Experiences of nursing staff on psychiatric care of depressed patients

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Bachelor's Thesis
11/2012

Degree programme in nursing
Nursing

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Type of publication
Bachelor´s Thesis

Date
09.11.2012

Pages
56

Language
English

Permission for web publication
(X)

Title
EXPERIENCES OF NURSING STAFF ON PSYCHIATRIC CARE OF DEPRESSED PATIENTS

Degree Programme
Degree programme in nursing

Tutor(s)
JAKOBSSON, Maarit

Assigned by
Central Finland Health Care District

Abstract

The thesis researched the views and experiences of nursing staff of psychiatric special care ward on psychiatric care of depressed patients. Because caring is patient/client oriented profession, it is essential to include patients and nursing staff in the development work. This assumption was basis for the thesis. The thesis aimed to add knowledge on the views of the nursing staff and to show how this knowledge can be used in development of psychiatric care. The thesis also pursued towards gathering development ideas from the nursing staff. The research was done in Central Finland Health Care District. To protect the anonymity of the nursing staff, specific detail of the ward is not given in the thesis. The theoretical part of the thesis describes objectively the nature of depression, experiences from depression and the treatment of depression.

The qualitative study of the thesis was implemented by the means of focus group interview. The sample contained 20 members of the nursing staff on that psychiatric special health care ward. The interviews were conducted in three different groups. The interviews were audio recorded and transcribed in Finnish because the interview language was Finnish. The material was analyzed by the means of content analyzes.

The results of the study describe according to the nursing staff what helps the depressed patient to recover. Also the results tell the developmental ideas of the staff for psychiatric hospital and outpatient care.

Keywords

Depression, psychiatric care, experience, special health care, development, nursing staff, patients

Miscellaneous

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OPINNÄYTETYÖN
KUVAILULEHTI

Tekijä(t) SUUTARINEN, Kreetta-Maija	Julkaisun laji Opinnäytetyö	Päivämäärä 09.11.2012
	Sivumäärä 56	Julkaisun kieli Englanti
		Verkkojulkaisulupa myönnetty (X)

Työn nimi
EXPERIENCES OF NURSING STAFF ON PSYCHIATRIC CARE OF DEPRESSED PATIENTS

Koulutusohjelma
Degree programme in nursing

Työn ohjaaja(t)
JAKOBSSON, Maarit

Toimeksiantaja(t)

Keski-Suomen sairaanhoitopiiri

Tiivistelmä

Opinnäytetyö tutki psykiatrisen erikoissairaanhoidon työntekijöiden kokemuksia masentuneiden potilaiden hoidosta. Lähtökohtana tutkimukselle oli hoitotyön potilaslähtöisyys ja hoitotyön luonteesta johtuen tarve ottaa potilaiden ja hoitohenkilökunnan kokemukset huomioon hoitotyön tutkimuksessa ja kehityksessä. Tutkimus tähtäsi lisäämään tietoa hoitohenkilökunnan näkemyksistä ja näyttämään miten tätä tietoa voidaan hyödyntää kehitystyössä. Lisäksi hoitohenkilökunnalta pyydettiin konkreettisia kehitysehdotuksia. Opinnäytetyön teoriaosuus kuvaa masennuksen luonnetta, kokemuksia masennuksesta ja masennuksen hoitoa. Tutkimus toteutettiin Keski-Suomen Sairaanhoitopiirissä.

Opinnäytetyön laadullinen tutkimus toteutettiin fokusoidun ryhmähaastattelun periaatteiden mukaisesti. Tutkimuksessa haastateltiin 20 psykiatrisen erikoissairaanhoidon osaston työntekijää, kolmessa eri ryhmässä. Haastattelut tallennettiin audiotallenteina ja litteroitiin suomeksi, koska haastattelut toteutettiin suomeksi. Tutkimus analysoitiin sisällön analyysillä.

Tutkimuksen tulokset kertovat mikä auttaa potilasta masennuksesta toipumisessa hoitajien mukaan ja mitkä keinot ovat tärkeitä potilaan hoidossa. Lisäksi tulokset kertovat myös kehitysehdotuksia koskien niin psykiatrista sairaalahoitoa kuin avohoitoakin.

Avainsanat (asiasanat)

Masennus, kokemus, psykiatrinen hoito, erikoissairaanhoito, kehitys, potilaat, hoitohenkilökunta

Muut tiedot

Contents

1. The voices of depression

Depression is the most common mental health disorder in Finland. About 250 000 individuals, 5-6% of the Finnish population suffers from depression simultaneously (Heiskanen, Huttunen & Tuulari, 2011, s.14). Depression which fills up the criteria of mental health disorder and requires treatment is estimated to concern about 20% of the population during their life time (Heiskanen, Huttunen & Tuulari, 2011, s.14). Depression effects individual's ability to function and physical health, and as depression prolongs it diminishes the quality of life significantly. During the last 10 years numbers of people receiving disability pension due to depression have significantly risen. According to Finnish social and health ministry's Masto- initiative the amount of people receiving disability pension due to depression has grown between years 1997 and 2008 from 2500 individuals to 4000 individuals (Arkio, 2009).

Finland has been developing its psychiatric care towards more outpatient based since the 1980's and since 1990's the municipalities have had the responsibility for developing psychiatric care (Keski-Suomen sairaanhoitopiirin valtuusto, 2007). The ways that municipalities develop their psychiatric care vary from each other, but the basis form for developing outpatient care is set in the Finnish legislation. The fourth paragraph of the mental health law highlights, that psychiatric care should be organized primarily as outpatient care (Mielenterveyslaki 4§, 2009). According to the law, the treatment should be organized so that it supports the initiative of the patients on searching for treatment for themselves (Mielenterveyslaki 4§, 2009). In this paragraph of law it is said that the municipality is responsible to organize psychiatric outpatient care to meet level of the needs of the municipality (Mielenterveyslaki 4§, 2009).

Evaluations of psychiatric outpatient care on the municipal level have been variable between municipalities, but Mielenterveysbarometri gives an evaluation on the national level. Participants of Mielenterveysbarometri are the whole population, people rehabilitating from mental health problems, next of kin and health care

professionals. The lack of health care resources is visible in the answers in the Mielenterveysbarometri of the year 2011 (Mielenterveyden keskusliitto, 2011). 63 % of health care professionals feel that mental health services are of good quality, but 95% of the same professionals felt that those in need don't receive enough mental health services (Mielenterveyden keskusliitto, 2011). Lack of staff can be seen also from the answers of psychiatrist and psychologists. 89% of psychiatrist and 92% of psychologists which participated in the mielenterveysbarometri agreed either fully or somewhat with the statement Outpatient care doesn't have enough staff (Mielenterveyden keskusliitto, 2011). At the moment there is a developmental plan for mental health and rehabilitative care called "Mieli ja Päihde". It gives developmental suggestions from the social and health care ministry to the municipal development until the year 2015 (Mieli - kansallinen mielenterveys- ja päihdesuunnitelma, 2012).

Jyväskylä belongs to the Central Finland Health Care District. In this district in the psychiatric health care is having an ongoing a project called "Arjen mieli" which is following the Central Finland overall plan project (Keski-Suomen Arjen mieli -hanke 2011 – 2013, 2011). Psychiatric outpatient care visits in Jyväskylä area have almost tripled since the year 1999 to the year 2010 but the basic health care visits have not increased during these years (APPENDICE 1). Both the current and the previous projects aim towards growing the role of basic health care and improving the skills of giving psychiatric care in the basic health care (Keski-Suomen sairaanhoitopiirin valtuusto, 2007; Keski-Suomen Arjen mieli -hanke 2011 – 2013, 2011).

The Central Finland overall plan project has begun in the year 2005 (Keski-Suomen sairaanhoitopiirin valtuusto, 2007). The task of the project was to evaluate the current psychiatric health care model and to create objective model and a development program for the years 2006-2010 (Keski-Suomen sairaanhoitopiirin valtuusto, 2007). Objective model they created is called "Keski-Suomen tavoitemalli 2010" and the development program is called "Keski-Suomen psykiatrisen hoidon kehittämisohjelma 2006- 2010 "(Keski-Suomen sairaanhoitopiirin valtuusto, 2007). The development suggestions of the overall plan considered amongst other things developing psychiatric outpatient care as the principal treatment form and reducing

the capacity to treat patients in the psychiatric hospitals to 172 patient places by the year 2010 (Keski-Suomen sairaanhoitopiirin valtuusto, 2007). As a result to this project, the need of psychiatric hospitalized care has been decreased 50 % in Central Finland and 100 vacancies have been transferred from hospitalized care to outpatient care (Keski-Suomen Arjen mieli -hanke 2011 – 2013, 2011). Since the year 2005 psychiatric patients' hospital places have decreased almost to half in Central Finland (Heikkilä-Kari, 2012). In the year 2005 there were 254 patient places and in the year 2011 there were 117 in Central Finland (Heikkilä-Kari, 2012). Also the usage of the psychiatric patient places has been decreasing evenly. Psychiatric hospital's patient place usage by Central Finland municipalities has decreased from 222 places at the year 2004 to 109 places in the year 2010 and it is still decreasing (Heikkilä-Kari, 2012). According to the prediction the usage of the hospital patient places would be decreased to 100 places during the year 2011 (Heikkilä-Kari, 2012).

Arjen mieli- project, which started at the end of the year 2011, aims is to improve mental health and substance abuse welfare work to measure up to the need of the population better than before (Keski-Suomen Arjen mieli-hankeen väliraportti 2011, 2011). One of the developmental principal of the project is to include representatives of patient and relative organizations and peer recovery support specialists to every stages of the development work (Keski-Suomen Arjen mieli -hanke 2011 – 2013, 2011). The long term goals of the Arjen mieli- projects include developing flexible access to treatment by developing co-operation, decreasing the need for hospitalized care and controlling total costs (Keski-Suomen Arjen mieli -hanke 2011 – 2013, 2011). In addition the project strives to improve the know-how on treating mental health and substance abuse welfare patients in social and healthcare (Keski-Suomen Arjen mieli -hanke 2011 – 2013, 2011).

