Order of the Minister of Social Affairs no. … of … September 2014
„Approval of Special Care and Welfare Development Plan for 2014 - 2020“

Annex

Ministry of Social Affairs

Special Care and Welfare Development Plan for 2014–2020

Tallinn 2014

CONTENTS

INTRODUCTION

Both in Estonia and Europe in general, mental and behavioural disorders represent an important component of burden of disease. Increased incidence of mental disorders and the raised awareness and improved attitudes of people have resulted in increased demand for mental health services.[1] In Estonia, the provision of special care and welfare services, aimed at developing the independent coping of people and supervising related activities, is organised at the national level. Special care and welfare services are provided to adult persons with special mental needs[2], suffering from either severe, profound or permanent mental disorder and who have been assessed and found to be in need of special care and welfare services[3].

Special care and welfare sphere of Estonia, as a sector governed by legislation, became 12 years old in the beginning of 2014. Looking back at the inception of special care and welfare as a separate component of social welfare, we can suggest the year 2002 as a start, announced by establishment of different support services, apart standard twenty-four-hour services, and distinction of twenty-four-hour services by target groups under a regulation of the Minister of Social Affairs, "Mandatory Requirements to Social Welfare Institutions and Services". The definition of special care and welfare was introduced to Estonian legislation on 1 January 2009, replacing the definition previously used in the Social Welfare Act of the Republic of Estonia with the term „social welfare services available to persons with special mental needs".

In 2012, the National Institute for Health Development commissioned the mapping and analysis of demand for mental health services[4], which aimed at preparing a qualitative overview of the range of mental health services, available to adults, and development requirements of this sphere in Estonia. Based on the outcome, development of a vision of a special care and welfare system and improvement of availability and quality of special care and welfare were highlighted among the identified needs.

The Special Care and Welfare Development Plan was developed to create a strategic framework for the sector concerned, establish goals and devise activities for more efficient provision of special care and welfare services that would support the needs of persons with special mental needs. The Development Plan will be later integrated with „Social Security, Inclusion and Equal Opportunities/Mainstreaming Development Plan for 2016–2023", which is supposed to ensure for better organisation of objectives, activities and measures, established in various development plans in general, therefore ensuring a common approach to social security sector.

For the purposes of the implementation of the Special Care and Welfare Development Plan, structural funds of the European Union will be used in 2014–2023 budget period to reorganise the special care and welfare infrastructure and improve the availability and quality of the services. By including the Structural Funds of the European Union, Estonia has also

[1] National Institute for Health Development (2012). Mapping and analysis of demand for mental health services.
[2] Persons will be entitled to special care and welfare services since the age of 18 years. Minors will be also entitled to twenty-four-hour special welfare services under a court order.
[3] Special care and welfare service requirement must be shown in the rehabilitation plan of the person concerned, psychiatric evaluation (supported life service) or a court order (reference for twenty-four-hour special welfare services under a court order).
[4] National Institute for Health Development (2012). Mapping and analysis of demand for mental health services.

taken the objective and commitment to observe the principles, laid down in the UN Convention of the Rights of Persons with Disabilities for the purposes of development of special care and welfare[5] and the principles for transition from institutional to community-based care (Annex 1)[6]. Reorganisation of special care and welfare was started back in 2006; implementation of the Programme for Reorganisation of State-owned Special Care and Welfare Institutions and Services[7] resulted in establishment of 550 new accommodation and service provision establishments all over Estonia, supported by the Structural Funds of the European Union, for persons with special mental needs who had, so far, lived in depreciated old manor buildings (five special care homes that had been operating on old manor houses were closed after the completion of new accommodation and service provision establishment). The Development Plan also includes a future vision – the goal of reorganising service provision establishment with more than 30 inhabitants and preferred development of supply and provision of support services, focusing on development of community-based, individually focused and high quality services.

[5] UN Convention of the Rights of Persons with Disabilities. In estonian available at https://www.riigiteataja.ee/akt/204042012005

[6] European Expert Group on the Transition from Institutional to Community-based Care (2012). Common European Guidelines on the Transition from Institutional to Community-based Care. http://deinstitutionalisationguide.eu/

European Expert Group on the Transition from Institutional to Community-based Care (2012). Toolkit on the Use of European Union Funds for the Transition from Institutional to Community-based Care. http://deinstitutionalisationguide.eu/

[7] Programme for reorganisation of state-owned special care and welfare institutions and services. http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/puudega_personsele/Erihoolekandeteenused /Riiklike_erihoolekandeasutuste ja -teenuste reorganiseerimise_kava.pdf

1. ANALYSIS OF CURRENT SITUATION

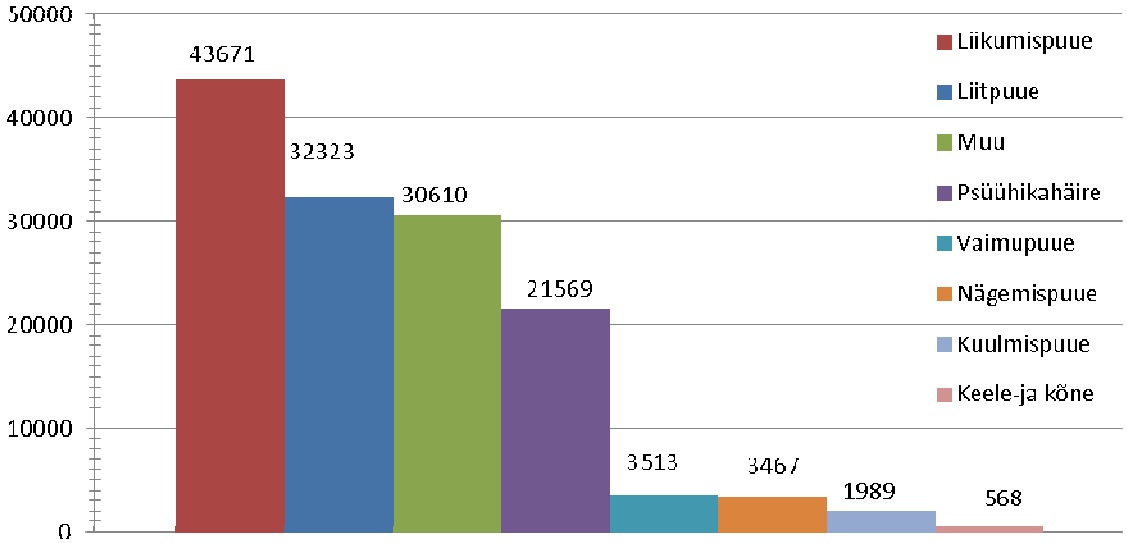
The analysis of the current situation is based on the fact that it is not possible to predict the sizes of special care and welfare target groups, based on the number of persons with mental disorder, their diagnosis or severity of their disability. Therefore, the fact that the target group is formed of adult persons with severe, profound or permanent mental disorders, entitled to special care and welfare services, is used as the starting point.

The analysis below summarised the main indicators of special care and welfare services' target group and their distribution by counties, providing an overview of future main providers of services and potential users of such services.

Disabled persons in figures

According to the information available from the Estonian National Social Insurance Board, on 1 January 2013 there were 137,710 disabled persons in Estonia. More than a tenth of the Estonian population are persons with officially diagnosed disabilities (10,4%). The number of disabled persons and their proportion among the population has consistently increased. Compared to 2006, the number of disabled persons has increased by *ca* 24 700 persons and their proportion among the population in general has grown by a fifth (two percentage points). Figure 1 summarises the number of persons with different dominant disability and persons with multiple disabilities as of 01.01.2013.

Figure 1. Disabled persons by dominant type of disability, 01.01.2013



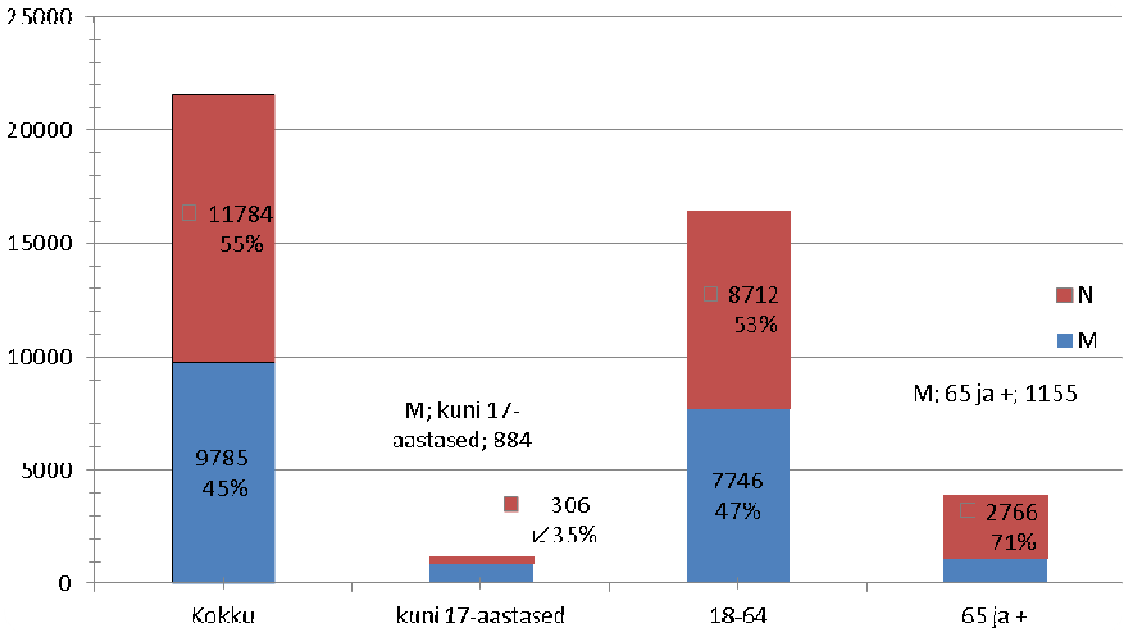
Source: Ministry of Social Affairs

Mobility disability
Multiple disability
Other
Mental disorder
Mental retardation
Visual disability
Hearing disability
Language and speech impairment

21,569 persons, i.e. 16% of the total number of disabled persons in Estonia, suffer from mental disorder as a dominant disability plus additional 8,029 persons (approximately 6% of

disabled persons) who suffer from mental disorder as a component of multiple disability. This means that at least 22% of disabled persons are persons with mental disorder.[8] Figure 2 shows that 55% of persons who suffer from mental disorder as a dominant disability are women. The proportion of women is the highest among persons 65 years of age and older (71%), and the lowest among persons under the age of 18 (35%). When speaking of age groups, persons aged 18–64 are most strongly represented among persons with mental disorders (76% or 16,458 persons), the proportion of persons 65 years of age and older is 18% (3,921 persons). The number of persons with mental disorder is the smallest among persons under the age of 18 (6% or 1,190 persons).[9]

Figure 2. Persons with mental disorder as dominant type of disability by age and gender, 01.01.2013



Source: Ministry of Social Affairs, Estonian National Social Insurance Board

Males, up to 17 years of age
Males, 65 and +
In total
Up to 17 years of age

The number of persons, suffering from mental disorder as a dominant disability, is the largest in Tartu county (approximately 3,000 persons), followed by Ida-Viru county (approximately 2,500 persons) and Jõgeva county (around 2100 persons). The number of persons with such a disability is the smallest in Hiiu county (less than 100 persons). As we compare the population numbers, persons have mental disorders most frequently in Jõgeva county (6.7% of the population) and Põlva county (6,5%) and most infrequently in Harju county and Hiiumaa (0.9% of the population of county). 65%, 25% and 10% of persons with mental disorder (dominant disability) have, respectively, severe, average and profound disability (figure 3).

