Protective Measures in Working with People with Intellectual Disabilities:

Carers’ Views on Protective Measures and Client Participation

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ABSTRACT

The object of this bachelor's thesis was to study the prevalence of actualized protective measures in working with people with intellectual disabilities and challenging behavior as well as to clarify carers' views on protective measures and client participation, and whether there are possibilities for empowerment. The setting for the study was Kuusela, a department offering care, guidance and rehabilitation to adults with intellectual disabilities and challenging behavior. The theoretical framework for this study was based on values of the social field and the operating environment of Kuusela and how empowerment can be reached through participation and the right to subjectivity, self-determination, and dialog.

Methods in acquiring the essential information were both qualitative and quantitative. Data on the prevalence of actualized protective measures was gathered through a documentary analysis. Data on carers' views on protective measures and client participation were gathered through a questionnaire consisting of a set of questions that were to be answered according to the Likert scale. The questionnaire also included two open-ended questions that required a written answer. The data were analysed according to qualitative content analysis.

The results showed that the number of actualized protective measures had decreased from the year 2008 to 2010. Results on the carers' views showed that protective measures are needed and justified in their work. Although they seem conscious of the inhabitants' right to participatory working methods, it was not seen clearly in the everyday life. Obstacles in the implementation of this right were seen as being related to the inhabitants' shortcomings and the carers' attitudes and know-how.

It can be concluded that continuous reflection on values and models of action is needed in order for the inhabitants' participation to be respected and implemented and for empowerment to be possible. The results showed that learning by living should be heightened through open professional discussions. The inhabitants' shortcomings should be dealt with in a professional manner and attitudes and knowledge on addressing these shortcomings should be dealt with through discussion and possibly through further training.

Keywords

people with intellectual disabilities, challenging behavior, protective measures, participation, empowerment

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TIIVISTELMÄ

Tämän opinnäytetyön tavoitteena oli tutkia suojatoimien määrää työskenneltäessä haastavasti käyttäytyvien kehitysvammaisten kanssa sekä selvittää hoitajien näkemyksiä suojatoimista ja asiakkaiden osallisuudesta sekä mahdollistavatko näkemykset voimaantumisen. Tutkimuksen tapahtumapaikkana toimi osasto Kuusela, joka tarjoaa hoitoa, ohjausta ja kuntoutusta aikuisille haastavasti käyttäytyville kehitysvammaisille. Työn teoreettinen viitekehys pohjautuu sosiaalialan ja Kuuselan toimintaympäristön arvoihin ja siihen kuinka voimaantuminen voidaan saavuttaa osallisuuden, itsemääräämisoikeuden, subjektiuden ja dialogin kautta.

Tutkimusmenetelmät olivat sekä kvalitatiivisia, että kvantitatiivisia. Suojatoimien määriä kuvaavaa aineistoa kerättiin asiakirja analyysin keinoin. Hoitajien näkemyksiä suojatoimista ja asiakkaan osallisuudesta selvitettiin kyselylomakkeen avulla. Kyselylomake koostui kysymyksistä joihin tuli vastata Likertin skaalan mukaisesti, sekä kahdesta avoimesta kysymyksestä, joihin tuli vastata kirjallisesti. Kyselystä saatu aineisto analysoitiin kvalitatiivisen sisältöanalyysin mukaisesti.

Tulokset osoittivat, että suojatoimien määrä on vähentynyt vuodesta 2008 vuoteen 2010. Tulokset hoitajien näkemyksistä osoittivat, että suojatoimet ovat tarpeellisia ja oikeutettuja. Vaikka hoitajat tuntuvat olevan tietoisia asukkaiden oikeudesta osallistaviin työmenetelmiin, se ei näkynyt selvästi jokapäiväisessä elämässä. Esteet käytäntöön siirtymiselle liittyivät asukkaiden vajavuuksiin ja hoitajien asenteisiin ja osaamiseen.

Voidaan todeta, että jatkuvaa arvojen ja työmallien pohdiskelua tarvitaan, jotta osallisuutta voidaan kunnioittaa ja toteuttaa, sekä voimaantuminen olla mahdollista. Elämällä oppimista tulisi tehostaa avoimella ammatillisella keskustelulla. Asukkaiden vajavuudet tulisi kohdata ammatillisesti ja niihin liittyviä asenteita ja osaamista pitäisi käsitellä keskustelun ja mahdollisesti koulutuksen keinoin.

Avainsanat

kehitysvammaiset, haastava käytös, suojatoimet, osallisuus, voimaantuminen

CONTENTS

1 INTRODUCTION

The object of this bachelor’s thesis was to study the use of protective measures in working with people with intellectual disabilities and challenging behavior. The main framework for this study was carers’ views on protective measures and client participation, and whether empowerment is possible.

Views on disabled people and their possibilities on influencing matters in their own lives have changed over time. When entering the 1990s human right aspects and the disabled person’s own expertise have been strengthened. A disabled person has changed from being a passive object of services into an independent operator. (Ministry of Social Affairs and Health 2006:8.)

Freedom to function and autonomy seem to be central concepts in the empowerment process. Many researchers have stated that empowerment is not very often possible as people’s choices and actions are unnecessarily guided. One’s personal control and hearing an individual’s voice are key in the empowerment process. Empowerment is difficult to obtain without a functioning community, confidential co-operation and an equal opportunity to participation. (Siitonen 1999:86.)

When working with people with intellectual disabilities situations arise when the person’s freedom and their right to self-determination have to be restricted because they cause a threat to their own wellbeing or that of others. (Harjula, Hiltunen, Kari-Koskinen, Poikonen & Raunetvuo-Penttilä 2009:4). However reflection on protective measures must be a constant task of the multi-professional team making decisions on the implementation of these protective measures. Client participation is to be enabled by the multi-professional team in question and seen as a positive influence on the matter and the individual. The ideal situation would be that discussions with the client would enable the use of alternative solutions to challenging situations and the need for protective measures would decrease or at best cease.

In part this study was instigated due to the authors own interest towards the subject areas. The author’s own interest on the controversy subject matter of protective measures as well as client’s right to participation and empowerment were partly derived from her own working experience in Kuusela. The subject matter was seen an intriguing matter to study, as previous studies did not exist.

The need for this study was seen in goals set in Kuusela, the setting for this study, as well as in goals set by the Social Services Department of Helsinki.

The Social Services Department of Helsinki has in "Vison for the year 2012, a Socially Intact and Plural Helsinki", listed *a customer-oriented service-culture* as one of their main goals. Goals within *a customer-oriented service-culture* are: including clients' participation in services, improving clients' freedom of choice and strengthening a respecting client-encountering culture. (Social board of Helsinki 2009:10.)

Kuusela has set various goals for the years 2010-2011. The two goals relevant in this context are:

1. Inhabitants are a part of decision making on their own issues, improving the inhabitants' control over their own lives and increase in interaction. These goals are to be met by involving and helping the inhabitants in being involved in decision making, taking into account the inhabitants' perspective, consideration and respect.

2. Unifying procedures in protective measures as well as executing them in a controlled manner. Protective measures are to be documented appropriately, so that actions become visible and more qualitative. These goals are to be met by enhancing statistical documentation as well as analysis based on the statistics. Conclusions made on the basis of the analysis are to be utilized in developing actions. (Department Kuusela 2009.)

The aim of this study was to shed light on issues affecting or even preventing participation as well as on factors that need to be taken into consideration when moving towards a more participatory culture of working in department Kuusela.

The study was conducted by both qualitative and quantitative research methods, by using a documentary analysis and a questionnaire that produced both qualitative and quantitative data.

The second chapter of this study introduces the setting and background relevant for this context. It offers a description on the functions of Kuusela and an overview on institutional care. It also describes intellectual disabilities and challenging behavior in people with intellectual disabilities.

The third chapter sheds light on protective measures in working with people with intellectual disabilities in intellectual disability units of Helsinki's Social Services Department.

The fourth chapter describes ethics and values as such as well as values in working in the social field, values of the city of Helsinki and values of Kuusela.

The fifth chapter seeks to describe how empowerment can be achieved through participation. Participation is seen as consisting of the right to subjectivity, dialog and self-determination.

The sixth chapter describes the object and methodology of the study. It includes depiction on research methods, data collection and – analysis and discusses the reliability and validity of the study.

The seventh chapter presents the results of the study, the eighth chapter conclusions drawn from these results and the ninth chapter proposes some ideas for further studies.

2 SETTING AND BACKGROUND

2.1 Kuusela

The setting for this study is department Kuusela, situated in Sofianlehto, an institution for people with intellectual disabilities. Kuusela is a part of services for adults in the city of Helsinki's Social Services Department.

Kuusela is a department for adult people with intellectual disabilities. Its purpose is to respond to challenging situations in demanding intellectual disability work. Kuusela permanently houses 11 inhabitants. In addition to the 11 permanent inhabitants Kuusela also offers housing as a crisis solution for one person at a time. Crisis housing is meant for people whose needs have not been met by services and supportive measures of open care. Daily actions in Kuusela are based on care, rehabilitation and guidance according to each inhabitant's individual care plan. The basic idea of the department is to strengthen each inhabitants own skills in life, according to their resources. The inhabitants are supported in life management, so that they could lead an independent as possible life. (City of Helsinki Social Services Department 2011.)

The definition "…respond to challenging situations in demanding intellectual disability work" refers to working with people with intellectual disabilities and challenging behavior. This (new) definition aims at being more neutral and less labeling towards the inhabitants.

The clientele of Kuusela is quite unique and once in a while fall into situations where protective measures are needed. According to unofficial statistics Kuusela has had to resort to protective measures more often than any other units for people with intellectual disabilities of the Helsinki cities Social Services Department. Because of its unique clientele and the high demand for protective measures Kuusela has been a part of developing models of action for whole of the city of Helsinki. Therefore it is important that the department's models of action be evaluated and improved based on these evaluations.

2.1.1 Institutional care

Long-term or permanent institutional care is necessary when the other alternative would be long-term care in a health center ward, a children's ward in a central hospital or in a psychiatric hospital, as they are only partly able to respond to the needs of intellectually disabled people's needs. Reasons for long-term institutional care can be for example physical or mental condition, reasons resulting from the lack of abilities in taking care of oneself or rehabilitation. Because of the challenges in their care people living in institutions cannot live anywhere else. Legislation on intellectual disabilities does in fact state that care is to be given to those that cannot survive without it. Institutional care can also be provided as a short term solution if a person is in need of rehabilitation, care related to a long term illness or care related to pharmaceutical safety. Institutions have throughout time been considered as having expertise in people with intellectual disabilities and challenging behavior. (Kaski, Mölsä, Manninen & Pihko 2002:353-354.)

2.2 Intellectual disabilities

According to the International Statistical Classification of Diseases and Related Health Problems, ICD-10, mental retardation (that is in this context referred to as intellectual disabilities) (F70-F79) is a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, for example cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition. (WHO 2007.)

According to the Finnish legislation on intellectual disabilities a person is entitled to the services of special welfare, when their development or mental ability to function is prevented or disturbed due to congenital issues or illness contracted during development, because of defect or handicap and who cannot receive the services they require based on another law (Laki kehitysvammaisten erityishuollosta, Legislation on special welfare for the intellectually disabled 1977).

People with intellectual disabilities face challenges in every-day functions due to imperfections in adaptive skills. Adaptive skills are best determined through examining adaptive behavior. Adaptive behavior refers to expectations that the social environment places on the individual. It should be recognized that if a person with intellectual disabilities has shortcomings in one area of adaptive skills, they are likely to have strengths in another area. Adaptive skills can be examined through ten different areas: Communication, taking care of oneself, living, social interactions, utilizing the community, autonomy, health and safety, functional ability to learn, leisure activities and work-skills. (Sundin 2003:10.)

Learning new things and conceptual thinking are more difficult for people with intellectual disabilities than others. People with intellectual disabilities face challenges in intellectual functions such as; *Understanding complex contexts and learning from experience*, which require the ability to keep several issues in mind simultaneously and the ability to remember important learning experiences. *Reasoning*, the ability to make observations on one's self and their environment and make conclusions based on them. *Problem solving,* the ability to understand what each situation is about and how to act in order to survive in it. *Planning own actions,* which demands the ability to focus, separating the relevant from the irrelevant, partitioning tasks and keeping focus, although obstacles may occur. (Verneri.net 2010.)

Ojanen and Seppälä (2004) have broadened the concept of adaptive skills towards psychosocial ability to function by emphasizing the individual's own, active role in their actions. The ability to function is then examined through the concept of life management, as it can be stated that every individual, even a person with intellectual disabilities, has the aspiration, want and need to control their own life. (Ojanen & Seppälä 2004:3-7.)

2.3 Challenging behavior in people with intellectual disabilities

In all people with intellectual disabilities as much as 30% to 50 % suffer from mental health and behavioral issues (Koskentausta 2006:1927).

Challenging behavior can be seen as resulting from mental health issues or behavioral problems. Seppälä (1997:18-23) suggest that the differentiation of mental health issues and behavioral problems can be found in how a person is orientated in a given situation. In behavioral problems a person's orientation is deficient, which leads to an unstructured interpretation and an unstructured emotional reaction. This leads to a situation where the person’s actions seem random. Therefore the flawed action leads to a random (positive or negative) result. The flawed action may become a permanent strategy for action if it is enforced.

