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Inspections of special care facilities for the mentally handicapped – use of coercion as a challenge

Starting points

Under the Parliamentary Ombudsman Act, the Ombudsman conducts the on-site inspections of public offices and institutions necessary to monitor matters within his or her remit of overseeing legality. Specifically, inspections must be carried out in prisons and other closed institutions to oversee the treatment of inmates. The sites inspected have traditionally included the operational units of intermunicipal joint authorities for special care, especially these authorities' central institutions, as provided for in the Act on Special Care Services for the Mentally Handicapped (hereinbelow the Mental Handicap Act). Ombudsmen have considered these institutions important inspection sites, because certain situations in caring for the mentally handicapped involve the use of coercion, by means of which an intervention is made in a person's fundamental rights, such as personal liberty and integrity. In addition, there is the question of protection under the law and other fundamental rights of these persons, who are incapable of ensuring them for themselves.

To facilitate the arrangement of special services for the mentally handicapped, the country has been divided into special care districts, of which there have been 15 since 1.1.2009, by Government Decree. The municipalities belonging to a special care district participate in a joint authority, which arranges the special care services that have been statutorily assigned to municipalities. Municipalities can also arrange special care themselves or purchase these services from another municipality or a private producer. The emphasis in the Ombudsman's oversight of legality in the sector of special services for the mentally handicapped has been on inspecting the central institutions maintained by joint authorities. There have traditionally been only a few complaints a year relating to special care services for the mentally handi-

capped, although the number has increased in recent years. The focus in this article is mainly on the Ombudsman's activities and observations during inspections.

Services intended for the mentally handicapped are called special care. Under the Mental Handicap Act, which dates from 1979, special care is provided to persons whose development or intellectual functioning has been impeded or disturbed as a result of illness, defect or injury that is congenital or has been incurred in early development. The purpose of special care is to promote persons' ability to perform their everyday functions, independently earn a livelihood and adjust to society. An additional aim is to ensure that mentally handicapped persons receive the education, medical treatment and other care that they need. Under the Mental Handicap Act, persons who can not receive adequate or suitable services as provided for in the Social Welfare Act, the Services and Assistance for the Disabled Act or other separate items of legislation are entitled to special care.

Sites inspected

Residential care for mentally handicapped persons is arranged mainly in the central institutions that are to be found in almost all special care districts. Only two of the districts, Etelä-Karjala and Keski-Pohjanmaa, lack central institutions of their own. In addition, the Keski-Suomi special care district recently closed its Suojarinne Service Centre and has decentralised services to its member municipalities and the Keski-Suomi Foundation for Care Services for the Handicapped. The central institutions contain both hospital-standard treatment wards and sections comparable to assisted-living facilities or care homes. In addition to long-term residential services, they offer mentally handicapped persons temporary stays for treatment, rehabilitation and examination. Some institutions also have sections that specialise in taking care of clients with psychiatric symptoms. The central institutions are nowadays often called service or rehabilitation centres.

The Ombudsman has inspected fourteen special care central institutions and the residential units belonging to them since the beginning of the present century. Thus central institutions located (or that were located) in all of the existing special care districts have been inspected in that time. They are: the Kolpene Service Centre in Rovaniemi (Lapland Special Care District), the Kuusanmäki Service Centre in Kajaani (Kainuu Special Care District), the Tahkokangas Service Centre in Oulu (Pohjois-Pohjanmaa Special Care District), the Suojarinne Service Centre in the Jyväskylä district (Keski-Suomi Special Care District), the Honkalampi Centre in the Joensuu district (Pohjois-Karjala Special Care District), the Vaalijala Rehabilitation Centre

in Pieksämäki (Savo Special Care District), the Kuusaa Rehabilitation Centre and Serviced Home in Kuusankoski (Kymenlaakso Special Care District), the Antinkartano Serviced Home in the Pori district (Satakunta Special Care District), the Peimari Service Centre in Paimio (Varsinais-Suomi Special Care District), the Ylinen Rehabilitation Centre in the Tampere district (Pirkanmaa Special Care District), the Eskoo Social Services Centre in Seinäjoki (Etelä-Pohjanmaan Special Care District), the Pääjärvi Rehabilitation Centre and Kauppila Care Home in Lammi and Rinnekoti in Espoo (Uusimaa and Etelä-Häme Special Care District) as well as the Sofianlehto departments in Helsinki (Helsinki Special Care District). In addition to these, the Ombudsman has inspected the Kårkulla Care Home (Kårkulla vårdhem), which is intended for Swedish-speaking people, in Parainen, an operational unit in the Åland Islands as well as individual operational units in Helsinki, Vantaa, Tampere and Rauma. Some of the latter inspections have been conducted by legal advisers, who then briefed the Ombudsman on their observations.

