

INPATIENTS' EXPERIENCES OF PSYCHIATRIC HOSPITAL CARE AND COERCION IN FINLAND

A Literature Review

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Abstract <p>Coercive measures and involuntary care have been a widely-discussed issue in psychiatric nursing. According to international research, patients' experiences of psychiatric care and hospitals are typically good, but coercive measures are largely criticized.</p> <p>The thesis examined previous research on patients' experiences in Finland by focusing on what kinds of experiences patients had had in Finnish psychiatric hospitals and how coercive measures had been experienced. The thesis also asked what practices were seen as coercive by Finnish patients.</p> <p>The study was a qualitative meta-analysis. The material consisted of six articles and dissertation studies from the years 1998-2014. They were examined by using thematic categorization and content analysis.</p> <p>Patients' experiences of care and coercion were divided in six categories which were present in the material: seclusion and isolation (both mental and physical), loss of communication, confiscation of property, restraints, daily routines at wards, and personal and emotional wellbeing.</p> <p>The findings showed that the biggest challenges in the Finnish psychiatric hospital settings were related to communication and patient-staff –relationships. Coercive methods were generally felt negative and humiliating, but according to the examined material, concrete, small practices can be taken to ease the patients' experiences and improve their autonomy.</p>		
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<p>Tiivistelmä</p> <p>Pakkokeinojen käyttö ja potilaiden tahdonvastainen hoito ovat olleet viime vuosina voimakkaan keskustelun kohteena psykiatrisessa hoitotyössä. Kansainvälisten tutkimusten mukaan potilaiden kokemukset sairaalahoidosta ovat verrattain hyviä, mutta pakkokeinojen käyttöä kritisoidaan laajasti.</p> <p>Opinnäytetyö tarkastelee aikaisempia tutkimuksia potilaiden kokemuksista Suomessa: millaisia kokemuksia potilailla on psykiatrisesta sairaalahoidosta Suomessa, millaisia tunteita hoitoon liittyy, ja miten potilaat kokevat erilaiset pakkokeinot? Opinnäytetyössä kysytään, mitkä toimenpiteet potilaat kokevat pakon käyttönä.</p> <p>Tutkielma on laadullinen meta-analyysi aiemmasta tutkimuksesta. Materiaali koostuu kuudesta artikkelista sekä väitöskirjatutkimuksesta vuosilta 1998-2014. Näitä on analysoitu teemakategorioiden ja sisällönanalyysin kautta.</p> <p>Potilaiden kokemukset on jaettu kuuteen aihe-alueeseen, joita materiaalissa esiintyy: eristäminen (sekä fyysinen että henkinen), kommunikaatiomahdollisuuksien puute, omaisuuden haltuunotto, sitomiset, päivärutiinit ja henkilökohtainen, tunnetason hyvinvointi.</p> <p>Työn vastaukset osoittavat, että suurimmat haasteet psykiatrisissa sairaanhoidon tilanteissa liittyvät kommunikaatioon ja potilas-henkilökunta -suhteisiin. Erilaiset pakkokeinot koetaan negatiivisina ja nöyryyttävinä, mutta materiaalin perusteella konkreettiset, pienetkin toiminnot ja muutokset voivat auttaa parantamaan potilaiden kokemuksia ja henkilökohtaista autonomiaa.</p>		
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1 Introduction

Psychiatric nursing is a vast, multi-dimensional field of study. Involuntary care, restrictive practices and coercive methods at mental hospitals have been one of the most discussed issues in what comes to care and good nursing practices (see eg. Välimäki 1998; Välimäki & al 2000; Sailas & Wahlbeck 2005; Suutala 1999). There are only few researches done on patients' experiences in Finland, and it is important to understand what the characteristics of Finnish mental health nursing are from the patients' perspective. This topic has been studied internationally to some extent, but not in a large quantity, and in Finland this topic is still quite new. It would be beneficial to know what kind of experiences patients have, and whether those experiences are similar in different studies and wards.

The background of this study is Mieli 2009-2015 -project, which is a national project for developing mental health care in Finland (see STM 2009). Mieli 2009 -project aimed at decreasing the number of seclusions and restrictions (later R/S) for the year 2015, and it is likely that the number of coercions has decreased, but it is still unclear how much. According to Keski-Valkama (2010) there was no decline in R/S numbers between the years 1990-2000, but the numbers of involuntary and in-ward care decreased from the 1990's at the same time with other changes in the health care system. Larger changes in social and health care, de-institutionalization, concentration on out-patient care with economic recession have diminished the number of hospital days, but it seems that after all

patients' involuntary hospitalization or use of coercive practices did not decrease despite the expectations at that time (Isohanni & al 2006; see also Latvala 1998, Kuosmanen 2009, 15-17; Salokangas 2013).

2 Concepts and the phenomenon

2.1 General aspects in psychiatric nursing

Psychiatric hospitalization, coercive measures and experiences about care have been largely discussed during the last years in Finland as well as in international context. However, there have been no studies on patient experiences in Finland till the last years (eg. Latvala 1998, 1). Patient-oriented research material in Finland is based on the few studies about the topic; there are few doctoral dissertations and other scientific studies about the subject (see review material of this thesis, appendix 1). Kaisu Hämäläinen (2014) who has done a case study about experiences of a coercion, has emphasized that collecting material was the hard part for carrying out a study about patients. This is an issue in all previous studies: there are only few of them.

In an international context it has been found out that patient experiences of mental care and hospitalization are rather good (Sibitz & al 2011; Priebe & al 2000) but coercion is seen mostly unnecessary and negative (Kuosmanen & al 2011). Soininen (2014, 11) has also pointed out, that experiences of involuntary care and psychiatric hospitals can be both positive and negative, and similar findings can be found in previous research. In some cases patients may experience coercive methods as more understandable if the treatment is explained and discussed afterwards (Holmes & al 2004; Soininen & al 2013). In that case experiences and feelings have to be analyzed and reasoned for the patient to deal with a problematic situa-

tion: why coercive methods were used and, if possible, offer a chance for a discussion with a team that was present in the situation. Duration of seclusion, reasons for it, and behavior of nurses have been the most problematic aspects for secluded and strained patients according to previous research (more Hämäläinen 2014, 11, 13).

