



ANED country report on the implementation of policies supporting independent living for disabled people

Country: Estonia

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The information contained in this report was compiled by the Academic Network of European Disability experts (ANED) in May 2009.



PART 1: EXECUTIVE SUMMARY AND CONCLUSIONS

Estonia has undergone substantial transition in recent years. In 2004 a comprehensive concept for the development of social welfare was elaborated. Following these basic principles, the Social Welfare Act has been amended. In accordance with this Act support for independent living has been targeted through several social services.

Over the time mainly the use of rehabilitation, technical aids, child care, specific needs for people with disability at the state level have been facilitated, but also at the level of local government the following services have been facilitated: social counselling, home care services, social housing, adapting dwelling, social transport, personal assistant. Services at the local government level are provided according to the assessment of the need.

In 2006 the situation in the sphere was evaluated from the viewpoint of these with special psychiatric needs / intellectual disabilities and the reorganisation plan was elaborated for years 2006-2021. The main principles of providing the services for independent living were elaborated.

Estonia has fragmented family structures due to long-term high mortality rates and almost 30% of the population is of immigrant origin. The country also has one of the lowest levels of the main health indicator – healthy life years - in Europe. Given these issues, clearly the rate of institutionalisation in the country does not correspond to the needs of the people involved. Trends towards independent living are monitored by the different services provided (see [Sotsiaalministeerium: Services Statistics](#))

In qualitative research on supports to facilitate employment disabled persons have pointed to several problems concerning support for independent living. The main problems concern a lack of resources, for which reason the services are not available for everyone.

There are several examples of good practice which prepare the disabled for independent living in Estonia: examples chosen here are those targeted for preparing young people ([Estonian Agrenska Foundation](#)) and mentally disabled ([Maarja Village](#)).



PART 2: LEGAL AND POLICY CONTEXT

The [Estonian Constitution](#) provides the basis for securing the main rights of all people living in Estonia, including disabled people. Par 34 states that everyone who is legally in Estonia has the right to freedom of movement and to choice of residence. According to par.26 everyone has the right to the inviolability of private and family life, but par. 27 also declares that the family has a duty to care for its members in need. More specifically par. 28 declares the role of state and local governments in securing quality of life for disabled people or others with reduced capacity to cope with their lives. Par. 28 says:

‘Everyone has the right to the protection of health. An Estonian citizen has the right to state assistance in the case of old age, incapacity for work, loss of a provider, or need. The categories and extent of assistance, and the conditions and procedure for the receipt of assistance shall be provided by law. Citizens of foreign states and stateless persons who are in Estonia have this right equally with Estonian citizens, unless otherwise provided by law. The state shall promote voluntary and local government welfare services. Families with many children and persons with disabilities shall be under the special care of the state and local governments’.

More specifically, the [Social Welfare Act](#)¹ regulates assistance to disabled persons with independent living in §26 ‘Social welfare of disabled persons’. This conceptualises state support as seeking to provide ‘equal opportunities’ and ‘active participation’ and independence. It includes provision for the development of treatment, education, rehabilitation, vocational training, adapted employment, transport, access to public buildings, personal assistance, guardianship, social services and benefits.

Provisions for better coping with independent living are also foreseen in other Estonian laws. For example, §3.9 of the [Building Act](#) states that ‘If required by the purpose use of the construction works, the works, parts thereof which are for public use and the premises and sites thereof shall be accessible to and usable by persons with reduced mobility and by visually impaired and hearing impaired persons’. In the [Language Act](#) §1.3 and 1.4 it has been stated that ‘Estonian sign language is an independent language and signed Estonian language is a mode of the Estonian language’. The state is required to promote them alongside the Estonian language. [The Occupational Health and Safety Act](#) (RT1 I 1999, 60, 616) specifies the need for adaptation to the workplace and work practices to accommodate the physical and mental capabilities of a worker with a disability. The [Child Protection Act](#) dedicates the whole of chapter 8 to disabled children and their rights, among others stating in par. 52 that the disabled child shall have ‘opportunities for education, development and self-realisation equal to those of able children’; in par. 54 that ‘public buildings, roads and means of transport used by disabled children shall be adapted to accommodate movement by wheelchair, crutches or other aids’.