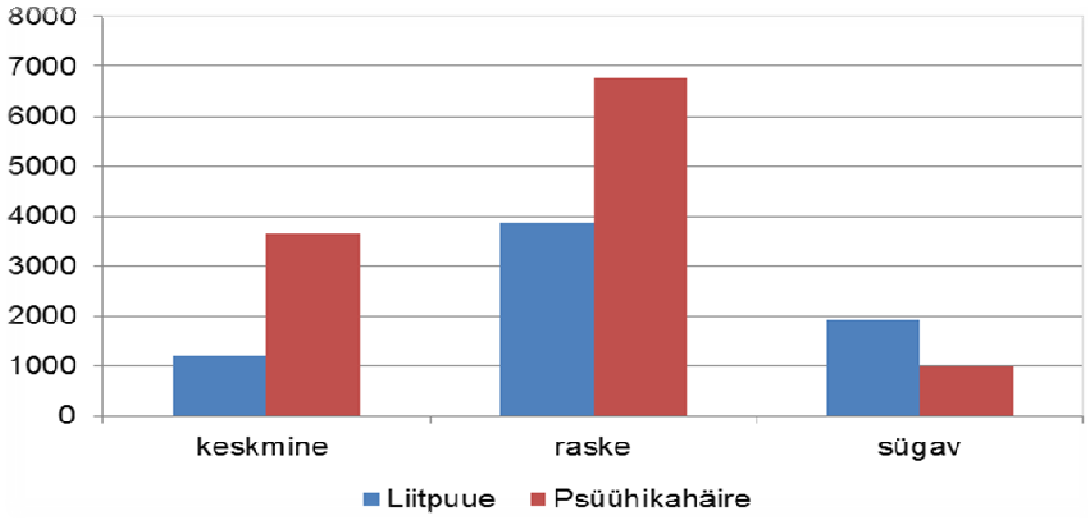
Special mental needs is a definition used to describe mental disorders that are listed as

[8] Here we should not forget that the type of disability does not cover all the persons with a diagnosis, which means that the total number of persons with special mental needs is bigger in Estonia. Total number of persons with mental disorder is given on page 8.
[9] As of 01.01.2013. Source: the Estonian National Social Insurance Board.

mental and behavioural disorders, or F00–F99[10], according to the classification, given in the international classification of diseases (ICD-10). According to the information available from the Estonian National Social Insurance Board, organic mental disorders, incl. symptomatic mental disorders, are among the group if disorders most often diagnosed in persons who suffer from mental disorder as a dominant disability and multiple disability (multiple disability includes mental disorder or mental retardation (diagnostic group F00–F09). This is closely followed by diagnostic group of mental retardation (F70–F79) – approximately in every sixth patient, mood swings (F30–F39) – in every tenth and schizophrenia, skizo-type and delusional disorders (F20–F29) – in every twelfth person.

The definition of mental disorder cover both persons with mental diseases and mental retardation. According to the Estonian National Social Insurance Board, special care and welfare service recipients are mostly persons diagnosed with mental retardation (42%) and schizophrenia, skizo-type and delusional disorders (39%). 9% have organic, incl. symptomatic mental disorders while nearly 4% have miscellaneous diagnoses (non-F-diagnostic group). The incidence of other diagnostic groups remains below 2%.

Figure 3. Persons with mental disorders according to severity of their disability, 01.01.2013



Source: Estonian National Social Insurance Board
Average
Severe
Profound
Multiple disability
Mental disorder

Main providers of special care and welfare services

By counties, at the end of 2013 the largest special care and welfare service providers were, according to Table 1, Harju county (23% of service slots), Jõgeva county (9%) and Saaremaa and Tartu county (equally, with 8%). It must be noted that at the end of 2013, the number of facilities offering special care and welfare services was the largest in Harju county (16

[10] International classification of diseases. ICD-10 Mental and behavioral disorders. http://www.kliinikum.ee/psyhhiaatriakliinik/lisad/ravi/RHK/RHK10-FR17.htm

facilities), Pärnu county (14 facilities) and Ida-Viru county (10 facilities). Other counties have less than ten service providing facilities. In other words, for example Saaremaa, covers 8% service slots with just five facilities while Pärnu county has 14 facilities to tend to 5% service slots.

Table 1. Number of facilities that offer special care and welfare services and service spots and their distribution by counties, at the end of reporting year 2013.

County	Service slots	Service providing facilities	Proportion %	Incl. support service slots	Proportion %	Incl. twenty-four-hour service slots	Proportion %
Harju county	1319	16	23	1022	34	297	11
Hiiumaa	42	2	1	42	1	0	0
Ida-Viru county	372	10	7	192	6	180	7
Jõgeva county	495	6	9	164	5	331	13
Järva county	253	6	4	101	3	152	6
Lääne county	344	6	6	110	4	234	9
Lääne-Viru county	286	6	5	161	5	125	5
Põlva county	306	5	5	144	5	162	6
Pärnu county	310	14	5	161	5	149	6
Rapla county	65	4	1	62	2	3	0
Saaremaa	455	5	8	80	3	375	14
Tartu county	456	6	8	383	13	73	3
Valga county	371	7	7	127	4	244	9
Viljandi county	416	8	7	173	6	243	9
Võru county	188	3	3	113	4	75	3
Total	**5678**	**104**	**100**	**3035**	**100**	**2643**	**100**

Source: Ministry of Social Affairs, statistical welfare reports

Heterogeneity of the potential target group for special care and welfare services and locations of target group all over Estonia were the most important starting points for the elaboration of the Development Plan.

Estimated number of persons with mental disorders

Possible increase in incurrence of mental disorders must be considered for the purpose of appraising the demand for special care and welfare services. According to the estimates, approximately 37% of Europeans aged 18–64 have experienced every year, at least one

form of mental disorder. According to the Green Paper that was drafted while developing the document "Improving the mental health of the population: Towards a strategy on mental health for the European Union", the practice of all the other countries shows that not all people with mental disorder seek for professional help; for example, only 26% of Europeans with mental disorder have looked for help.[11] As in Estonia, more than 27,000 new cases of mental disorder have been diagnosed every year during the recent years, considering the practice of other countries we can expect the importance of this problem to increase in Estonia, too. Therefore, it is important to suggest and develop services to increase or improve the options available to persons with mental disorders to take part in social life.

At the end of 2013, special care and welfare services were provided to 5,036 persons from 5,678 service slots[12] and, according to the information available from the Estonian National Social Insurance Board, 1,051 persons were waiting to be offered the services in January 2014.[13] Considering that in total, we have 35,626 persons with mental disorder in Estonia[14], the number of persons using special care and welfare services, compare to the total number of persons with mental disorders, does not seem as very large. According to the Estonian National Social Insurance Board, on 31.10.2013 12,417[15] persons were entitled to special care and welfare services[16], but they had not applied for the services or listed themselves or used such services). Therefore, the number of potential applicants, entitled to special care and welfare services, apart the current service users and those enlisted, is approximately three times (2.65 times, more specifically) bigger. In 2014–2020, at least of those 1,067 children and young persons with mental disorder, aged 11–17, who are currently not members of the potential target groups of recipients of special care and welfare services, due to their age, may added to this list. Figure 4 gives an overview of their places of living at county level.

Figure 4. Numbers of persons with mental disorder, aged 11–17, entitled to special care and welfare services, by counties

[11] Green Paper. Improving the mental health of the population: Towards a strategy on mental health for the European Union. Brussels 14.10.2005. COM(2005) 484 final version. http://ec.europa.eu/health/archive/ph_determinants/life_style/mental/green_paper/mental_gp_et.pdf
Secondary sources:
Wittchen HU, Jacobi F: Size and burden of mental disorders in Europe: a critical review and appraisal of 27 studies. European Neurospsychopharmacology, Volume 15 (2005), Number 4, pp. 357-376.
Percentage values based on Commission's own calculations.
Alonso, J., Angermeyer, M., Bernert, S. et al. (2004). Use of Mental Health Services in Europe: Results from the European Study on Epidemiology of Mental Disorders (ESEMeD) Project. Acta Psychiatr Scand; 109 (suppl 420): 47-54.

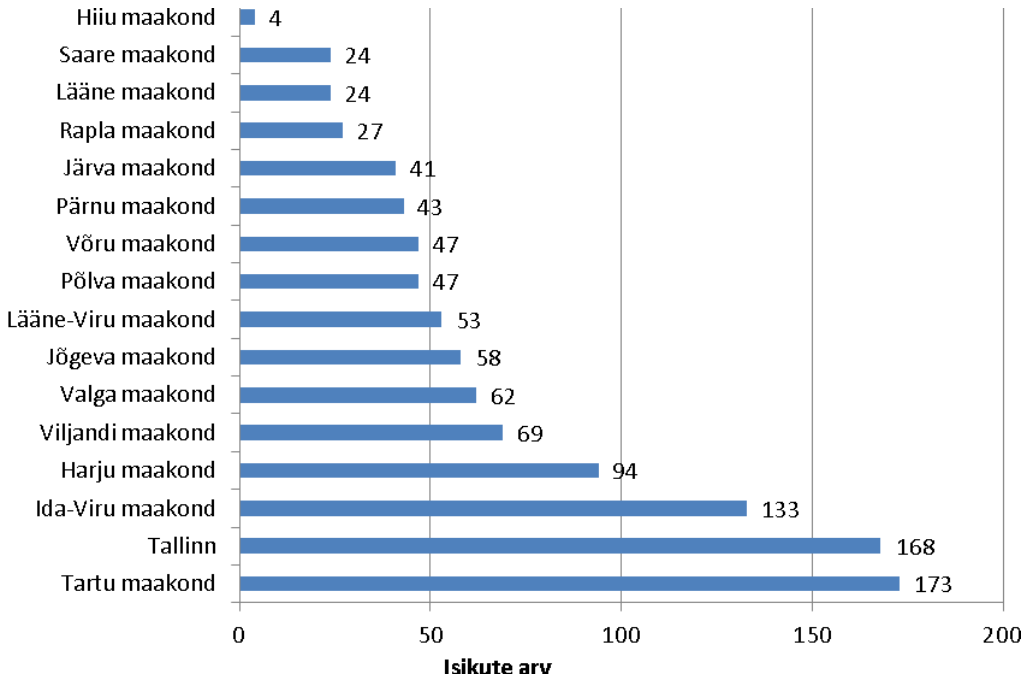
[12] Ministry of Social Affairs, statistical welfare reports.

[13] Information from the Estonian National Social Insurance Board.

[14] Persons with mental disorder and/or mental retardation (these disabilities may also be part of a multiple disability).