So, findings about patient's feelings at psychiatric wards have shown contradictory results. It has been found that psychiatric patients seem to be rather satisfied with their care, but the use of coercive measures and communication with staff are dissatisfactory and criticized, (eg. Jenkins & al 2002), which may refer to nurses' and doctors' inability to confront extreme cases in patients and deal with the situation. Coercive measures are commonly criticized, but, on the other hand, alternative methods are seldom used by the staff. Old traditions, routines and care practices may prevent hospitals from developing more patient-oriented treatment methods. These aspects are present both in international and in Finnish studies as I earlier wrote (Keski-Valkama & al 2010; Meehan & al 2010).

2.2 Coercive measures

A change from inpatient hospital care towards out-patient care and towards patient independency has been a trend for the last decades in nursing (eg. Välimäki & al 2001, 722-723). Statistics show that an average amount of R/S methods are used in Finland compared to other European countries (Keski-Valkama 2010). Researches done in European countries have shown that the use of coercion does not differ remarkably in numbers in the Western context (Suutala 1999).

Coercive measures in psychiatric care can be divided into different practices that are used in hospitals. Repo-Tiihonen & al (2012) use the term "R&S" to describe coercive methods (pakkokeinot) as restraints and seclusion. According to Repo-Tiihonen & others, coercive measures can be divided into the following categories: 1. involuntary (health) care (eg. medication) (tahdonvastainen hoito), 2. restrictions of movement / space, (liikkumisen ja tilan rajoitukset) 3. seclusions, (eristys) 4. checking possessions/ belongings, (omaisuuden tarkistus) 5. limiting communication, (kommunikaation rajoittaminen) 6. holding down and tying (sitomiset). These are defined in the legislation as well (L21.12.2001/1423b). Also Soininen & others (2013, 1) list coercive measures as follows: involuntary admission to observation and treatment in psychiatric hospitals, treatment against person's own will, and special limitations e.g. forced holding, isolation, seclusion, restraint or tying down, and limitations of contacts.

In most Western countries seclusion or restraint can be used only when there are no other means, there has to be a physician's decision and supervision, and it has to be done in co-operation with the patient (Muraliharan & Fenton 2006; European Charter of Patients' Rights 2002, see also Kontio & al 2012, 16.) Coercive methods are used for treating behavior that is harmful for the patient, other patients' or personnel. Most often coercion is used to deal with potential violence, agitation or disorientation (Raboch & al 2010), but Keski-Valkama and others (Keski-Valkama & al 2009) have emphasized that it is typical that coercion is used even when there are no clear signs of violence. According to Keski-Valkama (2010, 42), potential violence was present only in some cases of restriction or isolation that have been examined. The most common reason was agitated behavior (36-59 %), after that was violence (13-37 %) or potential violence (4-19 %) and destroying property (1-13 %).

In the European and Western context coercive methods are defined and ruled in international definitions of human rights and patient autonomy, and ethical premises in medical science and nursing (see the previous chapter). Cultural and national characteristics have an effect on the concepts of illness and mental care, but the international trends of involuntary care and coercion seem rather similar. (see Raboch & al 2010.) It is uncertain, however, if national and cultural characteristics or perceptions affect the practices used in different ways: for example, how the mentally ill are seen and cared for, and how patient autonomy or self-efficacy is respected at hospitals. Controlling mechanisms may be used to suppress problematic behavior in situations when it would not be needed. (Whittington & al 2009.)

According to previous studies, the negative effects of coercive methods can be strong: for example unexpected, cognitive changes due to sensory deprivation, lack of the possibility of normal social interaction, abrupt changes in daily routines, resentment, and restriction of an individual's right to freedom are listed as unwanted results (more: Keski-Valkama 2010). When seclusion or restraints are used, patients may suffer from strong additional trauma after the discharge and it may cause severe problems for recovery and rehabilitation if it is not discussed or treated afterwards (Hämäläinen 2014). Coercion and coercive methods are used to control patients when other methods are not efficient, but it is generally found that coercion can cause trauma and distress for both patients and staff. (eg. Frueh & al 2005; Holmes & al 2004.) According to previous studies, both patients and staff typically see R/S methods as negative, even if it is sometimes thought that only patients suffer from coercion (Brown & Toke 1992; Fisher 1994; Kaltiala-Heino 1999; Happell & Harrow 2010). Efficacy of care and hospitalization are also key factors in creating good practices, and it has been shown that coercion itself does not improve the patient condition

and cure of the mental illness (Wright 2003; Sailas & Fenton 2000). So patient-oriented care should always be examined and improved from the experiences and perspective of the patient: how their well-being and rehabilitation could be improved with the right decisions and practices at care.

2.3 Patient rights, self-determination and liberty

Patient as a silent outsider, who has to modify himself to the professionals' idea of normal behavior, and to other people's expectations of being "healthy", has been a common trend in mental health nursing and psychiatrics, according to Latvala & Janhonen (1997). It is said, that the history of western psychiatrics is seen as categorizing patients as controlled, incapable of doing decision for themselves and dominated by the medical science, which defines normality and abnormality, insanity or madness (Foucault 1980, also Pietikäinen 2013). At the same time, ways to control the so called abnormal behavior have been various, and in some cases, when the abnormality has been uncontrollable, coercion has been used to maintain normal, expected behavior, and professional power (Latvala 1998, 2).

On the other hand "patient empowerment" has become a trend which has emphasized patients' self-determination, decision-making and power to be part of the care in mental health system (eg. Malin & Teasdale 1991). Empowerment in the context of nursing is a "process of helping individual develop a critical awareness of the fundamental causes of his/her problems and a readiness to act on the basis of this awareness" (Latvala 1998, 6; see also Janhonen 1993, Rafael 1995). Välimäki & al. (2001) and Kuosmanen & al (2007) use the concept of liberty and its opposite, deprivation of liberty, to describe the means that are used at wards.

Deprivation of liberty can be explained as losing the control over one's own autonomy, and it defines psychiatric practices and methods as controlling and hierarchical. These means include all practices that are described by patients as coercive: seclusion and restraints, as well as locked doors and restricted communication with the world outside the hospital.