Most of the service centres or rehabilitation centres belonging to the special care districts were established in the 1960s and 70s. They are usually in scenically beautiful locations away from the centre of the locality. A centre contains several residential buildings, which often have their own yard areas for outdoor exercise. Dwellings can comprise three or four "cells", i.e. modules, each accommodating 4–8 persons. The residents of a module usually have their own rooms, but share the dining area and living room/lounge and the bathroom/sauna facilities. However, the rooms in buildings renovated in the 21st century often have bathrooms en suite. Residents of most centres have their own rooms, but there are some centres where two or even three persons share a room. Many institutions have a separate safe room (or isolation room), where a client who is behaving violently can be taken to calm down. As a general rule, a safe room is unfurnished and its window is shielded by a plexiglass screen. The room may contain an ascetic mattress, which is easy to clean and difficult to rip apart. Many institutions have over 100 inmates and an even larger number of staff. Some of the sites inspected have had a school attached to them and an activities centre for daily pursuits.

As a result of the ongoing restructuring of services, the number of mentally handicapped persons in institutional care has declined and is continuing to fall. Municipalities together with special care districts have been developing formerly institution-centred special care so that more persons are now catered for by a variety of assisted-living arrangements. The individual need for service can probably be implemented better by scaling down residency in institutions. On the other hand, concerns have been raised about how special competence can be safeguarded. The central institutions have long had a solid status as maintainers and

developers of special competence in care for the mentally handicapped and their expertise is strong in especially looking after autistic and mentally ill persons as well as those whose behaviour is challenging.

What is inspected?

One key perspective in inspections is implementation of clients' fundamental rights, such as personal liberty and integrity, freedom of movement and protection of privacy. A client's right of self-determination can be limited in many ways in an institution. By restrictions is meant, among other things, confining a person in his or her own room or the safe room, holding and binding, other restriction of movement as well as treating illness otherwise than based on consent. An inspection visit focuses also on other aspects of the conditions in which inmates live and their treatment, realisation of their privacy, their opportunities for activities (daily and leisure activities), the pleasantness of spaces and on how safety (such as fire safety and access to medicines) has been taken into consideration in everyday life. Also looked into on an inspection is how health services for clients, such as dental and basic health care, have been arranged. The number of staff and their competence, their opportunities to participate in training, the effectiveness of replacement arrangements and other personnel-related matters are likewise examined.

In advance of a visit, the site in question is asked to furnish material of relevance for an inspection, such as records of use of coercion (restriction of the right of self-determination) over a specific period (e.g. three months), the guidelines that the centre has drafted for the use of coercion, the annual report and other material describing the activities of the centre.

An inspection visit usually begins with a general discussion with the institution's management and key personnel on themes that have been announced in advance and other of the subjects mentioned in the foregoing. Themes can additionally include protection of clients' interests, records of use of coercion (which have been supplied in advance) and guidelines on the use of coercion. An inspection tour generally takes in wards, modules and care homes. Under the Parliamentary Ombudsman Act, the Ombudsman or her representative has the right to have confidential discussions with the staff of the institution as well as with others who work there and inmates. Inmates and their relatives as well as the staff have generally, at the Ombudsman's request, been informed in advance by the centre of the opportunity to have a confidential one-on-one discussion with the Ombudsman.

A protocol of the inspection that is drafted after a visit summarises the discussions that have taken place with the management and key staff of the institution as well as observations that have been made. This part of the protocol is public, whereas the entries dealing with confidential discussions are required by law to be kept secret and are therefore only for the Ombudsman to know.