Caring and nursing are patient oriented professions and until now including patients into the development work has been imperfect. This is the basic assumption that has kicked off this thesis. The research target of this study was experiences. This thesis aimed to add knowledge on the views of the nursing staff and to show how this knowledge can be used in development of psychiatric care. By hearing the experiences and visions of the nurses treating patients with depression or other

mental illnesses on being a client, the strive is to give a voice to the depressed via nursing staff. And one aim is also to encourage towards more studies over the experiences of patients. At the same time the members of the nursing staff are asked to present developmental ideas and evaluate psychiatric care. The evaluation only concerns one psychiatric care in Central Finland as the participants work as in Central Finland, but the aim is to find also more general developmental ideas.

2. Depression as a national problem

Depression is the most common mental health disorder in Finland. This is the reason why causes and effects behind it have been raised by both in caring sciences and in media. Depression is common also in many other developed countries. Severe depression has been estimated to be fourth of the leading causes behind incapacity to work and being unable to function (Raitasalo, Salminen, Saarijärvi & Toikka 2004).

According to the Green paper published by the Commission of the European communities (2005), depression and anxiety disorders are the most common forms of malaise in the European Union (Commission of the European communities, 2005). According to WHO approximately 121 million people suffer from depression globally (Mental Health – Depression, 2012). In the United States of America 10 % of the adult population (from the age of 18) suffers from depression yearly (American foundation for suicide prevention). Depression has been estimated to grow to be the most common cause of illnesses in developed countries by the year 2020 (Commission of the European communities, 2005). In the US it is already notably more common than coronary artery disease and cancers (American foundation for suicide prevention).

Terveys 2000- research conducted in Finland measured the commonness of depression. During the research period, from September 2000 till spring 2001, 5% of Finland's adult population had a depression episode and half had had depression

earlier or it had become chronic (Pekkanen, 2011, Lönnqvist 2009). The research also revealed that from the people who had had depression only half had received treatment for it and that only third of the cases of acute depression receive treatment (Lönnqvist, 2009). Lönnqvist (2009) states that when treatment most of the time isn't optimal, it is obvious, that depression in significant amounts causes the decline of quality of life and loss of ability to function.

2.1. Face of depression

Depression effects person in all aspects of life. Depression represents itself for the depressed as an experience that spreads to all aspects of living (Enäkoski, 2002). Depression is experienced as a slowly developing and changing wholesome process (Enäkoski, 2002).

Depression has been felt to affect the memory, concentration and generally the ability to cope in work and everyday life (Kalska, 2005, s. 39-53). The depressed person feels their thoughts occasionally as being stuffed and circulating (Enäkoski, 2002). Neuropsychological analyses haven't been able to prove the symptoms experienced by depressed patients, but still cognitive changes associated with depression have been found (Kalska, 2005, s.39- 53, s. 48).

Depression as an emotion is a normal reaction to loss, disappointment and failure, when it is short term and temporary (Kuvaja, Linqvist & Rasilainen, 2005, s. 6). This emotion transforms to pathological when it takes over the mind as too intense and chaining (Kuvaja, Linqvist & Rasilainen, 2005, s.6). According to the research done by Enäkoski (2002) depression is linked with negative emotions, for example guilt, fear, isolation, anger or sadness. Also the feeling of being an outsider, observing the world from outside, is part of being depressed (Enäkoski, 2002).

Negative life events and their amount and quality affect the risk of getting depression (Lönnqvist, 2009). Also so called changes affecting one's ability to cope

such as developing burnout symptoms and mild symptoms of depression increase the risk to get severe depression (Lönnqvist, 2009).

According to Enäkoski (2002) the experience of depression varies according to the nature of individual's vulnerability and specific features during lifespan. Also the emotional content of depression depends on the things, goals and relationships relevant to the individual and to which the individual has made emotional bonds and how the individual can control these relationships or threatening events (Enäkoski, 2002).

Stress also known as psychiatric strain is a positive or negative thing in individual's life (Lönnqvist, 2009). The effects of stress depend on the individual's ability to control stress (Enäkoski, 2002). In terms of depression risk, stress appears as negative aspect by straining the individual excessively, which may lead to psychiatric imbalance (Lönnqvist, 2009). Inner and outer resources such as social support network, the level of education, economic situation, personal defense mechanisms and social and health care services influence individual's ability to cope through negative life events and to avoid depression (Lönnqvist, 2009).

Depressiveness is clearly more common for females than in males (Lönnqvist, 2009). This gender difference has been explained via the combined effect of biological, psychological, social and cultural factors (Lönnqvist, 2009). Depressiveness has been seen to generalize during youth and to be most common in the middle-age (Lönnqvist, 2009). The elderly do not have more depression that the other parts of the population (Lönnqvist, 2009).

Coming down with depression has been seen to vary also between regions (Lönnqvist, 2009). No coherent data has verified about the occurrence of depression between the countryside and urban areas. The differences in the occurrence of depression have been seen inside cities and municipalities and being bound to the selection of the population or local cause factors (Lönnqvist, 2009).

Partly the tendency for depression is also familiar and genetic. On the genetic level genetic differences of some individuals combine with both stress and depression tendency (Lönnqvist, 2009). For example repeated threatening situations and violent mistreatment during childhood expose the individual to depression and anxiety in the adulthood (Lönnqvist, 2009). Also according to Kalska (2005) breaks in early nurture, traumatic losses and experiences are seen as developmental factors that expose individual for depression (Kalska, 2005, s.40). Nevertheless the risk for psychiatric illness and disruptions of development of these children can be minimized by the social support received in for example day care centers (Lönnqvist, 2009).

According to Enäkoski (2002) depressed people feel that reasons behind their depression are varying problems in both relationships and work (Enäkoski, 2002). From social factors one important risk factor is unemployment (Lönnqvist, 2009). The number of disability pensions due to depression has been increased significantly during last years. Arkio (2009) states, that "In the 2008 about 4000 persons started to receive disability pensions due to depression, whereas in the year 1997 the amount was 2500 persons" (Arkio, 2009).

During the year 2009, 8500 individuals started to receive disability pension due to mental health problems. For 48,7% , almost half of them, the reason was depression. (Maaniemi & Raitasalo, 2011). The 8500 mentioned above is equivalent to the total number of population in 14 smallest municipalities in Finland (Maaniemi & Raitasalo, 2011). The comparison used by Maaniemi and Raitasalo states how significant illness depression is nationally.

In the year 2009 depression was the reason for 2,4 million sickness benefit days (Maaniemi & Raitasalo, 2011). According to Gould and Hokkonen (44/2011, s. 3296-33297) the amount of people starting disability pension due to depression peeked to all time high in the year 2007, when 4600 Finns started receiving disability pension. After this the numbers have started decreasing and in the year 2010, 4100 Finns started receiving disability pension (Gould & Honkonen, 44/2011, s. 3296- 33297). Also great number of sick leave days is caused by depression (Lönnqvist, 2009).

During the year 2007 from all sick leaves every seventh sick leave day was compensated due to mental health disorder, mainly due to depression (Lönnqvist 2009). The disability pension costs due to depression were 410 million euros and the medication costs were 110 million euros in the year 2007 (Lönnqvist, 2009). According to Lönnqvist (2009) employment significantly decreases mental symptoms especially depression. This fact raises the question to the author, whether depressed are encouraged enough to stay in the working life by adapting the work conditions temporarily or does the majority only have the option to start receiving disability pension.

Increased mortality is linked to depression particularly due to suicide risk (Lönnqvist, 2009). Suicide risk is 20 times higher for the depressed in comparison to normal population (Haukka, Holma I., Holma M., Isometsä, Melartin & Sokero, 2010). Vähäkylä (2006) states that over 90% of people deceased due to suicide have a mental illness, depression being the most common. About ten percent of the population has serious thoughts of suicide. According to WHO 80% of the people who have committed suicide have had symptoms of depression (Dahlberg, Krug, Lozano, Mercy & Zwi, 2002). Patients receiving treatment in the basic health care have a smaller risk for suicide (Isometsä, 2011, s.32-33).

Patients who have partially recovered from depression have four times higher risk of suicide than fully recovered patients (Mielenterveys, 2008). About two thirds of all suicides are linked to depressive disorders (Isometsä, 2011, s. 32-33). All depressed patients have a risk of suicide, so suicide has to be taken under consideration in the treatment of any depressed patient (Isometsä, 2011, s.32-33). Nevertheless there are gender differences among the patients risk for suicide, males have two times higher tendency for suicide than females (Isometsä, 2011, s.32-33). The higher tendency of suicide for males is seen also globally (Dahlberg, Krug, Lozano, Mercy & Zwi, 2002). Detecting depression in males is also more difficult because they pursue psychiatric treatment less than females (Dahlberg, Krug, Lozano, Mercy & Zwi, 2002).

TABLE 1 Mortality and suicide rates in Finland and Central Finland (from a sample of 100 000 Finns) in the years 1990 to 2009 (Tilasto- ja indikaattoripankki SOTKAnet).

(Kuolleisuus= mortality rate, Itsemurhakuolleisuus= suicide rate, Koko maa = in Finland, Keski-Suomi = In Central Finland, yhteensä = together, naiset= women, miehet= men).