Growth of patient-oriented care and importance of patients' perspective is related to changes in nursing and medical ethics. Eila Latvala (1998, 23) defines patient-oriented care as informing patient about the illness in a way, that patient will understand it. Latvala continues, that "patient-oriented" means also acceptance of illness, acceptance of incapacities, and helping patients to find strengths in their lives. (Latvala 1998, 17.) Patient perspective is essential to understanding when the term patient-oriented is used: it has to be separated from patient-centered, which is more common in practice but more rarely used (compare Latvala 1998, 23). Closed hospital care is somewhat different from open wards and outpatient care. Rehabilitation and patient's own ability to take care of himself are different from those seen at wards, where intensive and acute mental treatment and methods are used to take care of the current condition. Patients are often in a situation where their ability and self-control are decreased and thus restrictions are used. During the last years patients have been encouraged to participate more in their own care both in health care system and in mental nursing as well, but it seems that many practices still rely on the nurses' active role (Kontio 2012, 179).

2.4 Examining experiences

Interest in examining patients' perspectives on coercion has increased rapidly in the late 21st century (eg. Meehan & al 2000; Hoekstra & al 2004; Holmes & al 2004; Keski-Valkama & al 2010; Kontio & al 2012). Nurses' feelings and experiences at psychiatric wards have been studied a bit more, and altogether the concept of experience has become a common trend in psychiatric nursing (see more eg. Latvala & Janhonen 1998; Hellzen & al 1995; Abma 1998). Experiences are subjective feelings, memories and interpretations of lived life and happenings. They are constructed from the individual's or group's personal, individual and subjective point of view, and therefore qualitative research is crucial in examining them. Experiences can be examined using qualitative perspectives, for example phenomenological approach, narrative studies, discourses, or ethnomethodology. (Perttula & Latomaa 2008; also. Alasuutari 2011; Tuomi & Sarajärvi 2009.)

Studying patients' experiences can be seen as gathering information about patient opinions about care. These can be categorized by using the terms patient-oriented and patient-centered perspectives. Patient-oriented mental care is based on the idea of the patient becoming a part of the nursing process and becoming the subject and participant in his/her own care (more eg. Meskanen 2013, 20-22). What is best for the patient and how the care should be done have been the key issues in the history of psychiatrics (eg. Pietikäinen 2013). From the 1980's patient-oriented care has become more focused on patients' participation, and during the last years issues related to patient's self-determination have been dis-

cussed more and more, at the same time with other changes in health care system and patient-centered nursing.

Kalle Achte (1994, 149-150) has argued that patients' attitudes and experiences of their own illnesses can be categorized as 1) a loss, insecurity and loss of self-esteem, 2) a threat or danger for physical or mental well-being, and thus it can be denied and resisted, or 3) it can be also a relief: to have a diagnosis and thus a named reason for certain problems. Problems that have reasons can be easier to deal with, and for a patient an experience of illness can be frustrating if it is not discussed and explained. Studies of patient experiences have shown that patients often feel alone with their feelings and stories (Pejlert & al 1995) and they have problems in having their experiences heard or illnesses explained (Abma 1998; Talseth & al 2001). Koivisto, on the other hand, has mentioned that patients should be able to express their feelings and patient experience should be the main factor in creating the care (Koivisto & al 2003). Koivisto writes that "psychiatric nursing should refocus care from the diagnosis and the disorders to the patients' experiences (Koivisto & al 2004, 270). So patients should be able to, "together with a nurse, to try to plan how they could cope with the distress" (Koivisto & al 2004, 270).

2.5 Legislation and practices in Finnish psychiatric care

The base of the Finnish mental nursing is on legislation (L21.12.2001/1423a; L731/1999) which defines the rights and services that have to be available for citizens and inhabitants, and also clarifies the use of mental health practices such as modes of care, voluntary, and involuntary treatment. The legislation that defines the use of coercion and involuntary treatment is included in altogether four laws: Mental Health Act (L1116/1990), the Act on Social

Work with Intoxicant Abusers (L41/1986), the Communicable Diseases Act (L583/1986), and the Act on Special Care for Mentally Handicapped Persons (L519/1977). The Law for mental health issues (L21.12.2001/1423a), The Act on the Status and Rights of Social Welfare Clients (L812/2000) and the Act on the Status and Rights of Patients (L785/1992) declare the rights and obligations of a patient, and the Law for Social Services defines the rights and obligations of institutions that organize/offer mental health services (L710/1982). The use of involuntary admission is also defined by the law, and according to legislation coercive measures can be used if other means are not strong enough to secure patients' care. A patient may be taken into involuntary admission, if s/he is a threat for him/herself or for other people. Patient's autonomy and personal rights must always be respected in coercion and involuntary care, but there are certain limitations to individual freedom:

Chapter 4 a (1423/2001)

Limitations on patients' fundamental rights during involuntary treatment and examination

Section 22 a (1423/2001)

Definition of a patient and general conditions for limiting fundamental rights

(1) In this Chapter 'patient' refers to a person admitted for observation or ordered to examination or treatment as laid down in Chapters 2 to 4.

(2) A patient's right of self-determination and other fundamental rights may be limited in virtue of the provisions of this Chapter only to the extent necessary for the treatment of the illness or for the person's safety or the safety of others or for safeguarding some other interest laid down in this Chapter. The measures shall be undertaken as safely as possible and with respect for the patient's dignity. When choosing and determining the extent of a limitation on the right of self-determination special attention shall be paid to the criteria for the patient's hospitalisation.

(3) The right of self-determination and other fundamental rights of a person ordered for examination under the provisions of Chapters 3 and 4 may be limited under the conditions laid down in this Chapter, although the person would not have been taken for observation or ordered to treatment. The treatment referred to in sections 22 b and 22 c may, however, be given to the patient against his or her

will only if it is necessary to avert a danger to the person's life or health. (21.12.2001/1423a)

Certain means can be used to restrict autonomy of patients who are taken into hospital care, and those specific, coercive methods are listed in the law as follows:

- *Care of mental illness*
 - *Care of physical illness*
 - *Restrictions in movement*
 - *Seclusion*
 - *Threshold of property*
 - *Checking patient's property or mail*
 - *Personal checkings/ examinations*
 - *Restrictions in communication*
- (L21.12.2001/1423b)*

Forced medication can be also used as an involuntary practice, and it can be very traumatic, though it is typically seen as a part of the care of mental illness (Raboch & al 2010). As Välimäki (2001, 525) mentions, all these laws are very general in defining reasons for coercion or limitations of patient's rights; they can be interpreted in circumstances that differ from each other, and they are easily interpreted from the hospitals' own perspective and from their practices. But the basis for the law is clear: one should be taken to involuntary admission only in case of a threat of violence or other threatening behavior. Coercive measures should be used only when there are no other means that would work. Patients have their self-autonomy, until they are unable to make the decisions in case of e.g. psychotic behavior or other severe problems.

