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MODELLING ENGAGEMENT OF PERSONS WITH A DISABILITY WHO LIVE IN SOCIAL INSTITUTIONS AS A MEANS OF SOCIAL WORK PROFESIONALIZATION

Master's Thesis

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Abstract

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Summary of the Master's Thesis

Master's thesis analyzes theoretical and practical questions of engagement modelling for persons having disabilities and living in a social institution as expression of professionalism of social work. Chosen research field – to reveal engagement modelling of persons having disabilities, living in a social institution. With a qualitative research using a semi-structured interview the aim was to reveal and assess the need of engagement modelling, its kinds and how that affects the lives of people with disabilities.

16 social workers and 16 residents of two social institutions were questioned with interviews. Interpretation of data collected during the study led to these conclusions: 1) life quality of disabled persons depends not only on said disability but also on adapted environment, support group, social relationships on an institutional level, opportunities to participate in leisure and engagement activities, satisfaction of individual needs, and a subjective evaluation of one's life quality; 2) with the help of constructive social services persons are given back the ability to care for themselves and to integrate in society again, they are promoted to live full quality lives, bigger social problems are prevented; 3) social institutions try to organize such engagement activities where moral, enthusiastic, support and satisfaction aspects dominate; 4) after analyzing attitude of specialists towards engagement modelling it was established that changes observed in social institutions are dedicated to increasing well-being of clients based on level of disability and needs. Most attention is paid to a safe and adapted environment of clients, satisfaction of personal wishes and requests, support of abilities. Social professionalism expression is revealed through organizing engagement because both institution's residents and staff are involved in activities. After analyzing attitude of residents towards engagement modelling it was established that choice to live in a social institution was affected by a wish to stay independent for as long as possible, to have an opportunity to spend free time according to interests and/or engage in organized activities. Residents are satisfied with offered activities but their new engagement needs are minimal. Institution's residents do not provide any specific requests or suggestions about a more interesting and meaningful engagement and their biggest expectation is related to their health condition improving.

Key words: disability, social institution, engagement modelling, professionalism.

Content

Introduction

A fast changing world with its various dangers and challenges can affect both a person's body and spirit but it also allows to choose ways of enhancement if everyday life. It is stated that social isolation and social exclusion affect a person's physical and mental health: life "outside of borders" and a low possibility to change anything. All Europe sees and predicts a rapid aging of its citizens and health problems associated with it. Ratio of the country's citizens who are incapable of working (65 years of age and older) and of a working age (15 – 64 years) is constantly increasing since 1990. At the moment the ratio is 26, 9 percent but it is predicted that it will 56,65 percent in 2060.

Usually a disability is diagnosed due to chronic non-infectious diseases (circulatory system, tumour, connective tissue and skeletal, diabetes, nervous system, mental or behavioural disorders). It has been observed that chronic non-infectious diseases comprise about 85 percent of all causes for disabilities. Traumas, accidents add up to only about 10 – 12 percent. According to World Health Organisation, there is about 1 billion disabled people 200 million of which need constant care. The number of disabled increases due to medical advancement because more and more people survive after difficult traumas, diseases and birth defects.

According to the Department of Statistics, at the beginning of 2015, 253,4 thousand citizens were considered to have lost their ability to work in comparison to 2014 this number has not changed much. Number of men and women receiving disability benefits differs very slightly: about 48 percent of men and about 52 percent of women. In 2009 the number of people who were identified as disabled for the first time started to decrease, i.e. 2008 – 27,2 thousand, 2009 – 22,8 thousand, 2012 – 14,3 thousand, 2013 – 13,8 thousand, and 2014 – 13,8 thousand again.

On average about 580 – 600 persons having a disability move in a social care institution a year in the country.

Relevance of the topic. Interest in the lives of the disabled increases and that is seen by a growing number of scientific publications on the topic: D. Krančiukaitė et al. (2007) researched the life quality of people who had suffered a major disease; B. Kreivinienė and J. Vaičiulienė (2012) analyzed how successfully people with disabilities live; R. Gurevičius and J. Jaselionienė (2012) with the help of Lithuanian citizens' health indicators sought to prove that an aging society has an impact of its development; I. Staškutė (2014) defined life related to health; K. Rūdytė et al. (2013) analysed an subjective evaluation of disabled people' participation in engagement activities; A. Kriščiūnas (2015) provided an attitude of nowadays society towards disability and others.

The relevance of the chosen topic is due to a changed attitude of the society towards disabilities, slowly fading away fears of loneliness and solitude, environmental changes of people

with disabilities and other. Increasing attention is shown to relationships among people, perception of a disabled person, ways (culture) of communication with such a person, incentives for help and services and other (Legkauskas, 2008). Answers to many questions can be found after analysing how disabled people are doing, how their lives change in cases when they have to move in social institutions.

The relevance of the topic at hand is also revealed by the abundance of scientific publications about the services provided by the social institutions: social care services in Lithuania are analysed in pursuit of the most attractive model (Išoraitė, 2007; Žalimienė and Lazutka, 2009; Nefas, 2009), problems of the disabled are analysed as well as means to solve them (Janušauskaitė, 2008), interest is shown to what factors affect the independence of people living in social are institutions (Orlova ir Gruževskis, 2014), psychological and social factors of adaptation of older people are evaluated (Gustainienė, Banevičienė, 2014) and similar.

Foreign authors also research life features of people with disabilities (Kern, 2010), analyse social problems of people with health problems and disabilities (Payne, 2009), identify obstacles that a person with a disability faces (Browne, 2012) and other.

The problem. Life changes of people with disabilities living in care institutions affect the need to research those life areas that are closely related to their health status and ability to adapt and stay active after life circumstances change. There have been numerous studies done in Lithuania: it has been researched what kind of attention is dedicated to the life quality of disabled people living in social care institutions (Janušauskienė, 2008; Vaznonienė, 2010; Gruževskis and Orlova, 2012), the connection between health affecting life quality and age has been analysed (Butikis, 2009; Šurkienė et al., 2012), features of life in social institutions have been revealed (Naujanienė, 2004, 2008), concept of a changed social model towards disability and aspects of interpreting a good life have been identified (Viluckienė, 2008; Krutulienė, 2012) and other.

It is not easy to study life problems of persons living in social institutions because most of these residents consider themselves as “written off”, “useless” people. Not only in Lithuania but also abroad scientists are interested in the processes of aging and their connections with health changes, life quality changes of people with disabilities (Peters, 2007; Bond, 2007). Borsbo et al. (2009), Arun et al. (2011), Barker et al. (2009) note that a crucial life quality factor of the disabled is related to psychological aspects, to an adequate evaluation of one’s condition. Reker, Woo (2011) distinguished the importance of psychosocial adaptation in seeking to survive and adopt a new perception, attitude, behaviour and other changes.

The year 2015 were announced as the year of a dignified old age. According to the Health Care Ministry, it has been attempted to reduce the negative effect of environment on life quality, independence and working capacity and to adequately prevent the risk of social isolation.

According to Remeškevičiūtė (2015), people with disabilities can also be happy, energetic and active participants in the society. However, it is essential to care for such a person so that he or she does not lack warmth, sympathy, attention. One stimulus to stay not only dignified but also an active person constantly interested in life actuality is engagement and the ability of social institution staff to model engagement activities with the help of professional skills. Raudeliūnaitė and Buškevičiūtė (2014) revealed the features of activities of social workers in providing social services in health care institutions, Baranauskienė (2007), Baranauskienė, Gudinavičius (2008), Baranauskienė, Juodraitis (2008) emphasized the orientation of professional rehabilitation changes of the disabled as an opportunity for the disabled to engage in work activities.

Social activeness, engagement and leisure of older people and people with disabilities were studied by authors Smeaton, Vegeris, Shin-Dikmen (2009); Coppock, Dunn, (2010) emphasized the need of social worker activities in the institutions where disabled people live; Berg-Weger (2010) focused on practical experience of social workers, Magnuson (2014) analysed the search of innovation providing social services to older people and people with various disabilities.

The need for new (alternative) engagement services is constantly growing, their nature is changing, so the need to evaluate the traditional services arises as well as how they affect the life of disabled people"

- what is the life quality of people with disabilities living in a social institution?
- what social services provided to them they value most and what would they like to get more of?
- how and in what ways can residents of an institution spend their leisure time and be productively occupied?
- what are the possibilities of social workers in a social institution to provide engagement services to disabled persons?
- how professionally are institution workers able to satisfy the engagement needs of the disabled people?

Answers to these questions will help to evaluate the efforts of social institutions in searching for the most attractive engagement models.

Object – engagement modelling.

Purpose – to reveal engagement modelling of people with disabilities living in social institutions.

Objectives:

1. to reveal the aspects of life quality of people having disabilities who live in care institutions.
2. to emphasize the significance of social services provided in care institutions.
3. to reveal the need for engagement of people with disabilities living in care institutions.

4. to study the attitude of specialists and residents about engagement modelling.

Methodology

1. Analysis of scientific literature.
2. Semi-structured interview for collecting extensive information about the subjective experiences of respondents and their attitude towards engagement modelling.

Participants

There are care institutions in most European countries. They employ specialists who get to care for persons with disabilities in various ways. The purpose led to an ethnographic study using interview and observation methods and to findings of attitudes of specialists and institution residents about engagement modelling: interview was conducted in Telšiai region Gedrimai and Pasvalys region Linkuva independent living homes – 16 residents and 16 social workers were surveyed. Life of the disabled was observed in one social institution (war veterans' home) in Kiev, Ukraine and 4 institution residents and 2 social workers were surveyed with interviews. Qualitative date were analysed and interpreted distinguishing main statements and the number of respondents in favour of the statements and making comparisons, generalizations and conclusions.

Structure. Thesis consists of an introduction, first chapter analyses theoretical aspects, the second one analyses results of empirical research. Conclusions and used literature are provided.

Definitions used in this thesis.

A disabled person – a person who due to a inherent or acquired physical or mental disability cannot control their personal or social life partially or completely, cannot perform their duties or use their rights that are guaranteed by the law (The Constitution of the Republic of Lithuania, 53 str.).

Social services – services that provide help to persons (families) who due to age, disability, social problems partially or completely does not have or has not acquired or lost skill and opportunities to care independently for their personal (family) life and to participate in societal life (http://www.socmin.lt/index.php?-1379504641).

Social protection – services that provide a person with complex help that needs constant specialist care. Social care by length is divided into day, short-term, and long-term (Lietuvos Respublikos Socialinių paslaugų įstatymas (2006, Nr.17-589).

Social care – services that provide a person with complex assistance that needs constant specialist care. Social care includes services such as assistance at home, social skills

training and support as well as other services (Lietuvos Respublikos Socialinių paslaugų įstatymas (2006, Nr.17-589).

Social institution – an established norm and values model that organises social life and social functions are performed (Andrašiūnienė, 2006).

Engagement means that a person is occupied (engaged) (Current Lithuanian Language Dictionary, 2012). Engagement is a very important phenomenon adding to the complex citizen participation in the economic, cultural, and social life and to their opportunities realization.

Engagement modelling – an active intervention with the main goal to systemically perform activities (Jurevičienė, Šapelytė, 2013).

1. THEORETICAL ASSUMPTIONS OF MODELLING ENGAGEMENT OF PERSONS WITH A DISABILITY WHO LIVE IN SOCIAL INSTITUTIONS

1.1. The concept of life quality of person with disabilities

A disability is a certain human bodily function disorder that interferes with proper everyday life activities. It is not a stable and static phenomenon because disabilities are related to certain life and activity circumstances that can change anytime. A disability can be inherent (stable) or acquired (temporary). Specialist evaluations show the variability of disability: mild disability (minimally disrupts everyday life); moderate disability (partially disrupted everyday life and functions); severe disability (a person is ineffective due to a complex disability) (Anča, Neimane, 2014; Viluckienė, 2008). Some disabilities are typical of aging processes and they are called acquired: that is short sightedness (vision impairment), hearing disorders, joint changes and other. There are other disability concepts clearly defined in the international functionality, disability and health classification (2001) for movement, sensory (vision and hearing), mental disabilities.

The definition of disability and attitude towards disability has been a subject of discussion for a very long time. The term "invalid" (*Latin* in – not, valid – proper) used to mean that a person all-together or partially lost working capacity due to an accident, disorder or old age and became "no longer adequate". This term emphasized the helplessness of a person and the degree of morbidity. Over time it was understood that it is inhumane to emphasize that which a person cannot do and not to notice that which they are able to do, so the term invalidity was changed into "disability" (Kriščiūnas, 2015). According to foreign scientists Paterson, Hughes (2000), Williams (2002), the view towards disability should be broader and there should be no prejudice because that equals discrimination towards a person.

As we can see, a disability caused by health status, personal and environmental factors can be varied and almost always is associated with a person's changed situation. The law of social integrity of the disabled of the Republic of Lithuania (relevant edition since 2013.07.02) states that the definition of disability shows that due to a person's bodily composition and function abnormality and due to unfavourable environmental factor interplay a long-term health deterioration reduces a person's opportunities of participating in the societal life and other activities. However, as the World Report on Disability (2014) states, people with disabilities also can remain independent as long as possible, have an opportunity to choose, be free and independent just like other people.

The level of disability is determined by specialists. For that purpose a person's health status, the level of everyday activity limitation, the level of lost functional abilities and the impact of environmental factors are evaluated in various ways in Lithuania. The law of integrity of the disabled of the Republic of Lithuania (relevant edition since 2013) states that the disabled are

guaranteed equal rights and opportunities, possibilities to participate in various events and means, and independence and the right to environmental access, place of living is ensured. Persons having moderate disabilities can choose Independent living homes even though it is quite a new phenomenon in Lithuania. According to the Ministry of Social Protection and Occupation, at the moment there are about 20 institutions providing such services. Independent living homes are such residences where the disabled who need constant intensive care can move in (Independent living homes – an opportunity to create one's life, 2015).

The concept of disability determines the need to evaluate the societal attitude towards the phenomenon of disability and the disabled and how that affects life quality of the disabled. It is still a prevalent medical attitude that a disabled person is perceived as a collection of disorders that comprise a person's identity and need to be treated. The medical attitude shows that a disabled person is perceived as a problem (or burden) to society, family, and the solution of which is difficult (Viluckienė, 2008).

According to foreign authors Smeaton, Vegeris, Sahin-Dikman (2009), Magnuson (2014), the modern democratic society views disability no longer as a person's physical (physiological) weaknesses and limited activeness but as a social process that is determined by time, environment, economic and social factors. This attitude changed the politics towards the disabled of most countries: various social institutions have been founded where the relationship between the disabled and others became more of a communal nature.