Kuolleisuus ja itsemurhakuolleisuus koko maassa ja Keski-Suomessa (100 000 asukasta kohti)								
			1990	2000	2006	2007	2008	2009
Kuolleisuus / 100 000 asukasta	Koko maa	yhteensä	1004,5	952,9	913,5	928,3	923,9	934,7
		naiset	976,1	953,8	884,3	900,1	909,5	909,8
		miehet	1034,8	951,9	943,9	957,6	938,9	960,6
	Keski-Suomi	yhteensä	1054,6	973,6	948,2	956,5	980,7	966
		naiset	1033,5	988,2	920,6	893,5	950,8	953,9
		miehet	1076,4	958,5	976,5	1021,3	1011,5	978,4
Itsemurhakuolleisuus / 100 000 asukasta	Koko maa	yhteensä	30,5	22,5	20,2	18,8	19,4	19,4
		naiset	12,5	11	9,6	9	8,6	10
		miehet	49,5	34,6	31,1	29	30,8	29,1
	Keski-Suomi	yhteensä	33,4	23,4	22,6	20,7	21,8	23,9
		naiset	15,3	9,6	11	8,8	8	10,1
		miehet	52,1	37,5	34,6	33	35,9	38

Â©; THL, Tilasto- ja indikaattoripankki SOTKAnet 2005 - 2011

The statistics of National Institute for Health and Welfare, which are visible on the table 1, also state the differences in numbers of male and female suicides. According to the statistic the numbers of suicides in both Central Finland and whole Finland have decreased form the year 1990 to 2009 by ten persons. During the year 2009 in Finland 19,4 and in Central Finland 23,9 residents committed suicide from a sample of 100 000 Finns. In the same year in the whole Finland 10 and in Central Finland 10,1 females from a sample of 100 000 committed suicide. Males committing suicide in a sample of 100 000 Finns in the year 2009 were in whole Finland 29,1 and in Central Finland 38. During the years suicide rates in Central Finland have been higher than the rates in whole Finland. Form the whole population about 2,5 % in Central Finland and about 2% in whole Finland died due to suicide during the year 2009. About half of the people who have deceased as a result of suicide have tried it at least once before (Haukka, Holma I., Holma M., Isometsä, Melartin & Sokero, 2010). According to WHO suicide tendency can be decreased by treating anxiety and depression and by improving early recognition and offering suitable treatment (Dahlberg, Krug, Lozano, Mercy & Zwi, 2002).

Depression is a disease with a multifactorial background. It is common, easily recurring and sometimes turning into a long-term disorder (Kuvaja, Lindqvist & Rasilainen, 2005 s. 6). Depression cripples one's ability to function and causes human suffering to the depressed and their significant others (Kuvaja, Lindqvist & Rasilainen, 2005 s. 6). Kuvaja, Lindqvist and Rasilainen (2005, s.7) state that "Over 300 000 Finns have depression that cripples their ability to function. Only every second patient gets proper treatment. People seek help from the doctors' practice only when the situation is hopeless".

2.2. Treatment of Depression

Diagnosing depression is based on symptoms, which have been occurring simultaneously for at least two weeks (Isometsä, 2011, s.20-21). Symptom chart is a tool used to help diagnosing. The chart is visible in the following table 2 (Isometsä, 2011, s. 20-21).

TABLE 2. Symptoms of depression (original Finnish table by Isometsä, 2011, s.20-21)

Symptoms of depression	
1.	Depressed mood
2.	Loss of pleasure
3.	Exhaustion
4.	Loss of self-confidence or self-esteem
5.	Unreasonable self-criticism or groundless guilt
6.	Recurrent tought of death or self-annihilation or suicidal behaviour
7.	Feelings of indecision or flightiness
8.	Psychomotorical slowdown or agitation
9.	Sleeping disorder
10.	Change in appetite or weight

Depressive disorders are categorized by the severity and quality to mild, moderate, severe and psychotic depression (Isometsä, 2011, 20-21). There are great differences in the severity of depressions even though the basic diagnosis is the same (Isometsä, 2011, 20-21). Severity correlates without dispute with the decrease in ability to function (Isometsä, 2011, 20-21). For example mildly depressed patient can still go to work, even they feel it to be harder than when they are healthy (Isometsä, 2011, 20-21). Moderately depressed person has clearly decreased ability to function and sick leaves are often needed (Isometsä, 2011, 20-21). In severe and psychotic depressions patient is often lacking all ability to work and requires continuous treatment in hospital setting (Isometsä, 2011, 20-21). During the treatment of the depression it is important to follow-up the severity of depression with diagnostic interviews and measuring scales (Isometsä, 2011, 20-21). Examples of measuring scales are DEPS (The depression scale), BDI (Becks depression inventory), HRSD (The Hamilton Rating Scale for Depression) and MADRS (The Montgomery–Åsberg Depression Rating Scale) (Isometsä, 2011, 20-21).

According to Enäkoski (2002), Depression is a multiple process which leads to re-evaluation of one's life situation. The feeling of control over one's life weakens both internally and externally and the depressed person's touch with the inner self is lost (Enäkoski, 2002). Enäkoski (2002) highlights the meaning of social support as an essential part in surviving from depression. The social support gives the depressed a chance to be themselves. Experiences of treating depression have led to the conclusion that every individual has forces that enable the recovery from depression (Lindfors, 2005, s.116-134). These forces help person to seize and improve their life (Lindfors, 2005, s.116-134). These forces include also the feeling of will, which assists starting of the process of transformation and fulfillment via one's own will (Lindfors, 2005, s.116-134).

The role of the nursing staff in the treatment of depression is to support the individual towards the change in their lives (Lindfors, 2005, s. 116-134). A way to do this is to lead the depressed to learn to appreciate themselves again (Lindfors, 2005, s.116-134). According to studies the feeling of self-worthiness helps the individual to

find their own strengths and join the world and to live their life in a new way (Lindfors, 2005, s.116-134).

For the depressed being heard and understood in encounters with professionals or significant others play also a great role in the healing process. Being heard and understood adds the feeling of self-worthiness (Lindfors, 2005, s.116-134). It is also important for the depressed to gain experiences of acceptance from others, so that the depressed can allow themselves to be who they are (Lindfors, 2005, s.116-134). Self-acceptance creates the basis for knowing oneself and via this becoming themselves (Lindfors, 2005, s.116-134). Being oneself is a lifeline for wanting to get well and learning from the illness and for self-improvement, hermeneutics (Lindfors, 2005, s.116-134). In the viewpoint of hermeneutics depression can be an experience that changes the person's life to be more versatile and rich, which build the self-knowledge (Lindfors, 2005, s.116-134).

Enäkoski (2002) highlights the overplay of individual's life control and loss of the life control. This will lead to limiting and minimizing one's life surrounding to be able to maintain life control. When control over one's life is overplayed, giving the control up because of depression is a very difficult thing to do (Enäkoski, 2002). It causes humiliation and insecurity for the depressed and thus deepens the depression (Enäkoski, 2002).

Also life experiences are important in the healing process. These experiences are gained from things that are positive and rewarding and thus increase sense of self-worth and enjoyment (Lindfors, 2005, s.116-134). Lindfors (2005, s.116.134) states that according to many studies, staff members and "experienced experts" the basis for healing from depression is taking responsibility of one's own life. Staffs role is to support and encourage this process of taking responsibility (Lindfors, 2005, s.116-134).

Treatment of depression in Jyväskylä region is organized as follows. Jyväskylä belongs to the Central Finland Health Care District and the following picture visualizes the psychiatric field (Figure 3). Treatment is divided to Child and adolescent psychiatry

and psychiatry (Seuri, 2012). There are two psychiatric hospitals in the Jyväskylä region, Juurikkaniemi and Kangasvuori hospitals (Seuri, 2012). Kangasvuori hospital treats mental health patients acutely and shortly and in Juurikkaniemi the treatment periods are longer (Heikkilä-Kari, 2012). General psychiatric ward offers psychiatric special health care for patients who have also illnesses that need somatic health care (Seuri, 2012). Patients of Kangasvuori hospital are directed for follow-up treatment to either Juurikkaniemi hospital, rehabilitation or housing services or to the responsibility area of psychiatric polyclinic (Heikkilä-Kari, 2012).

Only a small portion of depressed patients require health care on specialist level (Isometsä, 2011, s.25-26). Depressed patient needs psychiatric special health care when the depression is severe, psychotic or drug resistant, or when the depression is a threat to the patient's ability to function in long term (Isometsä, 2011, s.25-26). About 5-15% of depressed patients is estimated to be sent by general health doctor to psychiatric special health care (Isometsä, 2011, s.25-26). Majority of the patients suffering from mild or moderate depression are treated in basic health care in other words in health care centers or occupational health (Isometsä, 2011, s.25-26).

Psychiatric outpatient care is produced by Central Finland's health care centers outpatient units also known as psychiatric policlinics and similar offices (Psykiatrinen avohoito, 2012). The responsible unit for psychiatric outpatient care is the psychiatric polyclinic (Psykiatrinen avohoito, 2012). Psychiatric polyclinic works as consultation and appointment policlinic, to which patients are directed via doctors' referral (Psykiatrinen poliklinikkatoiminta, 2011). Psychiatric policlinic offers treatment for patients with severe mental health disorders and mental health illnesses (Psykiatrinen poliklinikkatoiminta, 2011). Temporary treatment periods in the policlinic are based on treatment plan and include multi professionally executed medical-, individual-, couple- or family treatment and also group treatment (Psykiatrinen poliklinikkatoiminta, 2011). Psychological and psychiatrical examinations are also done in the psychiatric policlinic (Psykiatrinen poliklinikkatoiminta, 2012).

Psychiatric policlinic offers consultative services outside the policlinic in the forms of psykiatrinen vanhustiimi (“Psychiatric elederly care team”) also known as PSYVA and tehostettu kotihoito (“Intesified home-care”) also known as TEHKO (Seuri, 2012). PSYVA offers basic health care consultation for patients over the age of 65 in form of house and hospital ward visits (Seuri, 2012). TEHKO also offers basic level consultation help but especially for patients in psychosis risk. TEHKO also helps for patients that have fallen for psychosis and need homecare acutely (Seuri, 2012). Psykiatrinen päivystystiimi (“Psychiatric on-call duty team”) also known as PSYPÄ, works under the responsibility of the psychiatric policlinic and offers consultative service in the emergency area of Central Finland central hospital (Seuri, 2012). PSYPÄ answers the questions on whether the patient should be treated in psychiatric basic care or in psychiatric special care (Seuri, 2012). PSYPÄ also treats patients in short-term crises treatment periods (Seuri, 2012). Psychiatric policlinic is responsible for the work of the 14 depression nurses in the Central Finland Health Care District (Seuri, 2012). Depression nurses work in the health care centers and treat patients with mild and moderate depressions (Seuri, 2012). Depressions nurses work together with patient’s own health care center doctors and with a consultative psychiatrist (Seuri, 2012). Psychiatric policlinic also carries the responsibility for organizing health care for substance abusers. It is organized today by substance abuse nurses in health care centers and by Sovatek- foundation (Seuri, 2012).