[15] Persons of at least 18 years of age, suffering from mental disorder and/or mental retardation and having been given a F group diagnosis as main or accompanying diagnosis (with the exception of people of retirement age, not having diagnosed with severe, profound or permanent mental disorder, apart dementia, or persons at least 63 years of age, diagnosed with F group diagnosis only (F00-F03)).

[16] Adults with severe, profound or permanent mental disorder.



Source: Ministry of Social Affairs, SKA materials

Waiting lists for services

The Estonian National Social Insurance Board will enlist persons, entitled to services, on a waiting list for special care and welfare services that the entitled person applies for, if the state budget lacks the funds or service provider, preferred by the person concerned, currently lacks the service slots.[17]

Although special care and welfare services are available in all the counties all over Estonia, the capacities of service providers of counties often do not match the number and demands of persons in need of special care and welfare services. On 31.03.2014, an amendment to the Social Welfare Act entered into force, requesting the Estonian National Social Insurance Board to keep county-based waiting lists for special care and welfare services, separately for each and every type of special care and welfare services, with the exceptions of persons referred for twenty-four-hour special care services with a court ruling. Persons are free to choose a suitable service provider and county and once a service slot opens in the county concerned, the next person on the waiting list will be offered the slot. Unfortunately, the practice of the Estonian National Social Insurance Board has shown that persons request services from very specific institutions even within the borders of a single county and are willing to remain on waiting lists for long periods of time, which shows that in reality, they do not need the service immediately after the needs for the service has been appraised. Persons on waiting lists are not required to accept the service and according to the regulation in force, they cannot be removed from the waiting lists without their own request. This has resulted in a situation where there is a long waiting lists for services, but in fact, the persons on waiting lists move neither up or down on the list.

The Estonian National Social Insurance Board analysed, in 2013, the reasons given by

[17] The Social Welfare Act.

people on waiting list for twenty-four-hour special services for refusing the service.[18] The following main reasons were given:

- according to the person concerned, s/he can still cope at home and does not need the service slot at the moment;
- the institution preferred by the person currently lacks the service slot and therefore the person wants to remain on the waiting list until there is a vacancy at the preferred institution;
- rehabilitation plan of the person concerned expired and a new plan is being developed;
- person in charge of the case was unable to contact the person or his/her next of kin.

Maximum cost of services

Pressure to increase the prices of services enhances simultaneously with the demand to increase the scope of services, as the current service prices do not ensure sustainable provision of services and sufficient quality of the services rendered. Maximum costs of special care and welfare services, cost items and the terms and conditions for disbursing the fees paid from state budget are laid down with the regulation of the Government of the Republic.[19] Insufficient funding is the main reason for poor availability of the services, suggested in the audit conducted by the National Audit Office in 2008[20]. Service prices do not match the real expenses. Over the years, prices have only grown according to the increase in the value of human resource component, but this has been not enough to ensure the availability of qualified labour and slow down staff turnover. Insufficient funding has been the main reason why the scope of services has not increased considerably over the recent years and waiting lists have not become shorter.

While the price of the services will only allow to cover minimum overhead expenses and hire only the cheapest, untrained labour that will not remain in the position for long and developing activities remain unavailable to persons with special needs within the framework of the service, service users will never develop to a level that would enhance their independent coping and decrease pressure on caretaking burden of families and the state budget.

[18] Statistical information from the Estonian National Social Insurance Board
[19] Maximum costs of special care and welfare services, cost items and the terms and conditions for disbursing the fees paid from state budget https://www.riigiteataja.ee/akt/129122013016
[20] National Audit Office (2008). Efforts of the state in organising welfare of persons with special mental needs. National Audit Office report to the Riigikogu. Tallinn: National Audit Office.

2. GENERAL GOAL OF THE DEVELOPMENT PLAN

Considering the bottlenecks of special care and welfare, highlighted by the users of special care and welfare services, their family members, representatives organisations and providers of special care and welfare services, the purpose of the UN Convention of the Rights of Persons with Disabilities that was ratified by the Republic of Estonia on 30 May 2012 and the commitments taken for 2014-2020 for the purposes of the Structural Funds of the European Union, the following general goal has been established for the Special Care and Welfare Development Plan:

ensuring adult persons with special mental needs with equal opportunities for self-realisation and high-quality special care and welfare services that are in line with the principles of de-institutionalisation

Table 2. General goal indicator

INDICATOR	BASIC LEVEL	TARGET LEVEL 2017	TARGET LEVEL 2020
Ratio of special care and welfare service slots to services that support independent coping and twenty-four-hour institutional care services *Source: Ministry of Social Affairs*	1.1 (2014)	1.5	2.5

As the goal is achieved, the number of service slots, supporting independent coping, will increase, compared to the number of twenty-four-hour institutional care service slots. Development of support services that are more closely linked to community, improving their availability and more flexible provision of such services will allow to anticipate the demand of persons for various forms of twenty-four-hour services and will support the principles of de-institutionalisation.

High-quality special care and welfare services means services that are in line with the principles of the European voluntary social welfare service quality framework[21]. High-quality social welfare services match the following criteria:
- availability – adults with special mental needs are offered sufficient possibilities to choose the most suitable service in the most suitable place;
- accessible – adults with special mental needs are provided with both physical access and relevant, neutral and complete information about the services available;
- affordable – services are either free of charge for adults with special mental needs or their families or offered for affordable charge;
- focused on individual – services available for adults with special mental needs are flexible and consider the needs of the person concerned and his/her family;
- integrity – social welfare, health care, labour market, educational and dwelling services, developed for adults with special mental needs, allow flexible combination with each other and avoid duplication, therefore allowing to save on resources;
- consistency – services, created for adults with special mental needs, will cover their needs consistently and coherently;
- efficiency – services offered to adults with special mental needs are specific and

[21] Council of the European Union (2010). European voluntary social welfare service quality framework: http://equass.ee/public/Sotsiaalteenuste_vabatahtlik_kvaliteediraamistik.pdf

measurable and their objectives can be achieved.

Self-realisation means the following opportunities, available for adults with special mental needs:
- opportunity to contribute – adults with special mental needs can contribute to issues, which are relevant for them, either themselves, or via representative or customer organisations;
- acquisition of education and participation in life-long learning cycle – adults with special mental needs can acquire an education that matches their abilities and thus participate in the life-long learning cycle;
- working life – adults with special mental needs can be employed, considering their maximum level of ability;
- place of living – adults with special mental needs have access to housing services, which will not link them to the obligation of using specific social welfare services.

3. SUB-GOALS AND MEASURES

Three sub-goals have been established to reach the general goal:
1) adults with special mental needs are ensured with equal opportunities for self-realisation;
2) special care and welfare services comply with the principles of de-institutionalisation;
3) special care and welfare services are of high quality and offered by qualified and professional service providers.

3.1. Sub-goal 1

Adults with special mental needs are ensured with equal opportunities for self-realisation

Achievement of the sub-goal will contribute to increased participation of adults with special mental needs in employment, vocational education and life-long learning cycle and increased social activity level.

Table 3. Sub-goal indicators

INDICATOR	BASIC LEVEL	TARGET LEVEL 2017	TARGET LEVEL 2020
Participation of adults with special mental needs in labour market[22] *Source: Ministry of Social Affairs. Study of Care-Taking Burden of Persons of Disabilities and Their Family Members PIU*	14% (2009)	16%	18%
Participation of working-age persons with special mental	6%	7%	8%

[22] Working-age or persons aged 16–64 with mental disorders, working as much as they like, and those who work but would like to be more heavily engaged. Proportion among all the working-age persons with mental disorder and/or mental retardation (as a dominant disability or a component of multiple disability).
[23] Working-age or persons aged 16–64 with mental disorders, learning as much as they like, and those

needs in education life[23] *Source: Ministry of Social Affairs. Study of Care-Taking Burden of Persons of Disabilities and Their Family Members PIU*	(2009)		
Social activity level of persons with special mental needs [24] *Source: Ministry of Social Affairs. Study of Care-Taking Burden of Persons of Disabilities and Their Family Members PIU*	56% (2009)	60%	65%

Employment is the key element for social inclusion and economic independence of the working-age population in general. According to the Study of Care-Taking Burden of Persons of Disabilities and Their Family Members (hereinafter the PIU) of 2009[25], 14% of persons with mental disorder and/or mental retardation, aged 16–64 (as a dominant disability or a component of multiple disability), were working[26] (12% were engaged as heavily as they wanted while 2% wanted more involvement). Unfortunately, the percentage of those wanting to work is much bigger. 35% of persons with mental disorder and/or mental retardation were not employed, although they wanted to work.

When studying nonworking persons, who had working experience, it was found that among persons with mental disorder and/or mental retardation, the most common reason for leaving work was their respective disability and related restrictions. 26% of non-working persons with mental disorder and/or mental retardation, who had working experience, mentioned their disability and related restrictions as the reason for leaving their most recent work place, while 1% gave their own sickness or injury as the reason and 21% retired from work as the consequence of old-age pension. 13% mentioned redundancy and 25% had some other reason for leaving work.

26% of non-working persons with mental disorder and/or mental retardation, who were interested in being employed, considered work load exceeding 30 working hours as the most appropriate solution. Such an opinion is quite close to the general opinion of disabled persons (24%) and may be due to the fact that in Estonia, working part-time is not very common. 34% found 11–20 working hours to be a suitable work load and 15% would have wanted to work 21–30 hours. Only 7% told that they would have wanted to work up to 10 hours per week. The need to earn money was the main motivator for getting employed; however, the chances for self-realisation were also mentioned as important. An opportunity to feel as a part of a collective and communicate with other people were mostly mentioned.

In 2012, AS Hoolekandeteenused conducted a substantial analysis of special care and welfare services, focusing on the level of education of persons, employed at social welfare institutions under a court ruling. The level of education of recipients of services was very different – 25% of recipients of services did not have basic education or had acquired their respective education according to simplified study programme, 26% had secondary education and 21% - basic education. The percentage of persons who had acquired vocational education was somewhat smaller (17%) while the number of persons with higher

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who learn but would like to be more heavily engaged in the learning process. Proportion among all the working-age persons with mental disorder and/or mental retardation (as a dominant disability or a component of multiple disability).

[24] 56% of persons, with mental disorder and/or mental retardation (as a dominant disability or a component of multiple disability), agreed fully or rather agreed with at least one of the statements (my life is interesting and diversified; I have been given all the opportunities for being active at political and social level).

[25] Soo, K., RAKE, Linno, T. (2009). Study of Care-Taking Burden of Persons of Disabilities and Their Family Members. SaarPoll OÜ, University of Tartu, Ministry of Social Affairs. http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/kogumik/PIU2009_loppraport.pdf

[26] As a dominant disability or a component of multiple disability.

education was extremely low (approximately 4%). Unfortunately, 52% of recipients of services had professional record.[27]

According to the PIU study of 2009, 45% and 40% of persons with mental disorder and/or mental retardation had, respectively, secondary or secondary specialised education and basic education without vocational education or a lower level of education. 7% of them had acquired vocational education with or without basic education and only 6% had acquired applied higher or higher education. Among persons with mental retardation, the percentage of those who only have basic education and no vocational education or even a lower level of formal education was prevalent (78%) and only 16% of these persons had either secondary or secondary specialised education.