3 Purpose, aim, and research questions

The aim of this study is to find out what patients feel at care, what experiences they go through, and what has been written about the

patient experiences at psychiatric care in Finland. The focus is on coercion and coercive practices, as they are the most offensive, invasive and discussed phenomena in current psychiatric care in Finland. The use of involuntary methods, involuntary care and coercive measures can affect the patient's attitudes, rehabilitation and future, and it is possible that experiences in hospital care influences the further management in the life (see Sailas & Fenton 2000; Suhonen 2007; Hämäläinen 2014). Therefore the whole nursing process is related to inpatients' time at wards. Finnish material and perspective will provide information for understanding Finnish health care: what are the challenges (and strengths) in mental health nursing? Practical improvements for reducing coercion are visible but there is a need for further research in Finland.

Research questions for this literature review are:

- What kind of experiences do patients have in Finnish mental hospitals according to previous studies?
- How are coercive measures experienced by patients according to previous research?

My interest in this thesis is not in the statistical analysis of coercive practices, but in the experiences and feelings that hospital care and coercion have provoked in patients. A change from involuntary, institutional practices to open wards and decrease of inpatient care is seen as an international goal, but what are the actual experiences of hospital care among patients.

4 Methodology

4.1 Defining literature review

Literature review is a meta-analysis or a descriptive, or a systematic analysis that is done of the previous empirical studies. It presents the results, perspectives and main issues in previous, selected studies, and it should also discuss the advantages and problems of the examined material. Literature review is typically a systematic review. It is based on full scientific principles and has its own research questions. According to Kiteley and Stogdon (2014), a literature review is a summary of ideas, approaches and findings of previously published topics and issues, and it should be an objective and analytical summary of previous studies (also Hart 1998).

Systematic literature review is well-representative, it uses explicit search criteria, and it should include systematically assessed studies that are relevant to the chosen topic (Cronin et al. 2007). Literature review should also be repeatable, and the large amount of carefully and systematically chosen material makes it generalizable. (also Kääriäinen & Lahtinen 2006.) A full scale systematic literature review aims to cover all published, academic studies done on the topic. Jones (2008, 32) has emphasized that literature review can provide current and evidence based knowledge on practical solutions, such as on efficacy of interventions, and so it is useful for estimating clinical and health care practices.

On the other hand, literature research can be also a qualitative analysis of earlier findings, and qualitative literature analysis review

can concentrate on certain topics and main theoretical approaches that examine the phenomenon and discuss its findings. This type of analysis opens new questions, new perspectives and highlights the main questions and approaches in the chosen topic. (eg. Cronin, Ryan & Coughlan 2007.) Narrative literature review is less generalizable than systematic literature review (Kiteley & Stogdon 2014, 11), and it will concentrate more on discussion and themes than summarizing results. I will combine the methods of them both: I will go through the basic findings systematically, but I will concentrate on a qualitative analysis of the chosen articles.

This literature review does not try to cover all researches done on the subject but instead it aims at offering a representative sample, which is then analyzed and interpreted in examining patients' perspectives. Meta-analysis of previous studies aims at understanding the trends and larger phenomena about the studied issues, and therefore this review concentrates on selected publications. This review is more a qualitative meta-analysis than a wide, full-scale review of all literature. Qualitative methods can be used to interpret social and cultural issues for small groups of people or for individuals, and that is also the purpose of this study (compare Tong, Sainsbury & Craig 2007).

I will use literature review to create an overall picture of this debated theme. Even if an empirical study would bring new information and material for analysis, a literature review helps to find the gaps and questions in chosen topic; what would be important to examine in the future. Finnish research about mental inpatients' feelings is mostly missing, and therefore literature review can reveal some new aspects for further studies.

4.2 Literature search and article selection

Article search and selection process was somewhat complicated. Unlike in many other topics, there were only few relevant articles found online for the review. After having a list of results I read the titles, after that I read the abstracts and if there were indications for possible use (eg. discussion of Finnish mental system from patients' point of view or reasons for hospitalization), I read the full article and checked the relevancy. So all articles were not found only by the mechanical search, but as a researcher I had to use my personal decision about articles which were possibly interesting and suitable for this study.

The article search and selection process was done through a search on common data-engines, Arto- and Nelli-multidisciplinary and multi-journal search which used information from Ebsco, PubMed, Medic- and Medline. I used articles that were written in English or in Finnish. First I tried specific, defined words for search (patient experience + coercive measures Finland), but they did not bring results, and I had to change them a lot as there were no articles found with specific words. Final articles were found with general words as is shown below (also appendix 2). After I had first results I went them through to find the relevant articles. Final studies were found with more work – they could not be found with just a title, but the experiences and patients' feelings were included in studies that focused on other topics and had misleading titles. Search words and results are listed in table 2 (appendix 2). There were also research material and articles that focused on pediatric care or on specific illnesses, but I did not include those as my focus is in adult psychiatry. I also checked the references of previous

studies to find out the possible studies that were not found by data engines.

Article selection criteria:

- Available as free, full article/ research paper
- Empirical, original hospital research material from Finland
- Focus of research in adults; adolescents and children excluded
- Quality of study > academic level, referee articles, doctoral dissertations or equivalent
- Journals and articles searched from specific online databases
- Material in Finnish and in English
- Found with defined key words for search (see table 2)
- Searches in English and in Finnish

In the beginning I did not want to concentrate simply on articles, as in Finnish material monographs are an important part in academic publishing, but finally it seemed clear that articles were the most efficient way to use material. Many articles that I found were part of wider research projects or dissertations, and in that case I also read the full dissertations to find out if they had more precise information about the issue. Finally I kept the chosen articles as my main material, and the meta-analysis is based on a narrow, but well-chosen and representative studies. I had two full dissertations as part of the review material, because their content was very relevant and original articles of those researches did not give enough information. I also read the references of previous research and checked if “a snowball-method” would bring more researches for a review. Alice Keski-Valkama’s (2010) dissertation was found from references from other studies. Even if it was not found with a data search engine, I chose it because of its very valid and relevant topic and it fitted in the search criteria. With more persistence and time there

might have been more articles online, but with limited timetable I concentrated on the material that was rather easily found.

