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PIRJO-LIISA HAUTALA-JYLHÄ

Psychiatric Post-ward Outpatient Services

Between Hospital and Community

Doctoral dissertation

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ABSTRACT

The purpose of this study was to describe and analyse the different conceptions of patients, inpatient ward personnel, outpatient services personnel and administrative personnel in psychiatric units concerning the psychiatric post-ward outpatient services. The study questions dealt with participants' conceptions concerning the substance of patient – nurse relationship, the substance of outpatient visits, the factors contributing to the continuity of care and the benefits of post-ward outpatient services.

A qualitative method with a phenomenographic approach was chosen for the study. The aim of the phenomenographic approach is to identify and describe the various ways in which people experience certain phenomena in the world around them. The second-order perspective is the essential one in the phenomenographic approach. The data were gathered by interviewing patients and personnel (N=28) in post-ward outpatient services. The data analysis resulted in the formation of main categories and subcategories that describe the participants' different conceptions of post-ward outpatient services. These categories constitute the study results.

According to the results of the study, the patient-nurse relationship was found to be of essential in successful patient care. A good and collaborative patient–nurse relationship creates the basis on which the post-ward services can be constructed. The study revealed the contents of post-ward outpatient visit to be quite varied, including many-sided assessment, medication monitoring, relapse prevention, supporting everyday life, motivation and recognizing the needs of family members. The study revealed a number of factors in post-ward outpatient services that supported the continuity of care. Two factors identified as essential were the possibility of the patients to contact the ward when needed and the personnel reacting to a patient missing a post-ward outpatient visit.

The psychiatric post-ward outpatient services provide care after discharge from the hospital to seven different patient groups. One of these patient groups was made up of those patients who previously had not been committed to using aftercare provided by primary health care or psychiatric outpatient units or were not committed to the prescribed medical treatment. Post-ward outpatient services improve the patient's managing at home and in community care. Post-ward outpatient services were found to be motivating and rewarding for the nurses while also posing them with new kinds of challenges and responsibilities. The nurses would be willing to provide more services than the personnel resources at the ward allow. Good co-operation among all of the actors involved with patient care improves the patient's abilities to survive the difficulties they face, while the lack of coordinated co-operation and unclear sharing of responsibilities decreases them.

National Library of Medicine Classification
Medical Subject Headings: Hospitals, Psychiatric; Psychiatric Nursing; Outpatients; Aftercare; Mental Disorders; Continuity of Patient Care; Nurse-Patient Relations

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TIIVISTELMÄ

Tämän tutkimuksen tarkoituksena oli kuvata ja analysoida potilaiden, psykiatrian vuodeosastojen työntekijöiden, avohoidon työntekijöiden ja psykiatrian vuodeosastojen johdossa toimivien erilaisia käsityksiä psykiatrian jälkipoliklinikkatoiminnasta. Tutkimuksessa etsittiin osallistujien käsityksiä potilas – hoitajasuhteen sisällöstä, jälkipoliklinikkakäyntien sisällöstä, hoidon jatkuvuutta edistävistä tekijöistä ja jälkipoliklinikkatoiminnan hyödyistä.

Tämän laadullisen tutkimuksen metodina käytettiin fenomenografista lähestymistapaa. Fenomenografisen lähestymistavan tavoitteena on tunnistaa ja kuvata niitä erilaisia tapoja, miten ihmiset kokevat ja käsittävät tietyt ilmiöt heitä ympäröivässä maailmassa. Fenomenografisessa lähestymistavassa on olennaista toisen asteen näkökulma. Aineisto kerättiin haastattelemalla kolmella psykiatrian vuodeosaston jälkipoliklinikalla hoidossa olevia potilaita ja jälkipoliklinikkatyössä mukana olevia vuodeosaston ja avohoidon työntekijöitä sekä psykiatrian vuodeosastojen johdossa toimivia (N=28). Aineiston analyysin tuloksena syntyneet pääkategoriat ja alakategoriat kuvaavat tutkimukseen osallistuneiden käsityksiä jälkipoliklinikkatoiminnasta.

Tutkimustulosten mukaan hyvä potilas – hoitajasuhde loi perustan jälkipoliklinikkatoiminnalle ja sillä oli oleellinen merkitys onnistuneelle hoidolle. Tutkimustulokset osoittivat, että jälkipoliklinikkakäyntien sisältö oli hyvin monipuolinen. Siihen sisältyi potilaan hoidon arviointia ja lääkehoidon toteutumisen arviointia, potilaan voinnin huonontumisen ehkäisyä, jokapäiväisen elämän tukemista, hoitoon motivointia ja potilaan omaisten huomioimista. Tutkimustulosten mukaan jälkipoliklinikkatoiminnassa oli monia tekijöitä, jotka tukivat hoidon jatkuvuutta. Kaksi oleellisen tärkeää tekijää olivat potilaan mahdollisuus ottaa tarvittaessa yhteyttä vuodeosastolle ympäri vuorokauden ja hoitajien aktiivinen puuttuminen, jos potilas ei tullut sovitulle jälkipoliklinikkakäynnille.

Psykiatrian vuodeosastojen jälkipoliklinikkatoiminta tarjosi jatkohoitoa seitsemälle eri potilasryhmälle. Yhden näistä ryhmistä muodostivat ne potilaat, jotka eivät olleet sitoutuneet jatkohoitoon perusterveydenhuollossa tai psykiatrian avohoitoyksiköissä tai eivät olleet sitoutuneet tarpeenmukaiseen lääkehoitoon. Jälkipoliklinikkatoiminta auttoi potilasta selviytymään kotona ja avohoidossa. Hoitajille jälkipoliklinikkatoiminta oli motivoivaa ja palkitsevaa, ja antoi voimia hoitotyöhön. Hoitajat halusivat tehdä enemmän työtä jälkipoliklinikalla, mutta tiedostivat vuodeosastojen rajalliset henkilöstöresurssit. Hyvä yhteistyö muiden potilaan hoitoon osallistuvien yhteistyötahojen kanssa auttoi potilasta selviytymään avohoidossa. Toisaalta taas puute yhteistyön koordinoinnissa ja epäselvä työnjako vaikeuttivat potilaan hoitoa.

Yleinen suomalainen asiasanasto: psykiatriset potilaat; jälkihoito; psykiatrinen hoito

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My husband Jukka has been the most valuable resource of love and care for me during these years. I extent my warmest thanks for your patience, understanding, positive attitude, great sense of humour and many encouraging discussions. You have also helped me in preparing the figures and tables for my thesis and articles as well as with the English language. Without you I would not have made it! I dedicate this work to you.

In Hilja cottage, November 2007

Pirjo-Liisa Hautala-Jylhä

LIST OF ORIGINAL PUBLICATIONS

The results of this thesis are based on the following original studies and referred to in the text by their Roman numerals:

I Hautala-Jylhä P-L., Nikkonen M. and Jylhä J. (2005) Continuity of care in psychiatric post-ward outpatient services - Conceptions of patients and personnel concerning factors contributing to the continuity of care. Journal of Psychiatric and Mental Health Nursing 12: 38-50.

II Hautala-Jylhä P-L., Nikkonen M. and Jylhä J. (2006) Conceptions of patients and personnel concerning the substance of post-ward outpatient visits in psychiatric care. Journal of Psychiatric and Mental Health Nursing 13: 61 – 69.

III Hautala-Jylhä P-L., Nikkonen M., Kiikkala I., and Jylhä J. (2007) Patient's and personnel's conceptions of patient-nurse relationship in post-ward outpatient services. International Journal for Human Caring 3, in press.

IV Hautala-Jylhä P-L., Nikkonen M. and Jylhä J. Conceptions of patients and personnel concerning the benefits of psychiatric post-ward outpatient services. Vård i Norden, submitted.

CONTENTS

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1 INTRODUCTION

A structural change of the psychiatric care system was started in Finland in the 1980s – about 20 years later than in most other western countries. The main objective was to shift the emphasis of care from inpatient care to outpatient care. The change has been motivated by international trends, economic and political factors and detailed plans. (Nikkonen 1995, 1996, Korkeila 1998, Tuori et al. 2000). The number of psychiatric hospital beds has been reduced and inpatient length of stay has been shortened. Correspondingly, the number of psychiatric outpatient visits has increased (Lehtinen & Taipale 2000, Lehtinen 2002, Tuori et al., 2000).

Various researches (Alanen et al. 1991, Anderson et al. 1993, Leff 1993, Parker 1993, Lehtinen et al. 1996, Hogarty et al. 1997, Korkeila 1998, Harjajärvi et al. 2006) show that when the emphasis of psychiatric care shifts to community care and hospitalisation becomes short-term, various individual alternatives in supporting the patient's coping are needed. In addition, the transition from psychiatric hospital to community is complex and can be challenging for many individual patients. In order to successfully discharge patient to the community, flexible and effective models and organisation of aftercare are required. (Forchuk et al. 1998b, Llewellyn et al. 1999, Aaltonen et al. 2000, Leff & Trieman 2000, Reynolds et al. 2004, Forchuk et al. 2005.)