As the debates on what aspect is best to analyse the concept of disability with continue, the main factors are distinguished that allow the disabled to avoid isolation and to a full, quality life – that is *a person's self disability perception* and an *open community.*

The perception of life quality is closely related to disability because often a person with disability does not feel happy and content with their life (Staškutė, 2014). It means life quality first of all is related to personal health (physical status). However, such a connection is only a part of the concept of life quality. Scientific literature provides a reasonable amount of definitions of life uality that emphasize not only health but also other important personal factors: good emotional status, strong social relations, material status and other (see Table 1).

Table1

Variety of Definitions of Life Quality

Description of Life Quality	Author (year)
Life quality – an individual perception of one's place in life related to personal goals, expectations, and interests.	WHO (World Health Organisation), 1993
Life quality definition describes persons' functional status and senses about their physical, mental and social life status.	Hays, Reeve, 2008
Life quality majorly depends on the disabled person's own attitude towards their disability: are they suffering because of it,	Borsbo et al., 2009

or are they trying to overcome the difficulties related to their disability	
Life quality is related not to the disability itself but to subjective evaluation of one's life quality and psychological factors, social participation.	Arun et al., 2011); Barker et al., 2009
Life quality contains a person's physical health, psychological status, level of independence, social relationships, reflects the degree of satisfaction about material, cultural and spiritual needs.	Rakauskienė, Servetkienė, 2011
Life quality is directed to a single person's life because it is important to understand the level of own disability and how physical, functional, emotional, and mental well-being has changed, how relationships with family members, friends, relatives change and other.	Staškutė , 2014

(Compiled by the author if this thesis based on the authors mentioned)

The ability of the disabled to broadly evaluate their situation, also called subjective assessment, is emphasized by authors of scientific publications: Kreivinienė and Vaičiulienė (2015), Krutulienė (2012), Rėklaitienė et al. (2011). Subjective assessment is significant to a person going through a disability because only they can tell how their life is affected by the disability, what consequences the disability has caused, what the attitude towards the changed life is and similar. Studies done in the USA confirmed that a disability more often is perceived as a social phenomenon when the main attention is directed to a person's ability to "deal" with the disability and to overcome everyday life difficulties (Paterson, Hughes, 2000; Williams, 2002).

Life quality perception and assessment of the disabled persons confirms that a disability in all cases disrupts the normal person's life, limits participation in wanted activities, does not allow for self realization as used to be. However, activity and engagement increase socialization of the disabled persons and improve their life quality. Engagement in favourable activities and an opportunity to participate in professional rehabilitation help to go through unpleasant sensations, inconveniences due to disability more easily, positively affect both physical and mental emotional health of the disabled (Krančiukaitė, Rastenytė et al., 2007; Baranauskienė, 2007; Baranauskienė, Juodraitis, 2008). According to the authors, disabled persons assess their life quality differently during various periods of their lives, therefore, when their health is better or when they engage in professional activities again, they can say that they are satisfied with their lives.

Sirgy at al. (2006) pointed out that negative physical sensations caused by the disability often are less important to the disabled persons when assessing their life quality than good mental well-being, emotional status, supplied life, opportunity to satisfy one's professional ambitions. According to Eurostat (2012), indicators of life quality contain several areas: 1) material conditions; 2) activity (occupation); 3) health; 4) leisure and social relations; 5) economic and physical security; 6) having rights; 7) environmental quality.

To sum up the life quality aspects of the disabled, the main factors influencing life quality of the disabled are revealed (Anča, Neimane, 2014), they are:

- Health – mental and physical health status,
- Life conditions and their adaptation according to personal needs,
- Personal material status,
- Family influence on the person,
- Occupation (quality leisure),
- Social relation on the institutional level: satisfaction of the need for communication, social assistance,
- Self assessment – attitude towards life, satisfaction of one's existence,
- Satisfaction and assessment of a person's individual needs.

According to the highlighted factors and various authors' opinions main principles can be formed that are the base for work with the disabled seeking to improve their life quality (Staškutė, 2014, Rūdytė, Tamosinaitė, Ramonaitė, 2013, Krutulienė, 2012 et al.) (see Table 2).

Table 2

The Main Principles of Improving Life Quality of the Disabled

Principles	Content describing the principle
Promotion of joining a community	*Availability of activities* – to ensure participation of the disabled in community's life and a general input to its richness and variety. *Environmental adaptation* – to guarantee availability of societal commodities. *Spread of information* – to form and keep connections with others seeking positive changes of societal attitude. *Spread of activity areas* – to help people participate in all life areas. *Creation of communication circle* – to help the disabled persons find friends, to keep them and widen their circle. *Creation of perspective* – to help people seek new opportunities, experiences and to try something new.
Promotion of choice and independence	*Social independence* – to help the disabled persons as much as possible independently manage their own lives. *To create conditions* to independently choose, to promote expression of personal opinion and requests.
Training competence and skills	*Methodical basis* – to create methods that would help people grow their self-perception, social skills and self-esteem. *Training* – to help gain new social skills and abilities. *Work (occupational) activity* – to improve spcoal skills that people already have by increasing opportunities in the occupational activities.
Respect to rules and a person's	*Concept of disability* – to form a positive attitude towards a

dignity	disabled person by providing information to society, to adhere to ethical standards. *Legal structure* – to ensure the quality and management of social services.

(Comprised by the author based on authors: Staškutė, 2014, Rūdytė, Tamosinaitė, Ramonaitė, 2013, Krutulienė, 2012 et al.)

Named principles are closely intertwined together but one of the principles – *respect towards a person's rights and dignity,* in other words, *forming an attitude towards disability* – is primal and the most important.

In conclusion it can be said that life quality and opportunities of the disabled are limited not only by bodily function disorders but also societal attitude towards disability. Medical attitude is still prevalent when attention is drawn to a person's physical flaws and not to individuality and strengths. Recently it has been started to view disability as a social process that is determined by time, environment, economic and social factors. A changing attitude enables to relate life quality of the disabled to not only health status but also to life conditions, their adaptation, family, social relationships on an institutional level, leisure quality, participation in the communal activities, engagement, self assessment, attitude towards life, satisfaction of individual needs. An important role goes to subjective assessment of self life quality and psychological factors, social participation.

1.2. Life in the Context of Care Changes in a Social Institution

Persons, having disabilities move in social institutions due to certain reasons: due to health status and due to lost capacity to work, due to loneliness and isolation, due to unsuited life conditions in the event of physical disability and similar. A disability makes one's life a difficult phenomenon that creates both social and economic consequences. A disabled person often has only one asylum – senior care homes or some other institutions that are still viewed negatively, with fear and mistrust (Kriščiūnas, 2015).

It is observed in scientific publications that analyse activities of social institutions that disabled people are most often referred (recommended to move in) to a social institution by social work specialists, medical workers (Žalimienė and Lazutka, 2009). It is not easy to decide to move to a social institution – a person who made such a decision lives through a difficult time because the conviction is still prevalent that a person who moved to an institution loses their independence, relationships with relatives, cannot satisfy all their personal needs, financial resources diminish and other (Žalimienė, 2007). The decision to move to a social institution is also often corrected by a

lack of certain concepts: what is a social institution, what functions it performs, what people live there, what kind of life awaits there, what staff works there and similar. A person's convictions, customs, established life rhythm and order, education, social status, perception of person's values and other play a big role (Vaškevičiūtė, Naujanienė, 2011).

Despite all the fears, according to Žalimienės (2007), life in a social institution guarantees the needed assistance and support for the person. Persons with disabilities in a social institution are first given opportunities to fulfil their basic needs: food, bed (individual space), shower, toilet (Giddens, 2005). During later stages other needs important for a full life of the residents in a social institution are satisfied as well, such as leisure, engagement, participation in local community activities and similar. According to Gudžinskienė and Mačiuikienė (2011), establishment of a quality life in a social institution already significantly widened the limits of perception of the main need satisfaction because a social institution tries to provide an opportunity for the disabled to manage their own lives every day – to have relations with other people, personal interests, to recreate possessed skills. Social institution staff helps the disabled persons to solve problems, organise the allocation of needed services, ensure needed care and a secure environment. The community of a social institution often becomes an environment where disabled persons can actualise their opportunities and wishes.

Mačiulis et al. (2012) calls life in a social institution an important life change that in the context of care is assessed inconclusively. Change as a process comprises many life areas, area of care included, when a person has to transfer from one status to another (sometimes from a worse one to a better one, sometimes from a better one to a worse one) (Burke, 2008). Usually changes in the care area happen when certain life elements need to be improved or even completely changed and such changes are specific for various resident groups including the disabled.

According to Giddens (2005), social changes need to be perceived much more broadly because they affect not only the person but they are the main changes of culture in a social institution and out of the service changes there over a certain period that reflect on people's lives. Social changes can be very different but they also have similar features: constant and uninterrupted changes having different consequences happen in every society. Social changes can be both thought of (conscious) and unplanned.

Since most of people's everyday life happens inside certain institutions, e.g. in a family, at work, in an educational institution, in a special institution and other, in the same way a social institution is perceived as a societal institution uniting residents living there to seek certain goals and changes. Večkienė et al. (2011) calls changes meant to improve life quality in a social institution – planned changes. Planned changes are much easier to implement in a social institution

when employing three main functions that influence both the institution itself and every its resident as well; they are:

- management of order,
- establishing priorities,
- conflict resolution.

Specialists in a social institution organise social life in a way that changes would happen consistently and thoughtfully (see Figure 1)

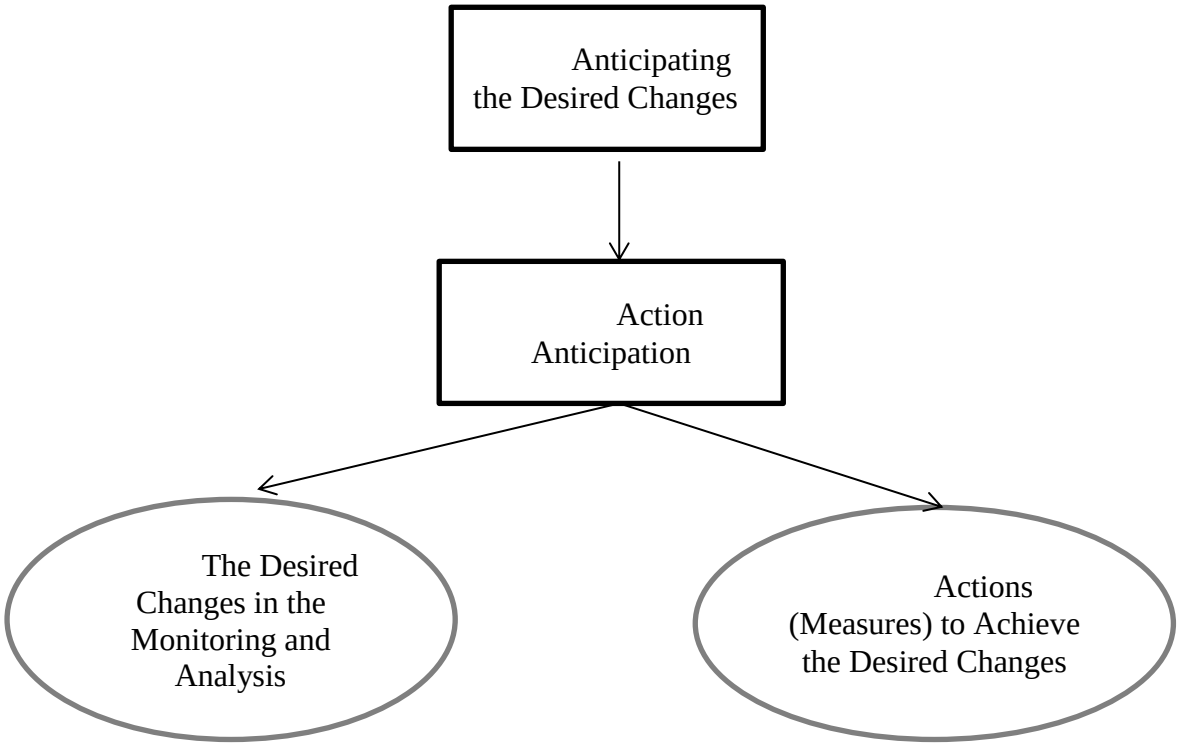

Figure 1. Process of Emplementing Changes (according to Grant A.M. ,O'Connor S.A., 2010)

One of the important changes in the area of care today is Independent Living Homes. As Žalimienė and Lazutka (2009) state, people move in Independent Living Homes freely and their residents receive a more proper (more quality) assistance, can use communal services: leisure, transport, medical, etc.

According to the Department of Statistics (2014), there were only 4 Independent Living Homes in the country (with 131 places) for senior people and adults with disabilities and 38 care institutions for adults with disabilities and 102 care institutions for senior people. Now around 1,1 thousand persons move in care institutions for seniors and disabled people. More than half of

these people move there from their own or their relatives' homes. Every year about 120 care home residents move to their relatives' homes.

Independent Living Homes were started in Lithuania based on foreign countries' model and using funding from the EU structural funds. Homes are furbished (adapted) in municipalities that are dedicated for people who can live on their own but who need assistance from social workers. Independent Living Homes are different from regular senior care homes in a way that their residents themselves prepare food, care for their household, and social workers as professionals help to foster their independence and responsibility. The need for such institutions is huge because they help to form integration between health and social services (Kudukytė – Gasperė, Jankauskienė, Štaras, 2013).

Even though life in a social institution for the disabled is often a "lifebuoy", recently many authors view institutional care critically. According to Lukamskienė and Budėjienė (2013), nature of organising and providing social care services keeps independence and autonomy of persons differently. It is thought that institutional social care services are restricting a person's autonomy the most.

Despite conditions in care institutions that ease lives of people with disabilities, on a state level it is foreseen to implement a process of deinstitutionalization and to gradually move from an institutional towards communal care model. For that purpose a legal basis is created based on general Europe's transition from institutional to communally provided care guidelines (2012): action plan of transition from institutional care to family and community-wide provided for the disabled and remaining without parental care children 2014 – 2020 (confirmed by the law of the minister of social protection and occupation no. A1 – 83, of 2014 February 14); Social services catalogue changes (confirmed by the law of the minister of social protection and occupation no. A1 – 377, of 2014 July 14).