Use of coercion

Something that has been reported during inspections in many institutions is that the clientele has changed in recent years. The proportion of clients who behave challengingly has increased, as has the number of various autistic features. In addition, so-called crisis treatment periods have increased. This notwithstanding, coercion is not used on all inmates of centres. A study of the use of protective measures in the Pääjärvi joint authority area during a six-month period in 2000 (Suomen Lääkärilehti 5/2003 pp. 499–504) gives a good indication of the situation. The objective of the study was to ascertain what protective measures were used and on what kinds of clients. At the time that the study began, the Pääjärvi Rehabilitation Centre and the Kauppila Care Home in Lammi had a total of 181 residents either in long-term institutional care or supported living. The actual study group comprised residents who had been subjected to protective measures in the period 1.1–30.6.2000. There were 19 such residents (10% of all). Protective measures were defined as being measures that limit a person's right of self-determination and are essential to safeguard treatment or to guarantee the safety, health or physical integrity of that person or others. The study revealed that the most commonly used protective measure was locking a person in his or her own room, which accounted for 95% of all protective measures. Less-used measures were holding, confinement in the safe room or application of strap restraints. The data revealed that in half of the instances where clients were held this was done to calm them down because of aggressive behaviour or to prevent self-harm, and in the other half the reason was to administer dental treatment, take laboratory samples or cut nails. It ought to be noted that in this study restrictions applying to the entire residential unit, such as locking the outer door of a ward to ensure residents' safety, were not classed as protective measures.

The Act and its shortcomings

Section 42 of the Mental Handicap Act contains a general provision on the use of coercion. It allows a person in special care to be subjected to coercion only to the extent that the arrangement of special care or the safety of another person absolutely demands. It was stated

in the legislative drafting documents that the provision would have to be applied as narrowly as possible. In practice, Section 42 has been interpreted as applying to all special care for the mentally handicapped, both involuntary and voluntary, as well as institutional and open care. As a general rule, the provision of special care is based on voluntary acceptance. However, the Mental Handicap Act makes it possible to arrange special care against their will for persons whose care cannot otherwise be arranged and who can be assumed will be in serious danger to their life or health without care, or whose behaviour and other factors reveal that because of their handicap they pose a danger to the safety of others and are in immediate need of special care. In practice, involuntary arrangement of special care has been rare.

Looked at from the perspective of the Constitution, the use of coercion means measures to which a mentally handicapped person is subjected and which restrict his or her fundamental rights. The fundamental rights that are impinged on are mainly the right to life, personal liberty and integrity (Section 7), the principle of equal treatment and non-discrimination (Section 6), freedom of movement (Section 9) and protection of privacy (Section 10). A situation in which different fundamental rights collide is often in the background when the right of self-determination is limited. Restricting a certain fundamental right is then a prerequisite for implementing another. For example, essential care of a person can in some situations require restriction of personal liberty.

It was stated in the Government Bill introducing the 1995 revision of the fundamental rights provisions in the Constitution that restriction of these rights or deviation from them must always be founded on legislation enacted by the Eduskunta. Thus restrictions may not be founded on Decrees, Administrative Orders or on so-called institutional power. An Act concerning restrictions is required to be precise and contain a clear demarcation of limits. The essential content of the restrictions must be set forth directly in the Act. Such matters as the extent of a restriction and the precise preconditions for it must also be specified. Further, according to the Government Bill, the possibility of restricting fundamental rights must exist only on grounds that can be regarded as generally acceptable. The restriction must be as minimal as possible.

As long ago as 1996, the Ombudsman recommended to the Government and the Ministry of Social Affairs and Health that the legislation on special care for the mentally handicapped should be explicated to ensure that the restrictions on the right of self-determination imposed in the course of this care are provided for precisely and clearly demarcated on the level of an Act in the manner that the system of fundamental rights presupposes. In a decision concerning the use of coercion in special care for the mentally handicapped (121/95), the Ombudsman found that the use of isolation as a punishment, the use of coercion on

behavioural modification grounds as well as the use of coercion due to inadequate personnel resources to be in violation of the fundamental and human rights provisions. The Ombudsman also found it important to define the concept of coercion in a way that prevented the kinds of practices that de facto involve the use of coercion, but are not acknowledged as doing so.

The essential content of restrictions imposed in care for the mentally handicapped, the extent of a restriction and the precise preconditions for imposing it are not expressed in the Act in the way that the Constitution requires when fundamental rights are being restricted. Restrictions of a mentally handicapped person's fundamental rights other than the right of self-determination should be regulated in an Act. Because the Mental Handicap Act does not meet the requirements of the Constitution with regard to precision and clear demarcation of limits in definitions of implementation of special care, the institutions that provide this care have had to ensure implementation of mentally handicapped persons' fundamental and human rights through their own guidelines and work practices.