Mental health issues are characterized with a different kind of orientation. The interpretation of the situation is often flawed, which may result from seemingly indifferent matters triggering images or memories of for example traumatic experiences or distorted interaction in relationships. The person’s emotional reaction and actions seem distorted and odd, which in the end leads to an unwanted result. Seppälä does however suggest that mental health problems and behavioral problems can appear simultaneously. (Seppälä 1997:18-23.)

Moss (1999) proposes that the differentiation between mental health issues and behavioral problems is artificial, as all behavior is a product of neurological and environmental factors. He feels that today’s knowledge on the origin of mental disorders and the effects of biological, psychological and social factors is not adequate.

There are various factors that predispose people with intellectual disabilities to psychiatric disorders. Negative experience of life, frequent failures and being teased may lead to low self-esteem and learned helplessness. Deficient social intellect and a lack in communication skills make functioning in social situations difficult. Possible sense- and motion disabilities, epilepsy and neuropsychological disorders, such as problems in attention, hyper activeness and lingual disorders both predispose to psychiatric disorders as well as influence their appearance. Mental health issues may also derive from factors related to family, such as stress in the family, parents’ psychiatric disorders, single parenthood and a poor socio economical standing. (Koskentausta 2006:1927-1928.)

Prevalence of psychiatric disorders is up to five to seven times more likely for people with intellectual disabilities than for people without intellectual disabilities. The most common psychiatric disorders in people with intellectual disabilities are autistic disorders, behavioral disorders, aggressiveness and harming oneself, disturbances in attention, schizophrenic disorders as well as mood-, anxiety- and adaption disorders.

Many non-psychiatric factors may also show symptoms that are alike with psychiatric disorders. (Koskentausta 2006:1927.)

Research on people with intellectual disabilities and mental problems began to increase in the 1980’s and 1990’s. Research findings portray that estimations on the prevalence of mental disorders in people with intellectual disabilities vary from 10-90%. Reasons for the huge variations may be found in the sample (whether people in institutional or open care are studied), behavioral problems (are they included or left out), reasons for intellectual disabilities, age, the level of intellectual disability and research and analysis methods. (Sundin 2003:12.)

According to Seppälä (1998:28-29) there are about 30 000 people with intellectual disabilities in Finland and about 3000-3500 of them (10-15%) are in need of care, rehabilitation or guidance because of their mental health issues. A quarter of them may suffer from severe mental health issues for example schizophrenia, other psychosis and severe mood disorders.

Montonen and Savila of Diakonia polytechnic conducted a study “Personnel’s Views on Mentally Retarded People’s Mental Problems in Residential Homes in Rauma” in 2006. The aim of the study was to find out how mental problems appear in intellectually disabled persons in residential homes in Rauma, what treatment methods are used and how one could improve the quality and availability of the care of intellectually disabled persons’ mental problems. (Montonen & Savila 2006:25.)

The main research findings were that intellectually disabled people’s mental problems appear quite similarly than those of people without intellectual disability. Montonen and Savila also concluded that living in a residential home is likely to influence the characteristics of mental problems, as there is lack in privacy. Another finding was that even workers that have known the client in question a long time, find it difficult to differentiate between mental problems and behavior resulting from intellectual disability. The employees also stated that problems in communication cause many of the problems in differentiating mental problems from behavior resulting from intellectual disability. It was concluded that aggressive behavior is not a trait connected to intellectual disability, but a sign of mental problems. (Montonen & Savila 2006:31-32.)

A majority of forms of challenging behavior have to do with interaction. Factors guiding behavior can be divided into internal and external factors. Internal factors are thoughts, emotions and psychological factors. Especially people with mild intellectual disabilities are able to recognize such factors. External factors can be divided into environmental expectations, wishes and space factors. Interactional situations have been made easier by deriving sets of rules for behavior; they tell us how to act in certain situations, or at least how not to. Most people with intellectual disability live with other people, with their family or with peers. Communal living is made easier by certain sets of rules. The essential factor in deriving rules is that the people affected by the rules be a part of the process. (Chydenius 2007:151-152.)

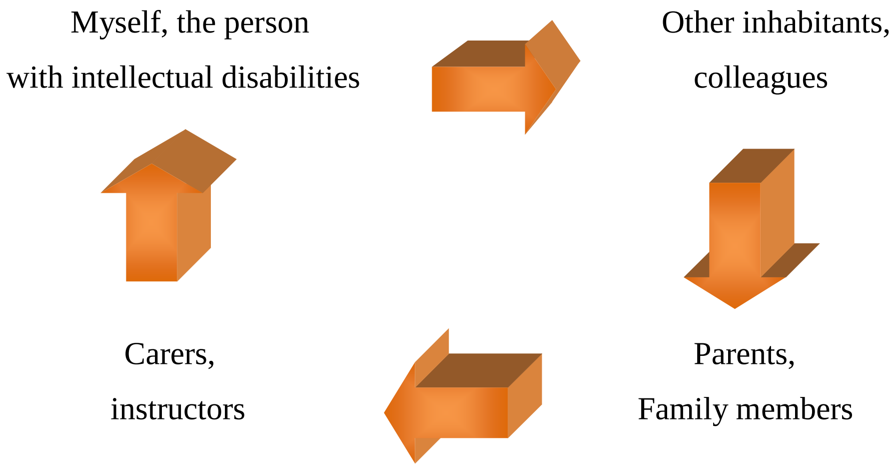


FIGURE 1. Factors affecting challenging behavior (Chydenius 2007:152).

The more parties in the graph above agree on the “problem”, the better the conditions are for changing the situation. The intellectually disabled person’s own opinion and motivational aspects related to it are of course pivotal. (Chydenius 2007: 152).

The behavioral therapeutic tradition has a strong standing in the intellectual disability field. Its strength is in the emphasis on environmental and communicative factors. Challenging behavior is seen as a result of distorted learning experiences and can be taught away from. The idea is to influence behavior either by strengthening positive aspects or by teaching replacing behavioral patterns. (Seppälä 1997:9.)

3 PROTECTIVE MEASURES

3.1 Legislation on protective measures

The Finnish constitution states that everyone is entitled to personal freedom, inviolability and safety. Personal inviolability should not be interfered with nor should ones freedom be taken without a legal basis. The same principles can be found in the European human rights treaty. The Finnish constitution also states that everyone is entitled to privacy, but also that everyone is entitled to necessary care. The Finnish law on special welfare for the intellectually disabled touches the issue of protective measures only be stipulating that ”a person in special welfare can be subjected to protective measures only to the extent to which the provision of special welfare or the safety of others requires”. (Harjula et. al. 2009:4.)

The Finnish law however does not give specific instructions on how the measures should be used, their justifications, methods, documentation or supervision. Legislative ombudsman Riitta-Leena Paunio has in her supervision visits to institutions for the intellectually disabled felt that services offered for the intellectually disabled should be developed so that the need for protective measures would decrease. She addressed that a law on the restrictions for the intellectually disabled should be derived already in 2009, but the law has been delayed.

The fact that the law stipulates that protective measures can be used in order to ensure provision of special welfare gives very good grounds for the revision of the law in itself, as it is no longer thought of as possible to implement protective measures on this basis. (Kari-Koskinen 2010.)

Forssen and Virtanen (2008:70) in ”Hoivaa ja huolenpitoa vaiko rangaistuksia ja kiusantekoa” – “Nurture and care of or punishments and teasing” a report on the use of coercive and restrictive (referred to as protective in this context) measures in social- and health care units in province of Southern Finland, reported that the employees’ need and want for a distinct legislation on the use of protective measures is great. Here is a quote from their study:

> *”The intellectual disability legislation does not, apart from a very general definition, give any instructions on the grounds for using protective measures, how they should be implemented or followed up on. We have waited for the new legislation for years, and in this place in time, when the service structure for people with intellectual disabilities is under construction the new legislation will hopefully take into account not only institutional living but also provision of services by municipalities, joint municipal boards and private service providers, as well circumstances and needs related to open care based living- and work services.”*

A distinct legislation would further the actualization of clients’ and patients’ rights as well as the legal protection of employees, as it has done in psychiatric hospital care, where the changes in the mental health act in 2002 have clarified the implementation of measures that restrict a person’s basic rights. (Forssen &Virtanen 2008:70)

At this point in time the law is being worked on and is planned to be ready in 2013. It has been planned to be much more exact than the one in force at this moment. It is planned to follow in the footsteps of the child welfare act that is very accurate and recognizes the values of the health and social services in Finland. It for example states what is in a child’s best interest and that a child should be treated according to age and developmental level. When in time the new law comes into effect, it is likely that the now withstanding model of action must be revised, in order for them to be compatible in all areas. However the model of action on protective measures used by the city of Helsinki can be used as a tool and even as a basis in preparing the new legislation. (Uotinen 2010.)

3.2 Model of action on protective measures in the city of Helsinki

When taking into consideration the above mentioned laws, the basis for the use of protective measures is that the intellectually disabled client’s physical freedom and the right to self-determination should be limited as little as possible. If other methods of working are not possible or are proven insufficient, protective measures should always be implemented so that the method chosen limits the client as little as possible for the least amount of time. (Harjula et. al. 2009:5.)

The least amount of time is described so, that whenever the grounds for the use of protective measures are no longer present the protective measure must be ended immediately. This requires continuous reflective professionalism from the people working in these situations.

In 2008 a work group gathered from representatives of Pääjärvi joint municipal board, Uusimaa special services-joint municipal board and the Social Services Department of the city of Helsinki have compiled an instruction on protective measures for the intellectually disabled by utilizing past instructions. This instruction has been utilized when deriving the city of Helsinki's instruction for the use of protective measures for the intellectually disabled. The instruction was published 1.12.2009. (Harjula et. al. 2009:3.)

3.3 Implementation

When working with people with intellectual disabilities situations arise when the person's freedom and their right to self-determination have to be restricted because they cause a threat to their own wellbeing or that of others. (Harjula et. al. 2009:4).

Sometimes the differentiation between protective measures and everyday interaction, care and rehabilitative measures is difficult. When such situations arise the differentiating factors are for example the measure's restrictiveness, the client's own will in relation to the measure and the duration of the measure. An individual worker cannot decide or be accountable for assessing the need for protective measures or the action to be taken in these situations. The decisions have to be made in a multi-professional team. The care community in charge of such issues should always have a responsible and open minded approach. Open evaluation is the best way to improve the basic rights of people with intellectual disabilities. (Harjula et.al 2009:3;7.)

Because protective measures are always a violation towards a person's freedom and inviolability the justifications, necessity and implementation have to be carefully considered from the individuals stand point. The person subjected to such measures is likely to feel deeply offended. For some people physical holding might be the worst possible measure as some people might feel safe in that situation. The way people feel and act in certain situations is always affected by their previous life experiences and therefore the used protective measure must always be thought of from the individuals stand point. For example when considering protective measures for a person with a history of being physically or sexually abused the use of physical restriction must be thought out very carefully. All in all restriction can generate very different reactions. As a positive standpoint the measure used can provide a sense of security and structure for the chaotic situation. As a negative standpoint restricting may lead to fear, a sense of humiliation or even violent behavior. Therefore it is essential that the situation be discussed about after it has happened and that the person subjected to such measures understands why they had to be restricted. As protective measures are not to be used as punishment, this should be made very clear to the restricted person as well. (Harjula et. al. 2009:6-7.)

The idea behind the use of protective measures is to relieve symptoms of mental distress and/or prevent a person from posing danger to themselves or others. The nature of protective measures entails that their use is based on research- and follow-up information, the methods used are principally agreed on beforehand and supervision and staffs’ presence is defined beforehand in a very precise manner. (Harjula et. al. 2009:7.)

If a person has a tendency to result in challenging behavior a multi-professional team draws up a security plan which includes anticipatory signs of protective measures, description of typical challenging behavior, guidelines and practical hints on avoiding protective measures, protective measures that can be used, guidelines for the implementation and monitoring of protective measures, necessary medication and how the situations resulting in protective measures are to be discussed about after the situation. The plan and permission given on the basis of the plan for the use of protective measures is evaluated every three months and if the need for protective measures is still thought to be topical, the permission is renewed by the doctor in charge of the client in question for a maximum period of three months at a time. Restrictions to a person’s liaisons are to be ended as soon as they are no longer needed and therefore permissions are evaluated on a day to day basis. Another exception is that when a person is in need of physical holding in for example dentistry care or during lab testing, the permission is evaluated after one years’ time and renewed for a maximum of one year. (Harjula et. al. 2009:17-18.)

Protective measures that demand decision making and documentation according to predetermined guidelines are: *Measures that limit an individual's physical freedom;* physically guiding a person/ moving a person against their own will, holding, the use of restrictive constraints, locking a person into a room, locking a person into a security room, limiting a person's freedom to move. *Measures that limit an individual's right to self-determination*; a necessary care action, confiscating one's belongings, inspecting ones belongings and deliveries, inspecting one's person, limiting one's liaisons. *Extreme measures;* limb restraints. (Harjula et al. 2009:8-9.)

The above mentioned terms have been derived from the mental health act, because as mentioned before the legislation on protective measures for the intellectually disabled is yet to come.