Several strategies and other development plans take into account the needs of disabled people for independent living. Estonia has undergone substantial transition in recent years. In 2004 a comprehensive concept for the development of social welfare (“[Hoolekande kontseptsioon](#)”) was elaborated, which elaborates the main principles to be attended in assisting people with independent living. Following these basic principles, the Social Welfare Act has been amended. In accordance with this Act support for independent living has been targeted through several social services.

¹ A version of the Act (used for subsequent quotations) is available in English at: <http://www.legaltext.ee/text/en/X1043K9.htm>



Several specific strategies have also addressed issues relevant to independent living - for example, [Estonia Housing Development 2008-2013](#), [Transport Development Plan 2006-2013](#), and the [Estonian Information Society Development Plan 2013](#).

In 2006 the situation was evaluated from the viewpoint of these with special psychiatric needs and a reorganisation plan was elaborated for years 2006-2021 ([Kokk & Kurves 2006](#)). The main principles of providing the services for independent living for people with special psychiatric needs were elaborated, with extensive recommendations and conclusions about service principles, quality and management.

Significant developments have been made in recent years where services for independent living are concerned. Whereas as recently as the end of the 1990s people with such needs were only provided with 24-hour care services, in the years that followed a full range of other services were also made available to them: support for everyday life; supported living; living in a community; and most recently (2001) support for employment. One of the main promoters besides the government has been the [Estonian Mentally Disabled People's Organisation](#). Proposals they have forwarded to the Chancellor of Justice, for example, concern the right to vocational training for those people who cannot attain basic or general education, provision for general education and at least a possibility of a three-year continuation study period in addition to the nominal time period for acquiring general education.

European Structural Funds for the years 2007-2013 have been invested in special training sessions to people with disabilities. The needs for different services for supported employment were also assessed through a qualitative survey of people with disabilities ([GfK Custom Research 2008](#)). The provision of national rehabilitation services has been mapped and assessed through the PITRA project, including consideration of personalised budgets (see [Roht 2008](#)) and the new Regulation of the Minister of Social Affairs No.35 has partly taken into account their suggestions.



PART 3: PROGRESS TOWARDS INDEPENDENT COMMUNITY LIVING

In Estonia, living in residential institutions has been historically very low. Partly this is due to the general context prevailing for 50 years - being incorporated into the Soviet Union. During this time there was practically no assistance other than state care in a few severe cases, which meant that these people were institutionalised for their lifetime. For intellectually disabled children there were special schools that they attended but in all other cases it was mostly family care. For example, of all school-aged children, disabled children attending special schools formed 2.7% in 1995. of these, 40% attended special boarding schools. Among school-aged children around 1% were in nursing homes (approximately 13% of disabled school-aged children).

The population age structure was generally very young for many years although it started to age significantly from the 1960s (Katus K., Puur A, Põldma A., Sakkeus L. Population Ageing and Socio-economic status of older persons in Estonia. UN, New York and Geneva 2003, [see tables](#)). Thus, the population trends in Estonia were in great contrast to that of the average of the Soviet Union. The nations in other countries, except Estonia and Latvia, originated from the regions with significantly later timing of demographic transition, which aside from much later entry into the ageing phase also meant different household patterns, i.e. the major part of the population in these countries lived in multi-generational households. Thus, the Soviet Union lacked a system of institutionalisation for other than purely medical reasons (although a certificate from a Psychiatric Hospital was often needed to confirm that a person did not have a mental disorder, and people reluctantly succumbed to treatment). In compliance with the central planning system, no country received larger resources than estimated for each country, relying on the average needs for the Soviet Union as a whole.

By 1989, the proportion of institutionalised people among the aged 50+ was around 1.1%, in 2000 it had risen to 1.7%. In the total population the proportion was 0.6% in 2000 (Population Census 2000). The Census data suggest that more disabled men were reported in institutions and more disabled women in private households (see table below).