Terminological diversity

In practice, a variety of concepts describing and defining the use of coercion have evolved in the institutions. Established terminology has not come into being, because the content of concepts has not been defined. The guidelines that the institutions have issued contain such terms and phrases as "coercive measure", "protective and safety measure" as well as "care measure". The use of coercion is also described as "restrictive measures" and "measures restricting fundamental rights and the right of self-determination".

In practice, measures can be either use of coercion in sudden and unanticipated situations or action that is approved and appropriately planned in advance for use in recurring situations that are similar to each other.

The choice of terminology can be examined from a variety of perspectives. If it is thought that the primary aim with measures is to protect the mentally handicapped person him- or herself or other persons, "protective measures" is an apt term. By contrast, what is often involved from the perspective of the mentally handicapped person is more a negative measure, which he or she can experience more as coercion than protection. On the other hand, the term used in the Act in force is pakko (which means "coercion", "compulsion" or "duress" in English). Indeed, the concepts should be defined in legislation so that the uncertain situation that has existed for a long time can be left behind.

Observations by the Ombudsman

Guidelines in institutions

Under the Mental Handicap Act, a State Provincial Office is responsible for the planning, direction and supervision of special care within its territory. The Ministry of Social Affairs and Health, in turn, is responsible for general planning, direction and supervision of special care. In practice, it has been evident that the State Provincial Offices have conducted hardly any inspections of central institutions and their involvement in planning and directing special care has been negligible.

In 1985, the National Board of Social Welfare sent a circular and a model set of guidelines on the use of coercive measures to the institutions that provide special care for the mentally handicapped. Coercive measures were defined as being confinement in an isolation room or the client's own room, forcibly administering medication, transferring to another ward as a coercive measure, the use of limb restraints, binding, the use of a treatment shirt and force-feeding. On the basis of this set of guidelines, the special care districts then drafted their own guidelines on coercive measures. Equivalent guidelines with models have not been renewed on the national level.

It is established practice that the instances providing services for the mentally handicapped have produced their own guidelines on the use of coercion, and this use has been recorded in accordance with these guidelines. The way in which the use of coercion is to be recorded is not regulated in the Mental Handicap Act. The guidelines in various institutions have been largely similar where the main principles concerning recording of coercive measures are concerned, because already the model guidelines issued by the National Board of Social Welfare stated what had to be recorded.

On one inspection visit, the Ombudsman noted that the guidelines on coercive measures in use in the service centre in question were too general given the demanding nature of the work. In addition, there was nothing in the activities of the centre clearly indicating long-term development of coercive measures or that consideration had been given to how the use of coercion could be reduced. Indeed, after the inspection, the Ombudsman asked the State Provincial Office for a statement on the matter. A social affairs inspector from the State Provincial Office then made a guidance and oversight visit to the service centre in question. It was explained in the report supplied by the State Provincial Office that the service centre had commenced a development project in which long-standing practices with respect to coercive measures were being reviewed.

The Ombudsman considered the development work that had taken place to be necessary. Also from the perspective of implementation of fundamental and human rights, she regarded the development work as essential. She further noted in her decision on the matter that practical care was so demanding that it would be good for the service centre's guidelines on the use of coercion to be more detailed with respect to both the grounds for using coercion and operational methods (1243/06). According to the decision, special challenges are encountered when, for one reason or another, a mentally handicapped person expresses his or her internal or external problems by seriously harming him- or herself, other persons or property. Use of coercion on unclear grounds can be punitive in character, something that can not be considered acceptable. In the Ombudsman's perception, it would be advisable for the guidelines to contain outlines of situations of the kind in which it is necessary to employ coercive measures for the good of both the client and other residents and staff members. In this context it would be natural to evaluate the various degrees of use of coercion and thereby possible primary modes of action that would mean a lesser intervention in the right of self-determination than earlier. If necessary, the preconditions for using coercion and the methods to be followed in doing this should be changed and complemented. To conclude, the Ombudsman emphasised in her decision that the use of coercion when working with mentally handicapped persons is always an extreme measure from the point of view of both the client and the care personnel.

On another inspection, the Ombudsman drew attention to the fact that in a service centre's guidelines the borderline between treatment measures and protective measures was problematic, for which reason it would be useful to explicate the guidelines in this respect (474/04).