The executive board of the Helsinki city special services, work safety offices and the Helsinki city's Social Services Department's ethical board all follow the protective measures implemented in the city of Helsinki, they also take part in evaluation and development of models of working. There are also various work groups founded especially for the purpose of evaluating and developing implemented protective measures and models of working. (Harjula et. al. 2009:27-28.)

3.4 Clients' participation

The guideline for the use of protective measures within the city of Helsinki addresses the issue of clients' active participation in many contexts. It urges that clients themselves are a part of the decision making process and that their ability to understand the issues and their individual ways of communicating are taken into consideration and acted on. Also ways of enabling the client's participation must be actively sought for. The ideal situation would be that discussions with the client would enable the use of alternative solutions to challenging situations and the need for protective measures would decrease or at best cease. The right (and responsibility) to discuss about situations that have resulted in protective measures has been given to both the person who has been subjected to protective measures and those who have been present and possibly somehow influenced by the challenging situation. (Harjula et. al. 2009:27.)

Self-determination is even emphasized in relation to the client's parents and other close family members (Harjula et. al. 2009:16), an issue that is often quite difficult as in many cases it is automatically thought of that the client's parents or other close family members are the client's best advocates. Unfortunately this is not always the case, and ongoing discussion on the right to self-determination has given the client more room to exercise this right.

4 ETHICS AND VALUES

4.1 The feminist approach to moral reasoning, "Ethic of care"

The renewed feminist interest in women's modes of moral reasoning largely stems from Carol Gilligan's studies of women's moral development. The intrinsic idea behind this particular feminist ideology is that men's and women's moral sensibilities tend to develop differently. (Kymlicka 1990:263.) Despite criticism on the straight forward division of the two sexes, Gilligan claims that women tend to reason in a different voice than men. These two voices have been characterized in terms of an "ethic of care" and an "ethic of justice", which Gilligan claims to be "fundamentally incompatible". (Gilligan 1986:263-264).

The differences in the "ethic of care" and the "ethic of justice" can be looked at under three headings: *Moral capacities* – learning moral principles (justice) versus developing moral dispositions (care), *Moral reasoning* – solving problems by seeking principles that have universal applicability (justice) versus seeking responses that are appropriate to the particular case (care), *Moral concepts* – attending to the rights and fairness (justice) versus attending to responsibilities and relationships (care). (Tronto 1987:648).

There is a difference in the kind of responsibility each ethic imposes on us. According to Sandra Harding (1982:237-238, 1987:297), Gilligan's research shows that ´subjectivity-felt hurt appears immoral to women whether or not it is fair´ whereas men ´tend to evaluate as immoral only objective unfairness- regardless of whether an act creates subjective hurt`. The fundamental difference between care and justice might be found in the contrast between taking subjective hurts or objective unfairness as the grounds for moral claims. Most justice theorists tie moral claims to objective unfairness rather than subjective hurt. (Kymlicka 1990:276.)

One argument can be that justice theories can be seen as applicable to autonomous adults and care theories to relations with dependants. Justice theories do in fact recognize that we have obligations towards dependant others, but they write as if these obligations are matters of ensuring a fair share of resources is allocated to children and the infirm. They do not discuss our obligation to provide care for the dependents. (Kymlicka 1990: 284, 292.)

Care theorists say that the conflict between autonomy and responsibilities for others must be decided contextually. We should judge the appropriateness of any demand for autonomy or reciprocity on the grounds of what is reasonable to expect from the individual being cared-for, along with what should be expected from such an individual given the nature of the caring relationship at hand (Wilson 1988:20). Care theorists, unlike justice theorists, do not try to resolve these issues by developing a comprehensive system of abstract rules that runs roughshod over the particularity of persons and their relationships. (Kymlicka 1990: 280.)

Although the feminist care ethic was initially developed in context of private relationships many feminists argue that it has public significance, and should be extended to public affairs. For Gillian, what joins people in this giant web of relationships is not necessarily any direct interaction, but rather a shared humanity. (Kymlicka 1990:264, 271.)

4.2 Values

The word “ethics” is of Greek decent and has been derived from the word “ethos”, which means “decent disposition”, “manner”. Ethics and moral are areas that reflect on and examine certain models of action, a person’s appropriate behavior. Ethics reflects on what is good and bad, right and wrong. (Aadland 1993:20-21.)

> *“Values are stars by which a person navigates in their life* (Aadland 1993:45).

Values and norms create a basis for ethical action. In order for a person to act in an ethically correct way, they must possess a certain basis by which they can reflect on the ethicality of their actions and decisions made. The core of this basis is ethical values. Values describe everything that is fundamentally valuable to a person. Values are permanent goals, ideals and priorities that are expressed through reflected, verbal statements and/or models of action. (Aadland 1993:45.)

Rokeach (1973) defines a value as a permanent belief that a specific aspiration or policy is socially or individually better than the one contrary or parallel to it. A value is often said to be a basis for decision making. Values can also be described as subjective. They are manifestations, judgments and appreciations of an individual. A conscious goal for actions, a purpose, is commonly thought of as a value. Values are goals for an ideal way of action, and they guide choices and assessments. (Hämäläinen & Niemelä 1993:11.)

4.2.1 Values in working in the social field

No common values have been defined for the social field, although in addition to knowledge and theory they are considered to be defining functions and professionalism in the social field. A common value basis for the social field is rather discussed through ethical principles that are based on widely accepted values in society. These values are for example justice, respect for human dignity, equality and general humane rights. Work in the social field is not based on the idea that these values have to be improved as such but rather on preventing the occurrence of contradiction in them as well as alleviating the effects these contradictions impose on an individual’s life. (Raunio 2004:74-76.)

4.2.2 Values of the city of Helsinki

The city of Helsinki has listed customer-orientation, sustainable development, justice, economic efficiency, safety and a spirit for entrepreneurship as their values. These values are functional values of the whole organization that influence leadership and staff as well as actions of the whole orgaization. Customer-orientation means that the work done in the city of Helsinki is done for its customers. The members of the municipality are the city’s most important customers. Sustainable development means that the city strives to offer future generations a healthy, safe and cozy Helsinki. In its actions the city for example pays attention to natures demands and builds a long-term and well lasting city. Justice is one of societies basic values, which in the cities actions means that customers are treated according to legislation and equally. Municipal decision-making is also just and democratic. Economic efficiency means that resources are used appropriately and efficiently, the aim is that the city does the right things as well as possible. Safety means that a member of the municipality can trust the basic services the city provides as well as the stability and quality of the services offered. Safety also means a cozy and safe environment that the city is creating. A spirit for entrepreneurship is above all understood as an internal entrepreneurship, which means the cities employees' own enthusiasm towards their work and a desire towards results and reaching set goals. A spirit for entrepreneurship also refers to an increase in and supporting the furthering of entrepreneurship that can be seen in the cities strategic course of conduct and industrial politics. (City of Helsinki 2000.)

In the context of social services the production of value for clients and defining benefit or value for clients is reinforced by an ethical point of view. It is a matter of principles linked to the word value, that are crystalized in a welfare states social politics, the idea of justice, human dignity, professional ethical norms and the social ethical course of conduct of the social office. (Social board of Helsinki 2009:11.)

4.2.3 Values of Kuusela

Common values are needed in a working community to clarify functions as they define a common goal and the employees' obligations and responsibilities. Common values and goals are to be seen as guiding the employees towards the right solution in difficult situations. In order for common values to be implemented they need to be fully comprehended and committed to, this can be best achieved through value discussions. (Juujärvi, Myyry & Pesso 2007:49-51.)

The main values of Kuusela are respect for human value and humanity, justice, safety, professionalism, presence and genuine encounterment and individuality.

The corner stone for respect for human value and humanity is that everyone is unique as an individual. The inhabitants are to be encountered as individuals, taking into account their developmental level. Inhabitants are to be treated in a humane way, remembering a correct way of speaking and behavior. Normalization, integration, individual growth and development are to be supported according to the individual's resources. Cultural pluralism is to be acknowledged and accepted. The use of humor must be carefully considered and professional.

Justice is to be maintained by providing holistic care to all inhabitants. The inhabitants are to be treated equally and everyone is expected to follow rules that have been compiled together. Challenging situations are not be provoked from, nor should the inhabitants be provoked. Inhabitants are entitled to their own opinions and feelings. Shortcomings in an individual’s ability to function are to be encountered professionally. Decisions on the inhabitants care are made and executed in a professional manner, not according to one’s own feelings. Decisions are discussed with the inhabitant, their family members and a multi-professional team.

Professionalism is described as the staff’s ability to master the basic functions of their work. The staff must possess theoretical knowledge and be able to apply this knowledge to practice. This requirement is met through training, emotional intelligence and the ability to use ones one personality as a tool of working in professional manner. The ability to encounter challenges and act in challenging situations and the ability to question matters are key components of professionalism. The inhabitant’s behavior must be interpreted in a professional manner.

Presence and genuine encounterment means that the staff is present and must have time for the inhabitants. Individual needs must be met and a genuine interest in their well-being is key. Interpreting the inhabitant’s moods, genuine caring and listening are very important in genuine encounterment. The inhabitant’s reciprocal interaction is to be supported as well as communication between the inhabitants and their families. It is only natural that the actions of the inhabitants raise a range of feelings within the staff. It is important that these feelings are recognized, but do not guide the staffs actions. When discussing and giving feedback on the inhabitants challenging behavior it must be emphasized that the unwanted action is reprehensible, not the individual.

Each inhabitant’s individual needs, life experiences, calendar age and social age are to be recognized and supported. The inhabitants are to be encouraged towards individual actions and to communicate their wishes, needs and emotions. A rehabilitation- and care-plan is derived for every inhabitant and care and guidance is given accordingly. The inhabitant’s right to privacy is to be respected, and their rooms should not be entered without permission or just cause. (Department Kuusela 2009.)

5 EMPOWERMENT

5.1 Empowerment as a theoretical framework

Empowerment has become a central concept in discussion on enhancing wellbeing in social psychology, upbringing and education, social sciences, social anthropology and health care sciences (Kaukola 2000:36). The prevalence of the use of the concept can be compared to that of the concept “motivation”. Heikkilä-Laakso and Heikkilä (1997:343-344) have in fact stated that while the post war period was focused on the omnipotence of motivation, the focus has now shifted towards the empowerment process.

The roots of empowerment can be found in anti-oppressive practice, in critiques of oppression from Black perspectives, feminism, campaigns against ageism and the disability movement. They have all converged on the concept of, and need for empowerment. The growing body of literature on anti-oppressive practice has been responsible, more than any other factor, for enhancing the significance of empowering practice. (Adams 1996:9.)

Empowerment literally means ’becoming powerful’. The Dictionary of Social Work defines empowerment theory as

> *“theory concerned with how people may gain collective control over their lives, so as to achieve their interests as a group, and a method by which social workers seek to enhance the power of people who lack it”* (Thomas & Pierson 1995:134).

Empowerment is seen as a process that evolves from the individual themself: power cannot be given to another person. It is a personal and social process that cannot be produced or created by another person. Empowerment can be environmentally based. An empowered person is characterized as being a person who has found their own resources, is self-determining and free from external constraint. The empowered person has throughout the process of empowerment become empowered themself, contrary to being empowered by someone else. (Heikkilä-Laakso & Heikkilä 1997:347-350; 358-371.)

Empowerment can also be considered as a means by which individuals, groups and communities become able to take control over their own circumstances and achieve their own goals, thereby being able to work towards helping themselves and others to maximize the quality of their lives. (Adams 1996:5.)

The concept of empowerment is based on helplessness or lack of power, referring to unreached goals and inadequate resources and opportunities, limits in options or inadequate work opportunities, whereby the individual is not able to choose what they do or how. Empowerment can also refer to a decrease in dependency and an increase in possibilities to affect, especially the ability to affect people, organizations and the environment, that have an influence on the person's own life. (Järvikoski 1994:118.)

Freedom to function and autonomy seem to be central concepts in the empowerment process. Many researchers have stated that empowerment is not very often possible as people's choices and actions are unnecessarily guided. One's personal control and hearing an individual's voice are key in the empowerment process. Empowerment is difficult to obtain without a functioning community, confidential co-operation and an equal opportunity to participation. (Siitonen 1999:86.)