4.3 Search process:

NELLI –database

Key words: "Finland + coercive measures

→ 138 relevant results, of which two chosen articles

- Kuosmanen, L. & al 2007. -> INCLUDED
- Välimäki M. & al 2001. -> This was not an empirical, original study

Key words: "patient+ perspective + psychiatry + Finland"

→ 161 relevant results, one chosen article:

- Salokangas, R. 1998. > This did not fit into category, as was shown when read the article later on.

ARTO –database

"pakkohoito" ("involuntary/ coercive care")

→ 96 results of which 3 applicable

- Soininen, P & al. 2013 > INCLUDED (same article as in 4.)
- Kaltiala-Heino, R. 1990 → No access online
- Vartiainen, H. 1994 → No access online, not original paper.

"pakkokeinot" ("coercive measures")

→ 39 results

not related to medical /psychiatric nursing, but to police and other institutions.

“psykiatria + potilas + kokemus” (“Psychiatry + patient + experience”)

→ no results

“Mielenterveys + potilas” (“mental health + patient”)

-> 32 results, of which 7 relevant results, 5 used articles + dissertations

- Koivisto, K., & al. 2004. -> INCLUDED
- Latvala, E. 1998a.-> INCLUDED
- Stenlund, M. 2007 -> not included, did not match the criteria
- Syrjäpalo, T. 2000 – not included, did not match the criteria
- Kontio, R & al 2012. -> INCLUDED
- Soininen P. & al 2013. -> INCLUDED
- Soininen P. 2014. -> not included, as the original material was same as in Soininen & al 2013.

4.4 Analysis and Overview of material

Main method for the analysis of research material was content analysis. Content analysis in the thesis was inductive analysis, which means that the perception is from the material towards the theory. Deductive analysis begins from the theory and finds the results from the material to support or oppose chosen theory or hypothesis (Janhonen & Nikkonen, 2003, 24; Kananen, 2014, 103–104.) but in practice these approaches are often overlapping in analysis process.

Inductive content analysis can be divided in three different stages (Janhonen & Nikkonen 2003, 26-30). Those are reduction, clustering and abstraction of data into general categories. This process can be explained eg. that all expressions which are found in the

material and are used in analysis are first summarized and written down. (Janhonen & Nikkonen, 2003, 26–30, Tuomi & Sarajärvi, 2009, 108–113.) Expressions are listed into similar groups which are then used to answer to research questions. Deductive analysis starts with theory, and inductive analysis aims at creating a theoretical perspective without theoretical presuppositions (Tuomi & Sarajärvi, 2009, 95–96). According to Tuomi and Sarajärvi, (2009, 123–124) material based analysis is a valid tool for a literature review, and it was chosen for this thesis as well; the approach emphasized expressions that came from the material.

Content analysis was started by reading the articles through for a few times. Sentences, chapters and words that were related to research questions were alleviated. According to Tuomi and Sarajärvi (2009, 110), analysis units can consist of sentences, single words or thematic units, and this was what was done in gathering the material (eg. expression: “there were few opportunities to communicate”). At this point analysis units were collected together according to research questions, but they were not defined or categorised too strictly, as method was to find material-based sentences and expressions. These units were collected to a new document and categorized into group according to similar characters. At this point research questions were not leading the analysis but the material which was the most important part for thematic clustering. Finally the units were categorized and given a common theme and a category, which are seen in table 3 (appendix 3).

As the articles had slightly different perspectives, I had to concentrate on thematic issues, not on strictly defined words or categories. That means I focused on the findings and parts which had the patient as their main subject, not on those that explained issues from a medical point of view. This was difficult, however, as the material was limited and there were lots of overlappings in thematic groups.

Overlappings and inter-connections between experiences, expressions and listed practices at wards were strong, so the analysis process was a cyclical, back and forth process more than going from one direction towards separated categories. Similar feelings were related to many sectors, and for example experiences of solitude were connected to number of practices. Differences in chosen studies appeared in research perspectives and questions. However, the findings had thematic similarities that were finally used in my thesis. Articles that I used in the analysis are listed in the appendix 1.

5 Results

5.1 Patients' isolation at wards

The use of seclusions and isolations was the most discussed and most often expressed method that patients talked about that affected their care. Isolation was expressed in many ways, combined and attached with other practices, and it was present in all articles.

Keski-Valkama's (2010) findings showed that patients who felt isolated and lonely had strong feelings of disintegration in relation to other people: they felt that seclusion and practices used at ward were harsh and patients' behavior led to worse because of that. Patients reported of crying, singing alone and other ways that they tried to cope with their emotions of solitude (Keski-Valkama 2010, 13-14).

Also a loss of self-determination, and inability to communicate to the world outside the ward were commonly expressed feelings among patients. They were part of the isolation and seclusion as well, but they were also a practice at wards in a larger scale: it was not possible to use the internet to have normal contact with the

people one was used to talking with. So seclusion and involuntary treatment kept patients unable to talk to other people, to other patients and in worst cases to nurses – loneliness was experienced in the seclusion rooms. In Keski-Valkama's research patients told about a fear of long-lasting, never-ending seclusion; even if seclusion was sometimes seen positive, it would have needed information, how long it was going to last (Keski-Valkama 2010; also Kontio 2012, 19). Agitated, disoriented behavior was the most common reason for leading to room-seclusion, even if there was no clear threat of violence. For patients this was difficult to understand and led to further behavioral problems.

On the other hand seclusion had also positive connotations: privacy, that was often missing at wards as rooms were shared with other patients, was possible in seclusion and that gave some patients time to think and feel better (Soininen 2013). According to Keski-Valkama patients felt seclusion beneficial for their care; it sometimes gave a way to control one's own behavior, it was a chance to have some privacy, and time to concentrate on one's own condition. (Keski-Valkama 2010). This has to be separated from involuntary, coercive isolation and seclusion, which does not make the patient relaxed but more often anxious and frightened. It is likely that patients' illnesses also have influence on that experience; oriented patients can be have more advantage of seclusion than eg. psychotic patients who do not comprehend the situation clearly. (Koivisto & al 2004.)

Locked doors were part of the seclusion. In Kuosmanen's study patients said that they felt deprived of freedom when they were not allowed to leave the ward (Kuosmanen & al 2007, 600). Doors can be locked so that patients are not allowed to go out, but there are also other, smaller areas that are locked, e.g. rooms or isolation areas. Locked doors are present also at other parts of the hospital;

nurses spent their time in their own areas, and patients are now allowed to go there. (e.g. Koivisto & al 2004, Kontio 2012, 19-21). So the distance and segregation between allowed and restricted areas is strong, and it represents the hierarchical elements of the care: staff decides which areas are “good” or suitable for patients, and patients do not have a possibility to change that. Medicine, dangerous objects, staff property and other “forbidden” things are not be left unattended. Potentially aggressive or disoriented patients can become a threat for themselves or others, and even the more healthy patients are not allowed to move around freely from one place to another. (Keski-Valkama 2010, 13-14.)