Post-ward outpatient services were initiated in several Finnish psychiatric hospitals in order to backup outpatient care. The concept of 'post-ward outpatient services' means that after discharge from hospital, the inpatient staff continues to work with the discharged patient and the patient returns to the same ward for outpatient visits.

The aim of this study was to get information concerning the psychiatric post-ward outpatient services from perspectives of post-ward outpatients, inpatient ward personnel, outpatient services personnel and administrative personnel in psychiatric units.

I took an interest in post-ward outpatient services when I worked as the head nurse in psychiatric inpatient and outpatient care and received information of its importance to patients from psychiatric nurses and statistics concerning the post-ward outpatient visits.

I could not find any studies concentrating on the post-ward outpatient services of psychiatric

hospital wards, but I found some studies in which post-ward outpatient services were referred to although a study subject was something else (e.g. Tuori 1987, 1991, 1994, Salokangas & Nordling 1992, Isohanni & Moring 1993, Korkeila & Tuori 1996, Rasinkangas et al. 1997, Aaltonen et al. 2000).

This research report consists of four original publications and a summary. The original publications describe and analyse conceptions of patients and personnel concerning factors contributing to the continuity of care (Paper I), conceptions of patients and personnel concerning the substance of post-ward outpatient visits (Paper II), patient's and personnel's conceptions of patient-nurse relationship (Paper III) and conceptions of patients and personnel concerning the benefits of post-ward outpatient services (Paper IV).

Chapter two describes the structural changes in psychiatric care in the 1980s and in the 1990s and the current situation in the 2000s. Issues of legislation, national recommendations and present challenges of psychiatric care are also described in the same chapter. The definition of psychiatric post-ward outpatient services is presented also in chapter two. The purpose of the study and the study questions are described in chapter three. The phenomenographic approach employed in the study is introduced in chapter four. The selection of participants, data collection and analysis are described in chapter five, and the study results are presented in chapter six. The credibility of the study, assessment of phenomenographic approach in this study, ethical considerations and discussion of the results are presented in chapter seven. Conclusions and suggestions for further studies are put forward in Chapter nine. Both the summary and the original publications include figures that will help to clarify the different phases of study and analysis and illustrate the research results.

2 BACKGROUND OF PSYCHIATRIC POST-WARD OUTPATIENT SERVICES

2.1 Structural changes in the psychiatric care system in the 1980s and 1990s

Psychiatric care system has undergone a thorough change in Finland during the past twenty years. There has been a shift towards outpatient care and intermediate forms of care. This is a global trend, which has been implemented in different ways in different countries. (Wahlberg & Sohlman 1993, Korkeila et al. 1996, Stengård 2005.) In Finland, the structural change of the psychiatric care system began in the 1980s, which was about twenty years later than in most of the western world (Nikkonen 1996).

Decreasing the number of psychiatric hospital beds began in the United States in the 1960s. This development was due to the increasing expenditure of the mental hospital system, the criticism directed towards the states' mental hospitals, and the change in social politics. The Civil Rights Movement, in particular, demanded an improvement in the quality of care and the restoration of patients' rights. (Fleck 1995, Korkeila et al. 1996, Nikkonen 1996, Salokangas et al. 2000.) In Great Britain, decreasing the number of psychiatric hospital beds had already begun in the late 1950s. Closing down mental hospitals and reducing the number of psychiatric hospital beds was done gradually unlike in the United States and Italy. (Thompson 1994, Nikkonen 1996, Canvin et al. 2002, Hyvönen 2004.)

In Italy, the reform of psychiatric care was carried out more rapidly and more radically than elsewhere in the western world. The intention was to stop admitting patients in psychiatric hospitals by the year 1980. In Sweden, the principles governing the re-organisation of psychiatric care in the early 1970s were locality, openness and emphasising the psycho-social approach. (Barbato 1992, Thompson 1994, Nikkonen 1996, Salo 1996.) Although this development started later in Finland than in many other countries, Finland has experienced one of the most rapid deinstitutionalisation processes in the whole world (Salokangas et al. 1985, Salokangas & Saarinen 1998, Stengård 2005).

In Finland the main arguments for the deinstitutionalisation process were the harmful effects of long hospital stays, the patients' right to live in the community and the high costs of hospital care (Nikkonen 1995, 1996, Korkeila 1998, Salokangas & Saarinen 1998, Tuori et al. 2000). The primary importance of community care was already emphasised in a committee

report by the National Board of Health (Lääkintöhallitus 1977), in which community care solutions were given first priority. In addition, after the Reform of the Law on Mental Health Care (Mielisairaslain osauudistus 1977), patients generally needed a doctor's referral in order to be admitted in a mental hospital, and further conditions were set for prolonged inpatient care. Furthermore, increasing community care and the measures support it was emphasised in the Report of the Committee for Mental Health Work (Mielenterveystyön komitean mietintö 1984) as well.

The objective of the National Development Project for the study, treatment and rehabilitation of schizophrenia (Skitsofrenian tutkimuksen, hoidon ja kuntoutuksen valtakunnallinen kehittämisprojekti) between the years 1981-1987, was to reduce in half the number of long-term schizophrenia patients within psychiatric hospitals in half during next ten years, and to advance community care and the measures supporting it. The Schizophrenia Project led to a fundamental change in the length of patients' stay in mental hospitals. However, the objectives of the schizophrenia project regarding the advance in community care and rehabilitation services were not fulfilled as expected, and community care was not able to make a breakthrough. Furthermore there was another important aim to reduce the amount of new long schizophrenia patients to a half (Salokangas et al. 1992, Salokangas et al. 1996, Sariola 2000.)

The structural change of the psychiatric care system was under control during the 1980s, whereas the change that took place in the 1990s was not considered to have been under control in all aspects. (Korkeila & Tuori 1996, Lehtinen & Taipale 2000, Tuori et al. 2000, Lehtinen 2002.) The controlled proceedings of the planned structural change was interrupted when the Act on Specialized Medical Care came into operation in 1991, state grant reform was made in 1993 and the economic recession begun in the early 1990s (Nikkonen 1996, Korkeila 1998, Lehtinen & Taipale 2000, Salokangas et al. 2000, Lehtinen 2002, Kärkkäinen 2004).

The Act on Specialized Medical Care (Erikoissairaanhoitolaki 1062/1989) joined the psychiatric care system under the administration of hospital districts in the beginning of 1991 and inter-municipal associations maintaining psychiatric hospitals no longer existed. Hospital districts were established in order to reduce overlapping administration, simplify the decision-making system and gain as much financial profit as possible from centralisation. While the change marked the end of an independent and specialised status for psychiatry, it also gave psychiatry the opportunity to become equal with the rest of the medical sciences.

The objective was to demystify psychiatry, improve patient rights and lower the threshold of seeking care. (Pylkkänen et al. 1991, Pylkkänen 1999, Kärkkäinen 2004.)

An extensive reform was planned in the state's grant and control systems between the years 1989-1993, prior to the economic recession and the financial crisis of the state. Originally, the purpose of renewing the state grant and control system was to change the service structure and infrastructure of both the public specialised health care and primary health care while giving the municipalities more financial latitude. One of the key ideas was to make these services more readily available and accessible. After the reform of the state grant system, the main responsibility for providing mental health services, too, was transferred to municipalities. According to the change, municipalities provide mental health services for their residents themselves, or, alternatively, purchase these services from a private provider. (Kokko & Lehto 1993, Valtionosuuslainsäädäntö 1993, Lönnqvist et al. 1998, Nikkonen 1998.)

During the recession between the years 1991-1994, the cuts in expenditure were directed particularly on mental health services, child welfare services and welfare for substance abusers. The total amount of expenses in specialised health care decreased by 18 percent. Most reductions within hospital districts were directed at psychiatry: its resources were reduced by over 40 percent. It has been estimated that the resources for psychiatric specialised health care were reduced by 26 percent between the years 1990-1997. Because of financial factors, the operation environment of psychiatry became, in many ways, more unstable than before, and the same applied to the work of the whole personnel. (Salokangas et al. 2000, Kärkkäinen 2004). It is difficult to estimate the real amount of resource cuts in psychiatry since a part of psychiatric units were transferred to primary health care organisations and patients were moved to live in rehabilitation homes while the municipalities were mainly responsible for their costs (Kärkkäinen 2004.)

The evident consequences of structural changes within the psychiatric care system were the decrease in the number of psychiatric hospital beds, shorter inpatient periods, increase in the number of outpatient visits and decrease in personnel (Tuori 1994, Lehtinen & Taipale 2000, Harjajärvi et al. 2006, Wahlbeck 2004, 2007).

In 1980, there were 4.2 psychiatric hospital beds per one thousand residents in Finland, which was one of the highest ratios in the world. In 1995, there were 1.3 psychiatric hospital beds and,

in the beginning of the 21st century, 1.1 psychiatric hospital beds per one thousand residents. (Tuori 1994, Korkeila & Tuori 1996, Korkeila 1998, Aaltonen et al. 2000, Salokangas et al. 2000, Kärkkäinen 2004, Salokangas 2004.)