Deinstitutionalization is related to a changed societal attitude to the disabled and changes in the area of care services (Thornicroft, Tansella, 2008). While implementing this process gradually it will be transitioned from an institutional care and a system isolating a disabled person to an independent life. A successful deinstitutionalization would allow a person living in an institution to become a valuable citizen who controls their life while receiving professional help. The main elements of this process are a cheap and adapted accommodation in a community, available public services, help of social workers (as personal assistants) and the community (Žalimienė, Lazutka, 2009). So that deinstitutionalization happens successfully it is necessary to consistently implement three stages (see Table 3)

Table 3

Stages of Implementing Deinstitutionalization

Stage 1	Suspension of accepting new clients to stationary care institutions (or releasing clients from stationary institutions).
Stage 2	Creation of alternative to stationary care services (personal assistant, protected accommodation, etc.) in the community (or referring potential clients to alternative institutions).
Stage 3	Promotion of independence of people with disabilities and transfer of existing engagement, employment, and learning services from specialized institutions to day centres or educational institutions in a community; extension of transport and other related services' net (or expansion of communal services).

(Comprised by the author based on the source: Dunajevas, What is Social Work, 2009)

It is expected that suggested community care and provision of services will be as close to the person and their place of living as possible because services are foreseen to be provided in small social institutions (or Independent Living Homes) or in a community. As stationary care becomes communal, sense of community, independence, activeness, perception of fullness of life should increase (Dunajevas, 2009).

To sum up, it can be said that most part of everyday life in nowadays societies happens in certain institutions but people move in social institutions for various reasons: health condition, loneliness, improper life conditions, lost capacity to work, etc. People with milder disabilities can move in Independent Living Homes – their relatives cook their food, care for their household themselves, and social workers help to flourish their independence and responsibility. It is strived for the disabled to created such an environment where they would have an opportunity to manage their own lives – to have connections with other people, personal interests, could recreated their once possessed skills. After implementing the started process of deinstitutionalization, it will be moved from institutional care and a system isolating a person with a disability to independent living in a community.

1.3. Social services provided to the disabled in the social institutions

Work in a social institution is directly related to social services that are defined in a broad and a narrow sense: 1) services provided to the society, e.g. education, health care, social security, sport, leisure, cultural services; 2) services that are provided by the current social security system including these social areas: disease, disability, senility, widowhood, family/children,

unemployment, accommodation, social isolation (Žalimienė, 2003). Social services also are called personal social services or social care services.

According to the data of the Ministry of Social Protection and Work of the Republic of Lithuania (2013), about 8,8 percent of all residents of Lithuania had various disabilities and had to seek (or were referred) assistance in social institutions, in the hopes of receiving social services. According to the Department of Statistics (2015), there are about 450 institutions in Lithuania that provide social services, those are stationary social care institutions, day social care institutions (centres) for the disabled, social service centres, providing assistance at home, rehabilitation institutions, etc. social services can be provided only by licensed institutions and professional specialists.

Opportunities of providing social services are analysed in scientific literature. For example, Žalimienė (2003; 2007) reminds us that providing social services first of all is related to care perception because assistance for a person is needed when there are no other means. Thanks to social services people can satisfy their physiological needs, have conditions that do not diminish a person's dignity, to recreate abilities of functioning in a society so that they can take care of themselves independently and similar.

According to Masaitienė (2010), when wishing to provide social services the stage of information about the necessity of services is very important because the end result of providing social services depends on how and what kind of information is gathered. Information helps to sort out data about the situation of a disabled person, their problems and needs. Information can be provided not only by the person themselves but also medical, social workers, family members, relatives.

Providing social services for the disabled (and senior) persons is based on these main principles (see Table 4).

Table 4

Main Principles of Social Care for the Disabled

Principles	Content defining the principle
Assuring dignity	Client (resident) is welcomed with respect, understanding, sensitivity
Privacy	There is no unnecessary interference. An opportunity for oneself to manage according to abilities is ensured. The right to have a private place is ensured and acknowledged.
Independence (autonomy)	Assistance is offered first of all for developing self-help so that a person could be as independent as possible in every life area. Services don't need to make a person more and more dependent on an institution.
Participation	An opportunity for a resident to say their opinion individually and through a resident council that represents residents in solving all related questions

Freedom of choice	Acknowledging the right to choose and ensuring opportunities to choose (talking about any life or activity area)
Assuring rights	Have the same rights as all citizens, cannot be limited because they live in a social institution.
Self-expression	Making opportunities to engage in favourable activities, to seek one's goals
Security	Physical, psychological security, absence of violence, absence of fear to complain and to be punished; to feel safe in all situations but not to be overly sheltered
Assuring supplies	Satisfying physiological needs, providing materially according to the country's living standards

(Comprised by the author based on the source: Žalimienė, Social Services, 2003; Žalimienė, Standardizing Social Care Services for the Seniors, 2007)

After collecting information about the necessity of services it is already possible to determine groups of people who the services will be provided to: that can be older people, people with disabilities, children remaining without parental care, children and family under social risk, social risk families, families fostering children, other persons and families. Social services can be provided both in social service institutions (social care homes, families, temporary living homes, day social care centres, Independent Living Homes, social care centres and other) and at the person's home (Žalimienė, 2003).

Social services catalogue (2006) forms a final goal of social services – to return personal abilities to care for oneself and to integrate in the society. Social services can also be provided for the purposes of prevention seeking to prevent social problems.

It means that a person has an opportunity to receive social services because state institutions collaborate in appointing them, so a person in need of care is not left alone (Žalimienė and Lazutka, 2009).

Social services in special literature are divided by this principle:

- general social services;
- special social services (see Figure 2).

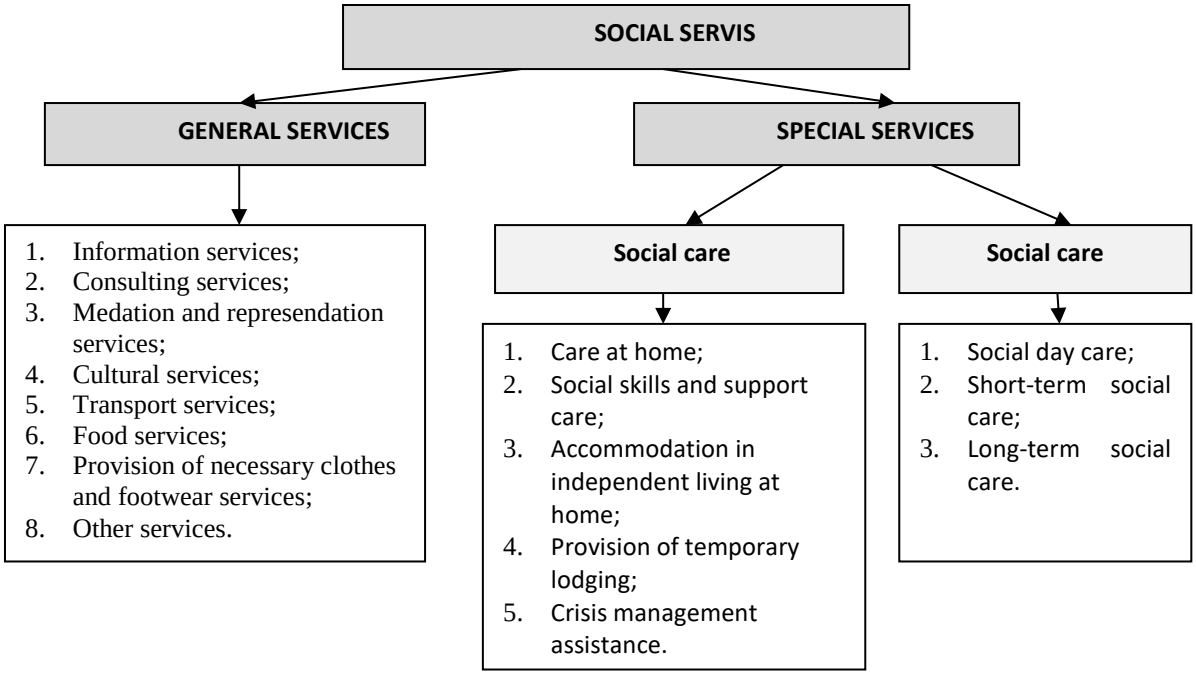

Figure 2. Kinds of Social Services

Source: Social Services Catalogue, 2006; Republic of Lithuania Law of Social Services, 2006

As Žalimienė (2003) points out, social services are services provided directly, i.e. providing information and consulting; assistance at home; nursing at home; care money, dedicated to pay for provided social services. Special social services are provided to persons when general social services are not effective. Special social services are such services that are provided to persons in purposes of care in stationary care and nursing institutions, rehabilitation institutions, day care institutions, temporary living institutions, other social care institutions.

List of general and special social services is established and its content is defined in the Social Services Catalogue (2006) that is prepared, confirmed and publicly announced every year by the Ministry of Social Protection and Occupation. Informational sources analyzing problems of gerontology emphasize that social services for senior and disabled people is one part of current system of social services that is very necessary and important. Especially relevant is the question of ensuring quality social services to the disabled. Often information sources provide a narrower service type grouping (Social Services, 2003):

- Social work services – collaboration, representation, communication, consulting, integration, social rehabilitation.
- Medical services – treatment (identified by the doctor attending); supportive; medical education; prophylaxis.

- Work therapy services – managing the environment, work according to interests, performing various household jobs, clearing facilities.
- Cultural services – participating in self-expression, cultural events, concerts, meetings, exhibition organizing, celebrating state festivals and birthdays.
- Household services – washing clothes and ironing them, cleaning facilities, managing them, disinfection.
- Religious services.

One or another type of social services for disabled persons are necessary in such cases when they cannot independently perform certain activities. Staff of social institutions as specialists in providing services help to create a full life. Living in a social institution besides general services are provided with other services according to need and personal financial opportunities (Bitinas et al., 2010). According to Remeškevičiūtė (2015), even though the net of social services in Lithuania functions not the first year, foreign examples show that senior, disabled persons in most EU countries have bigger social guarantees and income so they can choose more quality services and receive them in their own homes without moving to social institutions.

Having reviewed informational sources about social services provided in social institutions it can be noted that the main goal of social services – to satisfy a person's vital needs and to allow for life conditions that do not diminish a person's dignity when a person finds something difficult to do and to keep their independence as long as possible. Social services are provided in stationary care and nursing institutions, rehabilitation institutions, day care institutions, temporary care institutions, other social institutions. Persons living in social institutions are provided with general / special social services. The goal of specialists providing social services – to apply activities of care/assistance in providing services, to satisfy a person's needs, to improve conditions and life quality. Social services are one of help means in seeking to bring back ability to care for oneself and to integrate in society, promoting living a full life. Social services are classified in various ways and that shows that the system of social services in Lithuania is oriented towards various problematic situations and organized help is appointed to overcome various life difficulties, to prevent emergence of bigger social problems.

1.4. Engagement Modelling in a Social Institution

The more actively people are engaged in participation the more opportunities of their social life are increased. Among social services provided in social institutions there are day occupation, leisure services. It is noted in informational sources about social work that the good social work experience is related to greatly increased need for various social services, their variety, coverage of provision. Various social services can be created and guaranteed to own members in

social institutions and that way engagement can be successfully organized (Aperavičienė, 2009). Despite having various disabilities persons are encouraged to participate in engagement activities, to spend their time purposefully, to create social relationships, be "like the rest" despite their disability.

Even though engagement is often identified as leisure, it is also defined as one of the most important factors of personality development that allows a person to engage in desired activities (Paulavičiūtė, 2008). According to the author, criterion of rational free time utilization is a social responsibility – the more responsibly a person uses their time, the more they are mature as a person. It means that perception of engagement is inherent to fostering a wholesome person and social/cultural needs and skills implementation, and lack of engagement (or inability to rationally use one's time) can be called a problem of this century.

Concept of engagement has another meaning as well because engagement is often defined as everyone's wish to be provided work places (to have a permanent job). According to Račinskaja (2015), organizing engagement of incapable of working, having disabilities persons in a social institution can be called an unofficial engagement and can be equated to a purposeful time utilization. It is suggested for the engagement of disabled persons to create (or there already are created ones) special work places but those already are questions of integration in a job market.

When assessing features of engagement modelling in a social institution it is often imagined that people living there do absolutely nothing (are unoccupied) and have a lot of free time. That is a faulty perception of life of social institution residents. First of all, a day regime is established in stationary social institutions (if that is not an Independent Living Home) that needs to be followed: residents have breakfast, lunch and dinner at a designated time, time is dedicated for personal hygiene, medical procedures, etc. At the same time residents have time to communicate with one another, to listen to the radio, watch TV, read the press, go for walks, be in a fresh air.

Even though Social Services Catalogue (2006) points out that engagement services are provided, as Šinkūnienė (2005) notices, often engagement or leisure in a social institution is unorganized, i.e. passive. Author thinks that ways of spending free time – a personal freedom of choice of each individual that a person uses to express their will, reveal their attitude to a value system and show general inner culture. So, the main objective of engagement modelling in a social institution – to ensure such a quality of spending time that would help a person live life as varied as possible according to their wishes and possibilities.

When modelling engagement personal experience of staff of a social institution is very important: social realization, self-esteem, ability to critically analyze lives of clients and problems, to accept and reveal the ways of problem solving. According to Motiečienė and Naujanienė (2011), it is best to model engagement by developing it in a systemic way when different forms of knowing

and perception are recognized, new social work knowledge is created and a crucial condition for the development of engagement is applied – knowing what is happening in clients' environment. Proper engagement modelling in a social institution can be an example of a good experience for other institutions of a similar nature where persons having various health problems live. According to Myers (2010), communication of the disabled and ability to engage with the like-minded is very important because that strengthens a person's self-worth and improves wellbeing.

In the opinion of Žalimienė (2003), there should be such engagement services in every social institution that would improve client's life quality through activity and engagement. With the help of such services a person's everyday activity skills, abilities are fostered, physical activeness is kept, they are encouraged to take up interesting jobs, etc. It is recommended to also apply additional services that can diversify engagement, - culture and leisure services. These services relate to such activities as organizing self-interest activities, interesting meetings, concerts, lectures, religious festivals, excursions to cultural events, celebration of name-days and birthdays, and state festivals and similar.

Žalimienė (2003) points out such nature of engagement services that enables clients to be more active, that is:

Training/restoration of self-service skills;

Training elementary work skills;

Teaching work operations and other activities (e.g. drawing, moulding, etc.);

Organizing activities according to interests (knitting, sewing, weaving, etc.), various household works;

Cleaning the environment, facilities, etc.

Author emphasizes that it is necessary to include all social institution residents in providing services according to individual abilities. They need to be able to care for their hygiene, management of environment themselves, to do simple household jobs, cook, shop.