The study also focused on opinions, regarding learning. 3% of persons with mental disorder and/or mental retardation, aged 16–64, told that they can learn as much as they want; 2% told that they would want to learn more; 18% told that they are not learning but would like to learn; whereas 73% told that they are not learning and do not even want to learn. Health and economic reasons were most often suggested as the reasons preventing then from learning. Also, lack of information was mentioned and the fear of experiencing certain prejudice.

Just like people with mental disorders, mentally retarded persons also want to participate in the labour market. In a study that focused on the participation of young mentally retarded persons in labour market[28] their supervisors stated that according to their opinion, among mentally retarded persons there are more those who would like to work and they also put more effort into finding a job. In the study concerned, mentally retarded persons mentioned their wish to earn some money themselves, communicate with other persons or find something to do as main reasons for attending work. The need or wish to be a part of a collection was also mentioned. Mentally retarded persons were also interested in creating a routine, offered by employment, i.e. going to work in mornings and returning in evenings. Interviews showed that working will give people self-confidence, i.e. they are proud to be working.

The PIU 2009 study also included questions about satisfaction with life and social activities. 36% of persons with mental disorder described their lives as interested and diversified.[29] 41% agreed that they have been offered all the opportunities of being active at political and social level.

Among persons with special mental needs there are many more persons who would like to work, learn or get involved in social activities, yet are unable to do this for many different reasons.

The following measures will be implemented to achieve the sub-goal.

Measure 1.1. Creation of opportunities for vocational and life-long learning

At the moment there is no overview of the participation of persons with special mental needs

[27] *Ibid*.
[28] Kruuse, K., Otsa, M. (2014). Study on participation of mentally retarded people in labour market. OÜ InCase.
http://www.erinevusrikastab.ee/files/Tulemused.pdf
[29] Persons, with mental disorder and/or mental retardation (as a dominant disability or a component of multiple disability.

in life-long learning.[30] As we observe the level of education of persons with special mental needs, we will see that 40% only have basic education with no vocational education or even lower level of formal education.[31] Table 3 shows that in academic year 2013/2014, 342 children studied in a class for students with emotional and behavioural disorders who acquire basic education in accordance to the national study programme (NSP), simplified study programme (SSP), coping study programme (CSP) and special care study programme (SCSP) while 124 children studied in a programme focusing at teaching one student and 1,022 studied in small classes.

Table 4. Children studying in a class for students with emotional and behavioural disorders who acquire basic education, in a small class and in a programme focusing at teaching one student by study programmes in academic year 2013/14[32]

Study form	NSP	SSP	CSP	SCSP	Total
Class for students with emotional and behavioural disorders who acquire basic education	298	36	8	0	342
Small class	868	106	43	5	1,022
Programme focusing at teaching one student	101	17	4	2	124
Total	**1,267**	**159**	**55**	**7**	**1,488**

Source: Ministry of Education and Research

In academic year 2013/14, 531 students followed simplified study programme in vocational education (34 in vocational education programme without the prerequisite of basic education, 71 in vocational education programme based on basic education, 411 in secondary vocational education programme and 15 in vocational education programme based on secondary education) and 74 students followed coping study programme (2 of in vocational education programme based on basic education and 72 in secondary vocational education programme). Approximately 150 persons of the total number has special mental needs (incl. mental retardation)[33].

Considering that education is the most important competitive advantage in labour market, low

[30] Life-long learning includes, apart the formal system of education (kindergarten, basic school, gymnasium, vocational educational institution, college/university), also in-service and retraining offered outside the system, informal and formal education in all the diversity it offers. Opportunities for acquiring new knowledge and skills is offered at work-places, free and hobby education and youth work, also participation in the activities of civil society organisations or virtual space, where one can study either individually or with others. Life-long Learning Strategy for 2014–2020. http://www.hm.ee/index.php?0513767

[31] Soo, K., RAKE, Linno, T. (2009). Study of Care-Taking Burden of Persons of Disabilities and Their Family Members SaarPoll OÜ, University of Tartu, Ministry of Social Affairs. http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/kogumik/PIU2009_loppraport.pdf

[32] The table does not include students who acquire general secondary education in gymnasium, as classes for students with emotional and behavioural disorders can only be formed based on basic education. In academic year 2013/14, students who acquired their education in classes for students with mental disorder study in classes for students for somatic diseases, where it has been historically possible to acquire the level of general formal secondary education.

[33] Source: EHIS.

level of formal education means a serious problem for persons with special mental needs, which may considerably interfere with finding a job. Lack of consistent income means that people with special mental needs are even in a bigger threat of dropping into poverty and being secluded from the society. Unfortunately, the time for mental disorders becoming apparent is an important factor, characterising formal level of education. If mental disorders are diagnosed after persons have acquired formal education, re-training and ensuring the availability of life-long learning will have a huge role in ensuring life quality of the persons concerned.

Therefore, it is important to offer persons with special mental sufficient opportunities for vocational and life-long learning to ensure their social inclusion and involvement in social life.

Activities, implemented within the framework of the measure, are aimed at diversifying the opportunities for participation in vocational and life-long learning, available to persons with special mental needs, and development of a monitoring system for participation in studies.

Measure 1.2. Facilitation of participation in labour market and employment

Self-realisation through work is rather limited among persons with special mental needs: the percentage of employed persons is low while the desire of persons with special mental needs to work is much bigger. National measures, intended to facilitate recruitment of disabled persons, are not motivating for entrepreneurs, as these will mean extra work for companies, outweighing the benefits, offered by measures.[34]

Impact analysis of employment reform[35] also highlights the limited number of employers, willing to employ people with in-part capacity for work, and create flexible jobs, as one of the possible risks threatening the achievement of the goals of the reform. Insufficient increase of awareness of people with limited capacity for work and their problems and insufficient influence on improving the attitude of employers towards disabled persons as workers is also seen as the risk, accompanying the reform.

Considering the information provided above, it is necessary to develop activities that would facilitate employment of persons with special mental needs and enhance the awareness of employers of persons with special mental needs. The key element could be social awareness campaigns, that will support the willingness of employees, offer opportunities for part-time work and development of support services to support working.

Measure 1.3. Improved organisation of housing services

Chance to live separately from one's family will allow adults to become independent and self-sufficient. It is highly important to offer persons with special mental needs to live independently, separately from parents, should they desire the opportunity.

Users of special care and welfare services today live as owners in their own housing or in housing owned by local government or provider of special care and welfare services. Majority of adults with special mental needs, using various supporting special care and welfare services (supported living, supported working or supported housing), live in housing

[34] Soo, K., RAKE, Linno, T. (2009). Study of Care-Taking Burden of Persons of Disabilities and Their Family Members SaarPoll OÜ, University of Tartu, Ministry of Social Affairs. http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/kogumik/PIU2009_loppraport.pdf
Tallinn University of Technology (2014). Study on participation of mentally retarded people in labour market, http://www.erinevusrikastab.ee/files/Tulemused.pdf

[35] Vahopski, R., Lauri, M. jt (2014). Impact Analysis of Incapacity for Work Support Act – Ex Ante Evaluation. Saar Poll OÜ/ European Social Fund/ Ministry of Social Affairs.

belonging either to them or local government. Housing of community life and twenty-four-hour support service users usually belongs to providers of special care and welfare services.

Persons who are unable to acquire housing either for themselves or their families must be provided with housing by local government, as provided by the Social Welfare Act. According to a study, conducted by the Chancellor of Justice in 2011, 36 local governments out of 209 are unable to supply all those in need with a housing; including 27 local governments who lack sufficient number of housing.[36]

One of the main functions of the sub-measure is offering support to persons with special mental needs to facilitate their social activities, ensuring them equal opportunities for self-realisation and participation in educational and working life. Social coping and integration of an individual is supported by providing him/her with housing, provision of sufficient range of services that support coping and guidance. Therefore, it is important to develop and promote housing policies to facilitate living of persons with special mental needs in a close community and suitable housing.

Implementation of the measure will include analysis of current organisation of housing services and demand for such services, resulting in improvement of the process for supplying persons with special mental needs with housing.

Measure 1.4. Facilitation of advocacy efforts of adults with special mental needs

In Estonia, there are several advocacy organisations that have been established to represent the interests and rights of the most vulnerable target groups. The largest is the Estonian Patient Advocacy Association , which is an advocacy organisation of users of social welfare and health care services, and the Estonian Chamber of Disable People, which pursues the goal of being a national co-operation and co-ordination body for work, done in the sphere of disabled persons. Also, several project-based support and rehabilitation groups have been established and experience-based advisory services have been offered to support coping and social inclusion of persons with special mental needs. Advocacy and self-representation functions, available for persons with special mental needs or their next of kin, are today fragmented between several organisations or non-profit association. We lack a single organisation in charge, contributing to the adoption of decisions that concern adults with special mental needs.

Options available for advocacy are also strongly linked to appointment and organisation of custody, as appointment of custody is, in essence, restriction of fundamental rights of a person. Therefore it is important to use custody only for activities or situations where it is important for persons. Custody must be organised to support the satisfaction of interests and needs of the person in custody in the best possible way. According to AS Hoolekandeteenused, which is one of the largest institutions that provides special care and welfare services, around one half of 1,250 of their customers are persons on custody and for half of the cases, i.e. 625 persons, local governments is the custodian. In a situation where a single local government may have *ca* 100 persons on custody and the role of a custodian is not explicitly defined by law, lacking sufficient regulation, the interests and needs of a person on custody are often not represented in the best possible way. The problem of high-quality

[36] Office of the Chancellor of Justice (2011). Overview of compliance with priorities by the Chancellor of Justice in 2011.
http://oiguskantsler.ee/sites/default/files/ylevaade_prioriteetide_taitmisest_2011.pdf

custody and fulfilment of related functions becomes very acute, according to current organisation of custody, during the de-institutionalisation process – recipients of services will move out from old special care homes, however, their address is, according to the population register, the care home that is about to be closed.

The measure is aimed at supporting advocacy of adults with special mental needs or sustainable activities of self-representation organisations and allowing them to contribute to decisions that concern their lives. Also, the implementation of the measure will include analysis of problems and bottlenecks of the current organisation and appointment of custody and planning of activities required to solve the problems.

3.2. Sub-goal 2

Special care and welfare services comply with the principles of de-institutionalisation

After achieving the sub-goal, the number of twenty-four-hour service slots, available in larger units (with more than 30 places) will increase and community-based special care and welfare services will become available in smaller service units to avoid isolation and social seclusion of persons.

Table 5. Sub-goal indicator

INDICATOR	BASIC LEVEL	TARGET LEVEL 2017	TARGET LEVEL 2020
The percentage of persons, receiving twenty-four-hour special care services, living in service units housing more than 30 people, compared to the percentage of persons with special mental needs who receive twenty-four-hour care services[37] *Source: Ministry of Social Affairs*	65% (2014)	40%	30%

An European study[38] on number of persons, living in social welfare institutions, showed that in 2005, in Estonia, 7,243 persons lived in institutions with more than 30 places. Therefore, 539 persons per 100,000 inhabitants were institutionalised in Estonia, which gave Estonia the first place among the ranking of 28 countries. Although this number included various social welfare target groups, incl. adults with special mental needs, elderly persons and children, the problem is also characteristic of special care and welfare in Estonia.