Table 1: POPULATION WITH LONG-TERM ILLNESS OR DISABILITY, 31 March 2000 by Place of residence, Sex and Need for assistance*

		..living in private household	..living in an institution
Whole country	Males and females	97,929	5,225
	Males	46,289	2,768
	Females	51,640	2,457
* Living in private household - includes homeless persons.			

Amongst the total number living in institutions at this time, 3,810 were of Estonian ethnicity, 1,004 Russian and 212 other (and 199 unknown). Of those living in private households, 21,055 were reported as needing 'assistance in taking care of himself/herself' (3,576 out of 5,225 for those living in institutions). Of those in private households requiring assistance, 14,484 were Estonian, 5,169 Russian, and 1,367 other ethnicity.

Amongst the general population data 7,822 people were identified as living in 'social welfare institutions' (these are mostly homes for elderly people and long-term nursing care, but with minimal health care treatment) plus 310 living in 'health care institutions' (long-term nursing care facilities with treatment). 3,420 were described as living in 'other institutions' (most of these are younger adults and the figures include prisons, nunneries, special boarding schools for children with behaviour problems, military conscripts).



Thus, during the economic transition the capacity for institutionalisation has not increased greatly, however, by the same data over 14% of the population live alone and among those aged 50+ one-person households form more than 35% (Population census 2000). Family structures are fragmented due to high long-term mortality rates, almost 30% of the population is of immigrant origin and Estonia has one of the lowest levels of the main health indicator – healthy life years – in Europe. Clearly the proportion of institutionalisation in the country remains very low (see Sakkeus L. [Health development of the population of Estonia](#) and [Estonian Health Interview Survey 2006](#)). The main reason for the low level of institutionalisation in Estonia has not been so much the increase in support for independent living but economic reason. Although long-term care is supported by local governments, in 2006 long term institutional care cost over 55% of residents' income ([Mäe et al. 2007](#)).

Trends towards independent living are monitored by various service providers. Information has been available since 2003 when data on independent living support was collected for the adult population with special psychiatric needs. For this category of the population the proportion of institutionalised people decreased by 10% from 1998 to 2007. At the beginning of the period from 2003, 53% of this category of the population received long-term care in an institution. Between 2003 and 2007 this decreased to 48%. Among the services provided for independent living support for everyday living prevails² with more than 60% and a slightly increasing trend, followed by 20% for supported living³ and a decreasing proportion of supported employment (over 15%), leaving the support for living in the community⁴ with a marginal 1.3% of all the services provided. In comparison with those institutionalised support for community living is provided mostly for persons under 40 years of age who comprise 56% of all who have received such support. Of those institutionalised, older persons prevail with 58% being over 40 years of age (see Kreitzberg 2007, in [Mäe et al. 2007](#)).

However, there is little data to assess the overall services for support on independent living other than for those with special psychiatric needs, supported by state and described above. Even for this contingent it was estimated in 2000 that there were 7,000 persons with special psychiatric needs needing assistance, whereas support (mostly in the form of institutionalisation) was given to about 4,300 persons. Others were the responsibility of families. For all other disabled persons services are mainly delivered at the community level, where people depend to a great extent on their own resources and the inequality of distribution of resources between local governments. There is no comprehensive data about the delivery of these services.

In the data on the institutionalised adult population (except for the population with special psychiatric needs) it becomes evident from annual data about movements that of those leaving the institutions in 2007, 0.5% left to supported living, 4.7% left the institution to independent living on their own and almost 17% to independent living with a family. Over the years, with the rising admission rates, the proportion leaving to supported living has diminished significantly from over 4% at the beginning of 1998. The [rate of leaving the institution](#) for independent living has remained the same over time (not including people with mental health conditions).

Among the institutionalised adult population almost half were disabled people and more than 22% people with severe disability (figures from [Süsteemi H-Veeb](#)).

² Support for every-day living is the service for people with special psychiatric needs to support the stability in their health status, maintain their elementary abilities and acquire new ones, monitors their every-day life quality at the elementary level.

³ Supported living is foreseen mainly for people with intellectual disability who are living together in a separate house, carrying on their every-day life activities where their living is overseen by a specialist and they receive assistance with daily living.