Problems of engagement are solved on several levels, e.g. questions about how to engage residents are constantly being asked in European Union social institutions. Engagement modelling in foreign countries for the disabled is related to initiatives to better satisfy needs of residents and to increase their self-realization. Efforts to provide concrete assistance for the disabled are sponsored in the area of engagement, so social institution workers take care of people's engagement by thoroughly analyzing their personal needs and avoiding violations of people's rights (European Economic and Social Committee, 2011).

Communication satisfying a person's needs, meaningful engagement activities, favourable emotional environment are important factors for people living in a social institution.

Providing versatile assistance to institution residents is called social support. Of the items proving that people can feel happier if they are supported, according to Myers (2010), shows that:

- If a person can be the manager of their own time (can set goals and anticipate tasks that they can carry out);
- If searches for ways to spend leisure time (try what they want to take up);
- If engages in activities promoting movement (physical activities make a person not only healthier, more energetic but also more resistant to depression and anxiety);
- If prioritize relationships with peers (spend free time together, share the joy of communication).

Leliūgienė, Gailevičiūtė, Bajorienė (2013) recommend to apply various engagement forms for the disabled first of all using psychosocial assistance models. These more significant assistance models are offered:

- Conservative model – the means helping to restore lost functions when various interventions are offered to persons and engagement and leisure therapy is a part of this model;
- Model of a client's chosen goal – it is based on a person's need to develop specific skills so that later on they can engage in desired activities;
- Model of integration of services and interventions – when a client's needs are assessed and long-term and diverse program is applied.

Rimkus (2010) recommends applying a social work model that emphasizes client's strengths where the base consists of encouragement, agreement, assessment of effort, assistance helping a person to reveal their strengths:

- Attention is focused on the strengths of an individual, not on the pathology;
- Interpersonal relationships of a social worker and a client are essential and the most important;
- Assistance is based on a client's determination;
- People who are in the environment are understood as a resource, not a barrier;
- The most effective way of assistance is assistance in the client's environment;
- People having problems can successfully learn, grow and change.

Gvaldaitė (2009) emphasizes one more important social work model – enabling (or inclusion). Author defines the essence of enabling as a person's ability to "take life in one's own hands", to focus their effort in changing it, to adopt an active position towards reality. Growth of personal desire to act, discovery of new previously unknown inner resources, acceptance of difficulties and their positive interpretation are typical qualities of an "enabled" person.

Information sources about various engagement activities for the disabled state that next to active engagement activities a passive way of spending time is utilized that is more acceptable for persons with severe disabilities. While organizing passive leisure such an atmosphere is created that people willing so can relax, stay on their own, watch TV or read a book, listen to music, etc.

When analyzing information sources it was noticed that quite a few people moving in social institutions do not engage in any activities. There can be several reasons: part of the institution residents cannot accept the unfamiliar environment or motivate themselves with health problems. It was established that institution residents who actively engaged in various activities felt much better, became independent in everyday activities, their mood improved, they started to rejoice in the little pleasures (Zaborskienė, 2011).

Specialists advise that the only way to find out what people need is to ask them. There can be no forcing or imposition of different ideas. Specialist modelling engagement in a social institution can have the most interesting and original ideas but those thoughts and ideas can stay unimplemented if the resident is unable to clearly state their wishes. According to Sutton (1999), a person can be assisted by providing several real suggestions and encouraging to choose. It was noticed that residents of social institutions usually choose activities based on their experience, a lot of influence is also from social status, education, gender, character qualities.

It can be said that when modelling engagement in a social institution its specifics comprise many jobs and tasks – activity planning, composition of a concrete case effect plan, control of its implementation and assessment of effect, organization of various events and activities, etc. properly organized engagement activities can become an especially effective means of integration of the disabled in a society. It is attempted in a social institution to organize such engagement activities for the disabled where the moral, enthusiastic, support and satisfaction aspect would prevail.

1.5. Significance of engagement for a full life of people with a disability

Lithuanian Constitution (1992, clause 49) guarantees every person's right to rest and leisure. According to The Universal Declaration of Human Rights (1995, clause 24), every person can use not only their political and economic but also social – cultural rights.

The main objective of engagement in a social system – to ensure such quality of spending time that a person would not be on the side but would be able to engage in their interested activities (Biliuvienė, Jasevičienė, 2015). Situation due to disability affects people living in a social institution quite strongly. Inability to meaningfully and interestingly use one's own free time, poor

quality life cause many social problems: abusing alcohol, drug use and other addictions, crime of the public order, conflict situations among residents of institutions, etc. (Mikulionienė, 2012).

Specifics of engagement in a social institution are influenced by several factors: 1) status of social group and age (senior care homes, Independent Living Homes); 2) individual needs of residents living in a care institution, their interests and abilities; 3) competence of social workers when organizing engagement; 4) place of institution (city, region, village); 5) financial opportunities of the institution. In a social institution influence for engagement activities comes also from the fact that often residents for many reasons cannot independently choose types, forms and content of activities, therefore, it is necessary to create conditions to try various engagement areas, to find out what interests them, what they can do (Biliuvienė, Jasevičienė, 2015).

Foreign authors (Bond, 2007; Grobman, Bourassa, 2012) also emphasize the importance of engagement in a social institution. According to them, purposefully spent (engaged) every day for senior persons or disabled persons simply means a wholesome life. Therefore, engagement is viewed as a need that is necessary for a normal person's existence. According to Maslow's (2009) theory of needs, not only survival but also social needs are important for a person among which is a need for action.

As Viluckienė (2010) states, engagement activities help to better satisfy both inner – self-realization, psychological satisfaction, and outer – material and other needs. However, only a person who comes to terms with and accepts their disability is able to realize that they want and can live differently, more interestingly, more meaningfully. Various engagement activities can diversify lives of disabled people living in a social institution: e.g. ceramics, floristry, weaving, handicrafts, music activities, organized cultural activities: celebrating state, religious, calendar, social institution traditions, organizing excursions to events and places desired by the residents, cultural events in the institution and outside of it, sport activities inside and outside, board games, sport matches in the institution and outside of it according to health condition, etc. properly modelled engagement of residents of a social institution plays an important role because besides purposefully spending time it also creates great practical articles, souvenirs that can be given away, sold or used to improve environment. The most important is that participants of engagement activities feel like they are useful just as other people, regain their self-confidence.

According to Paulavičiūtė (2008), active forms of organized engagement are becoming more popular when more and more people are included in activities. Such activities have to be planned ahead by setting up engagement/leisure programs of institution's engagement. So that engagement activities are meaningful, fitting needs and opportunities, knowledge and skills are needed in choosing and applying various engagement activities: activities according to interests (clubs) or art activities, sport or other games, excursions, entertainment and festivals.

Significance of engagement is reflected by distinction, choice and application of activity stages (Mikelionienė, 2009; Bagdonavičienė, 2015):

1. passive engagement/rest (during this a person has a chance to regain physical and spiritual strength);
2. self-education (opportunity to gain, deepen or improve possessed knowledge);
3. self-realization (organizing entertainment and festivals that help to reveal a person's creative skills).

According to Šinkūniene (2005), *passive rest/engagement* and *self-expression* are more acceptable for residents with disabilities living in a social institution. So, when organizing engagement activities in a social institution attention is focused to degree of disability and age of residents. Obviously residents having a severe disability or movement problems cannot (are unable) to participate in active engagement events. Realistically, such people remain with only opportunities of passive leisure.

Payne (2009), Lazutka and Poviliūnas (2013), Magnuson (2014) were interested in even more active inclusion and search of innovation when satisfying engagement needs of people with disabilities. That is called ensuring *social participation*. According to authors, participation is the most important component of human development making conditions for a person to reach bigger opportunities themselves using gained skills developed in a certain social environment. Participation based on variety of forms is also perceived as an active form of public spirit. Concept of social participation includes a variety of activities beginning with a person's or group's engagement in various institutions and ending with a person's or group interpersonal relationships.

Engagement activities in a social institution help to strengthen skills of people with disabilities, provide an opportunity to spend free time meaningfully. Results of a 2011 scientific research "Voluntary Activities of Older People in the European Union" by the European Foundation for the Improvement of Living and Working Conditions confirm that people of older age and with health problems have various opportunities to participate in engagement activities. Study shows that there are various areas of activities where older people (and having disabilities) can participate voluntarily: most actively participate in activities of "Caritas", "Food Bank", "Order of Malta", and Lithuanian Red Cross. Lifelong learning is a very important aspects related to activities of the Third university. Activities of Lithuanian retiree union "Bočiai" have gained scale where they seek volunteerism of interpersonal relationships, kindness, humaneness, tolerance and democracy. Members of the union are united by one goal – to remain independent from others and valuable members of their communities when the pension age is reached and activities are based on people's opportunities and initiative so that they are both interesting and useful.

Usually participants of these activities are not those who live in institutions. However, according to Miežytė – Tijūšienė and Bulotaitė (2012), activeness and participation in any other activity for those who live in a social institution and cannot get involved in known organizations, associations and unions is no less important because it helps to improve physical health, broaden cognitive functions, deal with problems and difficulties. Engagement means that a person in the future will be less dependent from others, will successfully manage everyday activities, will be able to manage emotions (Salami, 2010). So, engagement not only helps to fight disability but can also fight negative emotions, loneliness, boredom, sense of meaninglessness.

Life quality of a person who lives in a care institution also depends on occupation with everyday activities. The more such activities, the more purposefully day is spent, the more the person feels as an independent person who does not need constant staff care. This idea is developed by Išoraitė (2005) emphasizing that one of the most effective ways to integrate a person into societal life is their engagement, i.e. occupation with any work/creative activities. Understandably jobs done by a person with disability are not always quality or productive but the fact of activity itself has a big social value. According to Ruškus (2002), during these activities disabled people learn to make decisions and be responsible for what they do and for themselves. Namely through activity the disabled learn again and remember many skills that are necessary for their further life.

The significance of engagement for the lives of disabled people was also defined by Myers (2000) and Pūras (2000) stating that activity makes a person's life of quality. Not having useful activities many disabled persons live without seeing a life purpose and meaning; boredom and monotony become their everyday escorts. Not having an occupation many are dissatisfied with everything and everybody. It means that various engagement activities are the best means not only to improve skills of social functioning but also to better know oneself, they promote success, increase self assessment, positive self perception. In all aspects happier are those who naturally get involved in various activities, then all kinds of leisure and rest hours become much more interesting.

In conclusion it can be stated that the main objective of engagement modelling in a social system is to ensure such quality of spending time that a person would not remain on the side but would be able to get involved in desired activities. Engagement activities in a social institution are affected by that how often residents themselves due to various reasons are unable to independently choose kinds, forms, or content of activities, so it is necessary to provide conditions to try various engagement areas, to find out what they are interested in, what they are occupied with. Engagement activities help to better satisfy both inner – self-realization, psychological satisfaction, and outer – material and other needs. When organizing engagement activities in a social institution, first of all attention is focused on the degree of disability and age. Engagement

activities are dedicated for renewal of lost work and communication skills or forming them and for supporting and forming an active life.

1.6. Expression of Social Work Professionalization in a Social Institution

Effectiveness of social services is influenced by staff providing social services, their competence, readiness to work with disabled persons. Social work is especially related to professional competence. In a general sense, competence is defined as a person's expression of qualification or ability to act influenced by knowledge, skills, attitudes, personality characteristics and values of an individual (Sadauskas and Leliūgienė, 2010; Jovaiša, 2007), it is an ability to perform a certain task in a real activity situation. Andrašiūnienė (2007) expands the concept of social work with additional statements: that is demonstration of effective activities, ability to do an activity well, authority to do something, to act, qualified knowing, effectiveness of which is determined by gained experience.

Social workers working together with other specialists perform various professional roles. As Johnson (2001) shows, a role is a means that a worker uses to express themselves in specific situations. So, perception of competence goes hand in hand with concept of roles because a social worker has to understand and be aware of their work and actions well. A social worker can professionally organize their work, become a productive worker only then when they understand the limits of their competence well and are able to take up roles. As Johnson states, perception of professional roles helps for a social worker to identify themselves as a member of social work profession. If a social worker does not perceive the significance of their professional role, then work with clients is unsuccessful, jobs are done that are not a part of competences of a social worker, many additional and unnecessary obligations are taken up, etc.

According to Pierson (2008) insights, principles of activities of a competent social worker in a community (or social institution) can be distinguished (see Table 5).

Table 5

Principles of Activities of a Social Worker

Principle	**Content of principles of activity of a social worker based on competences**
Commitment	• Foster and strengthen skills, knowledge, abilities and motivation to solve problems of community members; • Exercise such activities that would eliminate the causes of social problem appearance
Seeking	• create such an environment that community members desire;

	• seeking a varied flourishing of community members
Dispersion	• collection and utilization of knowledge about the needs of community members

(Comprised by the author based on the source: Pierson, Going Local Working in Communities and Neighbourhoods, 2008)

It is understandable that professional skills are very important for a social worker employed in a social institution so that they can implement action principles. Social worker's skills contain knowing how to communicate, evaluate problems and client's abilities, combine existing resources with needs, discover various techniques and methods. Next to learned practical skills personal qualities of a social worker and their work style also matter (Johnson, 2001). Only by having necessary skills a social work specialist can become a creative person able to always be next to a client and to help them change their life (Makštutytė, Vaškevičiūtė, 2011).

Ruškus, Naujanienė (2010), Žalimienė, Skučienė et al. (2013), Juozulynas, Savičiūtė, Jurgelėnas et al. (2013), Raudeliūnaitė, Buškevičiūtė (2014) et al., Gvaldaitė, Švedaitė – Sakalauskė, Buzaitytė – Kašalynienė (2014) analyzed questions of professionalization of social workers in their scientific studies because that is an important part of competence. In nowadays life when it is attempted to solve a person's right protection and safety questions – especially in social work – professionalism becomes the main value of a worker. Nevertheless, despite effort when preparing social workers a two-fold attitude towards a person is observed in the context of professionalization: 1) *positive attitude*, described as optimistic because it is attempted to see abilities to improve in every person even in cases of severe disability, a person is valued as a creating and feeling being; negative attitude – pessimistic attitude that manifests by neglecting and rejection of a person (especially disabled).

Vyšniauskienė, Minkutė (2008) emphasize a conviction that social workers doing their professional activities not only provide a concrete help to service users but also establish their profession in the society as a inseparable area of society's activities, as a necessary work for the stability and well-being of society. Authors distinguish one of the main goals of social work activities – improvement of life qualities of a service user and also their life optimization utilizing various activities. When seeking a goal social workers not only base and follow moral and social responsibility but also together with clients foster and promote perception of values because that is one of the most important and practically necessary factors when seeking professionalism.