Inhabitants of large institutions lack sufficient control of their lives and decisions that may

[37] This is based on common basic level of 2014, which shows that 65% of persons using twenty-four-hour services live in service units with more than 30 inhabitants. After the planned reorganisation of the service system, this level is expected to drop to 40% by 2017 and by 2020, 30% of persons using twenty-four-hour services are expected to live in these units; the level is expected to drop to 10% by 2023.

[38] Deinstitutionalisation and community living – outcomes and costs: report of a European Study http://inclusion-europe.org/en/projects/past-projects/decloc-report

affect them and the requirements of service providers are often more important than individual needs of inhabitants. Common trend in Europe is to facilitate transition from institutional care to community living. In 2012, an European expert group developed international guidelines for the most flexible implementation of the process. According to the expert group, institutional care always gives worse results, with respect to life quality, than community based quality services, and this may often result in life-time exclusion from community life and seclusion. European results have shown that community-based care will result in bigger independence and personal development, allowing to improve self-care and communication skills and reduce social seclusion.[39] Deinstitutionalisation does not only involve closing of large institutions; instead, this will cover increasing the scope of supporting services, more flexible and better available provision of services. Available studies confirm that most persons who have earlier been institutionalised will prefer community living, after having experienced high-quality community based services; their satisfaction and social inclusion levels are better and they have less problems with insecurity and loneliness than expected.[40]

Table 5 shows, by counties, number of twenty-hour-service slots in institutions with more than 30 service slots, considering the type of institutions. Separate group is formed of older type institutions (column 4), which are run in larger buildings, adjusted for that purpose. The number of old type institutions is the largest in Valga county and Viljandi county (3 institutions in both). In 2013, the largest number of users of twenty-hour-services lived in this type of institution in Saaremaa (377 persons) and in Jõgeva county (325 persons). In total, in 2014 in Estonia 65% of all the users of twenty-hour special care service live in old type institutions.

However, when comparing the two sides of the table, we will see that even today, smaller, family-house type service provision institutions are run at older institutions in different counties.

Table 6. Number of persons receiving twenty-four-hour special care services[41] in institutions with 30 and more service slots on 01.06.2014

County	Institutions with more than 30 service slots (family houses included)	Service users in institutions with more than 30 service slots (family houses included)	Institutions with more than 30 service slots (family houses not included)	Service users in institutions with more than 30 service slots
Harju county	4	293	1	168
Ida-Viru county	3	178	2	120
Jõgeva county	1	325	1	325
Järva county	2	162	1	98
Lääne county	3	215	0	0
Lääne-Viru county	2	126	1	66
Põlva county	2	149	1	140
Saaremaa	1	377	1	377
Tartu county	1	68	0	0

[39] European Expert Group on the Transition from Institutional to Community-based Care (2012). Common European Guidelines on the Transition from Institutional to Community-based Care. http://deinstitutionalisationguide.eu/

[40] *Ibid*.

[41] Table 5 shows the number of persons, using state budget funded service slots, on 01.06.2014.

Valga county	4	241	3	183
Viljandi county	4	260	3	177
Võru county	1	81	1	81
Pärnu county	2	114	1	64
Rapla county	0	0	0	0
Hiiumaa	0	0	0	0
Kokku	**30**	**2,589**	**16**	**1,799**

Source: Ministry of Social Affairs, welfare statistics reports; Estonian National Social Insurance Board

As we observe the users of special care and welfare services by years (table 6), we will see that the number of users of supported living services has dropped every year, while the number of users of twenty-four-hour special care services has increased. As we compare support services, independent living support service is most common (at the end of 2013 there were approximately 1,900 users of the services). Also, independent living support service is also the most fastest to render and most easily available – for example, it can be provided to persons during treatment, without the rehabilitation plan. Only two criteria must be met to qualify for the service – a person must be diagnosed, by a specialist, with severe, profound or permanent mental disorder and written appraisal or rehabilitation plan by a psychiatrist or rehabilitation service provider will be required for reference.[42]

Table 7. Number of users of special care and welfare services in 2008–2013 (at the end of the year)

Indicator	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Persons, single use	**4,549**	**4,655**	**4,666**	**4,659**	**4,680**	**5,036**
Males	2,429	2,498	2,487	2,487	2,501	2,684
Women	2,120	2,157	2,179	2,172	2,179	2,352
Incl. total number of users of support services, single use						
independent living support service	1,700	1,750	1,738	1,711	1,684	1,864
supported living service	616	585	557	518	520	573
community living[43]	47	50	65	106	117	137
employment support service	435	405	370	370	373	461
incl. twenty-four-hour special care services in total	2,346	2,457	2,78	2,463	2,91	2,643

[42] Hanga, K., Maas, H., Sõmer-Kull, S., Schultz, G. (2013). Analysis of organisation of social rehabilitation, technical tools of assistance and special care and welfare services. Estonian Chamber of Disabled Persons. http://www.sm.ee/fileadmin/meedia/Dokumendid/TVK/Uuringud__anal%C3%BC%C3%BCsid_ja_rahvusvahelised_kogemused/EPIK_analu%CC%88u%CC%88s_Sotsiaalse_rehabilitatsiooni_2c_tehniliste_abivahendite_ja_erihoolekande_korralduse_analu%CC%88u%CC%88s_2013.pdf

[43] Will be discussed under supported services, as this is twenty-four-hour supported services, not twenty-four-hour care service.

twenty-four-hour special care services	1,897	1,976	1,990	1,992	1,997	2,161
twenty-four-hour special care services for persons with severe, profound or permanent mental order with unstable remission	48	50	38	55	56	71
twenty-four-hour special care services for persons with profound multiple disability	223	239	253	256	269	283
twenty-four-hour special care services under court order	178	192	197	160	169	128

Source: Ministry of Social Affairs, welfare statistics reports

The following measures will be implemented to achieve the sub-goal.

Measure 2.1. Shaping special care and welfare services to ensure individual focus

Individual focus of special care and welfare services means services that are devised to match the requirements of an adult person with special mental needs and his/her family. Services with individual focus represent an important support to allow users of services make the most of their potential, contribute to their independent coping and participation in labour market and social life.

Implementation of the measure will include reorganisation of the structure of special care and welfare services and adjustment of the use and organisation of services to allow for more flexibility. An overview of services, offered to adults with special mental needs by local governments, needs to be developed. The Ministry of Social Affairs does collect information about services that local governments will be required to offer, but not about services offered to adults with special mental needs under a different name. We need to obtain an overview of the current situation, including the services currently offered by local governments, to shape new special care and welfare services and a service system.

After the introduction of new services and reorganisation of current services, the number of available special care and welfare services will be bigger than the five services, which are currently available. New services will match the needs of a specific target group; services can be flexibly combined and will be available at cost-based prices. The National Audit Office has, in its audit, also highlighted the need to differentiate services and apply different prices to different services.[44]

Within the framework of the measure, users of services have access to special care and welfare services flexibly, according to their needs, by month, hour, day and interval; also, services that are aimed at enhancing employment of adults with special mental needs and bigger support requirement will be available (for example, development of sheltered employment service, facilitation of social businesses, support person service etc) and decreasing the burden of family caretakers (for example, giving holidays to family caretakers by providing services to those cared for), also services offered by persons with special mental needs themselves (for example, experience-based peer consultations).

[44] National Audit Office (2008). Efforts of the state in organising welfare of persons with special mental needs. National Audit Office report to the Riigikogu. http://www.riigikontroll.ee/tabid/215/Audit/2025/WorkerTab/Audit/WorkerId/30/language/et-EE/Default.aspx

Measure 2.2. Reorganisation of special care and welfare infrastructure

According to the plans, in 2014-2023, large service institutions or institutions with more than 30 service slots, providing twenty-four-hour services, will be reorganised with some support from the European Regional Fund, including acquisition of housing for community living and giving preference to development and provision of social support services to anticipate and prevent institutionalised care.

Within the framework of reorganisation, persons with special mental needs, using the services, will move from depreciated buildings to buildings or facilities, suitable for the provision of special care and welfare services. Attention was focused to premises with conditions, not matching the needs, already in 2001 by an expert group in a management audit report on services available to persons with special mental needs.[45] A sustainable de-institutionalisation action plan will be also developed for the other institutions that offer special care and welfare services, aiming at development of service units with less than 30 service slots.

Experts have stressed that living in an environment as natural as possible is one of the normalisation component, preventing problematic behaviour. Hospital-type care units, where the physical environment, surrounding the customer, is restricted to a bed and bedside table, can be hardly described as natural living environment. Similarity to home, suitable simulation and comprehensibility are the key words for shaping physical environment. Limitation of living environment will make the environment smaller, safer and easier to comprehend. Whole institutions with countless bedrooms, personnel and storage facilities can be hardly a home for customers.[46]

Implementation of the measure will include mapping of the condition of available infrastructure and the need for organisation or reorganisation of such infrastructure. To support the process of de-institutionalisation, the definitions of institution and de-institutionalisation will be given a content for the purposes of special care and welfare in Estonia to ensure common understanding of these terms for persons with special mental needs, service providers, advocacy organisations of persons with special mental needs, civil servants etc partners.

Measure 2.3. Ensuring availability and accessibility of special care and welfare services

Implementation of the measure will include introduction of new services and reorganisation of services and de-institutionalisation, resulting in adults with special mental needs getting a chance to choose the most suitable services in the most suitable place. Accessibility of services will focus on supplying adults with special mental needs with relevant, neutral and integrated information about the services available.

The measure is also aimed at shortening the period, preceding the availability of services, for service users (incl. reviewing the purpose and process for the development of rehabilitation plans), and ensuring the availability of services within agreed reasonable period of time. Where appropriate, this will include the basic for maintaining the waiting lists and establishing more explicit criteria for remaining on the waiting lists.

[45] Centre for National Health and Social Policy (200/2001). Specialty related-management audit of institutions, offering state social welfare services to persons with special mental needs.
[46] Tõnisson, U., Salumaa, M., Klaassen, A. (2011). Probleemse käitumise ja juhendamise hea tava käsiraamat/Manual on Good Practice of Problematic Behaviour and Management. MTÜ Hoolekande Ekspertiisi- ja Nõustamiskeskus

Within the framework of the measure, problems with current special care and welfare services and service system will be solved before introducing new services and service system. Development of a separate support system or service required by persons diagnosed with addiction as a leading mental disorder will be analysed as a separate activity, and the need to train specialists who could offer special advisory services, as according to the current regulation, standard and special care and welfare services are unavailable for this target group and social welfare specialists lack the skills required to work with these people.

Also, an alternative solution will be searched for the current situation where persons using special care and welfare services, diagnosed with dementia, will no longer be entitled to special care and welfare services, once they reach retirement age, and they should be transferred to general care services, but local governments have problems with offering services to these people, both substantially and financially. We need to analyse whether people of retirement age, diagnosed with dementia, should be among the target group, entitled to special care and welfare services, or not.

Daily supervision and care services for persons with enhanced supervision and assistance requirements, not covered by the current independent life support service, are also among the most important efforts; legislation will be amended to introduce the definition of long-term sheltered work.