5.2 Participation through subjectivity and the right to self-determination

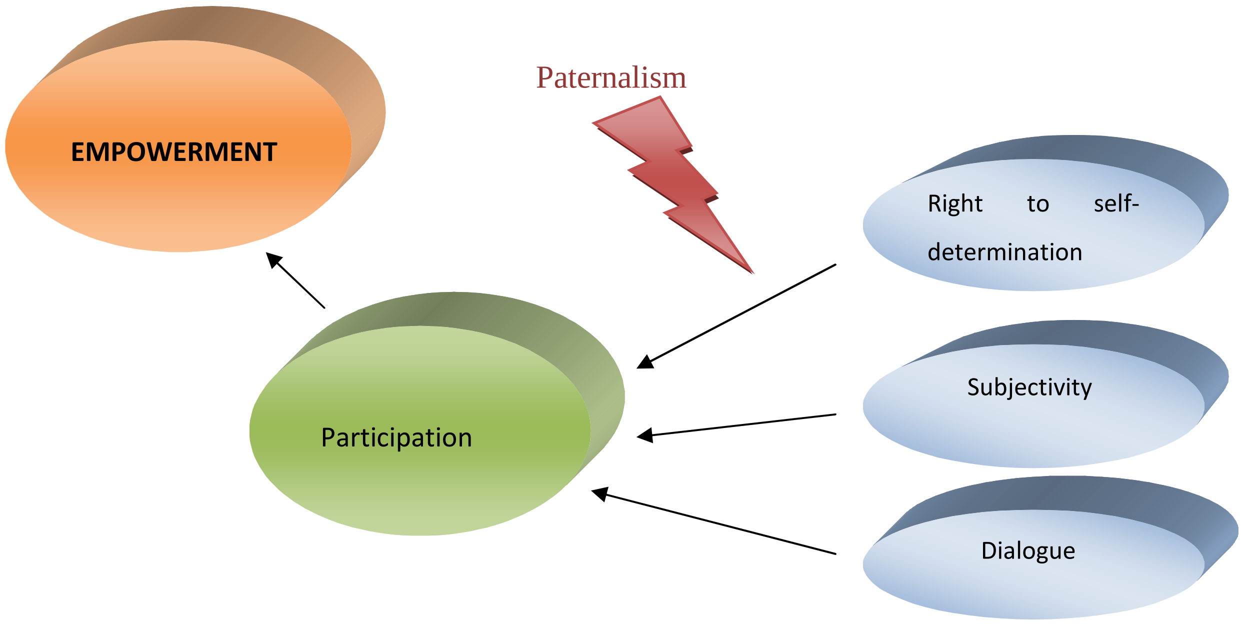


FIGURE 2. Components enabling participation and hence empowerment

The right to self-determination is defined as a moral right to freely make decisions regarding one’s own life and act on those decisions. According to Pietarinen (1998) the right to self-determination can be divided into three components: *competence:* a person’s ability to consider, decide and act, *authenticity:* an individual’s independence in decision making and power over other factors influencing the desired goal, *power:* in both the freedom to act, as well as receiving help. Based on the above mentioned concepts, the right to self-determination can be seen in a constricted way or an extensive way. If interpreted in a constricted way it is a competent and authentic enough person’s right to decide on their own a matters. A more extensive view point however also entails an individual’s right to competence and authenticity. (Pietarinen 1998:15-26.)

It can be thought, that most people with intellectual disabilities do not meet the criteria of self-determination as Pietarinen has described it. Pietarinen has stated that it is impossible to answer the question of where the line between competence and incompetence is to be drawn. The principle of ethical self-determination however requires that the threshold be placed as low as possible and let people act on their own decisions, if it does not clearly cause harm to others. Appreciating a person’s competence as such usually has a beneficial effect on their thinking and decision making skills. An individual’s authenticity cannot develop, if the individual’s thinking, decisions and actions are influenced and the individual is not given a chance to exercise subjective consideration. (Pietarinen 1998:39.)

The environments attitudes have a strong influence on a intellectually disabled person’s self-image. If a intellectually disabled person is thought of as an object of care, teaching and rehabilitation the person does not have an opportunity to form a positive self-image. When a person feels that they have the opportunity to influence and actively be a part of matters concerning their own life, their self-esteem is strengthened. Supporting intellectually disabled people towards adulthood should above all be support towards developing into an unattached subject. (Kaski et al 2006:224.)

Although an intellectually disabled person will need help on practical issues and mental support throughout their lives, the balance between independence and essential dependence must be pursued. (Kaski et al 2006:247).

Reija Lampinen (2010) disability ombudsman of the city of Helsinki has stated that:

> *"For people with disabilities the right to self-determination entails the right to support in decision making*.

5.2.1 Paternalism

Actions that limit an individual's freedom and right to self-determination are commonly referred to as paternalism. Paternalism relies on the idea that an individual does not always know what is good for them. Professional paternalism is referred to when patronizing and dismissing an individual's autonomy when working in for example social- and care professions. Paternalism can be divided into soft and hard paternalism. Hard paternalism is in clear violation of an individual's autonomy and can be seen as either strong paternalism or weak paternalism. Strong paternalism refers to actions when an individual is capable in decision making, but is still limited in doing so. Weak paternalism refers to actions when an individual's abilities are sometimes limited in decision making. As the person is seen, on occasion, to be limited in their decision making abilities it is thought that excusing them from this task is in their best interest. Soft paternalism, also known as nurturing control, does not clearly violate an individual's autonomy. The justifications for hard paternalism can (usually) be found on a legislative basis. Legislation can give grounds for forced help, to ensure the welfare of the individual and/or the society. (Hämäläinen & Niemelä 1993:69.)

Paternalistic patronizing can be seen as ethically justified and as protecting an individual's autonomy in the following cases:

1. A person can be refrained from hazardous decision making that is caused by ignorance and by giving them information on their actions.

2. Children and feebleminded can be protected from bad choices and decisions, because they are not (yet) capable of understanding the harm they are causing themselves or able to evaluate it reasonably.

3. A person who is temporarily overwrought or depressed can be prevented from hearting oneself, because their decision making does not necessarily reflect their true wishes.

4. When it can be assured that the person's free choices are in fact quasi-free choices due to social expectations and pressure. Judgments portrayed by the community, financial distress or manipulation through false images can lead to solutions that the person would not otherwise do. (Launonen & Puolimatka 2006:17.)

5.3 Dialog

Hannula (2000:82-83), differentiates two dimensions to portray oppression and freedom when describing Freire's pedagogical views, derived mainly from the "Pedagogy of the Oppressed" (1972). The dimensions are; a dimension reflecting the individual's and group's position object-subject and a dimension reflecting common functioning antidialog-dialog.

An individual's position, whether they are an object or a subject and the form of common functioning, antidialog or dialog in decision making, are factors describing freedom and oppression. Freedom is described as a state where free subjects can participate in co-operative, self-influencing decision making and the world is constructed throughout interaction. This is seen as true dialog. The opposite of freedom is true oppression, where parts of the people are treated as objects and their contribution to decision making is prevented. This is seen as antidialog. Oppression and freedom are not something that comes from outside a person that are to be yielded or pursued, but are a part of people's actions, that are focused on destroying humanity or making it possible. (Hannula 2000:82-83.)

Freire (1986) was concerned to engage in the process of conscious-raising to the point that people could overcome their oppression and challenge their dependence and powerlessness. Freire uses everyday terms in a special way to capture the essence of the process of overcoming oppression and empowering people. The heart of the process can be seen in dialogue between people. (Adams 1993:60.)

> *"the encounter in which the united reflection and action of the dialoguers are addressed to the world which is to be transformed and humanized, this dialogue cannot be reduced to the act of one person's 'depositing' ideas in another, nor can it become a simple exchange of ideas to be 'consumed' by the participants in the discussion…Because dialogue is an encounter among men who name the world, it must not be a situation where some men name on behalf of others. It is an act of creation; it must not serve as*

> *a crafty instrument for the domination of one man by another* (Freire 1986:61-61.)
>
> “*The consciousness of other people cannot be perceived, analyzed, defined as objects or as things -one can only relate to them dialogically. To think about them means to talk with them; otherwise they immediately turn to us their objectivized side: they fall silent, close up and congeal into finished, objectivized images.* (Bahtin 1991:68.)”

Graumann (1990) states that although “dialog” is defined in many ways, some issues can be agreed on. “Dialog” refers to mutual discussion and reciprocal exchanging of thoughts. The term “dialog” comes from the Greek word ´dialegesthai´, which means to speak and think together in manner that although issues discussed by participants differ from each other a commonality can be obtained between them. The goal of dialog is to move from two or more opinions towards one. (Graumann 1990.)

Markova (1990) describes dialog as a dynamic process between people defined by the socio-historical context and culture that the participants come from. Luckmann (1990) defines dialog as a universal form of humane communication. Dialog is face-to-face communication, which is described largely by instant interaction and reciprocity.

Lehtovaara (1996) describes open dialog as not being governed or guided by intelligence or will in pursuing attitudes towards reality, but that reality is more over looked at and listened to in a marveling fashion. Open, respectful and interested listening; listening to another person as an authentic person, as what they are or what they possess within, constitutes the core of open dialog. (Lehtovaara 1996:43.)

6 OBJECT AND METHODOLOGY

6.1 Object

The aim of this study was to determine the prevalence of protective measures in Kuusela as well as to shed light on the carers’ views on protective measures and inhabitant participation in the decision making process. The carers’ views were to be examined through a theoretical framework of subjectivity, right to self-determination and dialog, factors influencing possibilities for empowerment. The ultimate goal was to see whether empowerment was possible.

The study questions were:

- What protective measures are used in Kuusela in the years 2008-2010?
- In what quantity have protective measures been used in Kuusela in the years 2008-2010?
- What are the carers' views on protective measures?
- What are the carers' views on inhabitants' participation in decision making on protective measures?
- Do the carers' views on inhabitants' participation in decision making on protective measures support empowerment?

6.2 Research methods

This study was conducted as a multimethod study by using both qualitative and quantitative research methods.

Quantitative research seeks to measure various phenomena and factors affecting them as precisely as possible (Koivula, Suihko & Tyvärinen 2003:22, 37). Data on the phenomenon studied can be existing data in various registers or the data may be collected by the researcher (Heikkilä 2002:28-29).

Qualitative research is traditionally seen as a more flexible way of conducting research. The flexible nature of it gives grounds for researching everyday life situations and phenomena in a more humane way. Qualitative research is also characterized by the generation of theories, whereas quantitative research is seen as testing of theories. (Robson 2002:45-47.)

Making a distinction between qualitative and quantitative research methods is often problematic and many researchers do not even wish to make a clear distinction. For example qualitative research can be seen in a concise way and in connection only to specific methods of data collection, such as non-numerical ones. However, a research method cannot be defined exclusively through data collection methods. (Hirsijärvi, Remes & Sajavaara 2007:131-132.)

6.3 Data collection

Before any data was collected (or existing data used for the purposes of this study) a research permit was acquired from the ethical board of the Social Services Department of Helsinki, as the inhabitants were seen as not being able to grant permission on the use of their documents.

The prevalence of protective measures in Kuusela in the years 2008-2010 was studied mainly to act as a foundation for the rest of the study, it was studied through a documentary analysis. A common approach to documentary analysis is content analysis, the quantitative analysis of what is in a document. It differs from many of social science's other research methods in being indirect, as it is dealing with something produced for some other purpose. (Robson 2002:350.) Krippendorff (1980:21) states that:

> *"Content analysis is a research technique for making replicable and valid inferences from data to their context"*

Content analysis is seen as a secondary or supplementary method in a multimethod study (Robson 2002:352). The purpose of a content analysis in this context was to establish an overall view on how active a part protective measures play in Kuusela.

The data were collected from the Effica electronic documentation system, where all aspects of the inhabitants' care and rehabilitation are documented on a daily basis. No particular sampling was done as all of the inhabitants of Kuusela in the years 2008-2010 were included in the data collection. The recording unit was "Suojatoimi" ("Protective measure"), which was to be found as a heading (or part of the text in 2008) in all documentations regarding protective measures. The collecting of data and the producing of statistics based on this data was started already in 2009 as a part of the authors working tasks in Kuusela.

The documentation of protective measures into the Effica documentation system had gone through significant changes within the past few years. In 2008 protective measures were documented quite freely, without pre-set rules on what kind of information was to be given on the situation. In 2009, as the updating of the plan of action regarding protective measures had been ongoing, pre-set rules and directives were given on the documentation of protective measures. In practice the carers were to document the situation by answering ten pre-set questions on the situation and giving the text the instructed heading. The specific heading would make information gathering easier, especially after March of 2009 when a search engine was taken into use in the Effica documentation system. Although the use of the search engine would have made data collection for the purposes of this study easier, the author has seen it more reliable to "manually" go through each inhabitant's documents, as the search engine does not for example identify miss-spelled words and phrases.

Carers' views on protective measures and client participation were studied by quantitative and qualitative data collecting through a survey questionnaire. The corner stone of this part of the study can be found in evaluation research.

> "*Evaluation is often concerned not only with assessing worth or value but also seeking to assist in the improvement of whatever is being evaluated*" (Robson 2002: 203).

Although questionnaires are traditionally used to collect data from a much larger sample of people, a self-administrated survey was chosen in this context because it would allow anonymity, which in turn could encourage frankness when sensitive areas were involved. Surveys in general provide a relatively simple and straightforward approach to the study of attitudes, values beliefs and motives. (Robson 2002:233-234.) The resources in conducting this study in relation to the author's aspirations to get an overall vision on the carers' views were also in favor of using a survey questionnaire.

As the survey questionnaire was derived to measure the carers' attitudes, a scale-based questionnaire was chosen. A summated rating scale (Likert scale) was applied to the purposes of this study as items in a Likert scale can look interesting to a respondent, and people often enjoy completing a scale of this kind. The respondents' level of interest towards answering a questionnaire is in connection to the level of consideration on the given answers, if they feel the questionnaire is boring, they are likely to give perfunctory answers. (Robson 2002:293.)