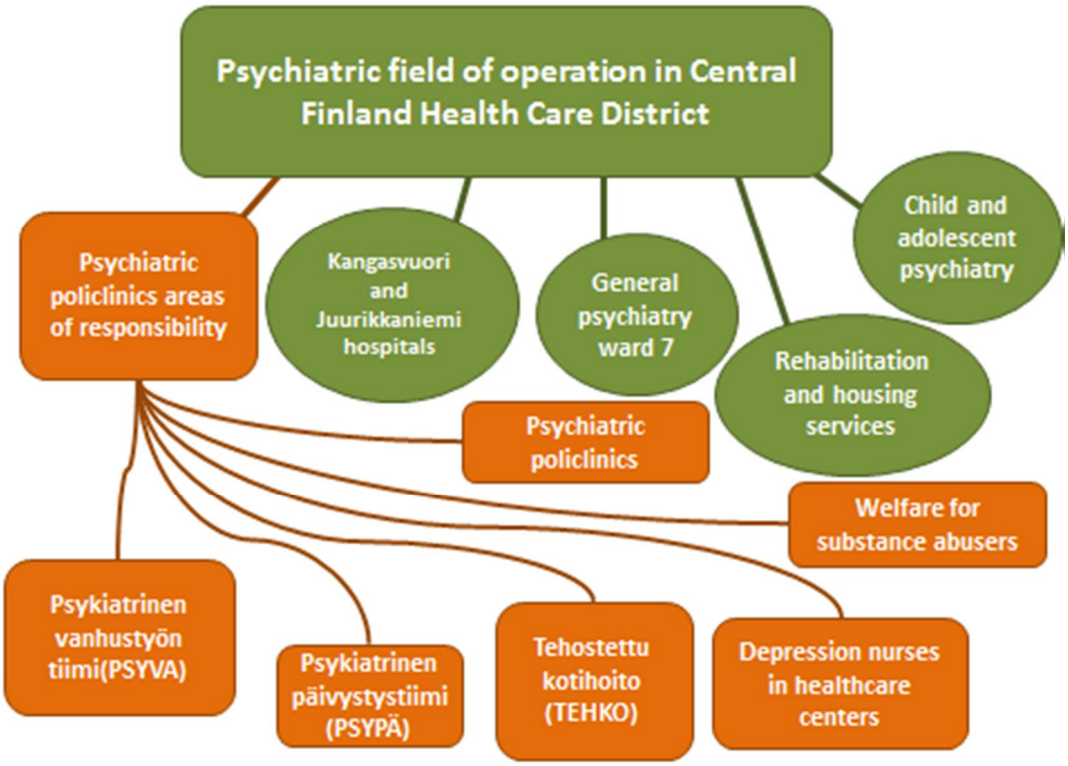

FIGURE 3. Psychiatric field of operation in Central Finland Health Care District (original figure: Seuri, 2012)

2.2.1 Ways of treating depression

Most common ways of treating depression are medical treatment and psychotherapy. Also biological treatments are used. Since the year 1990 the use of anti-depressants has increased steadily and grown eight times higher than before (Lönnqvist, 2009). The growth is due to the increase in long-term use and the use of anti-depressants in treating other mental health problems (Isometsä & Leinonen, 2011, s.72). According to the Mielenterveysbarometri of 2011, 41% of health care professionals felt that medical treatment of depression was excessive and 35% felt that it was proper (Mielenterveyden keskusliitto, 2011). In the same barometer 47%

of psychiatrists felt that use of anti-depressants in treating depression was appropriate and 27% felt that it was too low, meanwhile 63% of psychologists thought the use was excessive (Mielenterveyden keskusliitto, 2011). These numbers state clearly the dichotomy of the professional's opinions on the usage of anti-depressants.

According to Isometsä and Leinonen (2011) anti-depressants are recommended especially for the treatment of moderate and severe and dysthymia (chronic depression). Scientific proof of the effects of anti-depressants on these conditions is strong. There are benefits also for milder depressions, but these benefits are not as great. The response to antidepressants comes on average after four to six weeks after the beginning of medication. About half of users of medication become asymptomatic (s.72-81).

The effects of the medication should be assessed at least six weeks after starting the anti-depressants with the help of a symptom scale (Isometsä & Leinonen, 2011, s. 72-81). When the sufficient response to treatment has been reached, the medication should continue for at least six months after the acute stage. The goal of follow-up treatment is to prevent recurrence of depression. For patients suffering from recurring depression, anti-depressants are preferred for long-term, preventative medication. The effect of the drug stays the same for years, but there is a lack of evidence on the maintenance of effect in long term treatment (s. 72-81).

There are several different anti-depressants and they have various ways of effecting (Isometsä & Leinonen, 2011, s.72-81). There are no specific ways of determine which anti-depressants should be used for which type of depression (Isometsä & Leinonen, 2011, s.72-81). Medical treatment of depression is experimental and according to Isometsä and Leinonen (2011) finding the most suitable medication requires good and intensive co-operation and follow-up between the patient and doctor. Intensive co-operation is difficult due to shortage of doctors and the huge turnover of doctors as a result of the shortage (s. 72-81).

Enäkoski's (2002) doctoral thesis rises up a question of the ethically right to offer a depressed patient only or primarily antidepressants, even though the usage of these medications doesn't solve the vital problems of losing the feeling of life control and becoming estranged from oneself. According to Käypä hoito - recommendations psychoteraphy and antidepressants should be used together when treating mild and moderate depression (Isometsä & Leinonen, 2011, s.72-81). In severe depression the principal treatment would be antidepressants, electroconvulsive therapy (ECT) and psychotherapy (Isometsä & Leinonen, 2011, s.72-81). According to Käypä hoito-recommendations the treatment of psychotic depression should consist of antidepressants together with antipsychotics or ECT (Isometsä & Leinonen, 2011, s.72-81).

Despite of failed antidepressant trials new antidepressants are often recommended and prescribed, instead of offering other measures (Enäkoski, 2002). Fears of addiction, adverse effects and loss of control of one's body are associated with antidepressants (Enäkoski, 2002). These fears have an effect to the patient's attitude towards medication, which effects to the success of the medical treatment (Enäkoski, 2002). According to Enäkoski (2002) users of antidepressants have not received enough information on the medication and ability to participate on the decision making on their treatment.

However the mielenterveysbarometri (2011) states that 80% of people rehabilitating form mental health illnesses and 61% of significant others of mental health patients think that the medication received for mental health problems is adequate. Combination of medical treatment with psychotherapy have been proved to increase the effects of treatment (Isometsä & Leinonen, 2011, s.72-81). Combining accelerates treatment especially patients, that suffer from recurring or prolonged depressions and who have traumatic events or significant losses in their childhood or past (Isometsä & Leinonen, 2011, s.72-81).

Psychotherapy is professional action, which is based on the interaction between a psychotherapist and one or more patients (Kontunen, 2011, s.85). Psychotherapy aims to eliminate or ease mental illnesses or relationship problems, to support

mental growth and development and to increase individuals own readiness to solve one's problems (s. 85). The co-operation relationship between patient and psychotherapist is in an important role (Kontunen, 2011, s.88-89).

There are several different psychotherapies for example psychodynamic-, cognitive behavioral- and systemic psychotherapy (Kontunen, 2011, s.88-89). Patients own views on the background of their depressions influences on the decision about the psychotherapy that should be used (Kontunen, 2011, s.86). The length of psychotherapy varies between different therapies. Also the strength of the patient's ego and the quality of one's mental illness determines the effects on the length (s.86).

Differences between therapies are seen in the matters they emphasize (Kontunen, 2011, s.88-89). For example cognitive psychotherapy emphasizes person's ways of thinking and their beliefs, but also takes under consideration their emotional experiences, and learning history throughout their lifetime (Kontunen, 2011, s.88-89).

There are also group psychotherapies, which are shorter and which have given significant results on easing depressiveness (Hagman & Roine, 2011, s. 107- 108). Psychoanalytical group psychotherapy works through the principal of free discussion and association. The group members are connected to each other by the same mental illness. Group psychotherapy also exists in form of art psychotherapy where the picture made by the patient is used as extra tool of expression (s.107-108).

There are also biological treatments used for depression such as electroconvulsive therapy alias ETC, Trans cranial magnet stimulation and light therapy (Isometsä & Leinonen, 2011, s.80-81). ECT is recommended as primary choice of treatment especially in psychotic depressions, because it is often more effective than medical treatment (Isometsä & Leinonen, 2011, s.80-81). 70-90% of patients with severe depression get notable results from ECT treatment (Peltola, 2004). Patient receives ECT in venous anesthesia two to three times per week for six to 12 treatment times (Isometsä & Leinonen, 2011, s.80-81). Results of treatment are usually visible

immediately (Peltola, 2004). Due to its fast effectiveness, it's a unique treatment especially for patients with severe depression or high suicide risk (Peltola, 2004). ETC's side effect is post procedural amnesia, but there are no known long-term side-effects (Isometsä & Leinonen, 2011, s.80-81). The action mechanism of this treatment is not fully known, but the treatment both stimulates the synthesis of nervous growth and enhances dopamine neurotransmission (Isometsä & Leinonen, 2011, s.80-81).