⁴ Living in a community is supported living mainly foreseen for young people with intellectual disabilities, organised in a village-type surrounding to assist their coping with every-day living under supervision of specialists.



Unpublished data on the division of the expenditure between the institutionalized and those receiving support for independent living among the adult population with special psychiatric needs for 2003-2007 testifies that the proportion spent on support on independent living has increased from 23% to 28%. The proportion of expenditure paid by service recipients in these services remains around 14% over the years, being smallest for the support of every-day independent living and supported employment (from 1-5%). For supported living and those institutionalised personal contribution expenditure comprises almost one third of the total expenditure on these services. In 2007 total expenditure per person receiving these above-mentioned services comprised 52,200 EEK and for services supporting independent living they were over 23,800 EEK per person per year (Communication with Department of Social Policy Information and Analysis, Ministry of Social Affairs).

Family-type housing is the focus of policy intervention with regard to de-institutionalisation, however, it has a very long way to go, taking into account the economic situation.



PART 4: TYPES OF SUPPORT FOR INDEPENDENT LIVING IN THE COMMUNITY

The state compensates people with disabilities for the additional costs they incur due to their need for assistance. This need is determined according to the extent of disability, which can be moderate, severe or profound. The extent of disability is based on whether a person requires assistance 24 hours a day, 12 hours a day or at least once a week. The extent of a person's disability may change as a result of rehabilitation, the use of technical aids, adaptation of their living environment and other factors. While the need for assistance is in principle the basis for assistance, in practice, if there is a family member available to help then they will be expected to do so.

Rehabilitation services have been more facilitated since 2005 ([Sotsiaalministeerium: Rehabilitation](#)). Particular attention is paid to the development of rehabilitation services so as to improve the ability of people with disabilities to cope independently, increase their social inclusion and facilitate their working or taking up a job. Social benefits for people with disabilities are increasingly centred on rehabilitation, the aim of which is to teach people how to cope as independently as possible in the new situation they find themselves in.

Over time, other services have been provided at the local government level, according to an assessment of need. These include: [social counselling](#), [home care services](#) (particularly for domestic assistance to elderly people), [social housing](#), [housing adaptation](#) and [social transport](#).

The following services are available at the state level:

- Support for [technical aids](#) (described in 4.2)
- [Rehabilitation services](#)
- [Childcare](#) for carer of a child with profound or severe disability (in 2008 the state paid 5,800 EEK per child a year for such a service)
- Special care for people with special psychiatric needs. Special care services are available to adults who have developed a greater need for personal assistance, instruction and/or supervision due to severe or permanent mental disorder. [Regulation No 5](#) of the Minister of Social Affairs (January 9, 2008) specifies eligibility criteria.

According to [Ministry figures](#) 6,428 people were using home care services in 2007 (4,863 of them women, 1,565 men). Of these 3,960 were defined as having 'special needs', and the vast majority of these (3,176) over the age of 65. There has been a steady increase in the number of these service users, up from 2,927 in 2002. [Total expenditure on home care](#) increased from 18,454 EEK to 63,145 EEK in the same period, although the number of providers remains roughly constant.

In addition to personal assistance (described in 4.1) support in the community may be provided by social workers, support persons and childcare workers. A social worker is defined in the Social Welfare Act as a professionally trained person with higher education, usually engaged in organisation of welfare services, assessing the needs etc. A support person, providing assistance funded by local government, should empower and guide a person in their everyday life, exercising their rights and managing in difficult circumstances their everyday life. In the case of children it might also mean providing a secure and supportive living environment. Such support can be accessed either in school, at work or at home. It is offered not only for disabled persons but also for those who cannot manage their lives on their own (e.g. people starting their life in a community after imprisonment, children who need replacement homes etc.). A childcare worker is a person who assists a parent with their duties at home, work, education or care for a child, usually paid by parents themselves (the state pays childcare for severely or profoundly disabled children).



4.1: PERSONAL ASSISTANCE SERVICES

The Social Welfare Act (§26.6) makes specific provision to ‘appoint a support person or personal assistant, if necessary’.