As in cases where the design of the study is fixed before the main stages of data collection the design of this particular study needed to be piloted (Robson 2002:95,97). The head nurse of Kuusela acted as a test respondent. Her role was mainly to help the author with the layout of the questions and to reflect on how the questions were to be understood by the respondents.

The questionnaire was compiled so that the answers would portray carers’ views on the justification for protective measures, client participation and carers’ professionalism in relation to protective measures. The 31 questions that asked for a numerical answer, according to the Likert scale, were categorized as follows:

Justification for protective measures			
	Safety	Q´s number	1, 4, 7
	Psychic indisposition	Q´s number	2, 5, 8
	Life management	Q´s number	3,6,9,22,25
Client Participation			
	Planning	Q´s number	15,17,21,31
	Situations	Q´s number	26, 29
	Actualized protect. meas.	Q´s number	16, 27, 30
	General discussion	Q´s number	11,13,19,20
Carers’ professionalism and role		Q´s number	10,12,14,18,23,24,28

In addition to the 31 questions requiring a numerical answer two open ended questions were included in the questionnaire. These questions were derived on the basis of the author’s assumptions that the carers would feel that there was room for improvement on inhabitants’ participation on decision making on protective measures.

In autumn of 2010 the questionnaire was handed out to all 15 carers working permanently in Kuusela. Half of the respondents were male and half female. The carers were aged from mid-20’s to mid-50’s, they all had vocational training in care professions (practical nurse or professional titles preceding it) and had working experience in Kuusela varying from 3 to 20 years. In addition to the carers the questionnaire was also handed out to the head nurse of the department.

Out of the 16 questionnaires handed out 11 were returned over a timeline of a few months. Out of the 11 returned questionnaires nine included answers on questions requiring a written answer. The length of the answers varied from one word to several sentences.

6.4 Data Analysis

The data documented under the heading of “Suojatoimi” (“Protective measure”) were gone through and categories were made according to the different types of actualized protective measures. The categories were constructed according to the documented text that in turn was documented in accordance to the model of action in using protective measures in the city of Helsinki.

A table of the actualized protective measures was made according to the type of protective measures used in each inhabitant’s case. However it was seen best to make a separate, general graph on actualized protective measures for the purposes of this study, to protect the anonymity and rights of the inhabitants.

In addition to the content analysis made on the numerical data, the author wished to include a small amount of qualitative data on the type and prevalence of certain protective measures as well as changes in their prevalence. This qualitative data was analyzed alongside the quantitative categories, mainly according to the original table derived on each individual inhabitants actualized protective measures.

As the sample for the questionnaire on the carers’ views was quite small, all of the answers were included in the analysis. The quantitative data collected from the questionnaires was first handled manually to determine the frequencies of each answer. A table on the frequencies in answers according to question was made in Excel. The table could then be used to portray a weighted average, as well as making graphs to provide a visual aid in the portraying of results.

Qualitative data collecting in a multimethod approach, for example open responses in a questionnaire may be best dealt with by techniques of content analysis (Robson2002:456). The data collected from this particular questionnaire was analyzed through content analysis, with assistance of traits in grounded theory approaches, as the codes were based on the researcher’s interpretation of the meanings or patterns in the text (Robson 2002:458). The data was examined to derive categories by coding issues arising from the answers. As the data was quite small, the analysis was done manually to establish these categories.

Three categories could be derived on the basis of the answers to the first question on problems in participation; communication, inhabitants' shortcomings and attitudes towards the necessity of participation. Three categories could also be derived on the basis of the answers to the second question on improving participation; communication, forums and a professional focused ideology.

6.5 Reflection on reliability and validity

As the author has conducted the study in her own place of work and on a topic that she herself feels requires acknowledging, it raises various questions. As Kirby and McKenna (1989:46) put it:

> *"Remember that who you are has a central place in the research process because you bring your own thoughts, aspirations and feelings, and your own ethnicity, race, class, gender, sexual orientation, occupation, family background, schooling etc. to your research"*

Although `starting where you are` as Lofland and Lofland (1995:12-13) put it, is in many cases seen as bringing bias into the research the researcher's existing knowledge on the topic at hand can be seen as a positive contribution, especially in the planning phase. As the possibility for bias is constantly present in the research it will be necessary for the researcher to seek to counter this by examining the assumptions and values they bring to the situation. (Robson 200:50.)

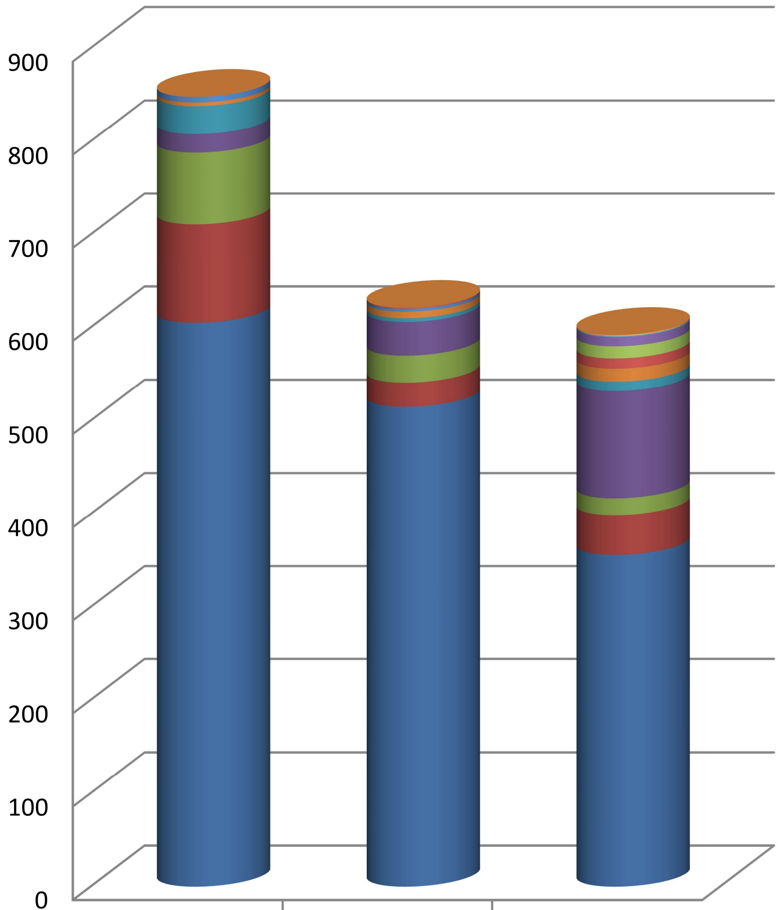
The author has sought out to identify possible biases and to eliminate them as much as possible. In turn acknowledging her own thoughts, aspirations and feelings on this subject and on the study conducted has contributed immensely to her professional growth. Although the author's own assumptions and values have been kept away from the study process as such, they have also been enriched through the process.

As it can be considered as a rule of thumb in research that the reliability of the research increases as the sample increases (Valli 2001:14), the sample used for this study can be seen as quite small. As this particular study was conducted for the purposes of improving models of action in particular in Kuusela it was seen fitting that the sample be consisting only of carers working there.

Because the sample was so small, the piloting of the questionnaire had to be done mainly by one person, who also answered the questionnaire. This may lead to the difficulty of her having a better idea of what of answers would be “good answers”. The author how ever has confidence in that her answers were not distorted because of being a part of the piloting.

As the subject matter had not been previously studied, a point of reference was missing in examining the reliability of the results.

7. RESULTS



	2008	2009	2010
🟧 Limb restraints	0	0	1
🟦 Room inspection	0	0	1
🟪 Sleeping in a careshirt	0	0	10
🟩 Careshirt	0	0	13
🟥 Limiting access to own room	0	1	11
🟦 Magnetic belt	6	3	0
🟧 Medication against will	4	7	14
🟦 Helmet and carevest	30	4	10
🟪 Holding/Physical Moving	20	36	115
🟩 Isolation into own room	77	29	18
🟥 Isolation into a security room	106	26	43
🟦 Sleeping in a locked room	605	515	356
total	863	625	602

FIGURE 3. Protective measures in Kuusela 2008-2010

7.1 The prevalence of protective measures in Kuusela 2008-2010

It was very often the case that one challenging situation resulted in the use of numerous protective measures. For example an inhabitant may have needed to be subjected to holding and later on physically moved to a security room and medicated against their will before their state of mind was normalized to the extent that they no longer caused a threat to their own safety or the safety of others.

7.1.1 Sleeping in a locked room

Sleeping in a locked room referred to an inhabitant spending their night(s) in their own room, which was locked from the outside. They had the opportunity to leave their room, if needed, under supervision.

As can be seen in the figure above, the protective measure described as “sleeping in a locked room” had the greatest prevalence in implemented measures. In 2008 the prevalence was 70%, in 2009 79% and in 2010 59%, of all implemented protective measures. Although almost all of the protective measures under the title “sleeping in a locked room” were done in full co-operation with the inhabitant(s), they were still classified as protective measures because of their restrictive nature. The decrease in number during the years is explained by the fact that for the most part of the year 2008 there were two inhabitants who were subjected to this protective measure each night, whereas in 2009 the other inhabitant had moved to another place of residence. In 2010 one inhabitant had still been subjected to the measure every night, until December of 2010, when an electronic devise was installed to monitor the inhabitant’s movement in and out of their room. After the installation of the devise and the inhabitant’s consent for the monitoring of their actions it could be agreed on by a multi-professional team that this type of monitoring was not to be classified and documented as a protective measure.

7.1.2 Isolation into a security room, Isolation into own room, Holding/Physical moving

Isolation into a security room referred to a situation where an inhabitant posed great harm to oneself or others and therefore had to be locked into a security room, a room that had been specially made for this purpose.

Isolation into one’s own room referred to a situation where an inhabitant posed great harm to oneself or others and therefore had to be locked into their own room.

Holding/physical moving referred to a situation where an inhabitant posed great harm to oneself or others and had to be calmed down by holding or physically moved to another location to ensure their safety and that of others.

The prevalence of “isolation into a security room” was in 2008 12%, in 2009 5% and in 2010 7% of all implemented protective measures. The prevalence of “isolation into own room” was in 2008 9%, in 2009 5%, and in 2010 3% of all implemented protective measures. The prevalence of holding/physical moving was in 2008 2%, in 2009 7%, and in 2010 19% of all implemented protective measures.

7.1.3 Other protective measures

The rest of the protective measures used throughout the years 2008-2010 can be seen as very strongly linked to individual inhabitants’ traits in behavior and need for protective measures and are not as commonly used as the ones mentioned before.

A helmet was used if an inhabitant endangered their own safety by hitting their head against the wall and a care vest was used if a person endangered their own safety or the safety of others by hitting, grabbing or otherwise pursued to do harm with their hands. Medication against will had to be resulted in when an inhabitant was not co-operative in taking calming medication in a challenging situation. A magnetic belt was used to tie an inhabitant to their bed, when they posed great danger to themself or others. Limiting access to own room had to be resulted in when an inhabitant pursued in doing harm to themselves by items found in their own room or when it was otherwise seen as harming to their wellbeing. A care shirt and sleeping in a care shirt were used when an inhabitant pursued to harm themselves or others and other protective measures had been proven insufficient. Room inspection had to be resulted in when an inhabitant pursued to harm themselves with items in their own room. Limb restraints were used to calm a person down in a very challenging situation, where the person was of great danger to themself and others.

Kuusela is the only unit within the intellectually disabled services of Helsinki that is equipped with the possibility of using limb restraints. One of the main reasons for taking this form of care into use (after several years of being out of use) is that it has throughout the years become evident that the inhabitants of Kuusela do not benefit from being moved to a psychiatric hospital, as they are usually not psychotic and therefore do not necessarily need psychiatric care as such. Fortunately there has only been one case of the use limb restraints as a protective measure in Kuusela.

7.2 Carers’ views on protective measures and client participation

The categories used in the compiling of the questionnaire were also used in portraying the results of the questionnaire.

Usually in fixed design experiments, results are reported in terms of group averages rather than what individuals have done. The relative weakness of this is however that subtleties and complexities of individual human behavior cannot be captured. (Robson 2002:98.)

The graphs portray the number of answers on the statement in question, according to the level of agreement; “1-I completely agree”,”2- I somewhat agree”, “3-I somewhat disagree”, “4-I disagree”. The fifth category “I cannot say/answer” was left out of the graphs, as calculation and results of the weighted average would have been distorted, if this fifth category would have been given a “weight”. The weighted average is portrayed on the far right of each question in the graph. The weighted average of each answer can be directly mirrored to the scale of agreement on the statement in question. For example a weighted average close to number one (1.00) means that an average answer to that particular statement is “ I completely agree”, and vice versa, a weighted average close to number four (4.00) means that an average answer to that particular statement is “I completely disagree”.