Records of use of coercion

The Ombudsman has on several inspections observed shortcomings in the way the use of coercion is recorded. Deficiencies in entries concerning the use of coercion came to light also during inspections of two centres in 2007. The Ombudsman asked the State Provincial Offices for statements on these matters.

In the first service centre (1047/07), it emerged that some members of staff were still observing the recording practice that had prevailed in the 1990s. According to this, there was no need to fill out a separate form concerning the use of coercion when a doctor had given advance approval for a measure. The practice has subsequently been changed to require that a form concerning use of coercion is always filled out after a measure. This notwithstanding, the old practice had clung to life. There were disparities and obvious shortcomings in the way

use of coercion was recorded in the service centre. There were also different, parallel forms in use and the practices followed varied from ward to ward.

In the other centre (3813/07), entries concerning coercive measures, which were called care or protective measures there, were often deficient. In some wards, no separate report about coercive measures had been made at all; instead, a measure had been entered on a list of coercive measures that must be kept and possibly entered in the client's daily report. The head doctor explained in the report that he furnished that with some clients the need to use coercion arose often. In such cases, a doctor can give advance permission for the use of a particular coercive measure, and then it suffices to keep a list of measures. The reason for using coercion is evident in the advance permission given by the doctor. The head doctor took the view that recording had been done comprehensively in the manner that the provisions require. He pointed out that the National Board of Social Welfare guidelines required only that a list be maintained, and a more extensive entry describing the event was optional.

The Ombudsman pointed out in the decision that she issued for this centre that it had not been stated in the circular or the model guidelines issued by the National Board of Social Welfare in 1985 that a list maintained by virtue of prior permission given by a doctor would be sufficient on its own. The circular and model guidelines had likewise not mentioned that prior permission from a doctor or the so-called permission practice, in accordance with which in certain cases only a "narrow" list used by a joint authority would be possible. In the Ombudsman's assessment, the list of coercive measures that must, according to the circular from the National Board of Social Welfare, be kept meant more detailed entries: the list should reveal, among other things, inspection of the isolated person and the inspector and the effect of isolation on the client. Use of coercion that frequently needs to be implemented must also be recorded, contrary to what the head physician stated in his report. In the Ombudsman's perception, a frequently repeated routine can not be, when the matter is examined from the point of view of a mentally handicapped person, such that he or she is isolated in his or her own room or the safe room or wrapped in a carpet. Also of significance is whether problematic behaviour is due to psychiatric illness (mental disturbance or some other reason). The Ombudsman stressed that, if a mental disturbance is involved, a health care professional must when administering health care and medical treatment comply with the Ministry of Social Affairs and Health Decree on medical records when arranging and implementing care of a patient. The provisions of this Decree include the principles and requirements to be observed when making entries in medical records.

The Ombudsman pointed out that defective entries make it difficult or impossible to monitor and oversee the use of coercion. Then the protection under the law of both the mentally handicapped person and the personnel is jeopardised. Detailed entries are essential from the perspective of oversight of use of coercive measures and when evaluating the success in achieving objectives that has been achieved by means of the measures. Entries make their own contribution to supporting efforts in the work community to lessen the use of coercive measures. Entries must also be mutually comparable between different units. In the view of the Ombudsman, it must be ensured when recording the use of coercion that the reasons leading to the event and the description of the measures are sufficiently detailed. Entries concerning coercive measures must clearly state what measure was employed, the factual reason for it, its duration, who has carried it out and its effect. Then the mentally handicapped person's fundamental and human rights are protected better than was the case in this instance. The Ombudsman referred in her decision also to Section 7 of the Constitution, according to which everyone has the right to life, personal liberty, integrity and security, and no one may be treated in a manner violating human dignity.

Personal integrity may not be infringed nor anyone deprived of liberty without a reason enshrined in an Act. Punishment-type deprivation of liberty can be ordered only by a court. Appropriate recording of deprivation of liberty is a prerequisite for, among other things, being able to make certain after the fact that fundamental rights have been safeguarded. In the Ombudsman's view, separate forms should always be used when making records so that comparison of entries is facilitated. Records help the staff of the institution and the authorities overseeing it to follow the grounds on which and to what extent coercion has been used. A further aim in recording use of coercion is to facilitate ex post facto evaluation of its appropriateness.