There has been a decrease in the duration of an average inpatient period within psychiatric hospitals. While the average inpatient period in 1980 was 222 days, in 1995 it was 62 days and in 2000 it was 37 days. The main reason for this development has been the decrease in very long-term (from 3 to 10 years or more than 10 years) inpatient periods, as the elderly psychiatric patients and those suffering from dementia have mainly been transferred elsewhere from psychiatric specialised care. (Stakes 2005.)

In 1995, there were 1.4 million visits to psychiatric community care within the psychiatric specialised care and primary health care, which is three times as much as in 1980 (Korkeila & Tuori 1996). In 2000, 1.6 million visits to community care were recorded (Stakes 2006). In the 1990s, psychiatric outpatient care was transferred from hospital districts, most often, to be included in the primary health care provided by municipalities (Lehtinen & Taipale 2000, Sohlman et al. 2003). Towards the end of the decade only 60 percent of all Finnish municipalities organised their psychiatric community care entirely through hospital districts (Sohlman et al. 2003, Kärkkäinen 2004).

There was a distinct decrease in the number of personnel in adult psychiatric community care between the years 1992-1995, but at the end of the decade their number begun to increase. The increase was directed at child and adolescent psychiatry, whereas the number of adult outpatient personnel was reduced by 9 percent. Personnel in psychiatric inpatient care was reduced by 29 percent between the years 1990-1993, but after this period, in 1995-1999, the number of personnel remained unchanged. (Tuori et al. 2000, Kärkkäinen 2004.) The Committee for Mental Health Work (Mielenterveystyön komitean mietintö 1984) required there to be the minimum of 65 community care professionals per 100 000 inhabitants. By 1992, the number of personnel in psychiatric community care increased to 51/100 000, but between the years 1992-1999 was again reduced to 46/100 000. (Pylkkänen 2000.)

The study by Kärkkäinen (2004) on the success of merging the psychiatric and somatic health care systems within different hospital districts indicates significant regional differences in the structures, quality and availability of services. Deficiencies were also observed in the

psychiatric care administration, compilation of statistics within the psychiatric care system and also in patient follow-up. Representatives of the psychiatric care systems felt that the merging of the psychiatric and somatic health care systems had failed especially with regard to the administration. The reasons for this were the unsatisfactory position of psychiatry within the new hospital district organisation and weak possibilities to affect the system. (Kärkkäinen 2004.) Furthermore, it has been suggested that the structural change within psychiatry was almost completely realised without an adequate data system and follow-up instruments (Pylkkänen 2000).

In spite of continuous efforts to develop community care, the variety of mental health services provided in many municipalities remained unsatisfactory. Inpatient care continues to be in many regions the most often used intervention, while the intended development in outpatient services has not been reached. There are regions in Finland where hospitalisation ought to be significantly reduced by making increased budgeting possible within the psychiatric community care. There is a need for 24-hour service units outside the hospitals, organised day activities and mobile emergency services for outpatients. (Harjajärvi et al. 2006.)

According to Korkeila (1998) although there were marked changes in the resources of the psychiatric services in the early 1990's, the need for and use of psychiatric hospital care has not been substantially decreased. An increase in the turn-over of patients significantly adds to the strain on the psychiatric wards and their teams. The increased number of visits to the psychiatric community care was not found to be associated with a reduction in the re-admission rate.

Studies observing changes in intervention practices and their effects on care results have shown that decreasing the number of psychiatric hospital beds is not connected with the mortality of schizophrenia patients (Heilä et al. 2005) and reduced times in inpatient care have not increased the number of suicides committed soon after the care (Sohlman et al. 2006). Viinamäki et al. (2001) found that patients suffering from depression showed symptom of depression after the end of their inpatient care period.

The structural change of mental health services is not as yet complete, which makes the development of both mental health work and mental health services a challenge to

municipalities also in the future. (Harjajärvi et al. 2006, Wahlbeck 2007)

2.2 Current situation in psychiatric care system in the 2000s

Specialised psychiatric care is part of the comprehensive mental health service system and mental health work (Lehtinen 2002). Mental health work refers to promoting an individual's mental health, ability to manage in everyday life and personal growth and preventing, treating and alleviating mental illnesses and other disturbances of mental health. Improving the living conditions of the population to prevent the emergence of mental illnesses, promoting mental health work and supporting the organisation of mental health services are also part of the mental health work. Also social and health care services provided to mentally ill individuals on the basis of their medically diagnosed condition belong to mental health work. (Mielenterveyslaki 1116/90.)

There are no studies addressing the worsening of mental health in Finland (Wahlbeck 2004). A comparison of the studies Mini-Finland (Mini-Suomi) (Lehtinen et al. 1991) and Health 2000 (Terveys 2000) by the National Public Health Institute (Kansanterveystieteen laitos) (Aromaa & Koskinen 2002) reveals no increase in the number of cases of mental health illnesses during the past two decades. The development of mental health does, however, differ from the development of somatic health, which for the last twenty years has been positive. Although the studies do not show deterioration of mental health, there is, however, an increase in the number of sick leaves and disability pensions admitted owing to mental disorders. Moreover, the increase in alcohol and drug abuse is predicted to result in an increasing number of individuals suffering from mental disorders. (Wahlbeck 2004, Wahlbeck et al. 2007.)

The concept of mental health work consists of promotion of mental health, prevention of mental health problems, providing mental health services within primary health care, specialised mental health services, specialised psychiatric care and rehabilitation. The most important parties involved in the field of mental health work include municipalities and joint municipal authorities, hospital districts, state-maintained institutions, private service providers and voluntary organisations. (Rimpelä 2001, Wahlbeck 2007)

At present there is a wide variety of mental health services available in Finland. Individuals

suffering from milder dysfunctions or problems are offered, among other things, support and guidance services related to different situations in life, whereas there are intensive and advanced treatments available for seriously ill individuals. (Lehtinen 2002, Välimäki et al. 2003, Pirkola & Sohlman 2005, Salokangas 2004, Harjajärvi et al. 2006.)

Visits to outpatient care units constitute the most central type of mental health services within primary health care and specialised health care. (Lehtinen 2002, Välimäki et al. 2003, Pirkola & Sohlman 2005, Salokangas 2004, Harjajärvi et al. 2006.) Specialised psychiatric outpatient care is produced by mental health centres or mental health services that are mainly organised as parts of municipalities' primary health care. In part, they belong to the psychiatric outpatient departments of hospital districts. (Kansallinen projekti terveydenhuollon … 2004.) The number of psychiatric outpatient visits is steadily rising and especially visits within primary health care have increased. In 2005, there were more than two million visits to psychiatric outpatient care within specialised health care and primary health care, while five years earlier the number of visits was only 1.6 million. (Stakes 2006.)

Psychiatric inpatient care is necessary in situations where outpatient services cannot provide adequate help to control the problems caused by the patient's mental illness. Inpatient care for psychiatric patients is provided, among others, at university hospitals, central hospitals, regional hospitals and also in independent psychiatric hospitals and state hospitals admitting criminal patients or patients that are otherwise difficult to look after. (Lehtinen 2002, Välimäki et al. 2003, Salokangas 2004, Pirkola & Sohlman 2005, Harjajärvi et al. 2006.) According to Wahlbeck (2004), contrary to the aim the realisation of psychiatric inpatient care includes features that do not support the emphasis towards outpatient care and patients' social integration. Also Harjajärvi et al. (2006) report emphasis on inpatient care within mental health services despite the attempts to develop the services towards a more outpatient-centred direction.

There are also intermediating services for individuals suffering from mental dysfunctions. These services have been developed between inpatient and community care with the aim to provide support for outpatient care and rehabilitation. The services include day hospitals, day activity centres, small group homes, rehabilitation homes, sheltered housing, work activities and club houses. (Lehtinen 2002, Välimäki et al. 2003, Salokangas 2004, Wahlbeck 2004, Pirkola & Sohlman 2005, Harjajärvi et al. 2006.) There is significant variation in the

availability of intermediating services between municipalities (Wahlbeck 2004). It is difficult to form a comprehensive picture of the situation concerning activities supporting community care owing to their production being distributed by hospital districts, municipalities and private service providers. (Lehtinen 2002).

2.2.1 Legislation related to the organisation of psychiatric care

The central laws controlling the organisation of mental health services in Finland include the Primary Health Care Act (Kansanterveyslaki 66/1972), Mental Health Act (Mielenterveyslaki 1116/1990) and Specialized Medical Care Act (Erikoissairaanhoitolaki 1062/1989). The responsibility of the organisation of mental health services has been enacted in the law to the municipalities. The municipalities may provide the services to their residents themselves or purchase them from hospital districts or other service providers. (Lehtinen 2002, Pirkola & Sohlman 2005, Harjajärvi et al. 2006.)