Trans cranial magnet stimulation (TMS) is equivalent to the effect of anti-depressants (Isometsä & Leinonen, 2011, s.80-81). Transcranial magnet stimulation activates brains cortical neurons from the outside of the skull, with the help of magnetic field (Isometsä & Leinonen, 2011, s.80-81). TMS treatment has very little side effects and the procedure doesn't require anesthesia. This treatment method is not common because it isn't more effective than other treatment methods (Isometsä & Leinonen, 2011, s.80-81).

Light therapy is used for patients whose depression is associated with certain time of the year such as seasonal affective disorder (Isometsä & Leinonen, 2011, s.80-81).

Adding physical exercise in addition to other treatment method has been discovered to speed up the treatment of depression, but the scientific proof of the effects of exercise on depression are still insufficient (Leppämäki, 2006). According to Lindfors Peden's studies have shown that exercising decreased the malaise of the depressed and feeling of unease in female patients (Lindfors, 2005, s. 116-134). Lehto (2012) says in a recent article that resent studies on depression have shown that "lifestyle treatment" is effective in especially prevention of depression. "Lifestyle treatment" is focused on treating depression as a disorder of the whole body (Lehto, 2012). In "lifestyle treatment" the depressed are encouraged towards exercise, healthy diet and sufficient sleep (Lehto, 2012). According to Lehto (2012) these are essential things when thinking about treatment which supports other necessary treatments.

The amount of information the patient receives from the illness and its effects on their well-being has been proved in the study by Oras. The study by Oras states that

insufficient knowledge caused fear for patients suffering from neurological symptoms (Lindfors, 2005, s. 116-134). These kinds of experiences have been also reported by the participants of the study that is discussed in the article of Lindfors (Lindfors, 2005, s. 116-134).

3. The aim and goals of the research

The aim of the research was to find out and collect the experiences of hospitals nursing staff on the psychiatric care of depressed patients via interview study. The goal of the research was to find out, how to develop the psychiatric care of the depressed from the hospitals point of view.

Research problems were:

1. How hospital's nursing staff experience the psychiatric care of depressed patient.
2. How the nursing staff would develop psychiatric care.

4. Implementation

4.2. Method

The research of this thesis was qualitative. Qualitative research method highlights the subjective nature of reality and the subjective nature of the knowledge gained from it (Juuti & Puusa, 2011). Essential in qualitative study is to emphasize the viewpoints of the participants and the interplay between singe findings and the researcher (Juuti & Puusa, 2011). In qualitative study the experiences of the research subjects are essential (Juuti & Puusa, 2011). The goal of qualitative study can be

either forming a theoretically worthwhile interpretation, gaining new knowledge, describing the phenomena, deepening understanding or interpreting a phenomena (Juuti & Puusa, 2011).

The research method of this interview was focused group interview. Focused group interview is used widely in researches which aim at developing service or operation (Kaila & Mäntyranta, 2008). Due to this it is a very appropriate tool for this thesis study. The strength of focus group interview is it's the ability to develop new ideas during the interview. New ideas are more easily accomplished via discussions inside the study group in comparison to individual interview.

Interviewees told freely about their experiences and discuss with the other group members. The interviewer had the possibility to clarify any unclear issues that came up during the interview. Because of this the full understanding was made certain and very little was left for assumption. Interviewer had the responsibility to give every participant the opportunity to express their experiences and opinions. Focus group interview created new viewpoints to the subject and created new research subjects. In these situations it was the interviewer's responsibility to limit the discussion to the topics of the research and collect possible new subjects for further researches. The interviews were recorded with an audio recorder. The interviews were implemented in Finnish.

4.2. Target group

The interviewees of the research were members of the treatment staff of one psychiatric special care ward. Participants were nurses, mental health nurses, head nurses, psychologists and social workers. Altogether there was 20 staff members interviewed. Group size was dictated by the number of volunteers. Interviews were implemented in three different groups and the group sizes varied from five to eight members.

4.3 Data collection

All of the staff members received a written bulletin about the thesis and its research and the research was introduced also during one staff meeting (APPENDICE 4). Volunteer interviewees took part in the study during their work shift. Interviews were implemented in the ward in a calm environment. One hour was reserved for each interview. Every group was interviewed on different day.

In the beginning of the interview the participants received information on the recording and possibility to discontinue the interview. Participants were asked to sign a written agreement to participate and give a permission to use the gathered data (APPENDICE 3) before the interview. They were also presented the bulletin about the thesis again (APPENDICE 4). Interviewees were also asked to fill up a document asking about their title and work experience in psychiatric field in years (APPENDICE 5). This data was used in the research results when referred to single comments.

During the interview the interviewees explained in free word their own experiences and opinions on the psychiatric care of depressed patients within the main themes of the interview. Main themes were experiences of the nursing staff on the psychiatric care of depressed patients and development ideas on the treatment. Interviewer guided the interview when needed with the research questions and asked the interviewees to specify their opinion to ensure understanding.

4.4. Data analysis

The audio recordings were transcribed in Finnish and referred to the interviewees via title and work experience to ensure anonymity. Altogether the interviews produced 42 pages of transcribed data. Data was analyzed only by the author of the theses and the analysis was done by the means of content analysis. In content analysis the material was divided in pieces from which similarities and differences were spotted out. These similarities and differences were then compared to each other and to different interviews. The goal of the analysis was to from a condensed scene from

the phenomena. This attached the results to a larger context and other studies over the same topic.

4.5. Results of the research

Three focus group interviews produced 42 pages of transcribed material. Two main themes rose from the material with content analysis. The author used these two themes in presenting the results. These themes go also together with the research problems (see page 22). The first theme was: “Experiences of nursing staff on the work with depressed patient. The second theme was “The follow-up care after hospital, which supports and would support depressed patient the best”. The results are also visible in a more compact form in the figure 4. In the figure 4 results are divided under headings: what helps during the treatment of depressed patient, developmental needs of hospital care and developmental needs of outpatient care (FIGURE 4)

FIGURE 4. Results of the research

4.5.1. Experiences of nursing staff on the work with depressed patient

Keeping hope of recovery up was highlighted by every research group as the main thing in depressed patient's treatment. Other central thing according to the nursing staff was building of trust between the patient and the caregiver. The different ways to keep up hope were psychoeducation on depression, building faith via discussion and also that the caregiver believes to patient's recovery. One nurse with 10 years of work experience in psychiatry said that the caregiver needs to again and again on daily bases to infuse faith for the future. And that depression can be recovered even though it may be frustrate and sometimes one goes one step forward and other times one step backwards. You have to, sometimes even excessively emphasize and

think about the positive factors, that you notice some spark of hope together with the patient.

Keeping up the daily routine and ability to function or recreating them both was seen very important in the beginning of treatment. Also athletic groups and other daily activities such as käspaikka and puutyöverstas were experienced as important. Käspaikka is place where patients can do arts and crafts with guidance. In puutyöverstas patients can do woodwork also with guidance. Still there were hopes to have more options for activities. In two interviews the lack of gymnastic hall, gym and library were brought out. One nurse with 2,5 years of work experience longed for guided activities, for example discussion groups also during weekends. These activities were seen as very necessary parts of psychiatric special care, because they support the keeping up of patient's daily rhythm and recovery of ability to function. One mental health nurse with about 30 years of work experience described nurses work to be like a personal trainer, who offers and makes with the patient a program, so that the patient can become empowered, rehabilitated and can live a normal life.

Also multi professional work approach was felt as important. The availability of social worker, psychologist, psychiatrist, occupational- and physiotherapist with short notice is an important resource. Social worker's help is especially important for the depressed, because as the burden of economic problems is lifted, recovery from depression is easier. The availability of social worker in crisis situations in hospital was compared to civilian life, where getting to social workers reception can take and require a lot of struggle with appointment and other things. Nurse with seven months of experience in psychiatric work commented that many people need help in filling up social work papers, which is surely very difficult task for a depressed individual with loss of ability to function.

Presence of significant others and family therapeutical approach was experienced as an important part of the comprehensive treatment of the patient. This has been executed via family meeting and couple meetings. Significant others can also be present in treatment negotiation and on doctor's rounds.

According to the staff, patients have felt important the own nurse and work group practices in hospital care. These practices reduce the amount of repetition and help the building of trust with the nurse. Also the versatility of the staff helps to build up trust. Diversity of people inside the staff offers the patient the possibility of finding a nurse that is “on the same wavelength” with the patient. Finding common ground and trust helps the patient to open up for discussions, which are substantial part of the work in psychiatric hospital. Encountering the patients as individuals and empathizing to their problems was felt as the strength of the ward treatment. Also several caregivers had received positive feedback on the length of treatment periods in the ward as the returning to home had not been hurried. One nurse, with 25 years of work experience in psychiatry, felt that ward treatment sees patient’s situation too narrowly and only in the framework of the ward.

According to the research study working with depressed patient requires perseverance and coping skills from the staff. Very intensive work approach was felt to take strength also from the nurse, especially when the treatment prolongs. Also the nurse’s sensitiveness to see the patient’s current state and acknowledging and interpreting it was seen as important part of the caring. One group also pondered upon the role of intuition especially in taking care of patients with high risk for suicide and saw the differences in staffs opinions and views as a weakness in these situations.

Every group told that the negative feedback from patients was mainly caused by the routines of the ward, not by the treatment itself. One mental health nurse with 30 years of experience had received criticism about the treatment plans in the beginning of the treatment. This complaint concerned the requirements of the patient to keep up of daily routines and starting them. However in the end of the treatment the patients have reminisced the beginning with humor as no one could get them out of bed.

The sum of many treatment methods was felt to cure depression. Medical treatment, discussions with nurses, peer support and other treatment procedures were all seen to be essential parts in recovery. None of the interviewees could say

specifically which individual, separate things had helped the depressed. Caregivers felt that even the depressed didn't know what had helped them. Mental health nurse with 30 years of work experienced stated that the goal in treating depressed is not to rehabilitate the individual exactly the same person as they were when they got ill. There needs to be some changes in other things too, than just that they recover. If there are some factors in one's life that have affected and predisposed that individual to the illness, then something has to be done to those factors.