Observations on the use of coercion

Safety vest

In one complaint, parents criticised the action of a rehabilitation centre belonging to a joint authority in its care and treatment of their autistic and mildly mentally handicapped child during a spell of rehabilitation (2756/06). Their child wore a so-called safety vest, which could be used in the same way as a normal vest in that the arms were completely free. However, it was also possible to fasten the sleeves in a way that limited freedom to move the arms. The wrists could also be fastened to the vest. The rehabilitation centre reported that the safety vest was used to prevent hitting, scratching and tearing. The parents would have liked the use of the safety vest to be discontinued. According to the ward nurse at the rehabilita-

tion centre, however, the child's behaviour was so challenging and aggressive that it was not possible to stop using the safety vest. The occupational safety section of the rehabilitation centre was of the same opinion.

The Ministry of Social Affairs and Health said in its statement that the use of a special garment (in this case a safety vest) can be considered problematic. In the view of the Ministry, since special garments are offensive to human dignity in character, their use should always be subject to precise separate assessment. The use of a vest (without the arms or parts of them being fastened) can in and of itself be regarded as an infringement of the right of self-determination, especially when the child or its parents do not agree to its use or consider it necessary. The Ombudsman pointed out in her decision that aggressive and violent behaviour justified the use of the necessary protective measures in the rehabilitation centre. On the basis of the material at her disposal, she did not find the protective measures taken there to be contrary to Section 42 of the Mental Handicap Act. In addition, she pointed out, it is possible for a minor to be subjected, even without its parents' consent, to restrictive measures that are considered essential to safeguard care of the child and are in accordance with its best interests. However, the legislation would need to be clarified in this respect. The Ombudsman referred to a report written by a Ministry of Social Affairs and Health working group in 2001 (Justified restrictions or bad treatment – report on coercive measures in social welfare and health care – working group report 2001:33). She stressed, however, that the use of a safety vest because of a client's aggressiveness is allowed only when this is inescapable and no milder means are available (the principle of proportionality). A safety vest may not be used for disciplinary or punitive purposes. In this same complaint case, locking the client in his own room was justified, because it was done for his own safety or that of others as well as to maintain his own circadian rhythm. Thus, in the Ombudsman's evaluation, what had been involved was a protective measure, the use of which should have been entered in the records in accordance with the rehabilitation centre's guidelines.

Safe room

On one of the Ombudsman's inspection visits, attention was drawn to the fact that the safe room in the institution was located adjacent to the ward's common lounge area, which could be seen through a window in the door of the safe room (117/08). Because there was no curtain on the window, it was possible that other residents of the ward could look through the window at the person in the safe room. The safe room was a stripped-down space with no furnishings or fittings. People were confined there because of their aggressive behaviour, which could continue while they were there. The Ombudsman found that it was inappropriate from the perspective of protection of privacy that the window in the door did not have a cur-

tain. Protection of the privacy of a client in the safe room requires a space into which other clients can not directly see. Secondly, also the fact that the safe room is located adjacent to the common area could disturb other residents if the client confined there behaved noisily.

The use of a separate safe room has been abandoned in some institutions. Then the only action possible is isolation in the client's own room. On the other hand, the staff of institutions have said during inspections that a safe room is a good alternative in prevention of violent behaviour. They pointed out that sending a client there already defuses the situation in the ward before violent behaviour occurs. They made the point that a client who behaves violently in the ward generally "loses face" in the eyes of the other residents. Others may also begin to fear someone who has behaved violently. Being sent to the safe room can feel like a salvation to a client, who escapes from a distressing situation to a place where he or she can safely vent aggression (3142/05).

Other observations

After an inspection of one institution, the Ombudsman launched a separate investigation into the use of coercion there (1047/07). The State Provincial Office stated in its report that it was unclear whether the coercion employed in the rehabilitation centre was a means of behaviour modification or a punishment. According to the statement by the State Provincial Office, it was very difficult to decide this from the documents provided by the centre, because the records of the use of coercion had revealed deficiencies, incompetence and probably also indifference. It is often difficult after the fact to prove the necessity or inescapability of a coercive measure.

The Ombudsman was unable on the basis of the material available to her to determine that the protective measures used in the centre were contrary to the Mental Handicap Act. She emphasised, however, that a client's fundamental rights could be restricted only when the restriction met the demands of inescapability, proportionality and purposefulness. Further, measures that restrict the right of self-determination, will and liberty of a mentally handicapped person residing in the centre must be employed only for reasons of safety and protection. The measures must be purposeful and correctly proportionate. No form of their use based on so-called institutional power or for the purpose of behaviour modification can be considered acceptable.