Social worker's professionalism is revealed when directly strengthening a person's social functions seeking their social integration – and that is one of the more important areas of

action of a social worker in a social institution. As Raudeliūnaitė, Buškevičiūtė (2014) notice, social workers have an opportunity to closely observe situations when disabled persons suffer from social isolation, so by including those persons in engagement activities they prove their competences as social workers.

According to Makštutytė, Vaškevičiūtė (2011), from the very beginning of social work practice social work was focused on satisfying a person's needs and widening of a human potential, so activities of a social worker is identified as a process of social work. Those are continuous and constant actions between a client and a social worker that include feelings, thinking and actions and are performed seeking set goals. The fact that social work is actually a process is proved by distinguished main stages: beginning of work, assessment of a client's situation, setting goals, intervention and evaluation of work process.

While analysing questions of professionalization it is noticed that most often the object of discussion becomes professionalism of single individuals (workers). Interest of a single individual's professionalization is very important because it shows how and when a worker gained specific science knowledge, how they are able to collect it further and use, develop competences, form, construct professional culture and professional identity, etc. Based on Dolgoff et al. (2008), it fits the dynamic of professional socialization where any worker becomes a socially acknowledged professional.

Sadauskas and Leliūgienė (2010) broaden the concept of professionalization of a social worker itself by stating that it is required from a social worker not only to have a baggage of gained knowledge but also to be able to identify new or not fully satisfied needs of social usefulness, to be able to construct and manage professional activity.

Andrijauskienė (2015) in her doctoral dissertation analyzes the system of social services and suggests to narrow a little bit the concept of social work by relating it more with professional activities and emphasizing that social workers are those specialists who enable people, families, communities and society to solve social and interpersonal relationship problems. So, the most important professional social work purposes at the moment must be: life quality, social fairness, social change and solidarity.

It is visible that improvement of professionalism is a constant and unending process. Based on data (2014) of Ministry of Social Protection and Occupation, about 40 events are organized for training and professional improvement of specialists, about 500 persons train there (social workers, their assistants, workers of disabled associations, etc.). Experiences of foreign countries show that a special attention is drawn to expression of professionalization of social workers. For example, in England interest is constantly shown to whether cared for persons receive a safe and effective care, whether social care services fit needs of cared persons, whether they are

being treated with dignity, whether qualifications of social care staff fits provided services. Rating of service providers is published online so that society could evaluate and choose social care providers according to their needs (www.anglija.today/socialinė-raida).

A care quality law regulates professionalization coming into effect since 1996 (Braakenbergas, 2001) in the Netherlands. The law provides main statements that care providers must follow: quickly and effectively apply social care forms for the client, systemically perform monitoring and control of provided care, it is emphasized that a proudly permissive and arrogant behaviour towards the clients will never be tolerated.

Jonavičius (2010) emphasizes changes of social work in Ukraine after the "Colour Revolution". There even now all the attention is focused on consolidation of democracy, a strong conviction to adhere to human rights standards and the principles of their legal state. A person's well-being and help for a person is one of the most sore problems in Ukraine at the moment, yet so difficult to implement.

Žalimienė et al. (2013), analysing professional well-being and new challenges for development of social services states that a bigger attention in foreign countries (e.g. Hungary, Denmark, Australia, Germany, etc.) is focused on that social workers would work with small client groups because that is the only way to do one's job professionally.

Social workers in Norway are first of all referred to preventative activities so that they could help avoid possible social problems. In a social service system in Norway the importance of democracy and local municipality, freedom of action of local municipalities (and social workers belonging to that link) are emphasized. Social workers know that they have to professionally ensure safety of people, ensure improvement of people's life conditions and necessary help to those who need it, provide people an opportunity to receive support and live independently while integrating in an active and meaningful community life (....of Non-stationary Social Services of Norway Experience, 2010).

In conclusion it can be stated that social workers wishing to work with disabled persons must have professional competence that is comprised of knowledge, values and skills. Besides professional knowledge, skills and abilities social workers in all situations must act ethically because without an inner ethics social workers cannot be real professionals. Also, understanding and cleverness are necessary so that with the help of special knowledge they could help strengthen confidence, adaptation to environment of social institution residents, would help to restore possessed abilities, would help to go back to cultural – societal life. Professionalism of social workers is revealed by their ability to keep contact (communicate) with clients, that way including them in the process of social work and making decisions. Social workers try to share their professional knowledge, skills, resources with their clients so that they could be responsible for

their own decisions. In many European countries politics of social well-being is directed towards support, promotion and sponsoring of independence of disabled persons.

2. RESEARCH OF MODELLING ENGAGEMENT OF PERSONS WITH A DISABILITY WHO LIVE IN SOCIAL INSTITUTIONS AS A MEANS OF SOCIAL WORK PROFESIONALIZATION

2.1. Research Methodology and Methods

Methodology – entirety of knowledge about methods where methods themselves and their creation are considered an object of research. The main object of methodology – organizing activities or preparation to perform research. Any scientific research is grounded methodically, i.e. a topic is clearly stated, research concept, hypothesis, research methods are described and so on. All that is understood as methodology (Bitinas, Rupšienė, Žydžiūnaitė, 2008).

According to the concept of methodology a qualitative research was chosen to reveal the topic of this thesis. This research helps to distinguish the dependence of object of cognition from context, environment when during the research a researcher seeks to reveal the qualities of an object in a natural environment. The main function of chosen method – organization and regulation of inner congition process or practical reorganization of one or another object. Correctly chosen and applied method allows to save energy and time, to find the shortest way to a search of results, helps to evoid mistakes during research process.

Kardelis (2007) emphasizes that qualitative studies are more often used in social sciences because they reveal feelings, experiences and other emotions of respondents that cannot be accounted for with any numbers. Bitinas, Rupšienė, Žydžiūnaitė (2008) emphasize that in order to perform a qualitative research an entirety of research principals, means and ways are important that help to seek the foreseen goal. So, attention is drawn to choice of research object, proper observation in participation, establishment of sample, interpretation of research data.

2.2. Research Instrumentation

An important aspect of this research is to observe and analyze how persons live who have disabilities and live in a social institution, what they do in their leisure time, how their engagement is being modelled. Even though social institution residents feel constant care of staff such questions remain relevant: how everyday, educational, cultural activities are organized, are people having disabilities satisfied with life quality in the institution, can they engage in activities that they find interesting?

In order to reveal the study a semi-structured interview method was used allowing to form the view of research object more in depth and more in detail, to better understand the chosen phenomenon (Kardelis, 2007). Interview method is collection of data while researcher observes and directly communicates with a respondent (informant). During an interview respondents (informants) can reveal their experience in their own words so in the process of the interview interesting data can be collected. Observation also happens during an interview because a researcher not only hears but also sees how a research participant acts, talks during an interview (Bitinas, Rupšienė, Žydžiūnaitė, 2008). The mentioned data collection method covers questioning participants and listening when the researcher seeks to understand the attitude, experience, evaluations, opinion of research participants (informants) and to interpret collected data. Interview helped to reflect social life in a social institution, the research itself was performed in natural conditions, in an environment familiar to residents and staff.

Two questionnaires were prepared: one for specialists (see Appendix No. 1) and one for residents of social institution (see Appendix No. 2). Both questionnaires contain 8 questions that are used to reveal:

- Some characteristics of research participants;
- Opinions of specialists and residents about work and life conditions;
- Attitude towards independent living homes as a social institution where most needs can be satisfied;
- Features of life in a social institution;
- Opportunities to bring institutional life closer to regular life norms;
- Relationships of specialists and residents;
- Expression of professionalism of specialists.

2.3. Research Participants

Interview was conducted in two social institutions: Independent living homes in Gedrimai, Telšiai region, and Linkuva, Pakruojis region. In reality 16 social workers and 16 social institution residents participated in this study. Anticipated length of interview was 1 hour. Respondents were given questions prepared in advance. Data collected during the research process were recorded in interview protocols, analyzed, and interpreted.

It was presumed that during interviews it will be revealed how engagement modelling is performed as an expression of social work professionalism for persons having disabilities, living in a social institution and whether they are satisfied with those activities.

The hope was that research participants will willingly answer given questions, tell about their work and life in an independent living home in detail. The main selection criterion of research participants – specialists work and residents live in Independent living homes.

During interviews researchers tried to keep the main ethical principals of research: privacy, agreement, kindness and volunteerism so that she did not cause dissatisfaction and stress. Attention was focused on respect to a person's dignity – before starting a conversation respondents were informed about research goals, objectives, relevance and a right to independently decide about voluntary participation in this research. Principle of fairness was also upheld ensuring anonymity and confidentiality of respondents about information obtained during interviews (Bitinas ir kt., 2008).

All research participants were coded so interview protocols were named: D1, D2, D3 and so on (staff), G1, G2, G3 and so on (residents).

It was planned to visit homes of Special war and work veterans, senior people and disabled care and Nov – Belickis psycho neurological men's boarding home in Kiev (Ukrain).

2.4. Interpretation of Research Results

2.4.1. Evaluation of Attitudes of Social Workers Working in a Social Institution towards Engagement Modelling of Residents

According to scientific literature, engagement modelling of persons with disabilities living in social institutions is not only necessary but simply inevitable. It is very important that disabled persons experience an even stronger sense of community, seek positive changes in their difficult situation. Social work professionals try to enable institution residents to act and live a full life (Baršauskienė, Leliūgienė, 2001).

Interpretation of research results was started by summarizing social workers' answers to given questions. Number of those agreeing to the statement not necessarily corresponds to the overall number of research participants because respondents were able to agree with several cases of activities.

The first question given to social workers was this: *who many years have you been working in the institution and what main things changed in the institution over the past 5 years? (see Table 1).*

Table 1

The Main Changes in the Institution over the Last 5 Years

Predominant Statements	Number of Respondents Agreeing to the Statement
Changes in the Institution	
Image of the institution changed (facilities, infrastructure, work and leisure conditions)	**10**
More qualified specialists and specialists providing special services are employed	4
Team work of institution workers has strengthened	4
More attention is focused on well-being of institution's residents	**5**
Social workers have become involved in project activities dedicated to organize engagement	**6**

Answering the first part of the question about the length of time worked in the social institution respondents provided different answers. It is possible that some respondents provided a general length of social or other work experience, others – years that they worked in the current institution. Based on obtained results it is clear that social workers have sufficient work experience because they work in the area of social work *from 4 to 19 years.*

As can be seen from predominant statements in Table 1, social workers emphasize, in their opinion, most important changes in the institution over the last 5 years: *image of the institution has changed, observed an active involvement in project activities, dedicated to engagement and that way was founded a bigger opportunity to spend more attention to the well-being of residents:*

"We work in excellent conditions because everything has changed essentially – new facilities, tidy environment" (D11); "*Compared to what was earlier, it is like day and night…"* (D6); *"I am satisfied with everything because image of our institution has completely changed both externally and in work quality"* (D8);

"Every year we win at least small projects and the money we receive goes to a better life of residents" (D12); *"I think that our residents are satisfied by what we do because on their own they would not be able to participate and see something more interesting"* (D13).

Visiting a social institution in Ukraine researcher talked to staff and asked to answer similar questions to the ones given to Lithuanian specialists. Ukrainian professionals said:

"Here changes especially from the material side are not very significant because there are not many opportunities yet to build new and modern homes for senior and disabled people. Staff do all the jobs and we can replace each other which is a big step to achieving team work";

"Various empty buildings are suited to be care homes or other social institutions, well, they do not fully fit the disabled but we try to help people, we provide help and hope for bigger changes in the future";

"A big achievement is that we can accommodate people having various disorders and disabilities in special homes".

Summarizing answers to the first interview question it can be stated that it is being sought to adjust social institutions to all help and in-need of service groups of residents – also to people having disabilities – and that way to improve life well-being. All social workers have sufficient work experience that is based on respondent answers about work experience. Concrete changes are observed in social institutions: work and life conditions have improved, more qualified specialists work there, project activities have increased.

Social work is closely related to professional competence based on a worker's functions that are declared in appropriate documents. Lithuanian Republic Social Protection and Work Minister's 2006 April 5th act (No. A1-92) states these social worker's functions: 1) social worker determines a social problem; 2) plans support; 3) provides support; 4) evaluates support; 5) collaborates with social partners; 6) improves professional activities.

Answering this question social workers defined *their functions as professional social workers* working in a concrete social institution (see Table 2).

Table 2

Statements Defining Functions of a Professional Social Worker Working in a Social Institution

Predominant Statements	Number of Respondents Agreeing to the Statement
Service (work) for the well-being of people	**16**
Ensuring and protecting residents' rights	**14**
Support of institution's clients in all life situations	**16**
Professional communication not only with all clients, but also with colleagues	11
Ability to provide concrete social services	12
Keeping confidentiality of information about clients	10

Based on respondents' answers, 3 most general functions of professional social workers were distinguished as they are defined by workers themselves: *service (work) for the well-being of people, ensuring and protecting of residents' rights, support of institution's clients in all life situations:*

"I am here so that I give all of my professional abilities for the people here" (D9)*;*

"Even though they [institution's residents] are quite independent, I still have to "stand" for them when needed, protect their interests, not allow for them to be hurt" (D10)*;*

"Sometimes we have to talk in a stricter manner but for their own well-being... I support them in every case but I want harmony and concord" (D13).

Social workers mentioned that it is very important to have enough information about the social relations of institution's residents: *"It is necessary to communicate and collaborate with relatives of residents"* (D2).

In the opinion of social workers, personal characteristics of specialists are very important to implement their functions, such as: "*...love of one's neighbour, wisdom, diligence, forgiveness, self-control, fairness...*" (D1);

Researcher managed to find out that Ukraine's social institutions pay more attention to the function of nursing and other social services are provided based on need because such opinions were heard:

"If they [institution's residents] do not have their relatives close we have to care for them and when they ask we have to reach medical institutions";

"There are more psychological health problems and we think it is due to conditions of the country";

"...people experienced various personal crises, lost relatives, they were arrested or ran away from the country. It is scary to think about... We try to bring them to reality even though not all will succeed."

It can be stated that social workers in social institutions performing their social work functions dedicate all their effort to their clients' life well-being. Based on the statements chosen by respondents these principles of functions of a professional social worker in a social institution were distinguished: 1) commitment to foster and strengthen skills of clients, their abilities and motivation to solve problems, 2) to do such activities that would help to eliminate causes of social problems, 3) strive to create environment favourable to clients, 4) collection of information about clients' needs and satisfaction of needs.