5.2 Experienced confiscations of property

Confiscation of patient's property was seen as part of the dominance, and the use of mobile phones or being able to keep other personal belongings was an important link to “normal life”. (Keski-Valkama 2010) Isolation and loss of contacts made some patients anxious, scared, and even aggressive due to frustration and fear, and it is a risk that these feelings caused by the care were interpreted as part of the illness by the staff (Koivisto & al 2004). Also Kuosmanen (& al 2007) reported that patients experienced a loss of autonomy and liberty when the staff took their personal belongings, and the patients were unable to use their own goods. This was a question of communication and liberty at the same time. Patients described the confiscation of their property as unnecessary and hair-splitting (Kuosmanen & al 2007).

5.3 Importance of communication

Isolation and loss of contacts took place in relation to friends, family and other patients, but also in relation to nursing staff. Human contacts were commonly needed, and relations to nurses were often the most important contacts that patients had at wards. In that sense relations with staff members were needed, and it can be assumed that they are significant for the care and well-being at wards. Communication and relations with the nursing staff were described as missing, and patients felt that they had no opportunity to communicate with people at ward (Kuosmanen & al 2007, 601).

In Latvala's (1998) research, patients' experiences and participation in care was expressed with three different nursing methods. Dialogical, participatory care was rare, and patients felt they were mostly subjects to nurses' and doctors' decisions. Findings in Latvala's study show that psychiatric patients were rarely active or responsible for making decisions about their care in the end of 1990's. From the examined patients 65% were seen as passive recipients, 22% as responsible recipients and only 14% as responsible participants (Latvala 1998; also Latvala & Janhonen 1998).

Somewhat controversial results were expressed in all studies, and experiences differed, but all texts emphasized the communication between nurses (and other personnel) and patients, and discussion beforehand and afterwards (Koivisto & al 2004; Soininen & al 2013). So, good communication seems to be the key factor for creating good care and helping patients to get the best from the hospital care. (Kontio, 2012.) In Koivisto's study patients said that they felt they were not trusted and they expected the nurses to take

them seriously and to try to understand what was happening to them (Koivisto & al 2004, 272).

In Keski-Valkama's research (2010) patients' hoped for a patient-friendly atmosphere; this was something that covered all the other aspects of care and practices. In my opinion this was the most important part of all results: communication and understanding of each other's perspectives was the main strength in creating good care. This was emphasized in Koivisto's (& al 2004) study as well. Possible alternatives for better care from the patients' perspective were written agreements about care, duration of seclusion or strains and so, definite and clear discussion between a patient and staff (Keski-Valkama 2010). Nurses' presence and "human connection" was important for those, who did not have other connections at ward or outside (Koivisto & al 2004).

5.4 Experiences of everyday life

According to the research material, everyday life at wards was controlled by hospital routines (Koivisto & al 2004; Kontio & al 2012; Soininen & al 2013). Timetable that was decided by the hospital and staff did not give much possibilities for changes; patients were seen as incapable of making their own decision, and changes would cause extra work (Latvala 1998, 71). Practical choices such as what clothes to wear, or what to eat, drink, or read during the days at care were important factors helping to maintain patients' self-determination and feelings of autonomy (Kontio & al. 2012) These factors were seen in other studies as well, but they were mostly expressed in Kontio's & others' (2012) research, on how to improve the experiences. Also basic needs should be taken care of better and staff should pay attention to atmosphere and cozyness of wards and seclusion rooms. (Kontio & al 2012.) Practical solu-

tions, discussions about daily activities or routines at ward helped patients to maintain their self-respect, individuality, autonomy and self-dominance, and it helped them to keep the functionality also in everyday life. (Latvala 1998.) This may further imply, that when patients' self-management and activity is supported at wards, their rehabilitation and condition after discharge might be better and easier. (compare Gibson 1991.) In Koivisto's material patients found it difficult to manage in their everyday life, and they felt they needed help in order to cope and have a structured daily life (Koivisto & al 2004, 271-272).

5.5 Problems in patients' emotional well being

In this group of results I will list the patients' feelings and expressions of personal experience which did not fit into other groups. These experiences belong to patients' personal descriptions of their mental and emotional conditions.

Soininen & al. (2013) examined patients' quality of life during care and after discharge from hospital, and they found out that while most patients felt their quality of life (QoL) at wards and in coercion as negative, the use of coercive measure did not simply increase negativity among patients. After the discharge there was no significant difference in patient's QoL in what comes to use of coercion or not having experienced it. In fact, those with coercive experiences had better feelings later in life than those who did not experience it (Soininen & al 2013, 3-4). These results cannot be interpreted so that coercion would have been beneficial, but as Soininen (Soininen & al 2013) emphasizes, other factors such as longitude of care, diagnosed illnesses and discussions related to experiences may have influenced these patients' well-being. In Koivisto's (& al 2004) study patients felt that the care they received was mostly

helpful but unstructured. Nurses did not reach the patients' inner world & understanding of experience, but disorders and diagnoses had a big role in the care and communication.

According to Kuosmanen & al. (2007, 602), patients described their feelings as “shock, humiliating, and hair-splitting”. These negative feelings were connected to loss of freedom and property, and coercion made them feel mostly self-defensive and sad. Patients expressed feelings of humiliation, loss of self-determination and anger. Some of them understood that hospitals needs rules, and could rationalize the unpleasant experiences by that. (Kuosmanen & al 2007.)

In Keski-Valkama’s study (2010, 13-14) patients felt that solitude and disintegration lead their behavior to worse, and they expressed that they did things such as singing or crying on their own. So to summarize, it is important to notice, how the methods and treatments used were in a crucial part in what comes to patients’ emotional well-being. It is worth asking, if this has influence on the patients’ mental state and mental condition as well, and if this worsens the patients’ mental illness and hinders their recovery in the care. Practices at care were related to patients’ images of themselves: psychotic illness made the sense of self “uncontrollable”, and other people were needed to create an organized and structured environment. (Koivisto & al 2004; Soininen & al 2013.)