In addition, one of the priorities will be the specification of target group, subject to twenty-four-hour special care services under court order, and the contents of such services. On 01.05.2014, 128 persons were using twenty-four-hour special care services under court order. Despite the fact that the number of users of this service do not form a large component of special care and welfare services, the target group is still important for a number of reasons. It is most important that we speak of service restricting on of the fundamental rights of a person – freedom of free movement. From the other hand, it is important to analyse the provision of the services for referral to the service would be justified and provision of services would contribute to the achievement of the desired goal. In 2013, AS Hoolekandeteenused conducted an analysis[47] to describe the persons, receiving special care services under court order, and to assess the services available. Based on this analysis, it can be said that the assistance requirements of the persons, receiving special care services under court order, are very different, depending on their diagnosis, education and other factors. According to the opinion, specified in the analysis by AS Hoolekandeteenused[48], approximately 50% of the persons, receiving special care services under court order, could have received some other service in 2012 (for example, demented elderly persons).

3.3. Sub-goal 3

Special care and welfare services are of high quality and offered by qualified and professional service providers

Reaching of the goal will improve, as the consequence of offering high-quality services, the opinion of adults with special mental needs regarding their ability to lead a full life. Quality of

[47] Unukainen, T., Müürsepp, L. (2013). Analysis of twenty-four-hour special care services, prescribed by court. AS Hoolekandeteenused. http://www.hoolekandeteenused.ee/media/valisveeb/Dokumendid/Vaelisveeb_-_rubriiki_arvamused_ja_analueuesid/20130722_OK_teenuse_analyys_HKT.pdf

[48] *Ibid*.

the services will be improved by increasing the number of special care service units, involved in the quality management system, funding of services will become activity-based and providers of special care and welfare services will be qualified and competent.

Table 8. Sub-goal indicators

INDICATOR	BASIC LEVEL	TARGET LEVEL 2017	TARGET LEVEL 2020
Opinion of adults with special mental needs regarding their ability to lead a full life [49] *Source: Ministry of Social Affairs. Study of Care-Taking Burden of Persons of Disabilities and Their Family Members PIU*	47% (2009)	52%	60%
Percentage of persons, having a special education or passed activity supervisor's training (260 hours) among those working as activity supervisors *Source: Ministry of Social Affairs*	0,7 (2012)	0,8	1,0
Number of special care and welfare service units that implement a quality assurance system *Source: Ministry of Social Affairs*	14[50]	Increasing	Increasing

At the end of 2013, the total of 1235 activity supervisors worked at all the institutions that provide special care and welfare services.[51] 186 (15%) of them had an education allowing them to be employed as activity supervisors. 704 persons had passed a training of activity supervisor (260 hours). 269 activity supervisors had also participated in in-service training – most of them had taken in-service training to work with persons with profound multiple disability or persons with mental disorder, characterised by unstable remission.

As we compare years 2009–2013, we will see that the number of activity supervisors has increased by approximately 15%. Over years, the number of activity supervisors with special education has been quite different and, compared to year 2009, the percentage of activity supervisors with special education has dropped, compared to activity supervisors working in general (from 18% to 15%). At the same the number of those who have passed a basic activity supervisors' 260 hour training has increased and the same goes for their percentage among employed activity supervisors (from 48% to 57%). Therefore, in conclusion it can be said that approximately 30% of activity supervisors do not have a basic formal education and they have not taken the basic 260 hour training of activity supervisors.

Table 9. Education of activity supervisors and participation in trainings in 2009–2012

[49] 47% of persons suffering from mental disorder and/or mental retardation as dominant disability or a component of multiple disability agreed or largely agreed to at least one statement of the two (disabled persons can lead a full life in our society; I feel valuable.

[50] Units that offer special care and welfare services and hold European Social Welfare Services quality assurance (EQUASS) certificate, 2014.

[51] Ministry of Social Affairs, statistical welfare reports.

	2009	2010	2011	2012	2013
Activity supervisors, in total	1,051	1,111	1,138	1,147	1,235
Having education allowing to be employed as activity supervisor	194	182	155	173	186
Having passed a 260 hour basic activity supervisors' training, according to the study programme, adopted by the Ministry of Social Affairs	502	548	578	625	704

Source: Ministry of Social Affairs, welfare statistics reports

Increase in the number of persons, having passed the basic training for activity supervisors, is explained by the increase in both the number of trainings, organised every year, and the number of training providers; the demand and scope of services has also increased. Over recent years, the main provider of basic training for activity supervisors has been the National Institute for Health Development; in years 2008–2013, a stable number of 70–80 persons has passed their training every year. Since 2011, other service providers have started to offer the training: Tartu Healt Care College, Pärnu College, Assistance Association, University of Tartu, Vocational Training Centre of Valga county.

The current mandatory 260 hour basic training of activity supervisors attempts to convey knowledge required to work with special care and welfare services' target group in general. In his or her work, activity supervisors will specialise in specific target group (for example, working only with persons with mental retardation, but not with persons with other mental disorders), therefore, it would not be necessary – and, considering the limited resources, even reasonable – to train all the activity supervisors in all the subjects; instead, they should be given basic level of knowledge and in-service training can later focus on specific target group that the activity supervisors will work with every day. Practice has also shown that conveying all the information, required to work with all the target groups of special care and welfare services, efficiently, during a single 260 hour training is not effective enough to allow to work with all the target groups, in reality. In addition, the current 260 hour training is not available immediately as the provision of services is started. According to the National Institute for Health Development, 488 persons were on a waiting list, in April 2014, to take the 260 hour basic training of activity supervisors[52].

The cost of services is also one of the components we need to consider when developing high-quality services. In 2013, the costs incurred by provision of special care and welfare services totalled to 25 million euros. As for the coverage of such costs, these are mostly funded by the state – in 2013, the state covered 67% of special care and welfare service costs. Personal contribution of the person involved totalled to 25%. Compared to the previous years, personal contribution has somewhat increased (in 2009–2011, it was 23% of special care and welfare service costs).

Table 10. Sources for covering special care and welfare services provision costs in 2008–2013[1]

Source	2006	2007	2008	2009	2010	2011	2012	2013
Total, thousands of euros	13,158	16,838	21,321	22,085	22,246	22,999	23,023	25,794
state[2,3]	8,720	11,023	14,662	15,102	15,279	15,576	15,646	17,284

[52] Statistical information from the National Institute for Health Development.

local government	1,061	1,631	1, 891	1,847	1,752	1,915	1,598	1,817
Contribution from service provider, his/her family member or custodian (own contribution)	3,250	4,001	4,699	5,066	5,116	5,386	5,655	6,531
other	127	183	68	70	99	122	123	161

[1] Indicators from 2010 and before have been converted into euros, using the following exchange rate 1 euro = 15,6466 Estonian kroons.
[2] incl. allocations from gambling.
[3] Since 2009, also includes the missing part of person's own contribution.

Source: Ministry of Social Affairs

In 2008-2012, the maximum amount of special care and welfare service costs per person per month, disbursed from state budget, did not change much, but since 2013 there has been some growth. For example, in 2013 the maximum amount of special care and welfare service costs per person per month, disbursed from state budget, increased by 3.7% per month and in 2014, 5.7% per month. In 2014, there was an a considerable increase in maximum costs, compensated from state budget for twenty-four-hour special care services, available to persons referred to care under court ruling.

Table 11. Maximum amounts of special care and welfare service costs per person per month, disbursed from state budget, euros

Service/year	2008	2009	2010	2011	2012	2013	2014
Independent living support	88.71	88.71	88.71	88.71	88.71	92.03	97.24
Support for employment	72.8	72.8	72.8	72.8	72.8	75.52	79.79
Supported living	138.1	138.12	138.12	138.12	138.12	143.29	151.4
Community living	228.55	228.55	228.55	228.55	228.55	237.1	250.52
Twenty-four-hour care services	375.1	375.1	375.1	382	382	396.29	418.72
Twenty-four-hour care services for persons with multiple disability	541.85	541.85	541.85	564.12	564.12	585.22	618.34
Twenty-four-hour care services for persons with unstable remission	541.85	541.85	541.85	564.12	564.12	585.22	618.34
Twenty-four-hour care services for persons, referred under court ruling	533.28	533.28	533.28	537.1	537.1	557.19	847
incl. minors							1,945

In 2013, the costs of supported services totalled to 5.9 million euros. The largest component of supported service costs consisted of state budget costs (approximately 61%). In comparison of sources, the percentage of costs covered by state budget have increased the most over the last years. At the same time, the contribution of local governments has decreased. Person's own contribution has been around 10–11%.

Table 12. Costs related to provision of supported special care and welfare services

and sources of such costs, 2006–2013

Source	2006	2007	2008	2009	2010	2011	2012	2013
Total, thousands of euros[1]	3,723	5,010	5,878	5,435	5,194	5,505	5,263	5,989
state, %[2,3]	56.3	52.1	56.3	57.8	58.3	55.8	59.2	60.8
local government, %	27.6	30.3	31.6	31.5	30	31.6	27.6	26.8
contribution from service provider, his/her family member or custodian (own contribution), %	13.6	14.4	11	9.6	10	10.7	11.2	10.3
Other, %	2.5	3.2	1.1	1.1	1.6	1.9	2.1	2.1

[1] Indicators from 2010 and before have been converted into euros, using the following exchange rate 1 euro = 15,6466 Estonian kroons.
[2] incl. allocations from gambling.
[3] Since 2009, also includes the missing part of person's own contribution.

Source: Ministry of Social Affairs

In 2013, costs incurred by provision of twenty-four-hour special care services totalled to more than 19,8 million euros. Compared to the distribution of supported service costs, the importance of costs covered from state budget is somewhat larger in the case of twenty-four-hour special care services (approximately 69%), while the contribution of local governments is very small (slightly above 1%), while person's own contribution is relatively high (approximately 30%).

Table 13. Costs incurred by provision of twenty-four-hour special care services and sources of such costs, 2006–2012

Source	2006	2007	2008	2009	2010	2011	2012	2013
Total, thousands of euros[1]	9,435	11,828	15,442	16,649	17,053	17,493	17,760	19,805
state, %[2,3]	70.2	71.1	73.5	71.8	71.8	71.5	70.6	68.9
local government, %	0.4	1.0	0.2	0.8	1.1	1.0	0.8	1.1
contribution from service provider, his/her family member or custodian (own contribution), %	29.1	27.7	26.2	27.3	27	27.4	28.5	29.9
Other, %	0.4	0.2	0.0	0.1	0.1	0.1	0.1	0.2

[1] Indicators from 2010 and before have been converted into euros, using the following exchange rate 1 euro = 15,6466 Estonian kroons.
[2] incl. allocations from gambling.
[3] Since 2009, also includes the missing part of person's own contribution.

Source: Ministry of Social Affairs

Therefore, it can be said that the scope of costs and distribution of sources is very different. Although the differences can be explained, to a certain extent, with both the content of services and their respective recipients, these differences also show whether the services are sufficiently available. For example, the National Audit Office has stated in its audit of 2008 that the main reason for poor availability of services is insufficient funding of services. The

audit by the National Audit Office also shows that service provision prices do not match the real costs.