The Primary Health Care Act (Kansanterveyslaki 66/1972) includes the provision of mental health services. The Act requires municipalities to provide their residents with those mental health services that can appropriately be provided in health centres. Also the Decree on Primary Health Care (Kansanterveysasetus 802/1992) includes regulations related to mental health services. (Lehtinen 2002, Pirkola & Sohlman 2005.)

The Mental Health Act (Mielenterveyslaki 1116/1990) defines the concepts, contents, and supervision of mental health work, the responsibility to organise it and, finally, principles for its organisation. The act requires each hospital district and the public health centres operating within the districts to ensure, in co-operation with the local municipal social services and joint municipal authorities that provide special health care services, that the mental health services within the region form a functional entity. Furthermore, the mental health services must be appropriate with regard to both their content and extent, i.e. the patients must be able to receive appropriate care when they need it. The Decree on Mental Health Care (Mielenterveysasetus 1247/1990) includes statutes that provide more details on the contents of mental health work and its organisation. (Lehtinen 2002, Pirkola & Sohlman 2005.)

The Specialized Medical Care Act (Erikoissairaanhoitolaki 1062/1989) regulates the organisation of specialised health care and related activities. Each municipality is required to

belong to some joint municipal authority of a hospital district. The hospital districts are responsible for managing the compatibility of special health services and, in co-operation with primary health care, planning and developing specialised health care to enable good co-operation between primary health care and specialised health care. The above-mentioned parties are also required to co-operate with the municipalities' social boards. (Lehtinen 2002, Pirkola & Sohlman 2005.)

The Ministry of Social and Health Affairs has started to work on uniting the Primary Health Care Act and Specialized Medical Care Act into Public Health Care Act. The purpose of the new law is to support and strengthen primary health care and improve the availability, development and efficient production of health care. The law also aims at supporting seamless co-operation between primary health care and specialised health care and improving their customer orientation, attempting to bridge health differences between population groups and different regions. The preparatory working group for the Public Health Care Act will present their proposition in February 2008. (Sosiaali- ja terveysministeriö 2007.)

From 2001, the Decree on Mental Health has included statutes for guaranteeing medical treatment in child and adolescent psychiatric services (Wahlbeck 2004). Legislation concerning the availability of care was extended in 2005 to cover the entire health care sector, as the changes concerning the maximum wait times for admittance to care in other than emergency cases in the Primary Health Care Act (Laki kansanterveyslain muuttamisesta 855/2004), Specialized Medical Care Act (Laki erikoissairaanhoitolain muuttamisesta 856/2004), Act on the Status and Rights of Patients (Laki potilaan asemasta ja oikeuksista annetun lain muuttamisesta 857/2004) and Patient Fees Act (Laki sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain 9§:n muuttamisesta 858/2004) came into operation (Wahlbeck 2004, Pekurinen et al. 2007). Legislation ensuring medical care, also known as the Guarantee of Medical Treatment, is the most significant reform in the Finnish health care since the 1993 state grant reform (Pekurinen et al. 2007).

The Act on the Reform of the Municipal and Service Structures (Laki kunta- ja palvelurakenneuudistuksesta 169/2007) came into operation in 2007. The purpose of the reform is to strengthen the municipal and service structures, develop service provision methods and organisation, to improve the municipalities' financial systems and state grant systems and to reconsider the task distribution between municipalities and state. The act requires the

municipalities to provide central social and health services to their entire population. The basis for this is to promote health and well-being among residents and improve co-operation in service organisation.

2.2.2 National recommendations guiding the system of psychiatric care in the 2000s

After the structural and administrative reforms, mental health services have been developed through information control. (Kansallinen projekti terveydenhuollon… 2004, Lassila 2006, Wahlbeck 2007.)

The social and health ministry administered projects titled Meaningful life! -Programme (Mielekäs elämä! - ohjelma) and Mental health in Primary services – Swallow (Mielenterveyttä peruspalveluissa – Pääsky) between the years 1998-2002. These state-wide mental health development projects aimed at finding new ways of developing mental health services. The Meaningful life! -Programme was used to create recommendations on the development of mental health services (Immonen et al. 2003) that focused on the seamless production and varied nature of services requiring the parties to agree on municipality-specific aims and distribution of work between different service providers. The municipalities are responsible for co-ordinating the co-operation and ensuring that the promotion of mental health and prevention of dysfunctions are essential and important parts of their mental health work. Suggestions for action (Kiikkala & Immonen 2002) in the Mental health within primary health care – Swallow Project emphasises the residents' participation and local, synergy-seeking forms of co-operation. Mental health services must be realised in a client oriented way and they ought to promote dialogue between clients and personnel.

The guidebook Signposts for creating the mental health work plan in the municipality (Tienviittoja kunnan mielenterveystyön suunnitelman laatimiseen) (Koivunen 2000) and Meaningful Life! Operation recommendations (Mielekäs elämä! Toimenpidesuositukset) (Immonen et al. 2003) were produced on the basis of the Meaningful life! –Programme.

The social and health service aim and action plan for 2000-2003 was used to create Quality recommendations for mental health services (Mielenterveyspalvelujen laatusuositus 2001) and Quality recommendations for the welfare of substance abusers (Päihdepalvelujen

laatusuositukset 2002). The structure of the Quality recommendations for mental health services follows the idea of mental health problems developing in a process. The recommendation requires municipalities to support their residents' well-being and mental health and provide help through primary services. It is expected that each resident receives adequate examination and care in accordance with his or her situation in life and the problem he or she experiences. Mental health services should respect human dignity and human rights and the care is realised according to a decision previously agreed upon. The recommendation gives first priority to community care and suggests all care to aim at rehabilitation. However when necessary, patients will be admitted to psychiatric inpatient care. The internal co-operation, responsibilities and distribution of work within the health care organisation have been clarified and agreed upon. The number and structure of personnel are defined as part of the overall mental health work plan and the employees' competence and work ability are cared for. The services and activities are supervised and assessment is used in planning further activities. (Sosiaali- ja terveysministeriö 2002.) The rapport of the implementation project concerning the quality recommendations was reported in 2005 (Upanne et al. 2005).

Both the Recommendations for the development of mental health services (Sosiaali- ja terveysministeriö 2000) and Quality recommendations for mental health services (Sosiaali- ja terveysministeriö 2001) consider it necessary to provide municipalities with an overall plan to co-ordinate the entire mental health work. The plan ought to be drawn up in co-operation with the many parties involved and, ideally, consider all the aspects of mental health work in its entirety. The co-ordination responsibility for mental health work is to be agreed upon in the municipalities' decision-making process. (Immonen 2005.)

The Quality recommendations for the welfare of substance abusers (Päihdepalvelujen laatusuositukset 2002) emphasise the primary nature of primary social and health services also within substance abuse care. Client oriented work is seen as both ethical and beneficial for the society. The recommendations suggest that there ought to be unrestricted availability of the services. The administration of substance abuse work must be strengthened and the number, competence and work ability of its personnel must be paid special attention to.

The National project to secure the future of health care (Kansallinen projekti tulevaisuuden …2002, 2004) and the National development project of the field of social services (Kansallinen projekti sosiaalialan…2003) are projects administered by the social and health

ministry and realised side by side. Both are based on the view that social and health services must be provided for the population with public funds also in the future. The projects include definitions of policy that are significant from the point of view of mental health services. The residents', clients' and patients' status, rights and ability to choose and act are emphasised. The client oriented nature of the services is considered the guiding principle and there are plans to further strengthen the possibility to provide mental health services within primary social and health services.

Ministry of Social Affairs and Health set up in 2003 the working group to study the division of work and work stress in mental services (Työnjakoa ja työnrasitusta … 2004). The working group proposes development of specific co-operation models, improvements in the division of work between social welfare and health care, co-ordination of specialised psychiatric care and mental health work on a larger scale and development of new patterns of action. Work stress should be relieved by adjusting the resources and clarifying patterns of action within primary social and health care services and specialised psychiatric outpatient care, securing competence, creating a flexible operational culture and launching societal discussion about the issue on work stress. In order to increase the attraction of mental health work, the Working Group proposes that its image should be improved, its leadership, contents of work and allocation of resources developed and education in the field reformed. Actions to develop the division of work relieve work stress and increase the attraction of work in mental health services presuppose concrete measures at the local, sub-regional and hospital districts that aim at developing, experimenting with and studying the proposed reforms and creating new patterns of action (Ministry of Social Affairs and Health 2004).

The Ministry of Social Affairs and Health has allocated grants from the joint funds of national health project and social services development projects' for the following three large, comprehensive projects of mental health and substance abuse care development launched in 2007: The Umbrella Project (Sateenvarjo-projekti) of the city of Vantaa, Ostrobothnia project (Pohjanmaa-hanke) of the Vaasa hospital district and the regional mental health and substance abuse care development project administered by the city of Rovaniemi. The projects aim at creating regional operation models with well-functioning work for the improvement of the residents' well-being and mental health and good co-operation between the municipalities' primary and specialised services and different service providers and professional groups. (Harjajärvi et al. 2006, Wahlbeck 2006.)