The Ombudsman underscored also that it is important to take clients' individuality into consideration. In her view, the use of coercion can not be based solely on, for example, the door of a room shared by two or more persons having to be locked for the night because of one

resident (as material sent before an inspection visit revealed had been the case with one client). A measure of this kind can violate the fundamental rights, such as freedom of movement, personal liberty and protection of privacy, of a resident whose actions do not make it necessary to lock the door. However, the Ombudsman did not take this individual case under separate investigation and she did not have access to information as to whether the action had actually violated the fundamental rights of another client.

The Ombudsman further pointed out that a key aspect of the use of protective measures (coercion) is the duration of this use. Their use should be limited to the time that is required to give the client him- or herself or another person direct protection. In addition, restrictive measures may be used only in situations where other measures are inadequate or inapplicable and therefore there is no alternative to resorting to them (the requirement of proportionality and inescapability).

On an inspection visit to one service centre, the Ombudsman drew attention to the fact that protective measures had been employed a lot there (474/04). In addition, differences could be observed between the different care homes in the centre with regard to whether the protective measure used had been merely isolating the client in his or her own room or using a treatment shirt or limb restraints. The head of services reported that there were different care cultures in the different homes. The management had intervened in this shortcoming and the matter was under deliberation. On this inspection visit, the Ombudsman emphasised that a suitable staffing level, increasing the amount of space per resident and arranging stimulating activities had been shown to reduce challenging behaviour on the part of mentally handicapped persons. Then the need to use protective measures was likewise lessened.

Participation of relatives

Parents complained about the action of one rehabilitation centre in failing to consult them concerning the use of protective measures on their minor child before detailed guidelines on the use of these measures were drafted for care of the child (2756/06). Nor had the protective measures forms been sent to the parents for their signature in accordance with the centre's own guidelines. In addition, the records of protective measures had not been drafted fully in accordance with the guidelines.

It was pointed out in the Ombudsman's decision that implementation of a client's right of self-determination presupposes cooperation and interaction between the client and the instance that arranges social welfare. The legislation on the status and rights of social welfare clients likewise requires the client to be consulted in the planning and implementation of

services. The Ombudsman took the view that also actual measures associated with social welfare, such as the protective measures employed, are service planning.

It emerged in the course of the discussions with residents' relatives during one of the Ombudsman's inspection visits that the relatives were not entirely satisfied with how the personnel had listened to them with regard to matters to do with the treatment of a client. For future reference, the Ombudsman drew the attention of the management to the importance of co-operation between the institution and residents' relatives (117/08).

Persons who have become handicapped when adults

It has emerged during inspections that institutions contain also persons who have become intellectually handicapped only after they had come of age. In the Mental Handicap Act, however, the way in which a mental handicap is defined is that a person's development or intellectual functions have been impeded or disturbed before reaching adulthood. With people who have become handicapped as adults, the use of coercion is particularly problematic, because restriction of their right of self-determination and other fundamental rights can not be done on the basis of the current Section 42 of the Mental Handicap Act. Restriction of a patient's fundamental rights during involuntary treatment and examination is regulated in the Mental Health Act, but involuntary psychiatric hospital treatment ordered for a person by virtue of the Act may be provided only in a hospital unit that provides psychiatric treatment. Thus neither of the two Acts can be applied in the institutional or housing services provided by a special care district.

The Ombudsman has informed the Ministry of Social Affairs and Health of this matter so that it will be taken into consideration in the preparatory work for amending the Mental Health Act and possibly any other legislation in the same conjunction (1218/04).

By rewarding or in some other way?

The Ombudsman encounters many kinds of challenges on her inspection visits to institutions. On one visit, for example, there was discussion of an under-18-year-old patient (3142/05), for whom means had been sought of ending his violent behaviour. The method adopted had been to use a spray bottle to spray the patient's face with room-temperature water when he began slapping other residents or a member of the nursing staff. The director of the institution reported that the use of the spray bottle had been deliberated for a long time in a working group and that the Autism Association, a person at the Kårkulla Service Centre specialising in autism as well as a lawyer from the Finnish Association on Intellectual and Develop-

mental Disabilities had been asked in advance if it was acceptable. It had not emerged from any of these conversations that a measure of this kind could not be employed. Also the client's guardian had, according to the director, found the method good and it was used in the client's home as well. The director also reported, however, that the spray bottle is no longer being used on the client in question in the institution; rewarding is now being tried instead. If, for example, the client's breakfast succeeds without slapping, he is allowed to throw a ball into a basket for a certain time. The client likes basketball a lot and experiences being allowed to throw a ball as a reward.