The following measures will be implemented to achieve the sub-goal.

Measure 3.1. Improving the efficiency of services

Efficiency of services means that services offered to adults with special mental needs are specific and measurable and their objectives can be achieved. At the moment, we cannot speak about a common and agreed definition of contents and outcomes of special care and welfare services in Estonia, therefore, the valid legislation allows diversified interpretation, depending on contents. The National Audit Office also mentioned, in its audit, insufficient regulation of service quality by the state, concluding that as the consequence of lack of service provision standards, it is not possible to ensure uniform and equivalent services to all the persons concerned. The National Audit Office conclude that it is necessary to establish service standards for all the services.[53]

More active attention has been given to defining the quality of social welfare services since 2010, once the implementation of Equass Assurance quality marking was started among the providers of rehabilitation services. In 2013, there were 29 providers of social welfare services in Estonia comply, according to an external auditor, with the Equass Assurance quality certificate and therefore, abide by the principles of the European voluntary social welfare service quality framework for the purposes of providing the services[54]. 14 of them are institutions that provide special care and welfare services.

Implementation of the measure shall involve development of the definition „quality of special care and welfare services", implementation of quality assurance system among the providers of special care and welfare services and establishment of state-imposed quality requirements for services. Supervision over service providers will have an advisory nature. Supervision over service providers can only be based on legislation. As legislation only establishes quantitative requirements to service providers, the current supervisory system is not focused on provision of services in practice. Quantitative requirements do not ensure service quality and are often too restrictive in nature as they do not consider all the needs of service providers (for example, the requirement for certain number of employees for the provision of different services).

Measure 3.2 Enhancing qualification of activity supervisors and quality assurance competence of heads of institutions

The Social Welfare Act lays down qualification requirements for activity supervisors, providing special care and welfare services. The requirements, laid down in the Social Welfare Act[55], have become restrictive and unreasonable for the purposes of today's practical work, involving users of services, and recruitment of activity supervisors. The absence of professional standard and study programme of activity supervisor, required to promote the profession of activity supervisor, is also a problem. Is would be appropriate to

[53] National Audit Office (2008). Efforts of the state in organising welfare of persons with special mental needs.
http://www.riigikontroll.ee/tabid/215/Audit/2025/WorkerTab/Audit/WorkerId/30/language/et-EE/Default.aspx
[54] Council of the European Union (2010). European voluntary social welfare service quality framework
http://equass.ee/public/Sotsiaalteenuste_vabatahtlik_kvaliteediraamistik.pdf
[55] Social Welfare Act, § 11[34] https://www.riigiteataja.ee/akt/121032014005

mention, as comparison, that professional standard and study programme are available for similar positions, for example, social care worker, activity therapist and social worker.

Important activities, implemented within the framework of the measure, include the development and implementation of a professional standard and study programme of activity supervisors. After the completion of a professional standard, a structure for training and in-service training, required to acquire the profession of an activity supervisor, will be developed; this will allow to give activity supervisors knowledge required to work with specific special care and welfare target group and acquire the necessary skills before the provision of services or immediately when commencing the provision of services.

Within the framework of the measure, quality assurance training courses will be also available to heads of institutions that offer special care and welfare services; the requirement to obtain knowledge, conveyed by training, will become a part of the quality requirements to be developed.

Measure 3.3. Development and funding of sustainable and evidence-based special care and welfare

Adults with special mental needs can use, apart special care and welfare services, rehabilitation services, organised by the state, and social services, developed by local governments. For ensuring common and sustainable system of services we need to analyse the links between special care and welfare services and organisation of special care and welfare with other social welfare services, available to adults with special mental needs, and their organisation and structure.

As for the current organisation of special care and welfare and rehabilitation system, we need to question the efficiency and transparency of funding of these two systems. Both spheres do have their own budget line, but as the users of special care and welfare services also have the right to use rehabilitation services, it is difficult to appraise, at administrative level, the efficiency of funding one or another sphere.

Considering the scope of changes that are to take place, over the nearest years, in the sphere of special care and welfare, the current resources are not sufficient for thedevelopment of new, evidence-based services and their structure and components needed to implement such services. Within the framework of implementation of the measure there will be a need for additional human resources, contributing to the development of evidence-based new special care and welfare system. Implementation of the measure will involve an analysis, whether it would be expedient to consolidate the resources at the Ministry of Social Affairs, some education and/or research establishment or to use some other methods. Evidence-based research and development activities can be used to shape the future of evidence-based special care and welfare.

Another activity, carried out under the measure, will include development and implementation of information systems, which will support the planning and implementation of state-owned measures, supporting adults with special mental needs. The information available, to a certain extent, via the Estonian National Social Insurance Board and also the Ministry of Social Affairs[56], do not supply all the information, which will be needed for strategic management of the sphere.

Activity based service price will be used as the grounds to offer services in accordance with a

[56] Data collected via S-web and H-web do not allow to develop individual-based statistical profile.

national standard. The current service price is not activity-based. Implementation of the measure will include cost analysis of maximum prices, established for special care and welfare services, review of cost components and establishment of services prices that match the requirements.

4. LINKS TO OTHER DEVELOPMENT PLANS

The Special Care and Welfare Development Plan is linked to the following development plans and strategic documents.

Development plans, developed by the Ministry of Social Affairs

Development Plan of the Ministry of Social Affairs sets the goal of improving life quality of people and enhancing social security. Among other things, improved availability and quality of social welfare services and development of measures that support independent living have been highlighted.

Social welfare concept (approved in 2004) has established more extensive employment of persons requiring special treatment and belonging to risk groups (people with disabilities, long-term unemployed, young and elderly persons), improved availability and quality of social welfare services and better living standard of people as its goals.

One of the goals of Children and Families Development Plan 2013–2020 is to ensure combined system of support and services to support adequate economic coping of Estonian families and offer stable feeling of security to families. The document also refers to the need to o develop services, needed by children with mental disorders, and need-based service network.

Public Health Development Plan 2009–2020 pursues the general goal of prolonging healthy life by decreasing premature mortality and incidence of diseases. The document also mentions the need to refer those who need care combined with treatment to an appropriate level of treatment and/or care, increasing the number of day and home-based services and mental health awareness of people. Mental disorders and psychiatric diseases have been mentioned as one of the most strongly emerging group of diseases. The importance of self-aid is also emphasised, stressing that every person can diminish health risks by making conscious choices in organising one's everyday life.

First Contact Care Development Plan 2009–2015 pursues the general strategic goal of ensuring first contact care that meets the expectations and needs of the society. The document also refers to insufficient co-operation with social and welfare system.

Estonian Health Care Network Development Plan 2004–2015 identifies services for the patients who no longer require expensive and high-technology active treatment. The purpose of the development plan is to improve the availability and quality of both inpatients' and outpatients' health care services. It has been mentioned, in the document, that day care and home-based service forms are poorly developed and therefore, people will be required to attend hospitals or care homes.

Psychiatry Development Plan for 2015 has established the goal of developing the principles of integrated treatment of patients, suffering from mental disorders and needing consistent treatment and attaching value to this type of treatment, combined with solving the problems of long-term treatment of patients with unstable remission. The development plan describes improved quality and availability of services as important for the purposes of developing the system of psychiatric aid, considering the general development of health care, estimated

incidence of diseases and introduction of new methods of treatment.

Development plans, developed by other government authorities

Competitiveness Programme „Estonia 2020“ aims at launching initiatives, developed for disabled persons and enhancing social cohesion and employment opportunities.

Integrating Estonia 2020 pursues the goal of building up integrated and socially cohesive Estonian society, where people with different language and cultural background could take active part in social life and share democratic values.

Active Ageing Development Plan 2013–2020 pursues the goal of diversified self-realisation of people, regardless of their age, and taking part in social life according to their wishes, needs and opportunities, thereby drawing the attention to continued contribution of sick or disabled persons and elderly persons to their families, communities and society in general.

Estonian National Strategy on Sustainable Development “Sustainable Estonia 21“ is aimed at improving welfare at all the levels, economic wealth, high level of security and diversified opportunities, which are also linked to improved life quality of persons with special mental needs.

Life-long Learning Strategy of the Republic of Estonia for 2020 pursues the goal of ensuring all the people Estonia with learning opportunities, matching their needs and abilities, during their life span, and opportunities for dignified self-realisation, as a person, in society, working and family life.

5. IMPLEMETATION OF THE DEVELOPMENT PLAN

The Special Care and Welfare Development Plan has established goals until the year 2020. Activities, distributed over years, are listed in the implementation programme, which also provides an overview of the implemented activities, persons responsible and available resources. Implementation of the activities will be monitored within the framework of annual reporting, introducing amendments or modifications, where appropriate.

Two bodies will be established to implement the development plan: Development Plan implementation steering group and Development Plan implementation monitoring committee.

The Development Plan implementation steering group will be established with a decree of the Minister. Members of the group will be responsible for the activities, specified in the implementation programme, or are closely and directly related to these activities.

The institution in charge and responsible for general implementation of the Development Plan and co-ordination of related activities is the Ministry of Social Affairs. The Ministry of Education and Research, the Ministry of Justice, the Ministry of Economic Affairs and Communication, the Ministry of Interior Affairs, the Estonian National Social Insurance Board, the Estonian Unemployment Insurance Fund and Foundation Estonian Qualifications Authority.

Co-operation with the following partners will be carried out for the purposes of the implementation programme: Chancellor of Justice of the Republic of Estonia, the Estonian Unemployment Insurance Fund, Association of Estonian Cities, Association of Municipalities of Estonia, Estonian Chamber of Disable People, Association of Providers of Special Care and Welfare Services, Estonian Association of Rehabilitation Institutions, Centre of Consultation and Expertise on Social Welfare, Estonian Association of Psycho-social Rehabilitation, Estonian Association of Caretakers, Estonian Caretakers of Next of Kin, Estonian Patient Advocacy Association, Estonian Advisory Committee of Heads of Social Welfare Institutions, AS Hoolekandeteenused, Astangu Vocational Rehabilitation Centre.

The task of the Development Plan implementation monitoring committee is to monitor that the solutions, developed by the implementation steering group, comply with the Convention of the Rights of Persons with Disabilities and observe the principles of de-institutionalisation, pointing the attention of the steering group to non-conformities. The Monitoring Committee will advise and instruct the Steering Group in the process of developing solutions.

The established committee of rights of disabled persons will discharge the functions of the Monitoring Committee.

6. IMPLEMENTATION PROGRAMME

Implementation Programme of the „Special Care and Welfare Development Plan 2014–2020“ lists the activities to be implemented during the period concerned, the respective deadlines, persons responsible for the activities and the sources of funding. The institution in charge for general implementation of the Implementation Programme is the Ministry of Social Affairs. Ministries and organisations involved, having approved the activities carried out within their respective administrative area, are also responsible for their implementation.

Resources, required for the Implementation programme within the administrative area of the Ministry of Social Affairs, will be allocated from the state budget and state budget strategy, programmes introduced by the European Social Fund and the European Regional Fund and other external funds. The Gambling Council will support the initiatives of civil society and NPAs that are in compliance with the strategic goals of the Special Care and Welfare Development Plan.