Finland has been active in bringing up mental health issues in European forums. Mental health issues were dealt with in European Conference on Promotion of Mental Health and Social Inclusion during Finnish EU-chairmanship (Lahtinen et al. 1999). On the basis of this conference a project by the name 'Mental Health Work to the European Agenda' was started and it was implemented as a part of EU action plan (Lavikainen et al. 2004). As a result of a minister conference organised by World Health Organization, European Union and European Commission a common action plan, 'Green Paper' was accomplished in Helsinki in 2005. The new mental health strategy proposed by the green paper should focus on the promotion of mental health, preventive actions, social inclusion, and the protection of the rights of people with mental disorder as well as on developing a European mental health information system. (Thornicroft & Rose 2005, EU Consultative Platform on Mental Health 2006, Wahlbeck & Taipale 2006.)

2.2.3 Present challenges of the psychiatric care

The following are the most central problems faced by present-day mental health services: fragmentation of administration into specialised health care, primary health care and social services (Salokangas 2004, Työnjakoa ja työnrasitusta …2004, Wahlbeck 2007), too small populations for organising psychiatric services (Salokangas 2004, Wahlbeck 2007), regional differences in community care organisation and resources (Salokangas 2004, Pirkola & Sohlman 2005), need for flexible and effective models and practices in psychiatric community care (Tuori 1994, Korkeila 1998, Salokangas et al. 2000), burn-out of psychiatric personnel (Salokangas 2004), increasing lack of personnel (Salokangas 2004, Työnjakoa ja työnrasitusta … 2004, Wahlbeck 2004, 2007, Harjajärvi et al. 2007) and increasing pressure on family members to care for the patient's management in everyday life (Solomon & Draine 1995, Stengård 2005).

The psychiatric community care is realised within different organisations; in primary health care, social services, private health care and, with regard to support services, also in the third, i.e. voluntary sector (Kansallinen projekti tulevaisuuden …2004). The seams of the fragmented service organisation reveal breaks in continuity and even gaping holes in the place of services. A more centralised coordination of service system solutions would secure and correctly allocate the limited resources of mental health services. (Wahlbeck 2004, 2007.) The situation is

especially difficult with child outpatient care where the responsibilities are shared between child and family guidance centers and child psychiatric outpatient care units (Wahlbeck 2007). Also the co-operation between substance abuse services and mental health services is considered deficient (Työnjakoa ja työnrasitusta … 2004, Wahlbeck 2004).

An adequate population base has been considered as a prerequisite for the organisation of varied mental health services within the region (Wahlbeck 2007). It has been suggested that the mental health centres should form large enough units, where all psychiatric specialities are available and where substitutes and educational and training activities could be organised without disturbing their main activities (Salokangas 2004).

There are regional differences in the availability of psychiatric community care and inpatient care (Kansallinen projekti terveydenhuollon … 2004). The psychiatric care provided by municipalities in public health centers has, in places, been organised unevenly and in a disconnected way. Studies have shown that the social situation and health of long-term psychiatric patients are worse than in other patients in poorly organised psychiatric community care. There is also too little co-operation between primary health services and specialised health services. (Salokangas et al. 1996, 2004, Taipale 1997, Kivinen et al. 1997, Korkeila 1998, Lassila 1998, Wahlbeck 2004).

There is a need for low-threshold, client oriented services near the homes within the psychiatric service organisation. Most community services today consist of the traditional type of visits despite the fact that there is a need for varied, developed, mobile and on-duty service alternatives. There are little organised day activities provided for mental health rehabilitation patients. Furthermore, in most cases there are no alternatives to traditional inpatient care when the patient is in need of acute 24-hour care. (Harjajärvi et al. 2006, Wahlbeck 2007.) The lack of municipal residencies with care services lengthens hospital stays because patients have to queue for adequate dwelling (Kansallinen projekti terveydenhuollon…2004). According to Korkeila (1998), the organisation of community care will not as such reduce inpatient care, but there is a need for personalised, well-allocated services for patients suffering from more severe disorders.

Burn-out is a very common phenomenon among psychiatric outpatient personnel (Korkeila 1998, Korkeila et al 2003, Salokangas 2004). Hyvönen (2004) found that efforts focused on

improving the mental health of an employee contribute to improving the mental health of the patients. Mental health workers must have access to supervision as individuals. Attention should also be paid to providing supervision as a team. (Tuori 1994, Aaltonen et al. 2000.) According to Salokangas et al. (2000), the working conditions and methods of psychiatric personnel require reconsideration and ought to be developed in order to meet today's standards. More attention should be paid also to the personnel's need for further education.

The problematic issues within mental health services include, on one hand, the low attractiveness of the field in the eyes of professional personnel and, on the other hand, lack of personnel resources. Owing to a long-term lack of personnel, the psychiatric community care has not been able to function optimally. It has been especially difficult to fill open posts of psychiatrists within community care. (Wahlbeck 2004.)

A service organisation emphasising outpatient care places accentuates the role of family members on taking care of the patient's management with everyday activities (Stengård et al. 1993, Shephard & Moriarty 1996, Stengård 2005, Wahlbeck 2007). Deficiencies in community care add to the family members' work load. (Wahlbeck 2007.) Psychiatric patients' family members have voiced many concerns related to their role as the close ones of a mentally ill person. The subjective strain experienced by family members includes many negative emotions, such as guilt, insecurity, hate and sorrow. Objective strain includes problems with caring for practical issues, organising free time, financial issues and social relations. (Schene et al. 1996). Stengård (2005) suggests that each family member's need for emotional, informational, practical and financial support should be acknowledged and assessed as a part of the routine clinical practice in psychiatric hospitals and psychiatric community care.

2.3 Psychiatric post-ward outpatient services

Various researches (Alanen et al. 1991, Anderson et al. 1993, Leff 1993, Parker 1993, Lehtinen et al. 1996, Hogarty et al. 1997, Korkeila 1998, Harjajärvi et al. 2007) show that when the emphasis of psychiatric care shifts to community care and hospitalisation becomes short-term, various individual alternatives in supporting the patient's coping are needed. In addition, the transition from psychiatric hospital to community is complex and can be challenging for many individual patients. In order to successfully discharge patient to the

community, flexible and effective models and organisation of aftercare are required. (Forchuk et al. 1998b, Llewellyn et al. 1999, Aaltonen et al. 2000, Leff & Trieman 2000, Reynolds et al. 2004, Forchuk et al. 2005.)

I have not found any Finnish studies where post-ward outpatient services had been studied from the same point of view as in my stydy. There are numerous studies where post-ward outpatient services were refered to. (Tuori 1987, 1990, Seikkula 1990, Salokangas & Nordling 1992, Isohanni & Moring 1993, Tuori 1994, Kokeila & Tuori 1996, Rasinkangas et al. 1997, Aaltonen et al. 2000, Haarakangas 2002). A literature research in Cinahl database in 2000-2005 with search terms 'outpatient', 'outpatient care', 'after care', 'continuity of care' combined with terms 'psychiatric nursing', 'psychiatric care', 'mental health services' and 'community mental health services' found no knowledge and no research articles concerning post-ward outpatient services.

No direct equivalent to the Finnish words 'jälkipoliklinikkatoiminta' (post-ward outpatient services) or 'jälkipoliklinikkakäynti' (post-ward outpatient visit) were found in international studies. Various models of 'case management' to help individuals manage within the community have been proposed in the USA and the UK. Case management is a client oriented operations model applied in social and health services designed to evaluate the health of an individual and to plan, produce and provide services and co-ordinate and observe the requirements of meeting the clients' needs. The basic principles of the model include client-orientation, responsibility, continuity of care and consistency with the aim of increasing the functional and financial efficacy. The care is realised with as stable and small a care team as possible to ensure that the basic principles of the model are met. The organisation is directed to function with the client at centre while all the care team members put their expertise to use to ensure smooth and seamless care. (Grönroos & Perälä 2002, Perälä 2003.)

One widely used case management model is called assertive community treatment (ACT). Assertive community treatment is rapidly implemented by many European mental health services (Sytema et al. 2007). ACT was developed to treat difficult-to-engage clients who have a history of so called 'revolving door' cycle of admission-discharge-readmission. (Burns & Santos 1995.) ACT aims to provide a complete care package. This includes treatment within community, a high level of staff support, a high staff to client ratio, an emphasis on practical activities of daily living, and a team approach to case management so that clients

have access to a number of staff. (Jones 2002, Watts & Priebe 2002.)

Another model with planned discharge for long- term psychiatric patients is called transitional discharge model (TDM). The transitional discharge model include two key components; first, bridging of the personnel of inpatient and community care, the inpatient staff continues to work with the discharged patient until a working relationship is established with a community care provider; second to use of peer support, which means assistance from former patients who provide friendship, understanding and encouragement. (Forchuk et al. 1998a, Forchuk et al.1998b, Reynolds et al. 2004, Forchuk et al. 2005.)