4.5.2. The follow-up care after hospital, which supports and would support depressed patient the best

Special health care workers felt that, the co-operation between the hospital and outpatient care works mainly good as it stands now. Arrangement of patient's follow up care is supported by early dialog of patient's situation with outpatient care by taking outpatient care along early on in the treatment. Also discussions with the outpatient care of the patient from before and informing them about the patient's situation supports the treatment. Nurse with 25 years of work experience said that all in all continuing dialog and interaction between patient, hospital and outpatient care is an essential thing.

The participation possibilities of outpatient care on treatment meeting and other meetings with the patient, is varying. Tehko and other similar groups got very positive feedback from flexible participation to treatment. The nursing staff wished for increased co-operation with policlinics during treatment. One nurse with 10 years of work experience in psychiatry had experienced that the co-operation with policlinics happens only when the hospital offers a new patient to the policlinic and when the patient's first appointment in the policlinic is settled.

The mutual view of the hospital staff was that, if the patient could meet the outpatient care already during hospital care it would help very much the starting of follow up treatment for depressed patient. This was managed to be organized with

some patients for example so that the mobile groups' of outpatient care had visited the patients during the "home leaves" during hospital care.

The experience of the nursing staff was that sometimes it is difficult to get appointments and organize outpatient care even though in general the system works quite fluently. Sometimes the hospital care is prolonged due to the length of the decision from outpatient care. The experience of the hospital caregivers is that especially for elderly patient finding suitable follow up care takes time when the right work group is found. One nurse with 18 years of work experience commented upon this that sometimes the hospital waits until the outpatient care accepts the patient. The question is which outpatient care group can take the patients or is there any group who would take the patient.

The amount of co-operation could be increased, for example through collaboration meetings, which are used on other psychiatric wards. Also there were developmental needs on the ability to reach the outpatient care units. The separate calling time to reach nurses of psychiatric policlinic would be especially useful. At the moment the call time is common for everyone, patients and care givers. The ward staff found this to be difficult when they tried to reach outpatient care.

In two research groups rose up the need for highlighting and messaging to outpatient care about the worry over some patients ability to cope of after hospital care and their need for intense follow-up and support. This support and the whole follow up care don't always come out as planned, despite the efforts hospital and outpatient care puts to the matter. This is partially due to the patients responsibility to execute and continue their treatment after hospital care. The nursing staff pondered in one group how it would be possible to be in touch with the outpatient care after the patient has left the hospital care. One mental health nurse with 30 years of work experience in psychiatry felt that policlinic visit to the hospitals after hospital care had been good and working concept and wished for that arrangement could come back in the future. One nurse with four years of work experience in psychiatry commented that sometimes one's own feeling is that, when the patient goes home

the nurse wonders how the patient manages and whether the outpatient care is sufficient enough. The nurse felt that this kind of dialogue is not discussed enough.

All interview discussions revealed that the co-operation with outpatient care could be eased if the hospital contacted the outpatient care as early as possible during hospital care. Also the research revealed the inequality of services in municipalities. Jyväskylä had more services than the other municipalities of Central Finland. The development should also improve the services in these other municipalities to reach equal psychiatric care level to every municipal.

The closing of psychiatric policlinics during July was felt problematic by both the hospital staff and the patients. One nurse with 31 years of work experience had pondered upon the subject many times and felt that it was incomprehensible that the closing is possible because the problems of the patients don't vanish for that one month. One nurse with 2,5 years of work experience had received feedback from the patients on the closing. The patients had said that there are no activities via outpatient care or anything else. Many of the patients had said that the summer time is worse than for example Christmas which has been considered usually to be the worst time of the year for the depressed. The hospital staff suggested as a problem solution the same kind of alternating holidays as the hospital staff has. The hospital staff has their holidays from May to the end of September.

The discussion about developmental need raised up several ideas. One group pondered whether it would be possible to arrange a day policlinic activity either in connection of outpatient or hospital care. Nurse with 31 years of work experience in psychiatry had the idea of the day policlinic to be terminable, for limited amount of times, and it would be group based and to offer peer support. Another idea similar to day policlinic was the idea of "AA-groups" for depressed which would offer peer support and sensible things to do. One nurse with four years of work experience in psychiatry thought that some kind of day policlinic could be cost effective if the patient didn't receive 24 hours of treatment for the whole hospital treatment period. In the beginning of treatment they would be in the hospital 24 hours but at the end of the treatment they could have some other system.

On developmental need was to increase the knowhow of the caregivers. According to hospital staff also the care and evaluation of need for treatment for the depressed in health care centers and emergency rooms would need further development towards faster addressing, intervening and guiding to care.

Nurse with 25 years of work experience in psychiatry felt that the patient would benefit most if the therapeutic relationship formed in hospital would continue in outpatient care after hospital care. The nurse wished that the workers were not as "bound to the walls" and that they would continue the treatment also at home. This would lessen the need for repetition when the workers in outpatient care knew the patient. The same nurse felt that when doing house call work the whole situation of the patient would be seen much more as a whole. The ability to help the entire family would be better as depression also affects the whole family in great amount.

The needs of dual diagnosis patients were highlighted in every discussion group. All groups shared the opinion that the care of patient with substance abuse and psychiatric problems needed special attention. Also the "one-door principle" wasn't fulfilled in the care of dual diagnosis patients. One nurse with four years of work experience in psychiatry told that when the patient with depression and substance abuse problem needs care they must to first go to the substance abuse treatment. And if the patient has depression they might not be able to commit to the substance abuse treatment and then they cannot receive psychiatric treatment either. Nurse with two years of work experience in psychiatry had very positive experience recently over the treatment of patient with dual diagnosis. The nurse had met together with the patient a substance abuse nurse. They had in this meeting pondered upon the treatment possibilities after hospital care with the substance abuse nurse or with Sovatek. The substance abuse nurse was very suitable to the needs of that patient, especially because the nurse had worked also with psychiatric patients and thus had tools to treat also the patient's depression. Inspired by to this the interview group thought that it would be necessary to have more information available for the hospital staff over the new units of outpatient care. Also new contacts with outpatient care should be created more often.

5. Discussion

5.1. Ethicality

The ethicality of the research has been under the consideration of the author throughout the thesis. When doing the interview frame and the research plan the question was whether it is ethically right to ask the workers of special health care to evaluate the work of outpatient care. However the co-operation between hospital and outpatient care is a crucial part of daily work for the special health care staff when arranging follow up care. When representing the results it is important to highlight that the developmental ideas and other estimates considering outpatient care are subjective.

The author of this thesis has studied in advance and got acquainted with the challenges of the focus group interview method and qualitative research. She has minimized them by acknowledging their possible effects on the results. The interview frame was done so that the questions would not manipulate the interviewees nor give possible preconceptions of the author over the study topic. The study material aimed to present objectively the experiences and opinions and contradictions of the care givers objectively.

The interviewees had been informed properly and results were presented to the interviewees verbally and in writing, after the thesis were finished. The special health care ward received the whole thesis in Finnish, due to the wards request. Because of this the interviewees won't have language limitations when they read the thesis.

The author applied and received a permission to conduct the study from the Central Finland Health care district. Also the vow of silence and the co-operation contracts were signed with the ward. Each participant signed a permission to use the research

material. The references to the interviewees and the ward in the thesis are done so that the anonymity is not risked. All study material, especially ones containing data that might comprehend the anonymity was dealt so that only the author had access to them.

The results of the study gave real, although subjective answer to the study questions. The research highlighted the viewpoint of the interviewees and the interaction between the author and single finding. Thus the central result of qualitative study, the experiences of the interviewees, was formed. In this study the researcher considers also the goals of qualitative study, gaining new knowledge, describing the phenomena and deepening understanding have been fulfilled.

5.2. The reliability, validity and generalizability of the research

According to Aaltio and Puusa (2011) the reliability and validity of the qualitative research is linked to the operationalization of the phenomena and putting it into empirically researchable form.

The reliability of qualitative research is measured by checking if the study situation, researcher or random factors have had an effect to the results (Aaltio & Puusa, 2011, s.153-166). The author strived towards objectivity in research situations and when analyzing the study material. Random factors that affect the results are more common in group interview than in individual interviews. Group dynamics and other random factors brought their own colour to the discussions and group dynamics were visible in every discussion. Noticing the group dynamics and other random factors was helped by the fact that the author knew participants on beforehand. This also helped the transcribing because the author could recognize every participant by their voice. The research situation was calmed by leaving the interviewees phones and other pagers out of the room. All research groups included care givers from different ages, male and females and also care givers with longer and shorter work experiences in psychiatry.

Varto (1992) states that the researcher is inevitably part of the area of study. This implies the structure of qualitative study which begins from one's experience and the way of expressing it, from which the researcher forms own experiences and expresses it by their own means. In other words the results of qualitative research are inevitably researcher's experiences of the interviewees' ways of express their experiences. The inevitable participation of researcher on the research, its results and presenting the results affects the reliability of the study. Researcher must acknowledge during the study the presumptions and their effect over the work. In this thesis the author strived for objectivity when analyzing the results and during the interviews, so that the reliability would be as strong as possible. The author has acknowledged that presumptions might be visible also in reporting and as basis for choices when considering the study and in the deduction process.

The best possible reliability was reached, because during the study the author did not participate in the discussion and let the interviewees discuss about the topics as freely as possible. Author only limited the group time wisely and by asking additional questions over the study's interests. These same additional questions the author asked also from the other study groups. In this part the author feels she has minimized her effects over the interviewees. The role of the author was to lead the discussion to other study questions and to control time use. The author didn't bring any opinions or presumptions to the discussion, so that the result would not corrupt. Also the research questions were generalized so that they didn't bring the author's opinions to the research situation.

Aaltio and Puusa (2011) state that, same result of two researches increase the reliability of the study. On the basis of these criteria this study has strong reliability as between the focus groups the ideas and themes that the discussions raised had more similarities than differences. According to the thesis author's opinion this fact tells about the success of the study regarding the reliability.