In the opinion of the Ombudsman, the use of a spray bottle or comparable method could be regarded as dubious if the client experienced it as a punishment. She found rewarding to be a better method, because in her view the primary option should be to try to guide behaviour with positive things. She considered it important that deliberation continue in the service centre as to how a different approach can be taken in protective measures in the wards, in a way that ensured the residents' personal integrity was infringed as little as possible.

Observations on development work in institutions

Some of the matters associated with the use of coercion that have arisen in the course of inspection visits have been dealt with in the foregoing. The Ombudsman has on these inspections over the years noted the efforts that institutions are making to develop their own work. Many of them have been found to have a variety of ongoing development projects. In one service centre, for example, small-group activities for mentally handicapped residents and factors that contribute to empowerment have been the focus of study and evaluation since as far back as 1989. Three follow-up reports have been published within the framework of the project. The most recent was titled "I may say myself – full empowerment in a community of the most severely mentally handicapped". The objective of this project was to help mentally handicapped persons achieve a greater degree of empowerment, increasing their ability to determine and plan their own lives (3335/08).

An interaction and communication project with the aim of improving interaction by taking the resident's needs and capacity into account was in progress in another service centre in 2004. The residents had been given a psychosocial assessment of capacity to function and this had been used as an aid in ascertaining, among other things, what kind of residential unit suited each individual best. A quality work project was additionally in progress in some of the serviced homes. Its objective was to draft a quality manual, in which a key theme is the safety of residents and personnel in serviced homes (474/04).

Something that has been highlighted also otherwise during many inspection visits is how care personnel have been trying to improve their understanding of residents' different ways of expressing themselves and reasons that lie in the background to any aggressive or otherwise unorthodox behaviour on their part. In addition, there have been efforts to develop nursing through information from various perspectives. On one inspection, for example, the Ombudsman was told that a nurse can easily experience feelings of guilt if a client behaves violently. In situations like that, the nurse thinks he or she is to blame for the client's challenging behaviour. A matter also highlighted on the inspection was an exploration then in progress to ascertain the nature of the linkage between violent behaviour on the part of mentally handicapped persons and their sexuality (1218/04).

Courses to train personnel in the institutions in matters relating to safety are also regularly arranged. A central theme in this training is controlled physical restraint of clients.

The future – a time of changes

In October 2009 the Ombudsman again recommended to the Ministry of Social Affairs and Health, as she had done in 1996, that the restrictions of the right of self-determination imposed in special care of the mentally handicapped be regulated precisely and with clear limits on the level of an Act, in the way that the system of fundamental rights requires (3381/09). She informed the Ministry that she had noticed on her inspection visits that shortcomings in legislation tend to make the demanding work involved in caring for the mentally handicapped even more difficult and facilitate inappropriate restrictive practices affecting clients. She pointed out that the public authorities must safeguard implementation of fundamental and human rights. It has taken unduly long to begin drafting legislative provisions regulating restriction of the mentally handicapped persons' right of self-determination. Indeed, she considered it very important that this legislative drafting be done as expeditiously as possible. She asked the Ministry to inform her, before the end of November 2009, what measures her recommendation had given rise to.

As a result of the ongoing restructuring of services in Finland, the number of mentally handicapped persons in institutional care has declined and is continuing to fall. As part of the reform of care for the mentally handicapped, but also as an aspect of a broad ethical discourse, the status and rights of these persons have been given attention in a new way in the units that provide institutional care and housing services. It was agreed in the Government's housing policy measures programme in 2008 that a scheme would be drafted to increase the availability of housing for handicapped persons, including the mentally handicapped,

and reduce the number of places in institutions. A working group that has studied the question of housing for mentally handicapped and severely physically handicapped persons has made a recommendation in which the principal focus is on examining the housing situation for the mentally handicapped, because their need is the greatest among the various categories of handicapped persons. In May 2009 there were still about 2,000 mentally handicapped persons in long-term institutional care. The working group has recommended that this number be reduced to below 500 by the end of 2015. This proposal includes measures to develop new housing solutions and promote individual living by mentally handicapped persons.