7.2.1 Justification and benefit from protective measures

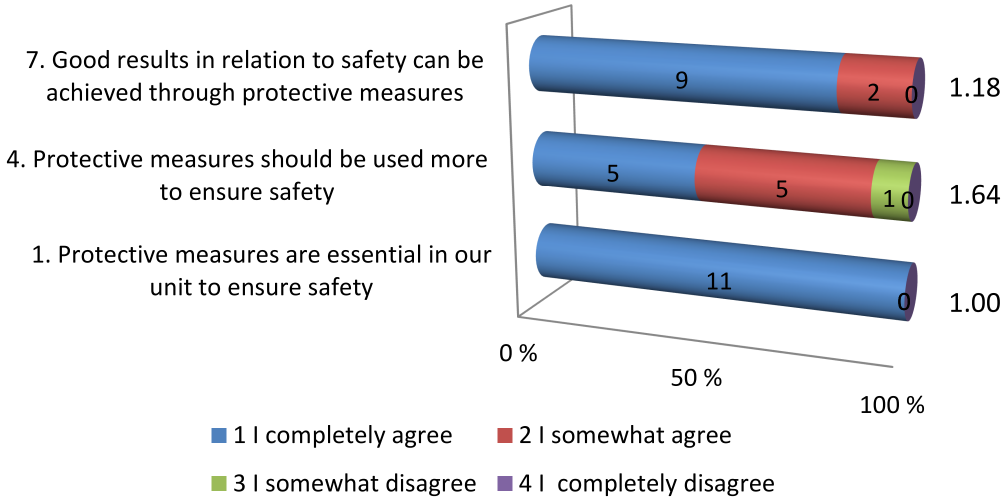


FIGURE 4. Views on protective measures in relation to safety

The respondents have completely agreed that protective measures are essential in ensuring safety. They have, on average, completely agreed that good results in relation to safety can be achieved through protective measures. Most of the respondents have agreed or somewhat agreed that protective measures should be used more to ensure safety. The average can be found between of “I completely agree” and “I somewhat agree”.

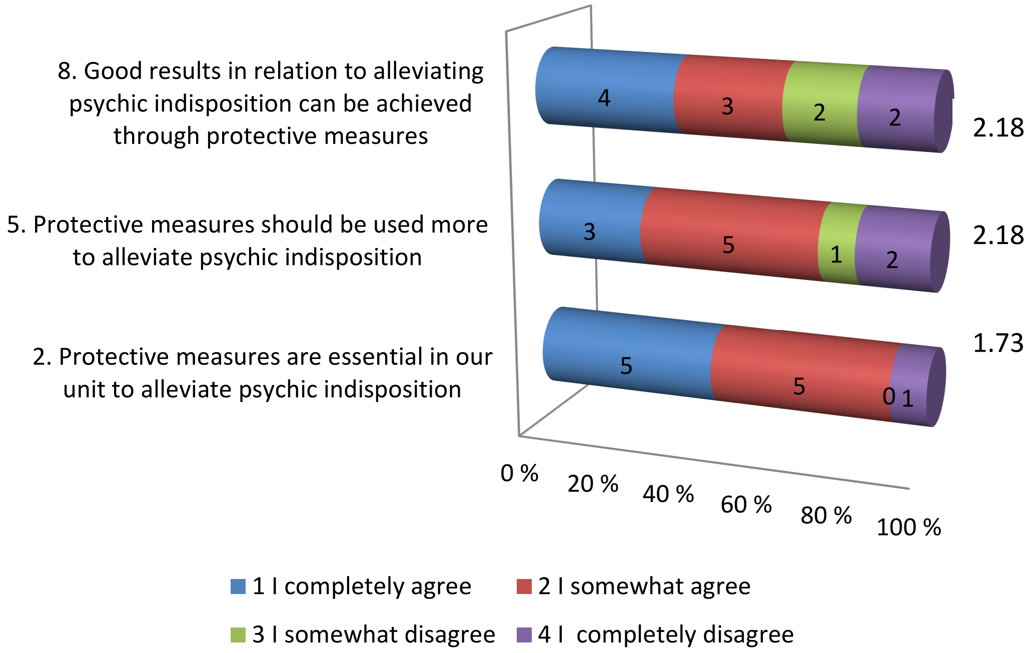


FIGURE 5. Views on protective measures in relation to psychic indisposition

A majority of the respondents have completely or somewhat agreed that protective measures are essential in relieving psychic indisposition. The average can be found in between “I completely agree” and “I somewhat agree”. The variation in answers on achieving good results through protective measures in relation to alleviating psychic indisposition and should protective measures be used more to alleviate psychic indisposition have been greater than in the question before. Never the less more than half of the respondents have agreed or somewhat agreed, leaving the average answer at a tad over “I somewhat agree”.

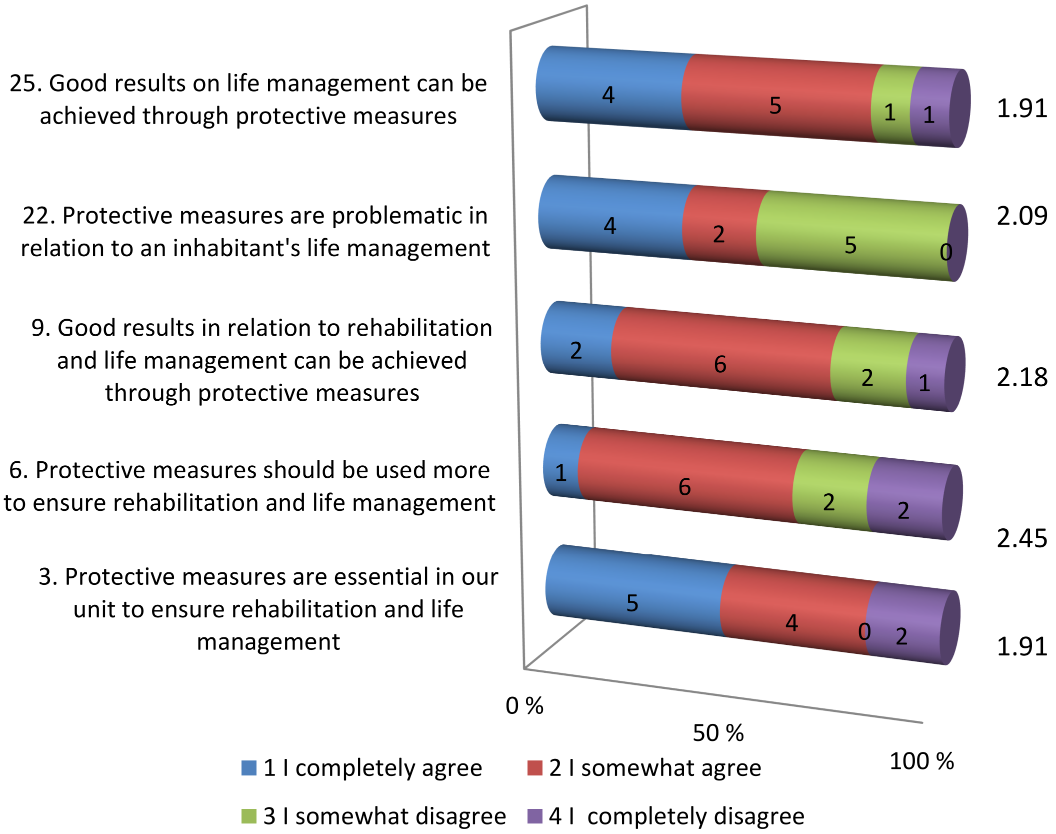


FIGURE 6. Views on protective measures in relation to life management

Most of the respondents felt that protective measures are essential in ensuring rehabilitation and life management. The average can be found quite close to “I somewhat agree”. Good results on rehabilitation and life management or life management through protective measures were seen in various ways, the average was however a tad above and under “I somewhat agree” The respondents had differing opinions on whether protective measures are problematic in relation to life management, the average could be found a tad over “I somewhat agree”. The respondents’ average views on whether protective measures should be used more to ensure rehabilitation and life management could be found between “I somewhat agree” and “I somewhat disagree”.

7.2.2 Client participation

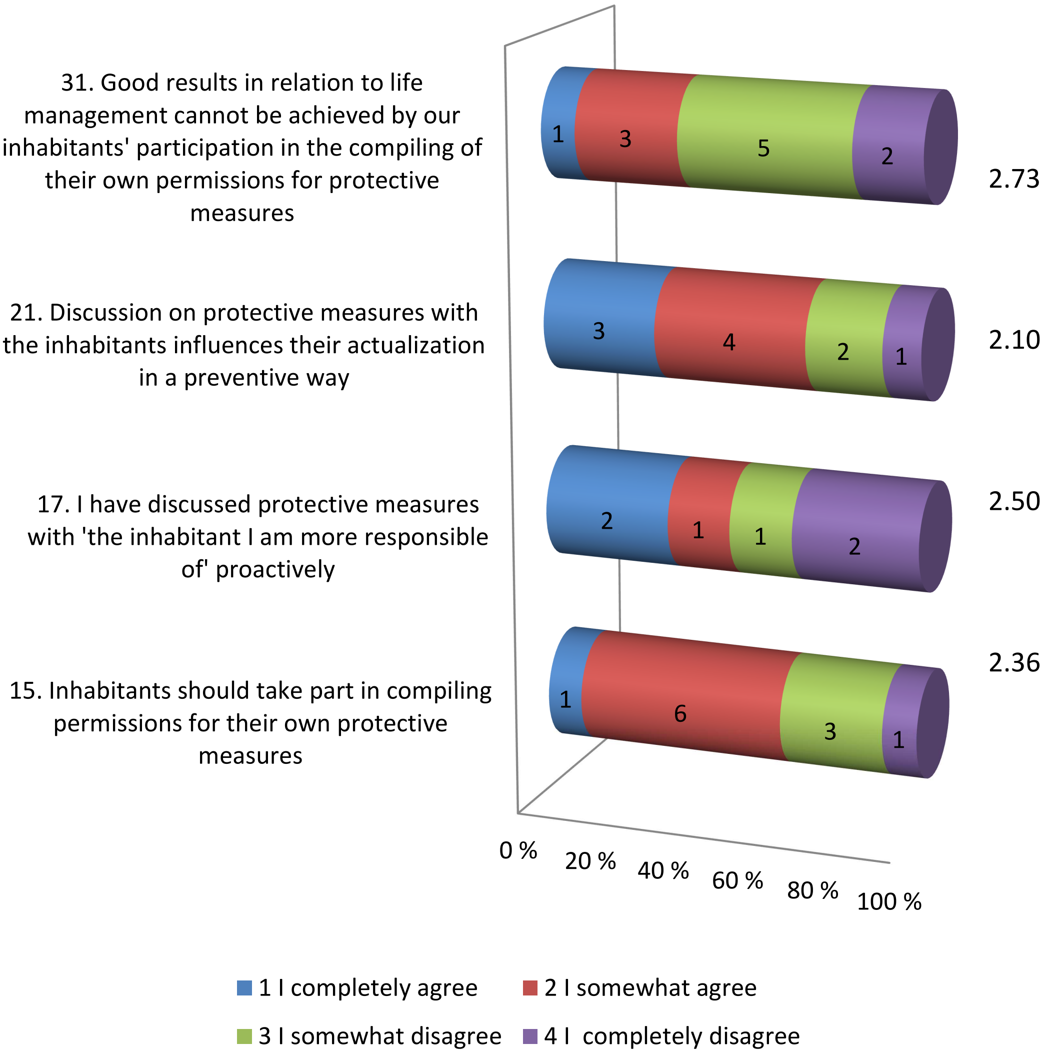


FIGURE 7. Views on protective measures in relation to participatory planning and discussion

The average answer to whether inhabitants should take part in compiling permissions for their own protective measures could be found between “I somewhat agree” and “I somewhat disagree”. The average on the respondents answers to whether they have discussed protective measures with the inhabitant they are more responsible for proactively could be found in the middle of “I somewhat agree” and “I somewhat disagree”.

The average answer to whether the respondents felt that discussion on protective measures could influence the actualization of them in a preventive way was found quite close to “I somewhat agree”. When asking the respondents whether good results in relation to life management cannot be achieved by inhabitants participation, the average was found close to “I somewhat disagree”.

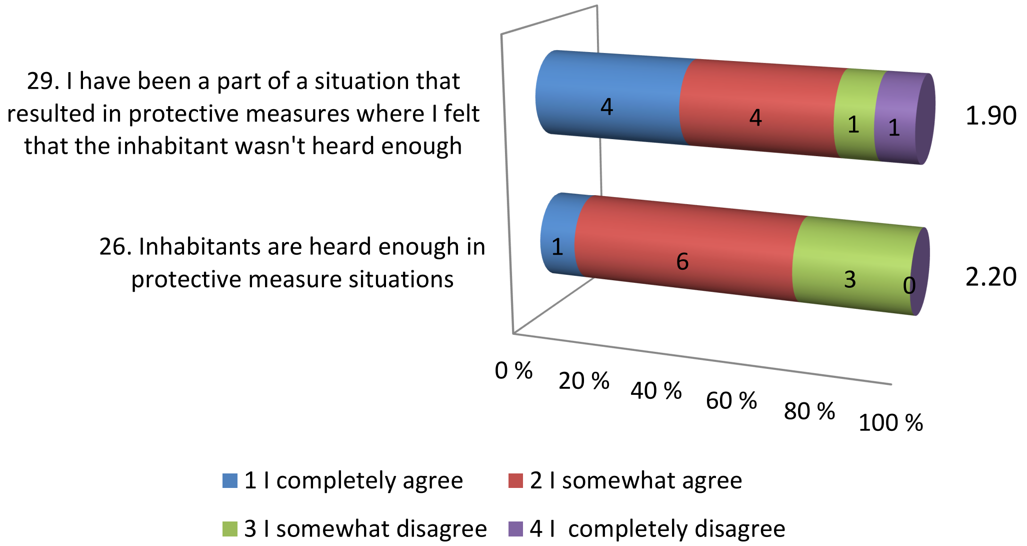


FIGURE 8. Views on protective measures situations

The respondents somewhat agreed that inhabitants are heard enough in protective measures situations. They also somewhat agreed that they had been a part of a situation that resulted in protective measures where they felt that the inhabitant wasn’t heard enough.