The activities, where the operating costs of the institution in charge are given as he source for funding, will not bring about the demand for additional resources; instead, these will be implemented on the account of available payroll costs.

More detailed budget of the Implementation Programme of the Special Care and Welfare Development Plan will be drafted after the development of annual state budget strategy.

ANNEXES

Annex 1. Terms and definitions, linked to de-institutionalisation

The European Expert Group on the Transition from Institutional to Community-based Care (EEG)[57] has explained the definition of de-institutionalisation as an institution.[58]

According to the EEG, institution is any residential care where:

1) residents are isolated from the broader community and/or compelled to live together;
2) residents do not have sufficient control over their lives and over decisions which affect them;
3) the requirements of the organisation itself tend to take precedence over the residents' individualised needs.

Although the focus of the definition, suggested by the EEG, is on the presence of institutional culture and specific number of inhabitants or any other figures are not given, allowing to classify organisations as institutions, the number of residents living together is still mentioned as an important value. Smaller number of persons living together will allow adoption of individual approach and individual choices with bigger probability and the absence of these is seen, according to the EEG, as one of the three parameters of an institution. Most definitely, residential care in small groups will not guarantee non-emergence of an institution and, first of all, we have to keep the three aforementioned definitions of an institution on mind.

Several countries have also established criteria for the size of groups living together and housing that offers the service.

According to the EEG, de-institutionalisation is a process that involves:

1) development of high-quality, individual-centred community based services, in order to eliminate the need for institutional care. Funding made available to services, offered by institutions, will be channelled to community-based services to ensure the funding of high-quality, individual-centred community based services;
2) closure of residential institutions, where adults with special mental needs live in separation from society/community and where the provision of services does not match the needs of persons and would not allow them to exercise their human rights;
3) provision of public services, for example, education, training, employment, housing, health care and transport, to adults with special mental needs.

According to the EEG, the term 'community-based services', or 'community-based care', refers to the spectrum of services that enable individuals to live in the community and, in the case of children, to grow up in a family environment as opposed to an institution. It encompasses mainstream services, such as housing, healthcare, education, employment, culture and leisure, which should be accessible to everyone regardless of the nature of their impairment or the required level of support. It also refers to specialised services, such as

[57] European Expert Group on the Transition from Institutional to Community-based Care
[58] European Expert Group on the Transition from Institutional to Community-based Care (2012). Common European Guidelines on the Transition from Institutional to Community-based Care. http://deinstitutionalisationguide.eu/
European Expert Group on the Transition from Institutional to Community-based Care (2012). Toolkit on the Use of European Union Funds for the Transition from Institutional to Community-based Care. http://deinstitutionalisationguide.eu/

personal assistance for persons with disabilities, respite care and others.

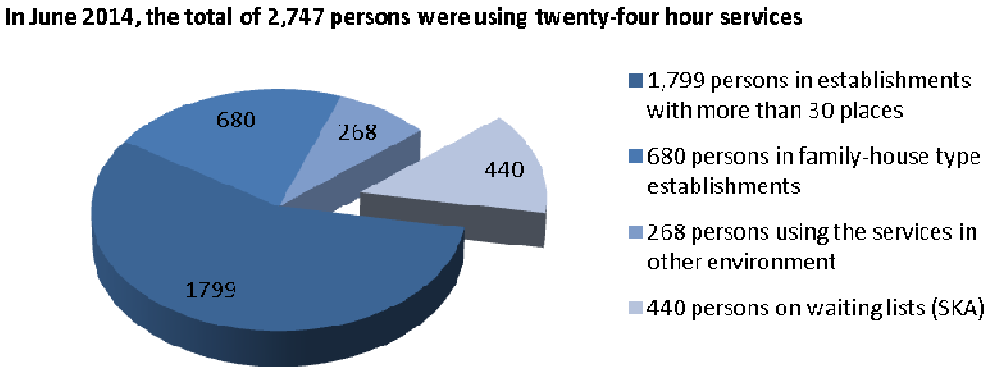
Annex 2. Trends in de-institutionalisation of special care and welfare and accompanying influences for Estonia

Persons with special mental needs have a need for a private housing that resembles home. Unfortunately, they also need to adjust their activities within the boundaries of their unit, and then in its immediate vicinity, to make more active use of the opportunities available. The more distant goal of de-institutionalisation of special care and welfare services is to offer a big component of the services outside institutional care. Estonia as one of the countries with the largest number of initiations must pass a transition period to allow persons, used to living in institutions, to adjust to more independent life style and increase the awareness and tolerance of the society with respect to the persons with special mental needs to allow the provision of community-based services. For that purpose, Estonia has chosen family houses and social welfare villages as an intermediate stage of the previous reorganisation period. The new period will focus on establishment and adaptation of smaller service provision units, with up to 30 service slots, and development of community-based services. Closeness of central settlements and availably of public and community-based services remains important; attention should be also paid to the condition of available infrastructure, the need to have it maintained or reorganised.

In 2014, twenty-four-hour special care services are available to 1,799 persons in service establishments with more than 30 service slots. By 2023, less than 170 persons should be living in institutions with more than 30 service slots and other service provision units will be reorganised into smaller units or transferred to smaller dwelling (apartments, terraced houses). In the planned service provision establishments, persons with special mental needs can live in living conditions, worthy of human beings, and become more independent in making decisions that affect their lives and issues that concern their lives. They will get access to activities, already available in the community or created within the framework of the measure (e.g. day care and employment centres) and accessible public and vital services (e.g. special medical care, shops, pharmacies). New establishments will offer living conditions that are as standard as possible and will ensure more privacy and personal attention and individual approach. Service provision establishments will be mostly established in the vicinity of larger settlements; this will allow to link the everyday activities of customers to local community. According to the plans, in larger institutions, with 170 service slots, persons using the services under court ruling, persons suffering from mental disorder characterised by unstable remission and persons with profound need for special care will remain.

As for support services, the circle of users of services will expand; this will allow supporting the health of persons, currently living at home and coping with some assistance, in such a way that their need for twenty-four-hour special care services can be avoided. Day care services will be available to decrease the care-taking burden of families, including increasing the scope of other support services (social transport, support person, personal assistant).

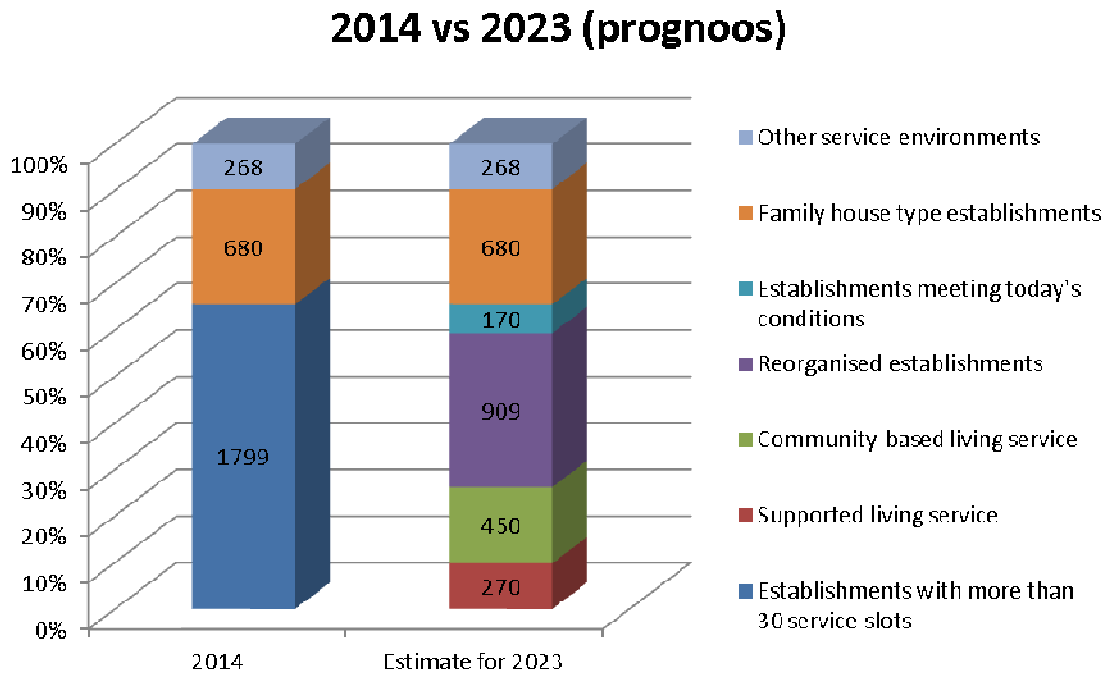
Figure 5. Number of persons, using twenty-four-hour services, on 01.06.2014



Source: Ministry of Social Affairs, SKA materials

Figure 6 depicts the changes that will take place in service provision structure, involving, above all, reorganisation of large establishments with more than 30 service slots and increase in the percentage of services, supporting more independent organisation of life, and other support services.

Figure 6. Planned changes in the structure of twenty-four-hour services in 2014–2023



Source: Ministry of Social Affairs, SKA materials

Increase in employment is one of the positive impacts of de-institutionalisation that should be mentioned: as twenty-four-hour services are offered in smaller establishments, there will be

an increased demand for activity supervisors, which will contribute, in turn, to increase in regional employment levels.

Improved availability of high-quality services and resulting decreased burden on families is only positive. Due to eliminating the waiting list of persons who need twenty-four-hour services, we can speak of reduced care burden for 444 families. As the possible impact we can assume average minimum wages and annual additional receipt for state budget, due to the taxes payable on the wages, amounting to 176.23 x 444 x 12 = 1 million euros.

In 2014–2020 we can also assume that some of the services will receive support from the Structural Funds of the European Union, capacity for work reform programmes: support to employment, sheltered work, testing and development of day care services will be covered, at least in part, from external funds, which will also help to reduce the pressure on state budget during the aforementioned years.

Annex 3. Institutions who participated in the drafting of the Development Plant

We would like to thank all the institutions and organisations who contributed to the drafting of the Development Plan. The following entities (listed in alphabetic order) participated in the process:

1. AS Hoolekandeteenused
2. AS Lõuna-Eesti Hooldekeskus
3. Astangu Vocational Rehabilitation Centre
4. Estonian Association of Caretakers
5. Association of Estonian Cities
6. Association of Municipalities of Estonia
7. Estonian Patient Advocacy Association
8. Estonian Association of Psycho-social Rehabilitation
9. Estonian Chamber of Disable People
10. Association of Providers of Special Care and Welfare Services
11. Estonian Advisory Committee of Heads of Social Welfare Institutions
12. Ministry of Education and Research
13. Centre of Consultation and Expertise on Social Welfare
14. Ministry of Justice
15. MTÜ HENK
16. MTÜ Iseseisev Elu
17. OÜ Pariisi Erihoolduskeskus
18. Ministry of Finance
19. Tallinn University
20. Pärnu College of University of Tartu
21. National Institute for Health Development
22. Estonian Unemployment Insurance Fund
23. Estonian National Social Insurance Board

Order of the Minister of Social Affairs no. … of … September 2014

„Approval of Special Care and Welfare Development Plan for 2014 - 2020“

Annex

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