In many health care districts the care practices have indeed been changed so that the boundary between outpatient and inpatient care has disappeared, and inpatient and outpatient care personnel cannot always be functionally distinguished (Korkeila & Tuori 1996). Isohanni and Moring (1993) suggest that it is time to critically study the distribution of care into outpatient and inpatient care. Hospital ward personnel can assume more responsibility for outpatients. This would form multifunctional units with varied work tasks for the personnel while the patients would receive inpatient and outpatient care from the same, familiar nursing staff. According to Tuori (1994), continuity of the care relationship is present if the personnel can flexibly move across the boundaries. This means, for example, that the hospital wards have a possibility to provide post-ward outpatient services.

The concept of ‘post-ward outpatient services’ means that after discharge from hospital, the inpatient staff continues to work with the discharged patient, and the patient returns to the same ward for outpatient visits. The concept ‘post-ward outpatient services’ will also be used in abbreviated form PWOS in this study. Correspondingly ‘post-ward outpatient visit’ is occasionally abbreviated as PWOV.

Post-ward outpatient services were initiated in several Finnish psychiatric hospitals in order to backup outpatient care. Post-ward outpatients visits have been depicted in the studies mentioned above. According to them post-ward outpatient visits are booked, if community care is insufficient to support the patient and prolonged hospitalisation would therefore be needed. Post-ward outpatient visits are used also in cases where the patients have special difficulties with confidence and commitment, or if they are unmotivated for long-term care and a transfer into outpatient care would seem to interrupt the treatment. (Rasinkangas et al.

1997.) Post-ward outpatient visits are booked also in cases where the patients' family is centrally involved in the care process (Rasinkangas et al. 1997, Aaltonen et al. 2000).

I took an interest in post-ward outpatient services when I worked as the head nurse in psychiatric inpatient and outpatient services. Charge nurses and nurses in three different adult psychiatric wards told me about post-ward outpatient visits and how much employees' time they seemed to need. On the other hand they felt that kind of work very interesting and valuable, but on the other hand they were worry about the resources.

I collected statistics on the post-ward outpatient services in Central Ostrobothnia Hospital District between the years 1994 and 1998. As a result of the statistic data analysis I was able to find out the following: From 1994 to 1998, the number of outpatient visits increased by 7.6 % (Table 1, Appendix 1), the number of patients in post-ward outpatient services increased by as much as 39 %, and the proportion of patients in post-ward outpatient services in relation to all inpatients had increased from 18.8 % to 48.7 % (Table 2, Appendix 1). The number of visits in relation to other outpatient visits (mental health services of hospital district) was 1.8 % in 1994, but in 1998 it had increased to 12.8 %. (Table 3, Appendix 1).

I also took a closer look at the group of patients that had post-ward outpatient visits ten times or more in 1998; total of 49 patients, 25 of them women and 24 men. (The participants for the present study were later selected from this group.) They were on the average 39.2 years of age. Most of the visits, 77 %, were visits to the primary nurse. The patients made on the average 18.3 outpatient ward visits a year. (Table 4, Appendix 2.) Most of the patients were unmarried, professional or unprofessional workers; single and retired (Table 5, Appendix 3). Most of them suffered from schizophrenia (Table 6, Appendix 4).

My next interest was directed towards the contents of post-ward outpatient visits and their task in psychiatric care system. As each patient's primary nurse was responsible for most of the post-ward outpatient visits, I became interested in the significance of the patient-nurse relationship that began during inpatient period and developed further during post-ward outpatient services. I was especially interested in studying the effects of post-ward visits on the continuity of care. These issues were later formed into the research questions of the present study.

2.4 Summary of the background of psychiatric post-ward outpatient services

The responsibility of organising psychiatric services has been transferred (Figure 1.) from central government to municipalities while the previous institution-based psychiatric care has developed towards varied, integrated community care and the service providers now include hospital districts, municipalities and both the private and third sector. (Lehtinen 2002, Harjajärvi et al. 2006.)

Also the care practices within psychiatry have gone through substantial changes. There has been a reduction in the number of psychiatric hospital beds, inpatient care periods have been shortened in duration and the number of visits to community care has been increased. The development resembles that of many other western countries (Sohlman et al. 2006). Despite the significant changes in resources available to psychiatric care, there has not been a similar reduction in the need for inpatient care. Instead, the high turnover rate of patients has increased the load on hospital wards. Increased visits to outpatient care have not been found to decrease repeated hospital admittances (Korkeila 1996). Attempts to develop psychiatric services towards a more community-oriented model have not affected the tendency towards hospitalisation in some regions (Harjajärvi et al. 2006, Wahlbeck 2007). The structural change in Finnish psychiatry is, at present, unfinished, and there is a further need to develop different alternatives for hospitalisation within psychiatric care (Harjajärvi et al. 2006.)

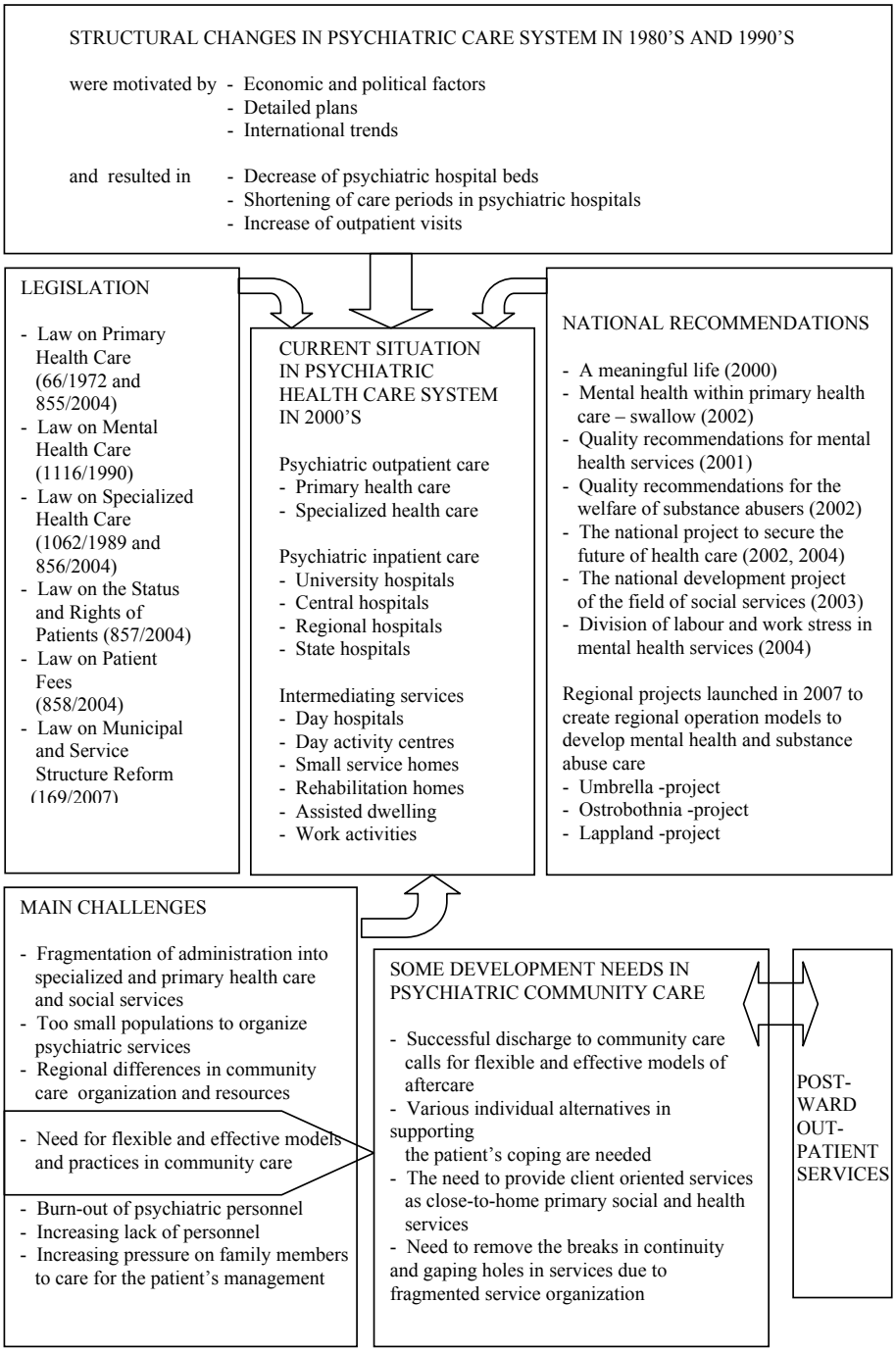

Figure 1. Summary of the background of post-ward outpatient services

In all psychiatric care there has been determined a maximum waiting periods for admittance by the Act on Specialized Medical Care from 2005 onwards. The realisation of the health care guarantee within child and adolescent psychiatry on the regional level is satisfactory. Also in psychiatry most of the hospital districts have been able to admit patients within the determined waiting period. The psychiatric statistics compilation systems are, however, considered deficient and non-uniform, which makes it impossible to receive up-to-date follow-up information about the situation on a national level (Wahlbeck 2007.)