Finnish mental wards typically treat different mental problems and illnesses at same wards. Patients who have severe drug or alcohol addictions, or are mentally disabled or have learning disabilities are not treated at mental wards, but patients with other diagnoses and illnesses such as psychotic/ schizophrenic, mood disorders, (bipolars, depressed, maniac), or personality disorders are commonly at “general” wards, at same hospital settings. Most typical mental

disorders or problems that patients had in examined material were mood disorders and schizophrenia. As Soininen emphasized, different illnesses may effect the practices used for treatment (Soininen & al 2013, 5; see also IsHak & al 2011), and that may influence the findings and results as well. For example, mood disorders typically have lower rates for subjective estimations of experiences than schizophrenic patients (m.a.). Koivisto and al (2004) have stated that patients need people – that means typically nurses – who understand their experience of illness and also its impacts on their lives and experiences. Thus the experience of illness is tied to care and time spent at wards (also Kilkku & al 2003). Patients' self-image of “being mentally ill” is related to their emotions at ward.

6 Discussion

The findings in the analyzed studies were rather similar: patients were often unsure why they were in seclusion, how long their care is going to last, and the interaction with nurses did not work. Coercion was experienced in practical caring methods and everyday routines that were used at hospitals. Occasionally patients told about the agitation that came from bad experiences, but it was not explained as the patients' problem but as a result of the conditions (eg. Kontio 2012, 20). For example violence, confusion or reasons leading to coercion experienced caused by patients did not appear in the material; even if it did exist at wards, patients did not tell about violent or simply aggressive behavior on their part. They felt unsure what was going on, and they felt confused because of their illnesses or because of not getting information. Numbers in Latvala's (1998) study show that the patients' own experiences and opinions are not part of the decision-making, but they mostly follow

the instructions and conceptions of good as defined by the professionals.

As I wrote earlier in the material search process, it was difficult to find articles and studies about the issue. As I found out in the material search, patients' will and needs are not expressed through the patient's own words, but through other perspectives, and through the nurses' or doctors' assumptions of what is understood as patients' orientation or needs.

According to the examined studies, there are several ways that could create more patient-oriented care at mental wards and practical solution that would improve experienced care. Patient autonomy can be respected and improved in many ways, and it is a question of small decisions and co-operation (Hoekstra & al. 2004; Kontio & al 2012, 17) can be implemented in practical decisions such as choosing clothes or making one's own meals. This seems to be similar in Finnish and in previous international studies. As Honkonen (2008) reminds us, a psychiatric will would be a way to help patients' and nurses' decision making when a patient is not capable of expressing the needs or fully comprehend the situation in an acute crisis.

The most important part of the care and patient understanding is the holistic, discursive perspective: one should ask what the patients themselves think they would need. Latvala & Janhonen (1998) have emphasized dialogical methods in nursing - patient perspective and good care should be part of nurses' communication with patients. Dialogue between nurses, doctors and other professionals and also with patients is needed to understand multiple perspectives. Dialogical, communicative nursing can be interpreted as oppositional to hierarchical, administrative or educational nursing, where nurses and doctors know what is best for the patient. This all

goes back to questions of power and domination: coercion is the ultimate means to make a patient adapt to the care.

Coercive measures, such as seclusion or restraints, are a controversial and discussed issue that raises a number of related ethical questions: when the number of personnel is limited and small, how much workforce should be used to taking care of the “difficult” patients? What are the ways to treat violent, aggressive or badly disoriented patients – if coercion should be reduced, what are then the occasions in which it should be used? According to examined material, coercion itself does not mean that care would be good or bad, but rather the difference is seen in how it is discussed, used and in which situations. Similarly, individual experiences are not fully understood if they are simplified as only positive or negative. A patient who suffers from a mental illness and is forced to stay at care needs more careful and multi-dimensional interpretation than just being asked if the experience was positive or negative.

In relation to the international material, Finnish studies do not provide much different opinions. Restrictions are present at wards in many ways. They appear as concrete acts of custodies (eg. of property) as well as symbolic and mentally demanding situations such as isolating patients from other people as I described in the previous chapter. Patients’ autonomy and decision making in practical solutions, such as clothes or daily routines, are present in most cases. (Hoekstra & al 2004). This means that the ways to improve care are already well known, and the information should be available, but the biggest problems and contradictions are in communication and implementation. When a patient is not able to communicate with the staff and express their feelings, it is unlikely that care is done in co-operation. Problems in communication might be a sign of staff in a hurry, but for the patients it can be a sign of being neglected and ignored. Emotional well-being was related to the pa-

tients' quality of life and mental state; it was not about being ill, but about patients experience about being ill or fine. Emotional well-being was connected to other factors at care as described in earlier chapters. Presence of other people, loneliness and solitude influenced their emotional state, and measures that were used at care created changing feelings and moods. Isolation was a mental, all-encompassing experience. Seclusion, on the other hand, was a more concrete, practical procedure or treatment that nurses could use.

Psychiatric nursing is a continuous process of getting to know the person and his/her changing needs, as Koivisto (Koivisto & al. 2004, 269) writes referring to Gastmans (1998) and Barker (Barker & al 1999). So the process of having time to comprehend, listen, and give a chance for a new understanding about patient's worldview should be the first premises of care.

7 Ethics, risk assessment and the reliability of review

Publications that were included in this paper were generally quite different. Research projects and their implications were not comparable, as researches had different methods, theoretical backgrounds and research questions to ask. So it was not reasonable to make quantitative analysis or comparison between the studies. Data that was gained does not offer answers for general trends or statistical analysis. Limitations of previous research offers possibilities for new studies, but it is also a challenge in literature review. Small amount of researches makes a review less liable.

In the article search I found many articles from the same authors, and it is worth asking how many of the researches have done the background researches together. I chose only one article from each empirical research, but it is unclear what the connections between the chosen studies are, and how much of the material is commonly gathered. Studies that I chose for my material were different in quantity and wideness: there were both articles and one full-length dissertation, but as I read dissertations, they all were article dissertations and only in few all articles or the summarizing text was relevant to my study. So I chose the most suitable parts of dissertations for this analysis. There was no reason to include all articles or parts of researches as they examined other issues.

As a researcher I had my own intentions and subjective perspectives, and even if I used database search methods and aimed at articulated and objective analysis, I have my personal intentions and possible errors in my thesis. From the chosen papers I found some papers more interesting for me, and that kind of personal things may influence readings. Even if a researcher aims at objectivity, it is never really possible in qualitative, human-related research (eg. Gergen 2001; Ratner 2002), and after all, in a qualitative analysis it is not a goal itself. Interpretations, narratives and experiences are always human-mediated results of human-selected material.