[Personal assistance](#) is funded at the local government level and aims at increasing independence and social involvement, while lessening the ‘burden of care’ for family members of a disabled person.

Local governments assist with hiring personal assistants to help disabled persons in all life spheres to maintain independent living in familiar surroundings. The provision of personal assistance is delivered to disabled persons, following an assessment by a local government social worker. It usually covers assisting persons with mobility, self-care or carrying out specific tasks like reading, writing or speaking on behalf of the disabled person.

The disabled person and the personal assistant make a contract where the tasks are described, together with the local government who pays the assistant. The disabled person may recruit the person who is going to assist him, but the decision about whether to provide the service is made by the local government on the basis of [assessment criteria](#) (e.g. based on severity of impairment, functional limitation, life activities, the extent to which assistance would make a difference to those activities, and the desired level of assistance compared to average expectation). Local government may decide that the disabled person pays up to 20% of the cost of the service out of his own pocket.

The Minister of Social Affairs and Minister of Science and Education provide for various services ([Regulation No. 61](#) is for domestic help, and [Regulation No. 25](#) for training and attainment of education). Some further information about services for disabled persons can also be found in a [booklet about personal assistance](#). Local governments organise and provide information about the personal assistance service (e.g. in [Tallinn](#) or in [Pärnu](#)) and also decide on local eligibility criteria. They further decide in which cases recipients’ should contribute financially. There are quite sizeable financial restrictions as the local governments have insufficient resources. For this reason not all local governments have, as yet, organised such a service in their community. Types and level of assistance therefore differ across the country.

Data about these services has only been available since 2006. In 2007, 40 out of 200 local governments provided this service. A total of 370 persons received assistance, of whom most were with people with mobility and visual impairments, male and from the capital (figures from [Süsteemi H-Veeb](#)). The main aim in using personal assistance services has been to cope better with family and domestic tasks and take part in social activities. Personal assistants are paid directly by the local government rather than by disabled people.

The qualitative survey ‘[Measures supporting employment of the disabled](#)’ dealt with various services which facilitate employment. In this report disabled persons pointed out that the main problem seemed to be the insufficient remuneration of assistants. Due to this, the role of a personal assistant is often taken over by a family member or a friend. If the service is not provided by a family member, the assisted person generally has to pay the assistant. Respondents also mentioned an aspect where there is room for development; namely that in addition to help with searching for assistants there should also be provision for pooling the help available. Personal assistance services differ by regions and supposedly depend on the wealth of the local government: according to a visually impaired person from West-Estonia, for instance, it would be fairer if the provision of service was harmonized all across the country. Problems relating to insufficient funding of the service were mentioned most frequently.



4.2: ASSISTIVE EQUIPMENT AND ADAPTATIONS

Children, adults and elderly people with disabilities who require prosthetics, orthopaedic devices and other technical aids are compensated by the state for 50-90% of the cost of the technical aid (the contribution by the state is determined in the Social Welfare Act (RT I 1995, 21, 323; /.../ 2004, 27, 180) and regulation of the Minister of Social Affairs No.79 (RTL 2000, 136, 2156; /.../ 2004, 11, 151) according to the type of technical aid in question). In making this payment, the proportion of the cost contributed by the state is only covered once the individual's own proportion has been paid. The amount is the difference between the total cost of the technical aid and the amount of the state's contribution, but not less than 200 EEK.

The [provision of technical aids](#) is primarily funded by the state (rather than local government). The following information has been reproduced from the [English version of the web site of the Ministry of Social Affairs](#):

Who is eligible for technical aids?

The following people are eligible to apply to purchase or hire technical aids at a discount or to have the costs of services related to such equipment compensated:

- the parents or guardian of a child;
- working age people whose incapacity for work is at least 40% (from 30 db of hearing loss in the case of hearing impairment) or who have a certified disability;
- self-injecting insulin-dependent diabetics for the purchase of glycometers; and
- old-age pensioners for whom technical aids improve their ability to manage.

Procedure for obtaining technical aids

1. Determining the need for technical aids

- The need for small technical aids is determined by a person's general practitioner or another attending physician.
- In the case of applications for more complex technical aids or prosthetics costing more than 20,000 kroons, the need for such aids is determined by a specialist or a rehabilitation institution.