Legislation concerning the project to restructure municipalities and service structures came into operation in February 2007. The law requires each municipality to organise its primary social and health services to its population. The focus is on improving the health and well-being of the population and strengthening co-operation in organising the services.

The national quality and development recommendations aim at producing uniform practices for mental health services. The recommendations do not, however, comment on how they should be realised in practice – this has been left for the regional parties to determine. The development of mental health services by means of providing information has not been found successful enough. (Lassila 2006.) The development recommendations have not evolved into concrete points of development and the mental health work remains quite backward in many municipalities (Työnjakoa ja työnrasitusta… 2004, Wahlbeck 2007). As few as one-fourth of all the Finnish municipalities had adopted a strategy or program for their mental health work by in 2005 (Harjajärvi et al. 2006). The recommendations and comments have, in part, been considered foreign to everyday work and difficult to put into practice. (Työnjakoa ja työnrasitusta… 2004). The public view is that the quality recommendations for mental health services are not realised in practical mental health work (Aspvik et al. 2007).

According to the Ministry of Social Affairs and Health (Kansallinen terveysprojekti tulevaisuuden … 2004), the quality recommendation work can be considered a successful method of guidance, but there are no detailed evaluations on the actual effects of the recommendations. The development of quality indicators for follow-up of the effects of quality recommendations is, at present, in its initial stage.

The psychiatric care system is faced with challenges and choices. There is a need for new solutions with regard to both the organisation and contents. (Wahlbeck 2007). Studies have

shown that a balanced psychiatric care system with a variety of community services and hospital services is more successful than a hospital-based care system. The development of community services remains the greatest challenge of the psychiatric care system as there is a need for 24-hour units outside the hospitals, organised daytime activities and mobile and on-duty community services. (Tuori 2004, Thornicroft & Tansella 2004, Pirkola & Sohlman 2005, Harjajärvi et al. 2006, Sohlman et al. 2006.)

3 PURPOSE OF THE STUDY AND STUDY QUESTIONS

The purpose of this study was to describe and analyse the different conceptions of patients, inpatient ward personnel, outpatient care personnel and administrative personnel in psychiatric units concerning the psychiatric post-ward outpatient services.

The following study questions were addressed:

1. What are the conceptions of the substance of patient – nurse relationship? (Paper III)

2. What are the conceptions of the substance of outpatient visits? (Paper II)

3. What are the conceptions of the factors contributing to the continuity of care? (Paper I)

4. What are the conceptions of the benefits of post-ward outpatient services? (Paper IV)

4 PHENOMENOGRAPHIC APPROACH

The term 'phenomenography' means describing or writing about a certain phenomenon. The roots of phenomenographic research lie in the University of Gothenburg, where Ference Marton begun his research on university students' different concepts on learning in the 1970s. He first introduced the term 'phenomenography' in 1981. (Marton 1981, 1986, 1988, Larsson 1986, Uljens 1989, Ahonen 1994, Järvinen & Karttunen 1997.) Since then Marton (1988, 1992) has described phenomenography as a research approach. The phenomenographic approach aims at studying concepts in order to identify the different experiential variations that the study participants use to experience, understand and create meaning out of the phenomena of the surrounding world (Marton 1988, 1992, Uljens 1992, Marton & Booth 1997, Wenestam 2000, Sjöstram & Dahlgren 2002).

The research approach got its name on the basis of the many similarities shared with phenomenology. According to the phenomenological way of thinking, subjective experience cannot be separated from the actual experience. Meanwhile, the phenomenographic approach accepts the existence of reality irrespective of the individual, even though the meaning of reality is understood to be based on the individual's conceptions and understanding. The meaning of reality not predetermined but founded on individual interpretation. (Uljens 1989, 1993, Marton & Booth 1997.)

Ontological engagements of phenomenography include a nondualistic approach to the human nature. The nondualistic conception of reality does not separate objective, real world from subjective inner world, but sees the world as existing in experience. The experience of the world is at the same time subjective and objective. Human experience is the relation between the objective and subjective world. An individual is part of the world and participates into shaping the reality through his or her experiences. (Marton 1986, 1994, 1995, Uljens 1991, 1992.)

Central parts of epistemological engagements of phenomenography are also based on the nondualistic conception of reality. Knowledge is rational, since the question is not how an individual gets to know the outside world but rather what kind of changes there are in the relationship between an individual and the world. Knowledge is also perceived as dynamic, limited and context-bound. Knowledge is dynamic, because it is formed in the continuous

process of observation and thinking. Human knowledge is also limited in the sense that an individual can only observe a phenomenon from one point of view at any given moment. Finally, knowledge is context-bound, because the structure of human consciousness allows for changing the point of view. (Uljens 1993, Marton 1995, Kokko 2004.)

The phenomenographic approach rests on the school of gestalt psychology. Emphasising the qualitative features of experiences and conceptions is typical to this school (Gröhn 1992.) Studies employing the phenomenographic approach investigate reality as conceptionalised by people, that is, the studies start from a conception. Everyday language often equates conceptions with opinions and connects them with values. However, the phenomenographic approach gives conceptions a deeper and wider meaning than everyday language. Conception is understood as a fundamental relationship between an individual and the surrounding world. (Marton 1986, Uljens 1989.) Conceptions always reflect the reality, culture and context that the individual lives in. Conceptions are not separate from their context, but whether or not the context is preserved in the final results depends on the researcher's solutions. (Marton 1995.)

The phenomenographic approach makes a distinction between what something is and how that something conceived to be. In the first case, interest is directed towards the phenomenon as such, which is known as the first-order perspective. The way a person conceives this phenomenon in reality is called the second-order perspective. This means that the researcher does not aim at describing the phenomena of reality and their essence as such, but rather orientates on an individual's conceptions of the surrounding world and makes conclusions based on them. It is the second-order perspective that is unique to phenomenography (Marton 1981).

The roots of the phenomenographic approach go back to studies on learning (Marton 1981, Larsson 1986, Uljens 1989, Ahonen 1994). The phenomenographic approach can be used to study a wide range of issues including approaches to learning and teaching, understanding scientific phenomena learned at school, or understanding general issues in the society unrelated to educational systems. But the approach may be and is applied to a variety of other issues, both inside and outside the field of education (Bowden 1995). The phenomenographic approach offers a well-founded basis for different kinds of nursing science studies that deal with conceptions of health, health care, illness and medical treatment in patients of different ages and backgrounds suffering from different conditions (Sjöström & Dahlgren 2002).

According to Metsämuuronen (2000), the phenomenographic approach could be applied to client service studies e.g. if there is reason to suspect that employees too easily assume that patients will understand what they are told. Professionals are prone to using concepts that are familiar to them, but a patient cannot be expected to always understand what they are being told. At worst, psychiatric care jargon can be misinformation that only increases feelings of anxiety and uncertainty. Behind each professional term there is, in fact, an everyday experience for a patient. To acknowledge this will give patients and their close ones a possibility to understand, find solutions and regain control of their lives. (Lehtinen 2003).Phenomenography is an approach that is often used in nursing research (Fridlund & Hildingh 2000) and has a high applicability to identify different human perceptions of a complex phenomenon (Marton & Booth 1997). In Finland, the approach has been employed in several doctoral dissertations on e.g. Finnish public health nurses' experiences of primary health care (Simoila 1994); head nurses' and charge nurses' conceptions of the fields of know-how within nursing (Nousiainen 1998); organisational culture in the institute of health care sciences as seen by teachers and students (Mäkisalo 1998); nurse students' conceptions of knowledge and the relationship between knowledge and action (Karttunen 1999); values and valuations concerning nursing work in health care students and nursing staff (Pihlainen 2000) and mental health care clients' and staff members' views of good mental health work (Kokko 2004).

A literature research (Linda, Cinahl, PubMed, USA National Library of Medicine) with search terms ‘phenomenography’ and ‘psychiatric nursing’ found 11 research articles from between 2000 and 2006. These studies addressed the following topics: psychiatric nurses` conceptions how group supervision influences professional competence (Arvidsson et al. 2000); psychiatric nurses` conceptions of how a 2-year group supervision programme influences professional competence (Arvidsson et al. 2001); supervisors’ conceptions of well-functioning support to long-term mental health patients (Björkman 2002); nurses’ conceptions of health processes promoted in mental health nursing (Jormfelt et al. 2003); patients’ conceptions of health processes promoted in mental health nursing (Svedberg et al. 2003); men coping with major depression (DSM-IV) with the help of professional and lay support (Skärsäter et al. 2003b); women’s conceptions of coping with major depression with the help of professional and lay support (Skärsäter et al. 2003a); mental patients’ conceptions of their relationships with nursing staff members (Högberg et al. 2004); patients’ perceptions of the

concept of health in mental health nursing (Svedberg et al. 2004), psychiatric care staff members' and care associates' perceptions of the concept of quality of care (Schröder & Ahlsröm 2004) and patients' perceptions of the concept of the quality of care in the psychiatric setting (Schröder et al. 2006).