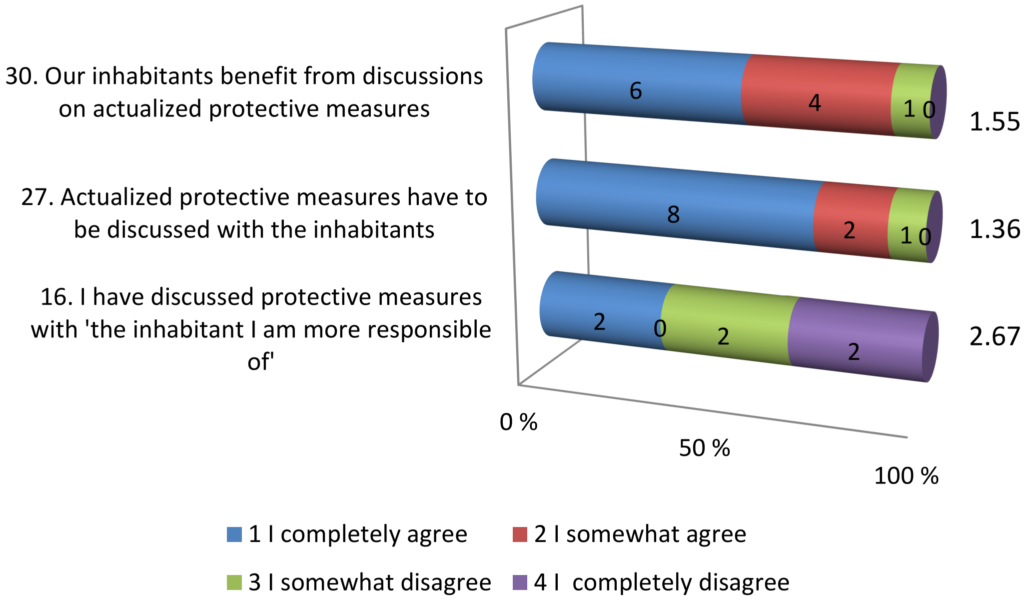


FIGURE 9. Views on discussion on (actualized) protective measures

The respondents, on average, completely agreed that actualized protective measures have to be discussed with the inhabitants. The average answer on whether the inhabitants benefit from discussion on the issue could be found between “I completely agree” and I somewhat agree”. The respondents average answers, on whether they had discussed protective measures after a situation where protective measures were used with the inhabitant they are more responsible for, could be found between “I somewhat agree” and “I somewhat disagree”.

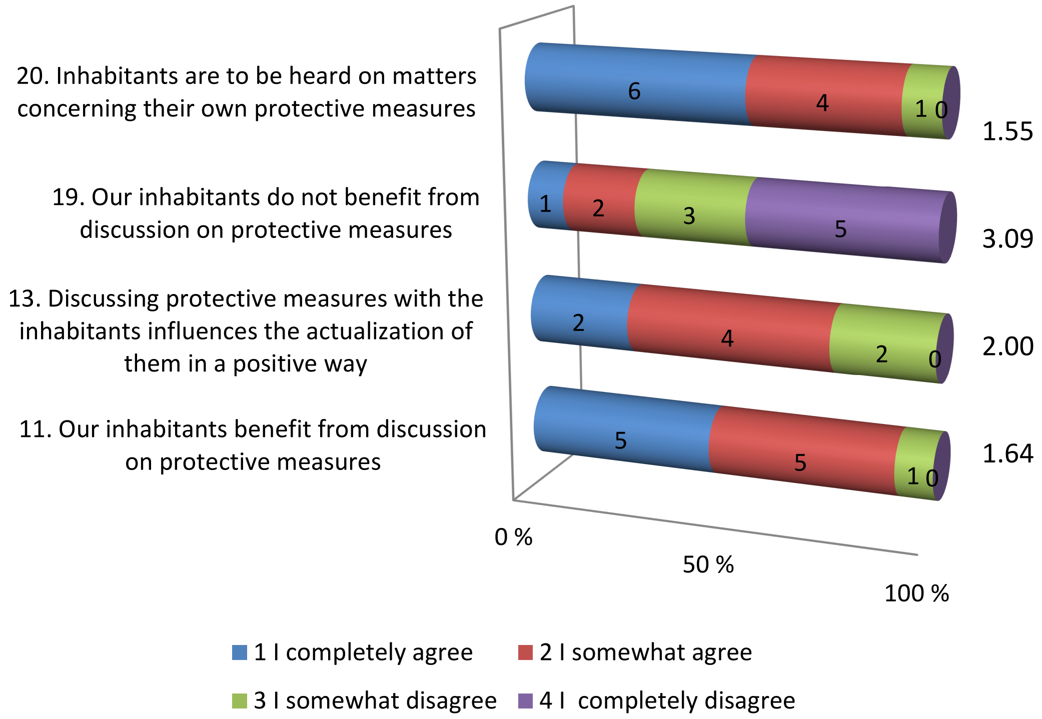


FIGURE 10. Views on participatory general discussion on protective measures

The respondents average answer on whether inhabitants should be heard on matters concerning their own protective measures could be found between “I completely agree” and “I somewhat agree”. The average on the respondents answers on whether inhabitants benefit from discussion on protective measures can be found between “I completely agree” and “I somewhat agree”. When the question was asked in a reverse way the average was between “I somewhat agree” and “I completely disagree”. The average answer on whether discussing protective measures influences the actualization in a positive way was “I somewhat agree”.

7.2.3 Carers' professionalism, own role

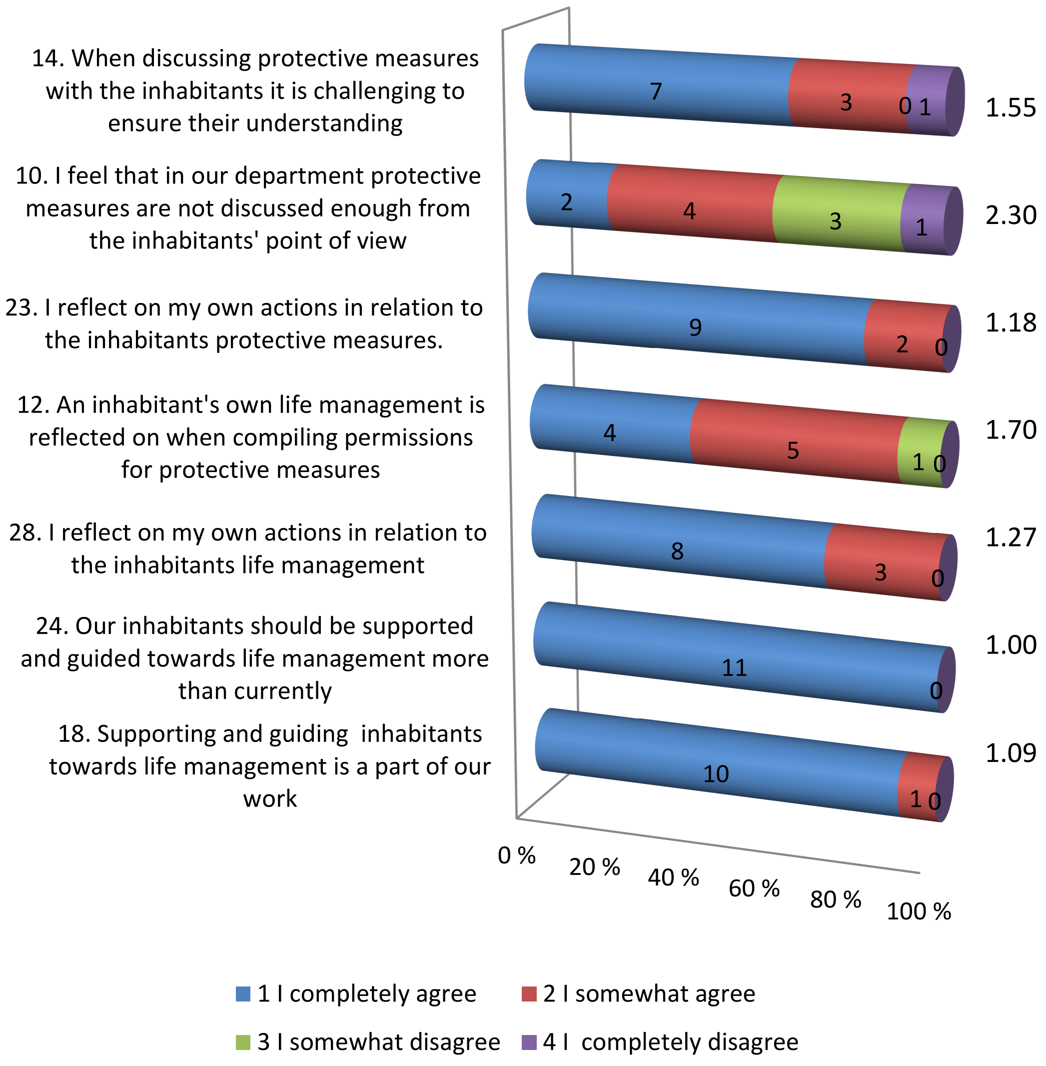


FIGURE 11. Carers' professionalism and role in the inhabitants' life

The respondents, on average, completely agreed that supporting and guiding inhabitants towards life management is a part of their work, they also completely agreed that it should be done more than is done currently. The average answer on whether an inhabitant's own life management is pondered when compiling permissions for protective measures could be found between "I completely agree" and "I somewhat agree".

The respondents, on average, completely agreed that they reflect their own actions in relation to the inhabitants' life management and on their own actions in relation to the inhabitants' protective measures.

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The average on answer on the statement 'I feel that in our department protective measures are not discussed enough from the inhabitants´ point of view' could be found between "I somewhat agree" and "I somewhat disagree".

The average answer on ´when discussing protective measures with the inhabitants it is challenging to ensures their understanding´ could be found between "I completely agree" and "I somewhat agree".

7.3 Problems in participation

Data on the answers to the question "What problems do you see in client participation in decision making and implementation in relation to protective measures?" could be categorized under three main categories: communication, inhabitants' shortcomings and attitudes towards the necessity of participation.

7.3.1 Communication

Seven of the nine written answers included mentions of problems in communication. Problems in communication were shortly described as difficulties in communication and inhabitants' imperfections in or lack of understanding and ability to communicate.

Problems in communication were partly seen to be in close connection to protective measure situations:

> *"Asukas ei ymmärrä välttämättä mitä hänelle puhutaan, varsinkin, jos tilanteessa on tunnetta – An inhabitant does not necessarily understand what they are being said, especially if the situation is loaded with feeling."*

Problems in communication were also seen as resulting from not having a common language. The lack of a common language was partly seen as a shortcoming in employees' know-how. In order for inhabitants to take part in meetings aiming at decision making (on their protective measures) they have to be able to understand what is said, therefore all participants should use plain language.

7.3.2 Inhabitants’ shortcomings

Many of the respondents referred to the inhabitants shortcomings in their answers. Shortcomings were seen as resulting from imperfections in cognitive abilities. The respondents mentioned issues such as poor memory, imperfections in understanding and processing information, lack of patience, not understanding causality, unrealistic expectations, difficulties in dealing with ones feelings and passiveness.

The inhabitants’ acquired and embraced (negative) models of action and a need for learning new models of action were also referred to.

However, the employees’ role as supporting the inhabitants because and despite their shortcomings was emphasized. Problems may have to do with inadequate preparation and support in decision making situations. One of the problems in participation was seen in employees’ attitudes:

> *“Ei haluta/kiinnosta saada asiakasta mukaan, koska hoitaja on”viisaampi”/ tietää paremmin – The client is not wanted to participate/there is no interest in having them participate, because the carer is ”wiser”/ knows better”*

7.3.3 Attitudes towards the necessity of participation

A few of the respondents dealt with negative attitudes towards the inhabitants’ participation in their answers.

> *“Ei välttämättä nähdä tarpeellisena asukkaan osallistumista, ei uskota, että tästä olisi jotakin hyötyä – Inhabitants participation is not necessarily seen as necessary, it’s not believed that this would be of some use”*

The inhabitants’ views were seen as being under minded, their views were not heard and if heard passed, under minded and even ridiculed. There were also mentions that protective measures are interpreted as an issue of power and that the department’s values and models of action are not abided by in everyday life. A need for further knowledge and adequate training on the issue also came up in one answer. Co-workers support or lack of it was seen as a possible problem in participatory practice. A need for an improved culture in professional conversation was also mentioned.

