlov does provide a rough diagram in which social and environmental factors have the largest impact, followed by health behaviour and medical care in roughly equal proportions, and last,

hereditary (genetic) differences. It is worth noting that these factors are not independent of each other. For example, social and environmental factors are largely mediated by health behaviour and medical care; medical care, in turn, depends on healthcare organisation, which is part of the social environment.

Complex human characteristics (e.g. behavioural patterns, personality traits, and mental health and related problems) arise from the interaction of genes and the environment, and they depend on many genes rather than just one or two. In this chapter, Akkermann et al. use the genetic risk score for depression, which encapsulates information on about a hundred known depression-related gene variants. The risk score is related to the likelihood of depression, but even with the highest risk score, a diagnosis of depression is far from certain, just as having the lowest possible risk score does not rule such a diagnosis out. Genetic characteristics are important but are not the only determinant.

In addition to genes, a number of environmental factors (see also Chapters 3 to 5) are known to affect the likelihood of mental health disorders. Factors that increase the likelihood of depression include physical, sexual and emotional abuse, stressful work, a sedentary lifestyle, and sleep disorders (Arango et al. 2021). Several of these factors are also discussed in the article by Akkermann et al. in this chapter; once again, the impact