The need for a technical aid is evidenced by a doctor's certificate or a rehabilitation plan setting out the need for such equipment.

The basis for the compensation of prosthetics costing 20,000 kroons or more a rehabilitation plan for children or working age people and a doctor's certificate or rehabilitation plan (if requested by a local expert committee) for pensioners. The client must cover the cost of production of a rehabilitation plan in the determination of the need for a technical aid. The fee for this is set in the agreement entered into by the county government and the rehabilitation institution.

2. Issuing a personal technical aid (PTA) card

In order to purchase or hire technical aids at a discount or to apply for initial compensation of the costs of services associated with them, applicants must approach their local county government (or local city district government in Tallinn) to obtain a personal technical aid card or PTA card.



These cards are issued to clients against signature on the basis of a doctor's certificate by the client's local county government or city district government, who keep account of the cards that are issued. In some counties the task of issuing PTA cards is delegated to local government social workers.

In the event of a change of address, a PTA card holder must contact their new county government, where their card will be re-registered and marked with a new number and issuing institution. The person who registered the original card is informed of these amendments.

In the case of prosthetics and other small technical aids costing less than 20,000 kroons which are repeatedly designated for use, applicants should directly approach the companies providing them in order to purchase or hire them at a discount and to apply for initial compensation of the costs of the services associated with them.

3. Approaching companies

After obtaining a PTA card an applicant can directly contact the company, organisation or institution providing the technical aids, which will sell, hire out or prepare the required aid after paying its own share of the costs and making the relevant transfers to the PTA card. The company approves the application with the county government before selling or hiring out the equipment. Companies which sell or hire out technical aids at a discount must, when doing so, assist clients in setting up and adapting the equipment as necessary and provide them with initial training on how to use and take care of the equipment.

4. Applying for more complex technical aids and prosthetics costing more than 20,000 kroons
The following documents must be submitted to the county government in order to purchase or hire more complex technical aids at a discount:

- application to the local expert committee (in free form);
- personal technical aid card;
- specialist's certificate or rehabilitation plan in the format established by the Minister of Social Affairs; and
- quotes.

The same applies in the following cases: the client requires one or more technical aids at a total cost of more than 20,000 kroons, including the cost of training services for use and maintenance; the client needs a new technical aid before the term of use of an existing aid has expired; or the client needs a technical aid which is not included in the list of technical aids.

An expert committee of the county government comprising at least five specialists and representatives of organisations of disabled people then decides whether to approve the application.

Financing

The purchasing and hiring of technical aids at a discount and the covering of costs of services associated with them are funded according to social assistance procedures:



- from means allocated from the state budget to county governments for the covering of the costs associated with the purchasing and hiring at a discount of technical aids on the basis of [Regulation no. 79 of the Minister of Social Affairs of 14 December 2000](#) (RTL 2000, 136, 2156; /.../ 2004, 11, 151) “Terms and conditions of and procedure for applying for technical aids and allocating them at a discount”;
- from municipal or city budgets according to procedures established by local government bodies; and
- from the individual’s own means based on the percentage set out in the annexes to the regulation.

Persons may receive the state-funded part anywhere where they reside; additional support from local governments is related to their actual residing in a specific community. Between 2001 and 2007 [recipients of technical aids](#) more than doubled (from 21,342 to 50,820). These items are primarily mobility aids, prostheses and hearing aids, rather than adaptive aids for independence in the home, work or education.

Except for children it is not possible to distinguish whether recipients are disabled or not. Among children, the proportion of those disabled increased over the period, particularly among those who received mobility aids, nursing care and visual and hearing aids. Among all recipients, the biggest increase occurred among those who received nursing care aids and prosthetics. Between 2001-2008 the proportion of state funding decreased from 77% in 2001 to 72% in 2008. The proportion of [state funding](#) also diminished by 10% in these years for Saaremaa county, where state funds comprise the lowest proportion (66%).