One of social worker's functions is to establish a social problem and after establishing it to take action in solving it. Social work specialists in social institutions can create and guarantee various social services to their members and to successfully model engagement (Aperavičienė, 2009). Even having various disabilities persons are encouraged to participate in engagament activities, to purposefully spend their time, create social relationships, to be "like everyone" despite their disability.

Respondents shared their opinions about activities held in the institution organizing engagement for persons having disability (see Table 3).

Table 3

Activities Held in an Institution while Modelling Engagement of Disabled Persons

Predominant Statements	Number of Respondents Agreeing to the Statement
Organization of work activities (cleaning environment and general and personal facilities, caring for flower gardens, trees and bushes, lawns)	**14**
Musical and art activities	9
Individual engagement hours based on needs (watching television, reading magazines, books, listening to radio)	**10**
Sport and board game organization	6
Training household skills (assistance preparing food, washing, ironing, caring for clothes and shoes)	**11**

After analyzing respondent answers based on the number of respondents agreeing to statements it is observed that modelling engagement social workers pay most attention to various work activities (such activities are performed by almost all social workers).

Some social workers are certain that for residents of poorer health it is more appropriate to model different – not work related – engagement activities: *"I encourage [to tell] memories, to say their feelings, to remember songs and poems once loved"* (D2); *"[I do] tea afternoons, individual talks"* (D4); *"We watch photographs..."* (D10); *"For the religious ones I help before religious festivals, we meet to sing carols"* (D15).

Social workers stated that instead of various engagement activities often they need to help residents in their household because come do not have everyday skills or their health condition does not allow them to cook, care for clothes, bedding, shoes and other themselves.

It was revealed that sport activities and music and art activities are more difficult for social workers to organize – they are organized not by all social workers. Such activities need special knowledge and abilities. Current situation is often explained by the influence of disabilities of social institution's residents and by the lack of need to engage in art/sport activities. However, the essence is in the planning of performed activities by an engagement specialist – there is a lack of flexibility to involve social partners in art and sport activities, to use inter-institutional relations.

In social workers' opinion, satisfaction of individual needs is also one of engagement forms: institution residents read, watch TV, listen to radio. This engagement practically does not need to be organized but social workers use an opportunity creatively to diversify individual engagement of residents:

"I always ask what they read about, what they liked and did not like, that way a discussion and a conversation happens instantly" (D7);

"There are quite a lot TV show lovers, so they cannot be disturbed then but I find time to talk and they willingly tell me how one or another episode ended. Sometimes I get into such conversations too deeply" (D9);

"One man constantly listens to news on the radio so often we talk politics and that is good because that man is curious at least in this manner" (D10).

Researcher managed to talk to Ukrainian workers about what activities they perform engaging disabled residents of institutions. An impression was formed that engagement modelling significantly differs from activities in Lithuania:

"*They [institution's residents] spend their leisure as they want, nobody organizes anything special for them"; "Here [in the institution] they live similarly to their homes – have a separate living space, often live with family so there are any big engagement problems. Well, unless some loner needs some help, then I help"; "Other institutions where disabilities are different, say, psychological disorders, people need to be engaged."*

In conclusion it can be stated that engagement in social institutions should be modelled by engagement specialists but not all institutions have this position. When modelling engagement activities social workers not only include institution's residents but it is also a good opportunity for them to apply theoretical knowledge and practical skills, to better know their skills, it promotes success at work. However, not all engagement activities are equally successfully performed by social workers because sometimes they lack knowledge and skills and institution's residents are different people, their social skills and needs also differ.

In essence successful engagement modelling is affected also by the independence level of a social institution's residents. According to Šinkūnienė (2005), when organizing engagement activities in a social institution attention is paid to the degree of disability and age because those having a severe disability or movement problems cannot (are unable) to participate in events of active engagement. In reality such people remain with opportunities of passive leisure.

Respondents said, *how many persons we need to work with, how many out of them are partially independent and independent.*

Based on data from Lithuanian respondents it was found out that they all have to work with people of limited independence:

"Only fifteen people are independent and the remaining 33 have various disabilities" (D1);

"Only two can be without my help" (D4);

"Out of 16 that I work with only six are fully independent" (D7);

"All my people are partially independent, all fifteen, well, some more than others" (D12).

In summary we can state that more than half residents of Independent living homes have limited independence. The remaining ones can live without special help and according to needs can participate in engagement activities. So, when modelling engagement social workers need to pay attention to disability degrees and apply appropriate engagement forms. In specialists' opinion, when in want to provide social services the stage of gathering information is a very important step because the final result of providing social services depends on how and what information is gathered. Information helps to find data about the situation, problems, need and abilities of a disabled person (Masaitienė, 2010).

Respondents shared opinions about *what personal needs and abilities of an institution's residents they pay most attention to* (see Table 4).

Table 4

Personal Needs and Abilities of an Institution's Residents that Receive the Most Attention from Social Workers

Predominant Statements	Number of Respondents Agreeing to the Statement
Personal wishes and requests	**9**
Support of spiritual tranquillity	6
Ensuring dignity	**11**
Need of personal space	**10**
Support for the ability to sow, knit (do handicrafts)	5
Support for the ability to draw and paint (engage in creativity)	5
Support for the ability to do small practical wood work	4

Table 4 provides predominant statements about personal needs and abilities of institution's residents that received the most attention of social workers. According to the number of respondents agreeing to the statement we can see that social workers pay most attention to *ensure residents' dignity* (every resident is met with respect, understanding, sensitivity), *the need for private space* (there is no unnecessary interruption, opportunities are made for everyone to manage according to their own abilities, the right to private space is ensured and acknowledged), *personal needs and requests* (acknowledgement of a right to choose and making sure there are opportunities to do what they favour).

Social workers shared their opinions:

"As it is said for those living in "government institutions" there is nothing more hurtful than disrespect, viewing a disabled person down, ignoring them" (D6);

"I cannot comprehend how I could and what right I would have to not value, single out, not try to understand a person that I must help" (D9);

"I pay most attention towards that out residents felt dignified all the time – surrounded by positive emotions, understanding, not humiliated by any chance" (D16).

Having (need of) a private space helps to remain dignified:

"I talk with every new resident about how he wants to live, whether or not he will be restricted by the fact that he will have to live another person and some are happy not to live alone" (D5); *"We must provide such conditions for every resident that he could have at least a small space in a room where he could feel comfortable, peaceful and could enjoy doing what they like"* (D13).

A bit less attention is focused on personal needs and requests because they are faced every day and there are quite a lot of them. Usually a request is for a concrete service:

"Almost every day one or another resident asks for this or that, for example, to buy something if they cannot go to the city themselves" (D6).

Supporting abilities is one of engagement forms so social workers help residents engage in what they like: *"I buy thread, colours, other materials needed for handicrafts... all social workers do that"* (D10).

In summary it can be said that social workers of social institutions pay most attention to environment where clients live so that they feel dignified and safe, then personal needs and requests are satisfied and abilities supported.

In a social institution engagement activities are affected by the fact that often residents due to various reasons cannot independently choose type, forms or content of activities so it is necessary to provide conditions to try various engagement areas, to find out what they are interested in, what they can do (Biliuvienė, Jasevičienė, 2015).

Respondents told about their achievements when modelling engagement of institution's residents and what goals they set seeking better results of engagement activities (see Table 5).

Table 5

Evaluation of the Most Significant Achievements when Modelling Engagement of Institution's Residents

Predominant Statements	Number of Respondents Agreeing to the Statement
Involvement of the most institution's residents in event participation	**16**
Gathered institution's "active residents" nucleus that plan and offer engagement activities	6
Establishment of preventative groups about the risks of addictions	4
Communication with specialists of other institutions when sharing the good experience of engagement organizing	**12**
Project activities dedicated for organization of purposeful leisure engagement	**10**

After analyzing answers of respondents the most significant statements were distinguished based on which better results of engagement modelling can be sought after. Respondents said:

"I am glad that more and more residents of "our home" participate in events" (D8);

"We do not need to promote especially, the hall is always full" (D9);

"I think I did my part so that there are no empty seats in events, we need to talk to everyone, not leave them behind" (D12).

Wisdom and flexibility are needed to reach the goal so social workers communicate with staff of similar institutions, share their good experience, visit each other, exchange event programs. Active involvement in project activities gives positive results because the money received allows to invite amateurs, interesting lecturers and others to events.

"For the project funds we organized a two-day health event – sport specialists taught how to exercise, how to improve health with the help of exercise" (D3);

"I invited a dietician who cooked together with residents various meals and discussed" (D11).

Specialists advise that the only guaranteed way to find out that people need – to ask them. There can be no intrusion of different opinions or coercion. Institutions form "active resident" nucleus that help to plan, offer engagement activities:

"I do not do anything without consulting residents, I hear their suggestions, requests" (D14);

"Every opinion of [residents] is important, then I say my own" (D4);

"Active residents are serious helpers, they have friends and acquaintances, connections that they cleverly use when we organize events and festivals..." (D9).

Doing nothing often becomes a purposeless time wasting. Especially men in such cases start to smoke, abuse alcohol, have conflicts. Establishment of preventative groups about risks of addiction – one of the new engagement forms when satisfying needs is combined with usefulness:

"I invited a policeman for a talk from Telšiai. He told about problems of drunk persons both in families and in public places, about drunk driving dangers in the roads. There were no morals or threats, only a humane, simple and understandable conversation" (D15);

"At least once a year I try to organize a meeting with specialists who talk about various threats that become addictions and ruin a person's life, about drugs, abusing medicine, addiction to buy, hoard unnecessary things and so on" (D12).

Researcher was interested in what Ukrainian social workers can tell about the most significant work achievements. Their answers were very short:

"Here [in the institution] everything happens naturally, free time is a free choice of people";

"Organization of engagement needs specialists who would know how to work with disabled."

In summary we can say that in Independent living homes social workers put a lot of effort so that residents' engagement was as interesting and varied as possible so they are not satisfied by usual work forms, they look for more significant versions of activities. Significance of engagement modelling is created by connections of social workers with institution's residents in trying to involve them in search of purposeful life in the institution.

Appropriate engagement modelling in a social institution can be an example of a good experience to other similar institutions where persons with various health problems live.

According to Myers (2010), communication of those having disabilities and ability to engage together with peers and other persons is very important because it strengthens a person's self-esteem and self-sense.

Respondents shared their thoughts about *who they communicate with outside the institution in improving engagement activities, what kind of help and from where they receive it* (see Table 6).

Table 6

Evaluation of Communication and Need for Help when Improving Engagement Activities

Predominant Statements	**Number of Respondents Agreeing to the Statement**
With staff of the cultural centre of the city's municipality	7
With staff of the parish	**16**
With the community of the village	**16**
With staff of the region and other region's senior care homes	**16**
With organizations of Caritas and the Red Cross	2
With students of social work	4
With school communities	6

Based on given answers it can be seen that all respondents agreed with these statements – they communicate with *staff of the parish, village community, staff of their region and other region's senior care homes.*

Opinions of social workers allow to evaluate the need of collaboration and help in these cases when Independent living homes are in the territory of a region (village):

"Our independent living homes are quite far away from the city so we simply must communicate and collaborate with the closest helpers – staff of the parish and village community" (D3);

"As I said, we cannot "fall out of context", we are not isolated from people so we invite village community to events, and parish staff helps us when filling documents" (D9).

"We are a subdivision of senior care home of our region so communication and collaboration is direct and continuous, we are given all needed assistance" (D11).

There is a little bit less communication with the city's culture centre, with Caritas and the Red Cross organizations, with school communities:

"Activities of the culture centre are more dedicated to youth so not always it is possible to find compromises, e.g. senior dance group cannot be invited because our hall is too small and it does not fit the choirs..." (D7); *"There is no more school nearby, only kindergartens and older students do not show a big wish to come visit us"* (D6).

Based on respondent answers we can see that students of social work are not fully employed who would find such collaboration with social institutions the best practical experience:

"We used to receive students more often, they used to come with such beautiful programs, knew how to communicate with every resident, they used to wait for the students... now these connections have waned" (D8);

"Changes happening in the education system have affected the inter-institutional collaboration, it turns out that some colleges have stopped working, there are less social work students... it is a pity" (D13).

We can say that social workers in independent living homes model engagement activities (improve) by being open to help and collaboration outside the institution, so better work results are expected. In specialists' opinion, it is very important to keep connections with the closest environment and institutions functioning in it. Inter-institutional connections are being strengthened and they help to improve engagement activities.

According to Paulavičiūtė (2008), criterion of a rational free time use is a social responsibility – the more responsibly a person uses one's time, the more he is mature as a person. So perception of engagement is inherent of purposeful education of a person and deployment of social/cultural needs and skills, and lack of engagement (or inability to rationally use time on hands) can be called a social problem.

The last interview question asked about *how institution's residents react to organization of engagement in the institution, how they involve residents in engagement activities* (see Table 7).

Table 7

Evaluation of Residents' Reactions to Engagement Modelling in the Institution

Predominant Statements	Number of Respondents Agreeing to the Statement
Favourable attitude towards held activities	**9**
Agreement to held activities	**10**
Careful and shy attitude towards everything in the environment	7
Being unsure of themselves to participate	5
Promotion, motivation is necessary	**12**
Complete disconnection with what happens in the institution	3

Social workers constantly observe and see how institution's residents react to engagement activities. That is illustrated by respondents' opinions because such predominant statements as these are distinguished: *necessary promotion, motivation, agreement to held activities, favourable attitude to held activities:*

"Even though the hall is full during events, we still need to promote and motivate – promise that the next time it will be even more interesting, more fun and so on" (D9);

"In essence it can be said that I receive agreement with what I do because no one disagrees straightforwardly but maybe they talk behind my back... it would be better if they said it to my face what they do not like" (D8);

"I can confirm that most institution's residents are benevolent, value my efforts, and sometimes they pity, say that so much work is needed" (D15).

Even though engagement helps to fight disabilities and can overcome various negative emotions, loneliness, boredom, sense of meaninglessness (salami, 2010), there are such institution's residents who are not sure of themselves, careful, doubt or refuse to participate in engagement activities:

"Usually they say, what am I going to do there, What am I going to see, do not want to..." (D2);

"When I invite them, they promise to come quietly but do not come, do not do what I asked them. They lack self-esteem and trust in others, ungrounded carefulness wins" (D14).