8 Conclusion and further research topics

As Kuosmanen & others (2007, 604) write, more research is needed in the field of psychiatric nursing and patients' experiences. There are several studies on the topic, but a deep understanding of

patients' feelings and narratives is still missing. In the future it would be good to do a larger full-scale study of implicit meanings among patients: how patients live at wards, what are their stories and what is more important: how does the patients' other lives influence the hospital experiences? Patients who come to care are typically treated as ill and as patients, but the context at hospital and context they are living in outside of ward affect the experiences as well. Now the achieved interview-material and analysis have given good openings for understanding the good and bad practices at wards, but they do not give a full picture of care from the patients' point of view. Deep qualitative research and large-scale national material are needed in the future.

A community created by staff and patients should be examined: how do constantly changing people (both patients and staff) influence the care at mental wards? Further research could also examine how patients' and nurses' feelings and practices differ at wards. Is there a patient perspective in literature or is it mainly doctor's and nurses' point of view? How do I measure patient's perspective in literature? It is also clear, that patients' experiences are not fully understood and studied in Finnish psychiatrics, and each ward and hospital have their own practices, which should be taken into notice and planned in ways that would improve communication with personnel and patients.

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Appendix 1.

Material for Review. Analyzed articles and researches.

Article/ Paper	Material & methodology	cus/ Aim	Main findings	Other
Kuosmanen, Lauri, Hätönen, Heli, Malkavaara, Heikki, Kylmä Jari & Välimäki, Maritta 2007. Deprivation of Liberty in Psychiatric Hospital Care: The Patient's Perspective.	51 patients interviewed, semi-structural interviews Inductive content analysis	Finding out whether patients had experienced deprivation of liberty	Feelings expressed: humiliation, loss of self-determination, anger, some understood that hospital needs rules-> rationalization. Deprivation common among patients.	Four categories of deprivation of Liberty: Closed doors, confiscation of property, communication, coercive measures (restraints, seclusion).
Kontio, Raija & al 2012. Seclusion and Restraint in Psychiatry. Patients' Experiences and Practical Suggestions on How to Improve Practices and Use Alternatives.	30 patients interviewed. Focused interviews Inductive content analysis	Psychiatric inpatients' experiences of improvement of R/S and their suggestions for better practices	Patients' perspectives received insufficient attention during seclusion/ restraint processes. Improvements that patients suggested not largely adopted into practice.	importance of patient-staff interaction ja communication meaningful activities for patients Planning in advance: making decisions together Basic needs Paying attention to atmosphere and cozyness of wards and seclusion rooms
Latvala, Eila 1998. Potilaslähtöinen psykiatrisen hoitotyön laitosympäristössä. (Patient-oriented psychiatric care in hospital(institutional settings))	16 patients, (also nurses and nursing students.) Interviews and videotaping.	Describing nursing in a psychiatric hospital, and to produce a model of nursing based on patient initia-	Three different categories of nursing relationship Most of the patient were passive recipients of care	Full dissertation read

		tives.	Nurses and patients opinions about questions and quality of care were quite similar despite patients negative experiences	
Keski-Valkama, Alice 2010. The use of seclusion and mechanical restraint in psychiatry. A persistent challenge over time.	671 written answers, 106 patient interviews. 83 follow up interviews.	Exploring the use of seclusion and mechanical restraints nationally and internationally, statistically and from patients' perspective	Only minor changes in use of R/S methods, Attitudes, caring traditions and patients' rights in great confrontation.	Full dissertation read and used for the review.
Soininen, Päivi, Putkonen, Hanna Joffe, Grigori, Korkeila, Jyrki, Puukka, Pauli, Pitkänen, Anneli, Välimäki, Maritta 2013. Does experienced seclusion or restraint affect psychiatric patients' subjective quality of life at discharge?	264 patients altogether; of which 36 in S/R and 228 non-S/R., Questionnaires	Exploring the effect of experienced R/S on the subjective quality of life Patients' answers analyzed after discharge: how was their quality of life	No significant difference in patient groups, so according to this study seclusion or restraints do not considerably influence on patients' quality of life.	Four wards with different types of practices.
Koivisto, K, Janhonen, S., Väisänen, L. 2004. Patients' experiences of being helped in an inpatient setting	9 interviews with patients who are recovering from psychosis Phenomenological analysis	Describing patients' experiences of being helped during a period of psychiatric hospital care	Patients felt care as helpful but unstructured Alleviation of disorders Nurses did not reach patients inner world & understanding of experience	Daily life structures and patient-nurse relation in important part

Appendix 2.

Table 2. Material search.

DATABASE	SEARCH WORDS	ALL RESULTS	FOR MORE INSPECTION	USED PAPERS
ARTO	“mielenterveys + potilas”	32	7	4
ARTO	“pakkohoito”	96	3	1
NELLI	“pakkokeinot”	39 results	0	0
NELLI	“psykiatria + potilas + kokemus “	0	0	0
NELLI	”Finland + coercive measures”	138 relevant results	2	1
NELLI	”patient+ perspective + psychiatry + Finland”	161 relevant results	1	0

Appendix 3.

Table 3.

Expressions in the material and thematic groups of listed experiences

Quoted expressions from the articles	Coercive measures described in the material	Feelings, emotions expressed	General category
Isolated from outside world Importance of family and friends Needed more contacts Had to ask nurse to open the doors Distressed and sad cause not being able to leave the ward Closed doors Mechanical restraints	seclusion Restraints	distress sad increased fears negative vulnerable helpless unnecessary punishment Deprivation	Isolation, seclusion
Few opportunities to communicate Lack of therapeutic interaction Problems in patient-staff relationships Did not get enough information	X	negative	Importance of Communication
Confiscation of property unnecessary and hairsplitting Confiscation of property as coercive	X	unnecessary and hairsplitting	Confiscation of Property
Lack of meaningful activities		Exercise of	Everyday life at

<p>Would need physical activity</p> <p>Care should restructure patient's capability of managing in daily life</p> <p>To be able to manage in everyday life</p> <p>No free access to toilet</p> <p>Management, decision making on daily routines</p>		power	wards
<p>Adaptation to illness</p> <p>All above</p>	X	Emotional wellbeing	Emotional wellbeing