The qualitative study '[Measures supporting employment of the disabled](#)' also asked about issues related to technical aids. In general, technical aids were available for physically disabled persons. Certain more expensive items were paid for on a case-by-case basis by local governments. Naturally, certain problems were mentioned here as well. These included:

- There were waiting lists for receipt of items, depending on the type of technical aid.
- Several products were considered to be very expensive, even if the patient only had to pay for 10% of its cost. Likewise, some products were not as useful, were not covered by benefits and not available for everyone.
- One respondent mentioned that the instructions for prosthetic appliances were defective.
- Some respondents talked about the technical aids not being connected to a rehabilitation plan. Problems included difficulties with obtaining the technical aid due to the absence of rehabilitation plan, or the aid not being mentioned in the plan.



PART 5: EVIDENCE OF GOOD PRACTICE IN THE INVOLVEMENT OF DISABLED PEOPLE

In general there have been significant changes in the environment in relation to independent living in Estonia over the years. In particular there have been significant improvements for people with mobility impairments, mainly concerning access to public buildings and internal design. However, the author did not find any statistical overview of these improvements. For that reason the example below is provided in the field which concerns people (particularly children) with intellectual disability. Because Estonia is small, intellectually disabled children usually attend one specialised day school in a county (like Tartu Maarja School in our example), and the following example comes from one county - Tartumaa. Similar approaches are also emerging in other counties where the parents collaborate and start an NGO-type enterprise in order to launch an environment for intellectually disabled young people to develop their abilities and to prepare them to cope with independent living as adults.

One of these examples of support towards independent living is the so-called [Maarja Village](#). Although there are similar organisations around the world, Maarja Village is a unique example in Estonia. Currently there are 26 young adults with mental disability living in this environment.

The following information is reproduced from their web site:

„Idea of founding Maarja Village has come from Tartu Maarja School and it is like a logical continuation to the work that is done with the children of Tartu Maarja School throughout the school years.

In 2002 the first class of Tartu Maarja School graduated. The fact that today these graduating young people have no prospects for their future development or a meaningful life has pushed us to start building Maarja Village. Until this day there is a situation in Estonia where the majority of youngsters with a mental handicap will stay at home after graduating from school. In most cases the contacts with people of the same age and disabilities will be lost and so will be the opportunity to develop and work according to their abilities. To all of the families with mentally challenged youngsters will such an ordering of ways of life mean that one of the parents has to stay at home or they will have to hire a guardian. As the second choice it is possible to put the young graduate into an institution together with the elderly. In this case they will be staying in a place which provides no developing or work possibilities for disabled people.

Maarja Village is necessary so that the people with mental disability who finish school can live a life that is humane and meaningful. When Maarja Village is completed it will offer its habitants a possibility to develop, work and be a part of cultural events. In the broad perspective it is the founders wish to create a living environment that is as close to real life as possible. The only difference is that the villagers will be supported and assisted in their everyday activities.

The most important thing about the creation of this village is that the weakest people of our community get to feel sincere happiness from their lives. They feel that someone in this world needs them and this nourishes their souls. Maarja Village is a bridge between people. It is the meeting point of the two worlds that have been living separately so far.“ (; See also the Estonian [Agrenska Foundation](#)

Tartu Maarja School has been initially a specialised school for children with intellectual disability, first for Tartu town and region. Those pupils who were residing in Tartu, attended the school on a daily basis, those who are from farther reside in a boarding facility during the school-days, leaving it for weekends and vacations.



The Village is the stage between starting to cope with one's own life while continuing their studies (acquiring the professions) and learning the abilities to cope with the tasks in daily living. The Village has developed into the community which is open to adolescence from all over Estonia with intellectual disability and over 18-years of age. In 2009 there were already 32 persons residing in this community, of whom the first 5-6 who have acquired the vocational skills are ready to start their entirely independent living (first through practice jobs and after 4-6 months in case of coping with the tasks they can start on their own). So for most persons it takes 5-6 years to go through this stage of learning and as this type of foundation was in Estonia the first one in 2003 – the next steps have not yet occurred.



PART 6: REFERENCES

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Additional [data information on social welfare services](#)

Caring in family...

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