Author has in the analysis striven to take account all possible answers concerning the theme. The interviews were uniform and had uniform threads regarding the results. In group interviews the author can't say with certainty whether all of the participants share the same vision, because the views of another participant regarding the expressed opinions is not asked. In these situations the author took advantage of the non-verbal communication in the group. The author has strictly kept to the comments of the interviewees when forming the results and thus striven to reach good reliability.

When considering at the reliability of the thesis has to be noted that the nursing staff at hand is working in a special care unit and thus has experiences only with those depressed who need special health care. The sample is quite narrow because majority of depressed are treated in outpatient care or basic health care.

Validity estimates whether the phenomenon has been measured accurately and if the study research handles the phenomenon which it is supposed to research (Aaltio & Puusa, 2011, s. 153-166). Validity in qualitative research means for example how intact the phenomenon of the study is (Aaltio & Puusa, 2011, s. 153-166). In this thesis the research the study problems are very broad, but it is justified because the goal of this study is to raise discussion and new ideas over the topic. If the research questions were too tightly set there wouldn't have been much discussion. In the authors opinion the research has been successful because it presents expected results as well as new ideas.

Because the amount of participant to the research is small there is a risk of the results to show only one side of the opinions of nursing staff. Acknowledging this the author has wanted to highlight the need for further studies over the topic.

Even though the generalizability of this research is critical due to the small sample, the research results are incisive and useful and add understanding over the state of the psychiatric outpatient care (Aaltio & Puusa, 2011, s. 153-166). It was important to aim to offer as good and incisive portrait over the world of experiences and visions of the interviewees (Aaltio & Puusa, 2011, s. 153-166).

5.3. Ideas for further research

This thesis aimed at collecting and describing the experiences of nursing staff of psychiatric special health care of the psychiatric care of depressed patients. The author's original idea for of thesis of the author was to interview depressed on their experiences over psychiatric outpatient care. The author was not able to conduct this study due to the new practices of Central Finland Health Care district. When changing the topic in the middle of the thesis the author pondered upon whether to interview the workers of outpatient care. Due to the permission practices being very time and resource consuming the author decided to do the study in a unit which was ready for co-operation. Because of this the author wants to highlight the need for further studies especially on the experiences of the depressed. This would give the depressed a voice and their experiences could be used to help the development work. Nursing students could be able to interview depressed with co-operation with Mielenterveyden keskusliitto. Also it would be important in the future to interview the staff of outpatient care.

When analyzing the results of the research and idea of increasing peer support came to the author's mind. Especially substance abuse treatment is starting to use "experienced experts" in the treatment and development of care. The author sees that people who have survived depression would have special skills and talent to be "experienced experts". This skill could be used for example in peer support groups. "Experts of their own experience" would generally work in the psychiatric field. Because only a person who has suffered from mental health disorder can fully understand the prejudices felt by the psychiatric patients and difficulties of getting treatment. Author's impression is that the new development projects have started to take into consideration the experiences of the mentally ill, more than before.

While doing the theoretical basis, the author also pondered upon the legal part which highlights the individual's own responsibility in seeking treatment. In practice seeking treatment especially during emergency hours is difficult. How for example

severely depressed person can find help in the multiform of psychiatric outpatient care? It would be important to research how the depressed could find and start receiving help the easiest way.

The author thinks that it would be necessary to also screen depression in basic health care with the help of BDI- form. Also the screening of somatic illnesses that may be behind depression (such as hypothyroidism) would be essential. In practical work the author has found psychoeducation as a very working tool. Especially the depressiokoulu book by Koffert and Kuusi (2009) has been a useful tool. The author hopes that groups based on for example depressiokoulu would be arranged more in the outpatient care.

One illness that caught the author's attention was chronic insomnia. When looking at the statistics of psychiatric illnesses in Central Finland, the author noticed that number of people suffering from chronic insomnia is twice the amount of people suffering from depression. Still the ways of treating insomnia are invalid in comparison to the cheer amount of Finns suffering from it. The ways are mainly medical. The medical treatment is recommended as short term therapy and by the experiences from the author's circle of acquaintances medical treatment is hard to get. The closest sleeping clinic is in Tampere and it's private. In work environment the author has noticed that also many of the nursing staff suffers from insomnia, partially due to shift work, and has medications for it. From the author's experience Insomnia has direct increasing relation to psychiatric morbidity.

In general the author sees it important to have mental health education for school children and their parents. This would help to decrease the psychiatric morbidity and help to get rid of the stigma attached to mental health disorders. This could also help to tame the raising numbers of isolated youth and decrease the amount of young people receiving disability pension in the future.

The social welfare services have developed in taking care of the children's needs when the parents have mental health illnesses. It is very good that they also practice now to do child welfare notifications with low threshold, when the parent goes to

the hospital. Still it would be important to prevent mental illnesses as early on as possible. Outpatient care treats mild and moderate depressions and it would be important to prevent the development of severe depression with early intervention. Prevention and early intervention the need for hospital care would decrease. Lönnqvist (2009) also brings out in his article the importance of screenings and informing people in prevention.

Other preventative actions according to Lönnqvist (2009) is to recognize personal risk factors and to develop adaptability skills with support, highlighting the importance of active exercising, screening and treating risk patients (e.g. stroke patients), following up and constantly supporting constantly people with depression.

The trend in development of psychiatric care is to raise the role outpatient care in the treatment system and shutting down hospital wards. Thus the treatment of severe depressions needs more development to respond to the patients' needs. When the role of the outpatient care is grown it is crucial for the development work to gather opinions and experiences also from the hospitals.

Psychiatric care, as all care is constantly developing. The author thinks that it is very important to evaluate the development work from the workers point of view as well as from the patient's point of view. The numeral measurements of good care are developed through care classification systems, but it would be important also to study the experiences. From the author's point of view especially in psychiatric care development patients' experiences and visions are very essential aspects. After all caring and nursing is and should also in the future be patient oriented.

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7. Appendices

Appendice 1

Psychiatric outpatien care visit in the years 1999-2010 in the whole country (koko maa), in Jyväskylä (Jyväskylä) and in Central Finland (Keski-Suomi).(Psykiatrian avohoitokäynnit = Psychiatric outpatient care visit, Perusterveydenhuollon mielenterveyskäynnit (muu ammattiryhmä kuin lääkärit) = Basic health care mental health visits (other care givers than doctors), Perusterveydenhuollon mielenterveyden lääkärikäynnit = Basic health care mental health doctors visists.) Tilasto- ja indikaattoripankki SOTKAnet. Terveyden ja hyvinvoinninlaitoksen sivulla. http://uusi.sotkanet.fi/portal/page/portal/etusivu

Psykiatrian avohoitokäynnit koko maassa, Jyväskylässä ja Keski-Suomessa

		1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Psykiatrian avohoitokäynnit / 1000 asukasta	Koko maa	234	218	254	275	254	260	261	268	276	287	276	301
	Jyväskylä	90	96	103	118	98	111	109	149	213	218	241	250
	Keski-Suomi	97	102	107	129	131	136	140	162	219	218	227	183
Perusterveydenhuollon mielenterveyskäynnit (muu ammattiryhmä kuin lääkärit) / 1000 asukasta	Koko maa	85,3	86,3	87,2	98,1	117,9	113,7	113,2	105,1	106,2	106,1	108,4	109,9
	Jyväskylä	157,7	173,4	144,9	203,9	208,5	200	172,2	168,6	180,1	169,3	158,9	160,2
	Keski-Suomi	192,1	187,8	173,7	203	215,3	214,8	199	193,9	203,5	199,8	232,6	223,3
Perusterveydenhuollon mielenterveyden lääkärikäynnit / 1000 asukasta	Koko maa	21	11,3	11,6	13,4	19	18,6	18,6	17,6	21,1	17,6	17,7	18,3
	Jyväskylä	50,9	49,5	40,4	47,6	47,4	51,9	50,7	37,2	35,6	36,7	35,6	33,3
	Keski-Suomi	47,6	45,4	39	40,9	40,3	47,3	46,6	39,3	37,6	35,9	50,4	46,8

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Appendice 2

Haastattelurunko

Haastattelun pääteemat kysymysmuodossa sekä tarkentavat kysymykset

1. **Minkälaisia kokemuksia teillä on masentuneen potilaan psykiatrisesta hoidosta?**

A. Minkälaisia kokemuksia teillä on yhteistyöstä sairaala- ja avohoidon välillä
   - Tulotilanteissa?
   - Sairaalahoidon aikana (esim. hoitoneuvottelussa)?
   - Jatkohoitoa järjestettäessä?
   - Mitkä asiat tukevat hoidon järjestämistä?

B. Minkälaisia kokemuksia teillä on masennuspotilaiden tyytyväisyydestä psykiatriseen hoitoon?
   - Miten potilaat ovat kokeneet saaneensa apua masennukseensa?

2. **Miten te kehittäisitte masentuneen potilaan psykiatrista hoitoa?**

Appendice 3

SUOSTUMUS

HENKILÖKUNTAHAASTATTELUUN

Minua on pyydetty osallistumaan opinnäytetyöhön liittyvään henkilökuntahaastatteluun.

Olen vastaanottanut, lukenut ja ymmärtänyt tutkimuksesta kertovan tiedotteen. Tiedotteesta olen saanut riittävän selvityksen opinnäytetyöstä "Sairaalan hoitotyöntekijöiden kokemuksia masentuneen potilaan psykiatrisesta hoidosta" ja sen yhteydessä suoritettavasta tietojen keräämisestä, käsittelystä ja luovuttamisesta. Minulla on ollut mahdollisuus kysyä tutkimusta koskevia kysymyksiä ja olen saanut riittävän vastauksen kaikkiin kysymyksiini. Tiedot antoi _____ , ___/___/ 20__ . Minulla on ollut riittävästi aikaa harkita osallistumistani tutkimukseen.