It happens that people who moved to social institutions do not engage in any activities. Reasons can be various: some residents cannot deal with their unfamiliar environment or motivate by their health problems (Zaborskienė, 2011). Respondents said:

"There are a few who do not want anything, they find it enough to watch TV, talk among themselves" (D5);

"Out of all residents only five categorically refuse to involve in institution's life and reasons are simple, they say they know how to engage themselves and have what to do. Nobody can make them against their will" (D13).

When researcher tried to find out how Ukrainian social workers evaluate their work she heard:

"We should ask everyone whether they are satisfied with our work or not"; "I have not asked and evaluated clients' reactions"; "Everything [in the institution] is good, [residents] live well, everything about them is done right, [they] do not have any complaints about anything."

In summary it can be said that it is important for social workers what reaction of residents towards engagement modelling prevails. It is observed that residents react differently but that is a normal reaction because participation in engagement organizing is a free choice. Even though reactions of institution's residents to engagement organization differ, they are not antagonistic. Residents choose engagement activities freely but there are residents who need motivation, promotion, convincing. Part of residents do not want to participate in engagement activities.

2.4.2. Evaluation of Attitudes of Residents Living in a Social Institution towards Engagement Modelling

Subjective evaluation of one's situation is significant to person experiencing disability because only he can say how his life is affected by the disability, what consequences it caused, what attitude to changed life is now, spending time (Kreivinienė and Vaičiulienė, 2015; Krutulienė, 2012; Rėklaitienė and i.e., 2011).

Residents of independent living homes shared their thoughts about *how long they live in the institution and what helped to choose the current living place* (see Table 8). 1 category was distinguished: *help to choose a current living place.*

Table 8

Choosing the Current Living Place

Category	Subcategory	Illustrating Statements
Help choosing current living place	Staff of care and curatorship	*"Institutions helped" (G1,G14);"Government people helped" (G3)*
	Relatives	*"Daughter" (G2, G6); "Sister" (G16)*
	Independent choice	*"I decided myself" (G4, G8,G9,G10, G12, G15)*

Based on data collected during the study it was found out that most respondents chose

a social institution – independent living homes – voluntarily and independently themselves. Others received help from relatives or were referred to by appropriate institutions.

Sometimes life circumstances make force people to choose a living place, e.g. *"A fire happened and I ended up here"* (G7).

Respondents said that they have spent different amount of time in a social institution – *from 1 month to 4 years.*

Given a similar question to institution's residents in Ukraine, they told: *"Medical staff advised"; "Social services referred"; "City municipality managed documents."*

In summary it can be stated that people reside in independent living homes by their own choice and/or with the help of relatives and after reference from care staff. Often choices to live in a social institution are affected by individual needs – some persons want to stay independent as long as possible and request only minimal help, while others need constant assistance.

It is not easy to decide to live in a social institution – a person who made this decision lives through a difficult time because the conviction is still quite alive saying that a person residing in an institution loses independence, connections with relatives, cannot satisfy all personal needs and so on (Žalimienė, 2007).

Respondents were asked how *they feel in the institution, what they do in their free time* (see Table 9). 2 categories were distinguished: *evaluation of life in the institution and leisure.*

Table 9

Feelings and Leisure Activities in the Institution

Category	Subcategory	Illustrating Statements
Evaluation of life in the institution	Life is good	*"Good" (G14, G8, G3), G7, G2); "I feel great" (G9)*
	Life is normal	*,,Normally" (G15, G10, G1);*
Leisure activities	Reading	*"I engage in reading" (G1); "I read books" (G8, G9, G13, G15)*
	TV shows	*"I watch TV" (G5, G10, G11);*
	Cooking	*"I cook for myself" (G3)*
	Being outdoors	*"I walk outside" (G2, G16)*
	Making handicrafts	*"I knit, make flowers" (G6); "I knit" (G16)*
	Communication with other residents	*"I communicate with those living here" (G2, G14)*

Analysis of resident answers shows that living in independent living homes everyone feels *good* or *normal*. Their feelings living in the institution respondents named as this: *"I sit as if I was waiting for something..."* (G12); *"It is still early to decide how I feel [lives for only a month and a half]"* (G11); *"I am very grateful to God and destiny for living here"* (G4).

Respondents spend their free time in various ways: read, watch TV shows, go outside, do handicrafts, communicate with other residents.

In conclusion, positive feelings of life in an institution are stated by most residents of independent living homes and they relate spending their time freely with a free choice to engage. Residents of social institutions positively evaluate their current life and think that they have opportunities to spend their free time as they wish. Actually, leisure engagement services should not make a person more dependent on the institution.

It is stated in the world report on disability (2014) that persons with disabilities can and should stay independent as long as possible, have an opportunity to choose, be free and independent as other people.

Respondents shared their opinions about what their level of independence is and whther they can engage in what they were used to (see Table 10). 2 categories were distinguished: *level of independence and opportunities of keeping earlier engagement activities.*

Table 10

Level of Independence and Opportunities to Keep Engaging in Earlier Activities

Category	Subcategory	Illustrating Statements
Level of independence	Lower than norm	*"My independence level is the first" (G2, G15);"I have about 35 percent independence" (G11)*
	Moderate (partial)	*"...third level" (G3)*
	Independent	*"I am fully independent" (G9); "I am independent" (G16)*
Opportunities to keep earlier activities	Disability limits	*"I cannot anymore due to physical disabilities" (G6), "Disorders of old age do not permit anymore" (G8)*
	Can partially engage	*"I can but I do not want anymore" (G4); "I cannot work because I am retired" (G9)*
	Cannot engage	*"What I used to do I cannot anymore" (G2, G3); "Not possible anymore" (G11)*

Based on answers of respondents about levels of independence it was found out that there are not many fully independent residents in the institution, most of them have moderate or severe disabilities. Current disabilities limit opportunities to engage in what they used to before moving to the institution.

In separate cases (examples of respondents G4 and G9) residents could work as earlier but they do not want active work activities or it makes more sense to receive retirement money because a bigger wage is not expected.

In conclusion it can be said that due to disability reduced independence is the main reason why residents of independent living homes cannot engage in what they used to earlier. There are exceptions but they are not dominating.

A person's convictions, traditions, established life rhythm and order, education, social status, personal value perception and other have a lot of significance for those living in a social institution (Vaškevičiūtė, Naujanienė, 2011).

So it was interesting to learn from residents themselves *what new they found out (learned) living in an institution* (see Table 11).

1 category was distinguished: *new knowledge and experiences.*

Table 11

New Experiences and Knowledge Gained Living in a Social Institution

Category	Subcategory	Illustrating Statements
New knowledge and experiences	More knowledge about services to disabled people	*"I learned a lot, what services I can get" (G2); "About the variety of services" (G3); "How to keep my health" (G12)*
	Patience and feeling of community	*"I learned to be patient" (G4); "I am sharing my experience with others" (G6); "I am part of a group" (G10); "To live next to various people and to not show my ambitions" (G15)*
	Adaptation to life in the institution	*"I do not express my opinion so much because not everyone understands it"(G5); "I understood that I also have to keep cleanliness, tidiness" (G9)*
	New friends	*"I found new friends, we do things together" (G8)*
	Opportunity to participate in various entertainment	*"I can have fun, participate in everything that is happening" (G13)*
	Nothing new	*"Nothing so far" (G11); "Nothing new" (G14, G16)*

Analysis of respondent answers shows that part of institution's residents did not have enough information earlier about services provided to the disabled and opportunities to use them. A part of respondents are happy to have found new friends and a new opportunity to participate in events. New experiences are important to institution's residents because they had to learn life in a communal home with strange people, learn patience, tolerance, friendliness and so on. There were those who said that they did not learn anything new (G11, 14, 16).

In conclusion it can be stated that Independent living homes try to explain residents their rights and opportunities to use all services meant for disabled people. Residents changed lifestyle and a new need to change, adapt to others, keep rules call new experiences and knowledge.

It is clear that it is not their aspiration to learn something new in the institution but they find it important to adapt to life in the institution.

Mačiulis et.al. (2012) life in a social institution call an important life change that is evaluated differently. It is often thought that institution's residents are restricted so their opinions about freedom to move are important.

Respondents talked about *how often they can go outside of the institution, where they go, what they do* (see Table 12). 2 categories were distinguished: *frequency of excursions and their purpose.*

Table 12

Opportunities to Go Outside the Institution

Category	Subcategory	Illustrating Statements
Frequency of excursions	Often	*"I often go to the city" (G9); "I often go places in the summer" (G10)*
	Rarely	*"Almost never" (G1); "Only in need" (G7); "There is no money" (G12)*
	Based on need	*"I can whenever I want" (G2)*
Purpose of excursions	To see a doctor	*"To doctors" (G1);"Only to doctors" (G16)*
	To see relatives	*"I go to see relatives" (G3); "To my sister" (G14); "...to my children" (G15)*
	To see friends and acquaintances	*"I go to see my friends" (G4)*
	Nature	*"I go fishing or mushroom picking" (G5)*
	To religious festivals	*"I go to religious festivals" (G8)*

Respondents said that they can go outside the institution whenever they want, their freedom is not limited by anything and they do this when they want – some more often, others more rarely, based on personal needs. Purposes of these outings are different and the main ones are related to the need to visit medical institutions, relatives, friends. Nature lovers can go fishing, berry picking, mushroom picking, walk around the area. Religious ones visit religious festivals individually or with peers.

Researcher asked some Ukrainian residents of a social institution about opportunities to go outside the institution and they said:*"Those who can, have energy and health, we freely do our business ourselves"; "I miss my former co-workers, so sometimes I visit them."*

In conclusion it can be said that residents of Independent living homes can go outside institutions based on their needs. They usually go to see doctors, relatives, friends. However, respondents do not fully use their free time because not even one noted that they go to city festivals, concerts, exhibitions, other cultural events. An assumption can be made that cultural needs of respondents are low or that they are limited by financial resources because most events are not free.

According to Paulavičiūtė (2008), criterion of a rational free time use is a social responsibility – the more responsibly a person uses one's time, the more he is mature as a person. So perception of engagement is inherent of purposeful education of a person and deployment of social/cultural needs and skills, and lack of engagement (or inability to rationally use time on hands) can be called a social problem. So respondents were asked *whether there are enough activities for them as residents of the institution, what else they would like to do* (see Table 13). 1 category was distinguished: *evaluation of activities.*

Table 13

Evaluation of Activities in the Institution

Category	Subcategory	Illustrating Statements
Evaluation of activities	Enough activities	*"Enough activities" (G2, G3); "Enough" (G7); "Fully enough" (G16)*
	Nothing new is needed	*"There is nothing new I want to engage in" (G5, G6); "Not everybody is interested" (G13)*
	There are not too many activities	*"Although there could be more" (G8); "They should participate more actively" (G15)*
	Not enough activities	*"There is never too much to do" (G10); "Some people need more" (G11)*

It can be seen from answers of respondents that opinions differ: some find enough activities, others think that there could be more. Opinion differences can be explained by different personalities and health conditions. Nobody answered the second part of the question, so the attempt to find out what residents would like to engage in additionally was not successful.

Residents of social institutions answered the given question very vaguely, they did not give details and did not name concretely any activity that they like, did not talk about what else they would like to engage in. We can state that respondents are satisfied with activities happening in the institution and do not talk about what else they would like because older people and having disabilities people view the future with care and do not tend to plan new things.

Job of a social worker covers ability to communicate (interact), to evaluate problems and abilities of a client, to combine existing resources with needs of clients. Next to gained practical skills personal qualities of a social worker also have influence, their ability to always be next to client and to help them (Makštutytė, Vaškevičiūtė, 2011).

Respondents were asked to share their opinions about *how they get along with institution's staff* (see Table 14). 1 category was distinguished: *evaluation of communication with the institution's staff.*

Table 14

Evaluation of Communication with a Social Institution's Staff

Category	Subcategory	Illustrating Statements
Communication with institution's staff	Get along well	*"Communication is good" (G1); "We get along O'K" (G2); "Good enough" (G14)*
	Honest communication	*"All staff are good and honest" (G4)*
	Understanding communication	*"Staff are great, they understand us" (G8); "...try to understand" (G9)*
	Normal communication	*"We communicate normally, like civil people" (G11);"I assess it as normal" (G15)*

Analyzing answers of respondents it was found out that there are not any bigger problems for residents of a social institution to communicate with staff – they get along well or normally. In residents' opinion, staff is sincere and understanding with them.

Residents of social institutions said that communication with staff is based on understanding, sincerity, sensitive reactions to residents' problems. It can be said that such relationships with staff residents define as friendly both ways and kind.

Even though it is already aspired to have clarity, kindness, humaneness, tolerance and democracy of relationships in a social institution, there still was an expectation to receive suggestions and requests. Respondents were asked to share thoughts about *requests and suggestions on how to live more interestingly and more meaningfully despite health problems* (see Table 15). 2 categories were distinguished: *requests and suggestions.*

Table 15

Requests and Suggestions

Category	Subcategory	Illustrating Statements
Requests	Tidying and improving environment	*"Request to clean the pond because it creates pollution and spoils environment" (G10)*
Suggestions	Improving infrastructure	*"I would suggest to make a slide for the winter, not for us but for children, they would come and we would watch them" (G9); "To make paths for walking" (G11)*

It is visible from answers received that requests and suggestions of residents are not related to a wish to live more interestingly and more meaningfully and they are more related to environment of the institution, its management, tidying, improvement.

Residents of independent living homes say that they have enough and are satisfied with everything, engagement activities satisfy them, they only need health, then there would be more willingness to do everything and more opportunities to participate. We can say that residents of social institutions are satisfied with held activities. They find it more important to remain healthier and independent.

Conclusions

1. Life quality of disabled persons depends not only on their disability but also from adapted environment, support of relatives, social relationships on an institutional level, opportunities to participate in leisure and engagement activities, satisfaction of personal needs, subjective assessment of their life quality.

2. By the help of constructive social services' system persons are given back their ability to care for themselves and to integrate in society, they are motivated to live a full quality life, bigger social problems are prevented.

3. Effective engagement activities are organized in social institutions where moral, enthusiastic, supportive and satisfaction aspects dominate.

4. After analyzing attitude of specialists towards engagement modelling it was established that observed changes in social institutions are focused on increasing well-being of clients' lives based on levels of disabilities and needs. The most attention is paid to safe and adapted environment of clients, satisfaction of personal wishes and requests, support of abilities. Social workers performing their work duties not only provide specific assistance but also establish their profession in the society, foster and promote perception of values. Aspiration of professionalism manifests especially through organizing engagement because during such activities both residents and staff are engaged.