7.4 How to enable participation?

Data on the answers to the question “How could inhabitants be included more in decision making on and implementation of protective measures?” could be categorized under three main categories: communication, forums and a professional focused ideology.

7.4.1 Communication

Emphasis was put on the use of plain language and alternative and augmentative communication methods.

> *“Selkokielellä, niille joilla riittää kapasiteettia selostetaan mitä mahdollisuuksia on olemassa turvata asukas, kun ilmenee haastavaa käytöstä – The inhabitants that have sufficient capacity are explained in plain language what possibilities there are to safeguard them, when challenging behavior occurs”*

In addition to plain language and the use of alternative and augmentative communication methods the answers described speaking calmly, double checking and repeating issues as being helpful in communication with the inhabitants.
Initializing the use of alternative and augmentative communication methods was seen as partly being a matter of attitudes towards the necessity of them.

7.4.2 Forums

Quiet conversations with a carer ´more in charge of the inhabitant´ and discussions in inhabitant meetings were seen as good everyday forums for discussing protective measures. Also processing discussions on actualized protective measures were seen as being beneficiary for the inhabitants.

Some of the respondents stated that the inhabitants should be included in decision making by participating in meetings that deal with the matter of protective measures. Also, the matter of protective measures should be addressed when deriving and updating the inhabitants’ rehabilitation plan.

Preparing the inhabitants for participating in decision making, and especially a good attitude climate towards preparation, was seen as an important starting point for participatory practice. The inhabitants were to be encouraged, guided and enabled to participate in dealing with their own issues and making thought out decisions on them. It was suggested that participation be started from making small scale decisions and with time proceeded into more challenging, bigger decisions. The decisions were to be evaluated together and the inhabitant was to be given a chance to make a new decision on the matter. The carers were to accept, that not all decisions are decisions that seem like good ones to them. The inhabitant was to be complimented on successes (in decision making).

7.4.3 Professional focused ideology

Although in many of the answers the idea that inhabitants should be told what protective measures can be used to ensure their safety, many answers portrayed a professional focused state of mind in decision making.

> *“Ensisijaisesti suojatoimiin liittyvä päätöksenteko on moniammatillisen työyhteisön ja toteutus hoitajien tehtävä – Primarily decision making on protective measures is a task of the multi-professional working community and implementation a task of the carers”*

A need for respecting and treating the inhabitants as equals, as well as a want to empower them was said to be lacking at least in some parts. It was stated that learning by living is the best way to improve participation: models of working should be supportive of participation and actions should be evaluated through open and professional conversation. The need for a clear model of action for working in a participatory way was also mentioned. A need for further knowledge and training on practical methods of working in a participatory way in relation to protective measures also came up in the answers.

8. CONCLUSIONS

It can be concluded that the prevalence of protective measures was in direct connection to the inhabitants’ mental condition and how they individually showed symptoms of their poor mental condition. If even one individual inhabitant was going through a difficult period in their life it could affect the occurrence of protective measures considerably. The individual traits of their behavior and need for protective measures determined which protective measure were used and therefore heavily occurred.

The number of actualized protective measures was seen to decline significantly in the year 2011 because of the bringing into use of technical aids in monitoring a person’s actions. This of course looks good in statistics, and limits the person less than before but does not eliminate the fact that the person is still under strict monitoring. Therefore the basis for even this type of monitoring has to be based on very solid grounds.

The changes in the prevalence of certain protective measures could be found in individual inhabitants need for protective measures as well as in the models of action. Most likely one of the biggest contributors to the changes in prevalence is the bringing into use of a model of action “Avekki”.

> *“Avekki” as a word is derived from the Finnish words* ***A****ggressio,* ***V****äkivalta,* ***E****nnaltaehkäisy/hallinta,* ***K****ehittäminen,* ***K****oulutus and* ***I****ntegraatio – Aggression, Violence, Prevention, Developing, Training and Integration. In addition to these words the ideology of “Avekki” includes the themes of working together and a sense of community, that are starting points for training on the prevention of violence. The “Avekki” model of procedure is targeted towards work situations in care-organizations where employees encounter aggressive patients or clients. The model of procedure recognizes legislation on aggression and violence, legislation on patient care as well as legislation on work safety. Central principles in the model of procedure are employees’ safety, early prevention, minimal restriction and use of force as well as not inflecting any pain on the patient/client. An aggressive person is supported and helped in controlling their own aggression or violence. The values of the model of procedure*

> *are based on generally accepted national moral views and ethical principles, which are guided by the ideology of respecting dignity and treating people in an equal way as well as treating a person as an individual. (Hakkarainen, Heikkinen, Hietanen, Jokiniemi, Lommi & Taattola 2007:4.)*

Despite the necessity of protective measures, the constant need for development and improving current models of action has to be seen as a corner stone when working with issues that limit a person's right to freedom and self-determination in a way that using protective measures does.

It can be concluded that the carers generally saw the necessity of and accepted the use of protective measures in furthering safety, psychic indisposition, rehabilitation and life management. Ensuring rehabilitation and life management through protective measures was not seen as appropriate as using protective measures to ensure safety and improving psychic indisposition.

Protective measures influencing safety, inhabitants' psychic indisposition, rehabilitation and life management may have been seen as intertwined matters, as a person with poor psychic indisposition is likely to result in behavior that leads to the need for ensuring safety. Great potential for rehabilitation is most likely not seen as a part of a person's life when their life situation is so chaotic. Finding an appropriate and effective protective measure to ensure the inhabitants safety in troublesome times is likely to affect various other aspects of their life and make their rehabilitation possible, including an improved possibility for life management.

The carers views on the inhabitants' participation were mainly limited to awareness on the inhabitants rights to participatory working methods and the ideology that their participation would have a positive effect on the actualization of protective measures and the inhabitants' own life management. These ideas however were not seen in the everyday work of the carers.

Problems in participation were seen to be very strongly linked to problems in communication. This matter could be addressed by offering the inhabitants better possibilities in communication by using plain language and alternative and augmentative communication methods. The carers know how and attitudes on the issue would need to be addressed as well.

The difficult nature of the client group may be one of the main factors leading to a paternalistic culture within Kuusela. The inhabitants were seen as having difficulties in many areas and therefore participation was seen as difficult and even useless.

Discussion on actualized protective measures was given a stronger worth than other forms of participation. Although this ideology was quite strong in the carers views, it had not been actualized to a very great extent either.

The carers felt that as individuals their views and attitudes on participatory practices are intact. This unfortunately was not always seen in the work community let alone as participatory working methods. It can be concluded that more systematical models of action in participatory practices should be derived to ensure a higher potential for the inhabitants participation and life management and in turn empowerment. Improving an open and professional conversation culture among the carers was seen as a corner stone for deriving these models of action. Also the possibility for further, adequate training seems to be needed.

J. Kumpuvuori in “Perusoikeuksien rajoittaminen kehitysvammapalvelujen toteuttamisessa” - “Limiting basic rights in the realization of services for the intellectually disabled”) (2006:61-62) states that although legislation on protective measures needs to be precise, legislation in itself would not make the implementation of protective measures adequate but also training is needed for (possibly negative) settled practices to be improved towards a more respectful culture on the limiting of basic human rights. Kumpuvuori (2006:61-61) states that training should be offered to professionals as well as for people with the intellectually disabled people that have to be subjected to protective measures.

Although the carers recognized that supporting and guiding inhabitants towards life management was a part of their work they felt that this should be done more than is currently done.

As a final conclusion it can be stated that possibilities for the inhabitants’ participation and thus empowerment do exist but in order for them to be actualized the matters described above need to be addressed.

9. PROPOSALS FOR FURTHER STUDIES

The author wishes to propose that the matter of protective measures in working with people with intellectual disabilities, and client participation in this context could be studied further.

One idea for a study would be a follow-up study in the same setting to evaluate changes in the carers’ attitudes, conducted in the years to come.

A study conducted in a different setting and/or with a different client group would offer a reference point for these matters. Matters affecting participation and employees’ views could be better described by referencing the variables.

Another proposal would be to study the inhabitants’ own views on their participation. This would set high demands on the person conducting the study, as the client group is quite unique and challenging, but would describe the feelings of the people who most of all are affected by these issues.

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Hei!

Seuraava kysely liittyy opinnäytetyöhöni. Palautathan sen lokerooni mahdollisimman pian.
Kovasti kiittää hän, Aino

Vastaa kysymyksiin seuraavan asteikon mukaisesti
1 Täysin samaa mieltä
2 Jokseenkin samaa mieltä
3 Jokseenkin eri mieltä
4 Täysin eri mieltä
0 En osaa sanoa/vastata

1. Suojatoimet ovat välttämättömiä yksikössämme turvallisuuden kannalta.

   1 2 3 4 0

2. Suojatoimet ovat välttämättömiä yksikössämme psyykkisen huonovointisuuden lievittämisen kannalta.

   1 2 3 4 0

3. Suojatoimet ovat välttämättömiä yksikössämme asukkaiden kuntoutumisen ja oman elämän hallinnan kannalta.

   1 2 3 4 0

4. Suojatoimia tulee käyttää enemmän turvallisuuden takaamiseksi.

   1 2 3 4 0

5. Suojatoimia tulee käyttää enemmän psyykkisen huonovointisuuden lievittämiseksi.

   1 2 3 4 0

6. Suojatoimia tulee käyttää enemmän asukkaiden kuntoutumisen ja oman elämän hallinnan takaamiseksi.

1 2 3 4 0

7. Suojatoimilla voidaan saada aikaan hyviä tuloksia turvallisuuden kannalta.

1 2 3 4 0

8. Suojatoimilla voidaan saada aikaan hyviä tuloksia psyykkisen huonovointisuuden lievittämiseksi.

1 2 3 4 0

9. Suojatoimilla voidaan saada aikaan hyviä tuloksia kuntoutumisen ja oman elämän hallinnan kannalta.

1 2 3 4 0

10. Osastollamme ei mielestäni keskustella tarpeeksi suojatoimista asukkaan kannalta.

1 2 3 4 0

11. Asukkaamme hyötyvät siitä, että heidän kanssaan keskustellaan suojatoimista.

1 2 3 4 0

12. Suojatoimilupia laadittaessa asiaa pohditaan asukkaan oman elämän hallinnan kannalta.

1 2 3 4 0

13. Suojatoimista keskustelu asukkaiden kanssa vaikuttaa niiden toteutumiseen positiivisesti.

1 2 3 4 0

14. Asukkaiden kanssa suojatoimista keskusteltaessa ymmärryksen varmistaminen on haastavaa.

1 2 3 4 0

15. Asukkaiden tulee osallistua omien suojatoimilupiensa laadintaan.

1 2 3 4 0

16. Olen keskustellut suojatoimista "vastuuhoidettavani" kanssa suojatoimitilanteen jälkeen.

1 2 3 4 0

17. Olen keskustellut suojatoimista ”vastuuhoidettavani” kanssa ennakoivasti.

1 2 3 4 0

18. Asukkaiden kannustaminen ja ohjaaminen oman elämän hallintaan on osa työtämme.

1 2 3 4 0

19. Asukkaamme eivät hyödy siitä, että heidän kanssaan keskustellaan suojatoimista.

1 2 3 4 0

20. Asukasta tulee kuulla omiin suojatoimiin liittyvissä asioissa.

    1 2 3 4 0

21. Suojatoimista keskustelu asukkaiden kanssa vaikuttaa niiden toteuttamiseen ennaltaehkäisevästi.

    1 2 3 4 0

22. Suojatoimet ovat asukkaan oman elämän hallinnan kannalta ongelmallisia.

    1 2 3 4 0

23. Pohdin omaa toimintaani asukkaiden suojatoimiin liittyen.

    1 2 3 4 0

24. Asukkaitamme tulee kannustaa ja ohjata nykyistä enemmän oman elämän hallintaan.

    1 2 3 4 0

25. Suojatoimilla voidaan saada aikaan hyviä tuloksia oman elämän hallinnan kannalta.

    1 2 3 4 0

26. Asukkaita kuullaan suojatoimi tilanteissa tarpeeksi.

    1 2 3 4 0

27. Toteutuneita suojatoimia tulee käydä läpi asukkaiden kanssa.

    1 2 3 4 0

28. Pohdin omaa toimintaani asukkaiden oman elämän hallintaan liittyen.

    1 2 3 4 0

29. Olen ollut mukana suojatoimeen johtaneessa tilanteessa jossa koin, ettei asukas tullut kuulluksi tarpeeksi.

    1 2 3 4 0

30. Asukkaamme hyötyvät siitä, että heidän kanssaan käydään läpi toteutuneita suojatoimia.

    1 2 3 4 0

31. Asukkaidemme osallisuudella omien suojatoimilupiensa laadintaan ei saada aikaan hyviä tuloksia oman elämän hallinnan kannalta.

    1 2 3 4 0

Seuraaviin kysymyksiin toivon kirjallista vastausta. Voit kirjoittaa vastauksesi myös koneella ja liittää ne tähän.

1. Millaisia ongelmia näet asukkaiden osallisuudessa suojatoimiin liittyvään päätöksentekoon ja toteutukseen?

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2. Miten asukkaita saataisiin enemmän osallisiksi suojatoimiin liittyvään päätöksentekoon ja toteutukseen?

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