Minä annan luvan itseäni koskevien, haastattelun aikana esille tulleiden tutkimuksen kannalta tarpeellisten tietojen käyttöön opinnäytetyössä.
Kaikki minusta haastattelun aikana kerättävät tiedot käsitellään luottamuksellisina. Haastattelussa kerätyt tiedot käsitellään siten, ettei henkilöllisyyden selvittäminen ole myöhemmin mahdollista.

Ymmärrän, että osallistumiseni tähän tutkimukseen on täysin vapaaehtoista. Minulla on oikeus milloin tahansa tutkimuksen aikana ja syytä ilmoittamatta keskeyttää tutkimukseen osallistuminen. Tutkimuksesta kieltäytyminen tai sen keskeyttäminen ei vaikuta työhöni. Olen tietoinen siitä, että minusta keskeyttämiseen mennessä kerättyjä tietoja käytetään osana tutkimusaineistoa.

***Allekirjoituksellani vahvistan osallistumiseni tähän tutkimukseen ja suostun vapaaehtoisesti tutkimushenkilöksi**.*

_____ _____
Allekirjoitus *Päiväys*

_____
Nimen selvennys

Suostumus vastaanotettu

_____ _____

Opinnäytetyön tekijän allekirjoitus *Päiväys*

_____

Nimen selvennys

Alkuperäinen allekirjoitettu tutkimushenkilön suostumus sekä kopio tutkimushenkilötiedotteesta jäävät opinnäytetyöntekijän arkistoon. Tutkimushenkilötiedote ja kopio allekirjoitetusta suostumuksesta annetaan tutkimushenkilölle.

Appendice 4

TIEDOTE TUTKIMUKSESTA

Sairaalan hoitotyöntekijöiden kokemuksia masentuneen potilaan psykiatrisesta hoidosta

Pyyntö osallistua tutkimukseen

Teitä pyydetään mukaan hoitotyönopiskelijan opinnäytetyöhön, jossa tutkitaan sairaalan hoitotyöntekijöiden kokemuksia masentuneen potilaan psykiatrisesta hoidosta. Opinnäytetyön ja tutkimuksen tarkoituksena on kerätä hoitotyöntekijöiden kokemuksia niin masennuksen hoidosta kuin yhteistyöstä sairaalan ja avohoidon välillä. Olen arvioinut, että soveltuisitte mukaan tutkimukseen, koska työskentelette psykiatrisen erikoissairaanhoidon osastolla. Tämä tiedote kuvaa opinnäytetyötä ja teidän osuuttanne siinä.

Osallistumisen vapaaehtoisuus

Osallistuminen tähän opinnäytetyöhön kuuluvaan tutkimukseen on täysin vapaaehtoista. Voitte kieltäytyä osallistumasta tutkimukseen tai keskeyttää osallistumisenne syytä ilmoittamatta milloin tahansa.
Teidän ei tarvitse osallistua tähän tutkimukseen työnne takia.
Lukekaa rauhassa tämä tiedote. Jos teillä on kysyttävää, voitte olla yhteydessä opinnäytetyön tekijään tai tutkimuksen ohjaajiin. Jos päätätte osallistua tutkimukseen, pyydämme teitä allekirjoittamaan liitteenä olevan suostumuslomakkeen.

Tutkimuksen toteuttaja

Tämän tutkimuksen toteuttaa Jyväskylän ammattikorkeakoulussa opiskeleva hoitotyönopiskelija (sairaanhoitajan opintosuuntaus) Kreetta-Maija Suutarinen. Tutkimuksen rekisterinpitäjä on Jyväskylän ammattikorkeakoulu ja psykiatrisen erikoissairaanhoidon osasto, joka vastaa tutkimuksen yhteydessä tapahtuvan henkilötietojen käsittelyn lainmukaisuudesta. Opinnäytetyöntekijän ohjaajina

toimivat Jyväskylän ammattikorkeakoulun puolelta hoitotyön lehtori Maarit Jakobsson ja osaston puolelta apulaisosastonhoitaja ___ ja sairaanhoitaja ___.

Tutkimuksen tausta ja tarkoitus

Tämän opinnäytetyön tutkimuksen tavoitteena on selvittää, miten hoitohenkilökunta kokee masentuneen psykiatrisen hoidon, mikä on hoitajien kokemus masennuspotilaiden tyytyväisyydestä psykiatriseen hoitoon ja mitä sairaalan hoitohenkilökunta kehittäisi psykiatrisessa hoidossa.

Suomen lainsäädännössä on määrätty avohoidon ensisijaisuus psykiatrisessa hoidossa ja kuntien velvollisuus kehittää tarjoamaansa hoitoa kuntalaisten tarpeita vastaavaksi. Tämän johdosta on tärkeää ottaa huomioon myös sairaalan työntekijöiden näkemykset hoitotyötä kehitettäessä. Keski-Suomen psykiatrisen avohoidon viimeisimmän kehitysprojektin jälkeen on tarkoituksena vähentää sairaansijoja edelleen. Tämän vuoksi on tärkeää varmistaa masentuneen potilaan hoidon jatkuvuus sairaalahoidon ja avohoidon välillä ja kehittää sitä. Tämän opinnäytetyön lähtökohtana on kehittämistyön edistäminen tutkimalla hoitotyöntekijöiden kokemuksia ja kehitysideoita keräämällä.

Tutkimukseen pyydetään mukaan henkilöitä, jotka osallistuvat hoitotyöhön tällä psykiatrisen erikoissairaanhoidon osastolla.

Tutkimuksen aikana haastatellaan vähintään kymmentä osaston hoitotyöntekijää. Tutkimus on laadullinen ja kokemuksellisuuteen keskittyvä, jonka johdosta haastateltavien määrä on pieni.

Tutkimusmenetelmät ja tutkimuksen toimenpiteet

Tutkimukseen osallistuminen kestää yhden tunnin.

Tutkimukseen sisältyy yksi ryhmähaastattelukerta.

Tutkimus toteutetaan siten, että opinnäytetyöntekijä haastattelee teitä kuuden-kymmenen hengen ryhmässä osaston rauhallisessa tilassa. Ennen fokusoitua ryhmähaastattelua saatte kirjallisena teemoitetut haastattelukysymykset. Haastattelussa saatte kertoa omin sanoin kokemuksistanne tutkimuksen teemoista ja osallistua keskusteluun muiden osallistujien kanssa. Haastattelu nauhoitetaan audiokasetille, jonka opinnäytetyöntekijä purkaa kirjoittamalla paperille ja sen jälkeen poistaa audiotallenteen. Haastattelussa kerätty materiaali säilytetään tutkijan

toimesta huolellisesti salassapitosäädösten mukaisesti ja tuhotaan tutkimuksen valmistuttua. Haastattelun aikana teitä pyydetään täyttämään esitietolomake, jossa kysytään ammattinimikettänne ja työskentelyaikaanne psykiatrisessa hoitotyössä. Esitietoja käytetään opinnäytetyössä teihin viitatessa, esim.: ”Mielenterveyshoitaja työskennellyt psykiatrisessa hoitotyössä 20 vuotta”.

Tutkimuksen mahdolliset hyödyt

Tutkimus auttaa selvittämään, miten psykiatrista hoitoa tulisi kehittää. Masennuksen hoidosta voidaan myös saada hyödyllistä lisätietoa.

Tietojen luottamuksellisuus ja tietosuoja

Tutkimuksessa henkilöllisyytenne sekä muut tunnistettavat tiedot ovat ainoastaan salassapitovelvollisen opinnäytetyön tekijän tiedossa. Kaikkia teistä kerättäviä tietoja ja teidän kertomianne asioita käsitellään siten, ettei yksittäisiä tietojanne pystytä tunnistamaan opinnäytetyöhön liittyvistä tutkimustuloksista, selvityksistä tai julkaisuista.

Teidän tietojanne ei tallenneta mihinkään tutkimusrekistereihin.

Tutkimustuloksissa ja muissa asiakirjoissa teihin viitataan vain ammattinimikkeen ja työuran pituuden perusteella.

Kaikissa tapauksissa tietojanne käsitellään luottamuksellisesti.

Jos osallistumisenne tutkimukseen jostain syystä keskeytyy, keskeyttämiseen mennessä kerättyjä tietoja käytetään osana tutkimusaineistoa.

Tutkimuksen valmistuttua tutkija hävittää keräämänsä tutkimusmateriaalin.

Tutkimuksen kustannukset ja taloudelliset selvitykset

Haastattelu toteutetaan työvuoronne aikana, joten teille ei koidu haastattelusta taloudellisia menetyksiä.

Tutkimuksen päättyminen

Tutkimus päättyy haastattelutilanteen jälkeen. Opinnäytetyötä ei teille toimiteta erikseen, mutta se on saatavissa Jyväskylän ammattikorkeakoulun kirjastosta ja se toimitetaan osaston henkilökunnalle sekä sen tulokset esitellään suullisesti osastolla.

Lisätietoja

Jos teillä on kysyttävää tutkimuksesta, voitte olla yhteydessä opinnäytetyön tekijään tai opinnäytetyön vastaaviin.

Heidän kanssaan voitte keskustella kaikista tutkimuksen aikana mahdollisesti mieltänne askarruttavista asioista.

Yhteystiedot:

Opinnäytetyöntekijä:

hoitotyönopiskelija Kreetta-Maija Suutarinen, sähköpostiosoite

puhelin numero:

Opinnäytetyöstä osastolla vastaavat:

apulaisosastonhoitaja

Opinnäytetyöstä Jyväskylän ammattikorkeakoulussa vastaava:

hoitotyön lehtori, työnohjaaja Maarit Jakobsson, sähköpostiosoite ja puhelinnumero

Appendice 5

Esitietolomake:

Ammattinimike:
Työskentelyaika psykiatrisessa hoitotyössä (vuosina):

Esitietolomakkeen tietoja käytetään opinnäytetyössä tutkimustuloksissa viitattaessa yksittäisen henkilön vastauksiin esim. niitä suoraan lainattaessa. Viittaukset tehdään niin, ettei työntekijää ole mahdollista tunnistaa valmiista opinnäytetyöstä.