After analyzing attitude of institution's residents towards engagement modelling it was established that choice to reside in Independent living homes was determined the wish to stay independent for as long as possible, to have opportunities to spend their free time based on their interests and activities enjoyed previously. Residents are satisfied with offered activities but their needs for new engagement are minimal. Residents do not reveal any specific requests or suggestions about more interesting and more meaningful engagement and they relate their biggest aspirations with better health condition.

Literature

1. Anča, G., Neimane, I. (2014). *Practical Manual for Target Groups "How to Recognize and Communicate with People Having Disabilities."* Riga.
2. Andrašiūnienė, M. (2007). *Dictionary of Social Work Terms*. Vilnius: Ciklonas.
3. Andrijauskienė, L. (2015). *System of Social Services in Lithuania in the Context of Modernizing Public Management.* Doctoral Dissertation. Vilnius: Mykolas Romeris University
4. Aperavičienė, G. (2009). *Social Work with Families of Social Risk*. Vilnius: Kronta.
5. Arun, M. P., Bharath, S., Pall, P. K., Singh, G. (2011). Relationship of Depression, Disability, and Quality of Life in Parkinson's Disease: A hospital-based Case-control Study. *Neurology India*, vol. 59, issue 2.
6. Bagdonavičienė, N. (2015). *Problem of Activeness of Old and Senior People in Situations of Disability in Care Homes: Aspect of Social Work.* Master's Thesis. Šiauliai.
7. Barker, R. N., Kendall, M. D., Amsters, D. I., Pershouse, K. J., Haines, T. P., Kuipers, P. (2009). The Relationship between Quality of Life and Disability across the Lifespan for People with Spinal Cord Injury. *Spinal Cord 47*, p. 149–155.
8. *General Guidelines of Europe's Transition from Institutional to Communal Provided Care* (2012). Brussels.
9. Berg – Weger, M. (2010). *Social Work and Social Welfare.* London: Routledge.
10. Bitinas, B., Rupšienė, L., Žydžiūnaitė, V. (2008). *Methodology of Qualitative Research*. Klaipėda: College of Social Sciences.
11. Biliuvienė, A., Jasevičienė, Z. (2015). *Organizing Engagement of Clients when Providing Assistance at Home. Professional Studies: Theory and Practice.* 15, p. 48 – 55.
12. Bitinas, B., Guogis, A., Migun, L., Važgytė, G. (2010). Improvement of Administration of Social Services in Lithuanian Municipalities: Case Study of Vilnius and Varėna Regions. *Social work,* 9 (1), p. 18 – 26.
13. Bond, J. (2007). *Ageing Society: an Introduction to Social Gerontology*. London.

14. Borsbo, B., Peolsson, M., Gerdle, B. (2009). The Complex Interplay between Pain Intensity, Depression, Anxiety and Catastrophising with Respect to Quality of Life and Disability. *Disability and Rehabilitation 31(19)*, p. 1605–1613.

15. Braakenburgas, H. (2001). Social Work Quality Management in the Netherlands: Principles and Attitude. *STEPP, 10*.

16. Browne, T. (2012). *Social Work Roles and Health-Care Settings*. New Jersey.

17. Burke, W. W. (2008). *Organization Change: Theory and Practice.* Thousand Oaks, CA: Sage.

18. Coppock, V., Dunn, B. (2010). *Understanding Social Work and Mental Health*. London: Sage.

19. Dolgoff, R., Loewenberg, F. M., Harrington, D. (2008). *Ethical Decisions for Social Work Practice*. Gengage Learning.

20. Dunajevas, E. (2009). What is Social Work. *STEPP: Social Theory, Empiricism, Politics and Practice,* 5, p. 17 – 28.

21. European Economic and Social Committee (2011). Brussels.

22. Giddens, A. *Sociology.* Vilnius, 2005.

23. Grobman, L. M., Bourassa, D. B. (2012). *Days in the Lives of Gerontological Social Workers: 44 Professionals Tell Stories From "Real-Life" Social Work Practice With Older Adults*. Harrisburg, PA: White Hat Communications.

24. Gudžinskienė, V., Mačiuikienė, D. (2011). Assessment of Assistance Provided by Social Workers to Senior Persons Living in Social Care Homes. *Social Education*, 15.

25. Gvaldaitė, L. (2009). Enabling in Social Work. *STEPP*, 5, p. 42 – 53.

26. Hays, R. D., Reeve, B. B. (2008). Measurement and Modelling of Health-Related Quality of Life. *International Encyclopaedia of Public Health*, p. 241–252.

27. Išoraitė, M. (2005). Administration of Social Services. Vilnius: Mykolas Romeris University.

28. Jonavičius, L. (2010). *The Structural Influence of External Factors on the Transformation of Post – Soviet Regimes: Cases of Ukraine and Georgia. Summary of Doctoral Dissertation*. Vilnius.

29. Johnson, L. C. (2001). *Social Work Practice. General View*. Vilnius.

30. Kardelis, K. (2007). Methodology and Methods of Scientific Research. Kaunas: Technology

31. Kern, D. (2010). *Social Pedagogy and Older People in France*. Bremen: Europaischer Hochschulverlag GmH and Co.

32. Kriščiūnas, A. (2015). Disability and Attitude towards it in Modern Society. *Health Sciences,* 1, p. 5 – 14.

33. Krutulienė, S. (2012). Life Quality: Defining the Concept and Relationship with Terms of Good Life. *Culture and Society,* 3 (2), p. 117 – 130.

34. Kudukytė – Gasperė, R., Jankauskienė, D., Štaras, K. (2013). Integration of Health and Social Services. *Politics and Management of Health,* 1 (4), p. 127 – 146.

35. Lazutka, R., Poviliūnas, A. (2013). *Recommendations of the European Commission about Assessment of Active Involvement Realization: Research of National Strategies.* Vilnius, VU Publishing House.

36. Leliūgienė, I., Gailevičiūtė, R., Bajorienė, A. (2013). *Organization of Educational Cultural Activities for Residents of Care Homes. Science and Educational Processes*, 2 (17), p. 14 – 27.

37. Lithuanian Republic Social Protection and Work Minister's 2006 April 5th Act No. A1-92 "About Qualification Requirements of Social Workers and Social Work Assistants, Training of Social Workers and Social Work Assistants and Confirmation of Description of Procedure of Certification of Social Workers" (2011-01-07 Edition). *State News*.

38. Lukamskienė, V., Budėjienė, A. (2013). Social Services for Senior Persons: Aspects of Self-Help and Social Care. *Gerontology, 14 (4),* 228 – 234.

39. Mačiulis, V., Stigienė, S., Buginytė, A., Mickienė, F. M. (2012). Assessment of Service Quality, Specialists' Work and Environmental Factors of Republic Vilnius Psychiatric Hospital. *Health Sciences,* 1, p. 5 – 14.

40. Magnuson, F. (2014). Reshaping Eldercare Towards new Pofessions. *Social Work,* 13 (2), p. 179 – 191.

41. Makštutytė, R., Vaškevičiūtė, L. (2011). Professionalism of a Social Worker in the Aspect of Communication Competence. *Social Work. Experience and Methods,* 8 (2), p. 23 – 37.

42. Masaitienė, D. (2010). *Analysis of Social Work Assistants'' Activities of Retiring Homes*. Master's Thesis. Kaunas: VDU.

43. Maslow, A. H. (2009). *Motivation and Personality.* Vilnius: Apostrofa.

44. Miežytė – Tijūšienė, M., Bulotaitė, L. (2012). Social Activeness and Psychological Well-being of People of Retiring Age. *Gerontology*, 13 (4), p. 199 – 205.

45. Mikelionienė, R. (2009). *Leisure Organization of Senior Persons in Lazdijai Region Care Institutions.* Master's Thesis. Vilnius.

46. Mikulionienė, S (2012). *Main Problems of Senior People's Activeness in Lithuania.* Vilnius: MRU.

47. Myers, D. G. (2010). *Psychology.* New York: Worth Publishers.

48. Motiečienė, R., Naujanienė, R. (2011). Social Work with Families of Social Risk: Critical Reflection of Experiences of Clients and Social Workers. *Social Work. Experience and Methods*, 7(1), 19-31.

49. Study of Opportunities in Lithuania of Adaptation and Realization of Norway's Experience in Non-stationary Social Services (2010). Vilnius.

50. Payne, M. (2009). *Adult Services and Health-related Social Work*. New York: Palgrave.

51. Paterson, K., Hughes, B. (2000). *Disabled Bodies, in the Body, Culture and Society: An Introduction.* Buckingham: Open University Press.

52. Paulavičiūtė, A. *ABC of Event Organization.* Vilnius, 2008.

53. Pierson, J. (2008). *Going Local Working in Communities and Neighbourhoods*. New York: Routledge.

54. Pūras D. (2000). *About Mental Health and its Disorders.* Vilnius.

55. Račinskaja I. (2015). Challenges of Globalization and Provided Opportunities for Engagement Conditions in European Union Countries. *Business in the XXI century*, 2, p. 52 – 62.

56. Raudeliūnaitė R., Buškevičiūtė E. (2014). Work Features of Social Workers when Providing Social Services in Health Care Institutions: Analysis of Experience of Social Workers. *Social Work*, 13 (2), p. 204 – 220.

57. Reker, G. T., Woo, L. C. (2011). *Personal Meaning Orientations and Psychosocial Adaptation in Older Adults*. London: Sage.

58. Remeškevičiūtė, M. (2015). Most Important – Communication and Ability to Actualize Oneself. *Šiauliai plus, November 11th.*

59. Rimkus, V. (2010). *Social Support.* Klaipėda: KU Publishing House.

60. Ruškus, J. (2002). *Phenomenon of Disability*. Šiauliai: Šiauliai University Publishing House

61. Rūdytė, K., Tamosinaitė, I., Ramonaitė, V. (2013). Subjective Assessment of Participation in Engagement Activities of Persons Having Physical Disability. *Professional Studies: Theory and Practice,* 1 (11), p. 101 – 108.

62. Sadauskas, J., Leliūgienė, I. (2010). Structure of A Social Worker's Competence to Act in a Community. *Social Work,* 9 (2), p. 56 – 63.

63. Salami, S. O. (2010). Retirement Context and Psychological Factors as Predictors of Well-being among Retired Teachers. *Eur J Psychol*, 2, p. 47 – 64.

64. Independent Living Homes – Opportunity to Create One's Own Life (2015). *Friendship*, 20.

65. Sirgy, M. J., Michalos, A. C., Ferris, A. L., Easterlin, R. A., Patric, D., Pavot, W. 2006. The Quality of Life (QOL) Research Movement: Past, Present, and Future. *Social Indicators Research* 76, p. 343–466.

66. Report of Social Protection and Work Ministry's Activities (2014). Vilnius.

67. Catalogue of Social Services (2006).

68. Staškutė, I. (2014). Concept, Observation and Assessment Methods and Significance of Life Quality Related to Health. *Politics and Management of Health*, 1 (16), p. 7 – 19.

69. Smeaton, D., Vegeris, S., Sahin – Dikmen, M. (2009). *Older Workers: Employment Preferences, Barriers and Solutions. Equality and Human Rights Commission Research Report,* 43.

70. Sutton C. (1999). *Social Work, Community Activities and Psychology.* Vilnius: VU Laboratory of Special Psychology.

71. This Autumn Quality of Social Care Providers in England will be Evaluated. www.anglija.today/socialinė-raida. Žiūrėta 2016 06 12.

72. Šinkūnienė, J. R. (2005). Leisure Studies and Administration of Recreation. *Social Work*, 4 (1), p. 122 – 130.

73. International Classification of Functionality, Disability and Health. World Health Organization (2001). Geneva.

74. Thornicroft, G., Tansella, M. (2008). *Better Mental Health Care.* Cambridge University Press.

75. Vaškevičiūtė, L., Naujanienė, R. (2011). Decision of Senior People to Live in Long-term Care Homes. *Bridges,* 2, p. 107 – 124.

76. Večkienė, N. P., Brunevičiūtė, R., Saulenienė, S., Ražanauskaitė, V. (2011). Interdisciplinary Communication in the System of Health Care. *Professional Studies: Theory and Practice* 8, p. 308 – 317.

77. Viluckienė, J. (2010). "Disbodied" Concept of Disability of Social Model. *Philosophy. Sociology*, t. 19, 4, p. 45 – 52.

78. Vyšniauskienė, D., Minkutė, R. (2008). Professional Ethics of Social Work. Kaunas.

79. Williams, G. (2002). *The Sociology of Disability: Towards a Materialist Phenomenology, in Disability Reader: Social Science Perspective*. London: Cassell.

80. Zaborskienė V. (2011). *Subjective Experiences of Senior Persons Living in Care Institutions. Master's Thesis.* Kaunas.

81. Žalimienė, L. (2003). *Social Services.* Vilnius: VU Laboratory of Special Psychology

82. Žalimienė, L. (2006). Standardizing Social Care Services for Senior People. *Gerontology*, 8 (1), p. 44 – 54.

83. Žalimienė, L., Skučienė, D., Junevičienė, J., Gataūlinas, A. (2013). *Professional Well-being in the Sector of Social Work in Lithuania.* Vilnius: Lithuanian Social Research Centre

84. Žalimienė, L., Lazutka, R. (2009). Social Care Services in Lithuania: from Hierarchal to Mixed Care Economic Model. *Money Studies*, 2.

Summary

APPENDICES

Appendix 1

Questionnaire for Social Workers

1. How many years have you worked in the institution and what main things changed in the institution over the last 5 years?
2. How would you define your as a professional social worker functions working in this social institution?
3. What activities do you do in this institution when organizing engagement for persons having disabilities?
4. How many persons do you work with? How many of them are partially independent or independent?
5. What personal needs and abilities of institution's residents do you pay most attention to?
6. What are your most significant achievements when modelling engagement of residents and what goals do you set in seeking to achieve better results of engagement?
7. What do you collaborate with outside the institution in order to improve engagement activities? What assistance do you receive and where does it come from?
8. How do institution's residents react to organization of engagement in the institution? How do you involve them in engagement activities?

Appendix 2

Questionnaire for Institution's Residents

1. How long have you lived in this institution? Who helped you to choose the current living place?
2. How do you feel in this institution? What do you do in your spare time?
3. What is your level of independence? Can you engage in activities you previously enjoyed?
4. What new have you learned since living here in this institution?
5. Tell me how often do you get to go outside this institution? Where do you go, what do you do?
6. In your opinion, are there enough activities for residents of this institution? What else would you like to engage in?
7. Share your opinion about how you get along with institution's staff?
8. Would you have requests, suggestions how it would be possible to live more interestingly and more meaningfully despite health problems?