A study employing the phenomenographic approach is always based on empirical data. Studies in this vein aim at presenting (as many as possible) qualitatively different ways of approaching certain concepts and phenomena. The said variations in thinking arise from the study material: interviews and written documents (Larsson 1986, Uljens 1992). Most often the study material is collected through interviews. Interviews should be by nature as open as possible to enable the emergence of individual conceptions (Marton 1986, 1992).

There are generally four stages in studies using the phenomenographic approach: choosing the research subject; theoretical preparation; data collection and data classification. The first stage involves the researcher paying attention to a certain issue or concept that appears to divide conceptions and interpretations. In the second stage the researcher gets theoretically acquainted with the research subject and prepares a preliminary analysis of related aspects. The researcher then moves on to stage three and interviews individuals that express different perceptions on the research subject. Here the aim is to have the participants express their conceptions of the studied phenomenon. The fourth and last stage is about analysing written text. (Ahonen 1994, Marton 1994.)

It is to be kept in mind when choosing participants for the study that they ought to bring as broad a variation of possible of the phenomenon under study (Martin & Booth 1997). To ensure as broad a range of conceptions as possible, the participants must be chosen carefully (Larsson 1986, Uljens 1989). Thus, data collection within the phenomenographic approach is more about depth than width, often resulting in a small number of participants – often only about twenty persons. (Ahonen 1994.)

It is characteristic of the phenomenographic approach, as of qualitative studies in general, that both data and purpose of the study affect the phases the researcher goes through when forming the categories describing the data. It is essential that the researcher reads through the data various times during the analysis process, reflecting on his or her own understanding and the experience brought about by the data. (Larsson 1986, Uljens 1992). The researcher

searches the data for qualitatively different conceptions of the research subject and uses the expressions describing them to form units of meaning. Units of meaning are then used to form categories describing the conceptions. (Marton 1988, 1994, Ahonen 1994, Svensson 1977) Combining units of meaning into categories is based on the idea that the researcher will search them for shared thought elements (Ahonen 1994). Categories describing the participants' different ways of thinking constitute the most significant study results. (Larsson 1986, Järvinen & Järvinen 1995, Häkkinen 1996.)

Each category is supported by expressions and their meanings – sometimes only one, sometimes several. Researchers are interested in their qualitative differences rather than their number or representativeness within a certain set. Furthermore, the number of expressions supporting a category is not essential because qualitative research generally focuses on such a small number of participants, that the representativeness of the categories within, for instance, an age group cannot be determined. The theoretically most interesting category may be quite marginal in the data. Even if represented by only one individual, its qualitative content can make it interesting. The quality of the study is usually improved if the researcher is able to combine categories into higher level categories that explain the conceptions on an even more general level. (Ahonen 1994.)

Categories formed within the process of data analysis are abstract in three senses: they are selective, compressing and organising in relation to the data (Uljens 1989). Categories can be described vertically, horizontally and hierarchically. Horizontally formed descriptive categories are equally important. Vertically formed descriptive categories are classified on the basis of their frequency or chronological order according to a certain criterion arising from the data. Hierarchically formed descriptive categories are on different levels of development in terms of e.g. how organised, theoretical or extensive the conceptions are. (Uljens 1991.)

Criticism towards the use of the phenomenographic approach has addressed, among other things, the generalisability and presentation of the results and the researcher's role in the process. Gröhn (1992), for instance, has criticised the generalisability of the results in practical problem solving situations and the applicability of context-bound concepts learned in teaching situations to the context of practical work. Furthermore, she argues that sufficient attention has not been paid to the changing of conceptions as partly individual, partly social phenomenon. Gröhn also proposes that studies should employ different ways of thinking in

order to find the most developed explanation so that the reader would not be left with the understanding that all the presented conceptions are equal.

Uljens (1993) criticises the phenomenographic approach for allowing little reflection when presenting the results as compared with phenomenology, where reflection is essential. According to Säljö (1994), the phenomenographic approach does not account enough for individual experience. Marton (1995) expresses the need to clarify the role of the researcher during the research process. Häkkinen (1996) has proposed that phenomenographic studies should aim at examining interview comments as conceptual entities that would bring out the wider context of an informant's expression. She also suggests that both the interaction between researcher and informant and the effects of theory on interpreting the meaning of expressions be clarified. Häkkinen (1996) has also described phenomenographic analysis as difficult to realise, since there are no detailed descriptions on the stages of the analysis in neither theoretical presentations on the study or in studies themselves.

The purpose of the present study is to describe and analyse the conceptions of patients, inpatient ward personnel, outpatient services personnel and administrative personnel in psychiatric units concerning the post-ward outpatient services. The phenomenographic approach allows for describing individuals' and participants' conceptions. It also enables one to do research on a little-studied topic, such as post-ward outpatient services, with an inductive emphasis. While compiling the research plan, this author considered the possibility of using other approaches. One of the options was phenomenology. However, its central objective, which of bringing out the essence of a phenomenon, did not correspond to the purposes of the present study: to describe and analyse the participants' different conceptions and their variations. Meanwhile, the phenomenographic approach was well suited for this purpose. The phenomenological method requires participants to have a personal experience of the studied phenomenon (Giorgi 1988). It is, however, possible for one to express one's conception concerning post-ward outpatient services even if one has no personal experiences of them.

Frilund (1998) describes the phenomenographic approach and phenomenology by defining their study questions, analysis method, analysis content and analysis profound. The study question in phenomenographic approach is ”how”, the analysis content is ”conception” and the analysis profound in ”description”. Correspondingly, the research question in

phenomenology is ”what”, the analysis content is ”meaning” and the analysis profound in ”understanding”.

The phenomenographic approach does not set out to study ”how something is” (first stage point of view, where the interest lies on finding the essence of a phenomenon and reality as such), but ”how something is perceived to be” (second stage point of view) and what the world looks like from the viewpoints of different individuals. This is why the present study does not aim at studying the essence of post-ward outpatient services, but rather analyses and describes how the participants perceive, experience, observe and understand phenomena and events associated with post-ward outpatient services. It is also not considered essential to find out why the participants think as they do, but to attempt to describe the qualitative differences in their conceptions (cf. Larsson 1986, Uljens 1993, Häkkinen 1996).

In this study phenomenography is understood as an approach. Reasons for this choice are Marton's (1995) and Marton and Booth's (1997) analysis on the essence of phenomenography. They see phenomenography not as a research method, despite its methodical features, but as an approach, because it is related to certain methodological principles. Also Uljens (1991) argues for his view on phenomenography as an approach with the included interpretative method of data analysis. Furthermore, the most recent literature suggests that phenomenography is an approach (Marton & Booth 1997, Sandberg 2000, Sjöström & Dahlgren 2002).

Phenomenographic approach explains decisions concerning information retrieval on the basis of the multidimensionality of consciousness (Marton 1985). On the grounds of the intentional nature of consciousness, phenomenography is descriptive research, where an individual's conceptions of a phenomenon are described with contentual terms without translating them into symbolic language. Conceptions are described in their own contexts without a predetermined theory (Uljens 1992). In the present study this means descriptive research tasks, data collection through a themed interview, carrying out a data-based analysis process and adhering to the participants' original expressions when presenting the results.

5 DATA, DATA COLLECTION AND ANALYSIS

This chapter describes the selection of the participants and explains how the data collection and data analysis were carried out. The different phases of the study are presented in Figure 2.

5.1 Participants

When selecting the participants for the study I attempted to include people that would represent as wide a variety as possible of the phenomenon under study (see, among others, Marton & Booth 1997) in order to be able to expect that all the different ways of experiencing will be accounted for (Bowden 1995). There is the total of 28 persons participating in the study (N=28): patients cared for at three adult psychiatry post-ward outpatient services (5), inpatient ward personnel (13), outpatient care personnel (5) and administrative personnel (5).

The patients at three adult psychiatry post-ward outpatient services were selected as participants for the study as follows: At the onset of the study in 1999 I compiled a list of all the patients cared for at the post-ward outpatient services in 1998. I then narrowed down the search to include the patients that had used the outpatient services 10 or more times. There were altogether 49 of these patients, and they had made on the average 18.3 visits to the post-ward outpatient services in 1998. (Table 3, Appendix 2, Table 4, Appendix 3, Table 5, Appendix 4.) In collaboration with the inpatient ward nurses participating in the present study I selected 12 patients to be sent a request to take part in the study. However, only one patient agreed to participate. I then asked the nurses who acted as nurses for outpatients in post-ward outpatient services to inquire whether the patients would like to participate. The nurses received as an aid a written description on the purpose of the study and the realisation of the interviews. This resulted in 4 more patients agreeing to participate. There were 4 women and 1 man among the participants.

The interviewed inpatient and outpatient personnel included individuals representing different professions: nurses (7), mental health nurses (2), psychologists (2) and social workers (2). Psychiatric unit administrative personnel included charge nurses (3) and physicians (2). The inpatient ward charge nurses acquired the participants amongst inpatient ward personnel, while I asked the outpatient ward personnel and psychiatric unit administrative personnel

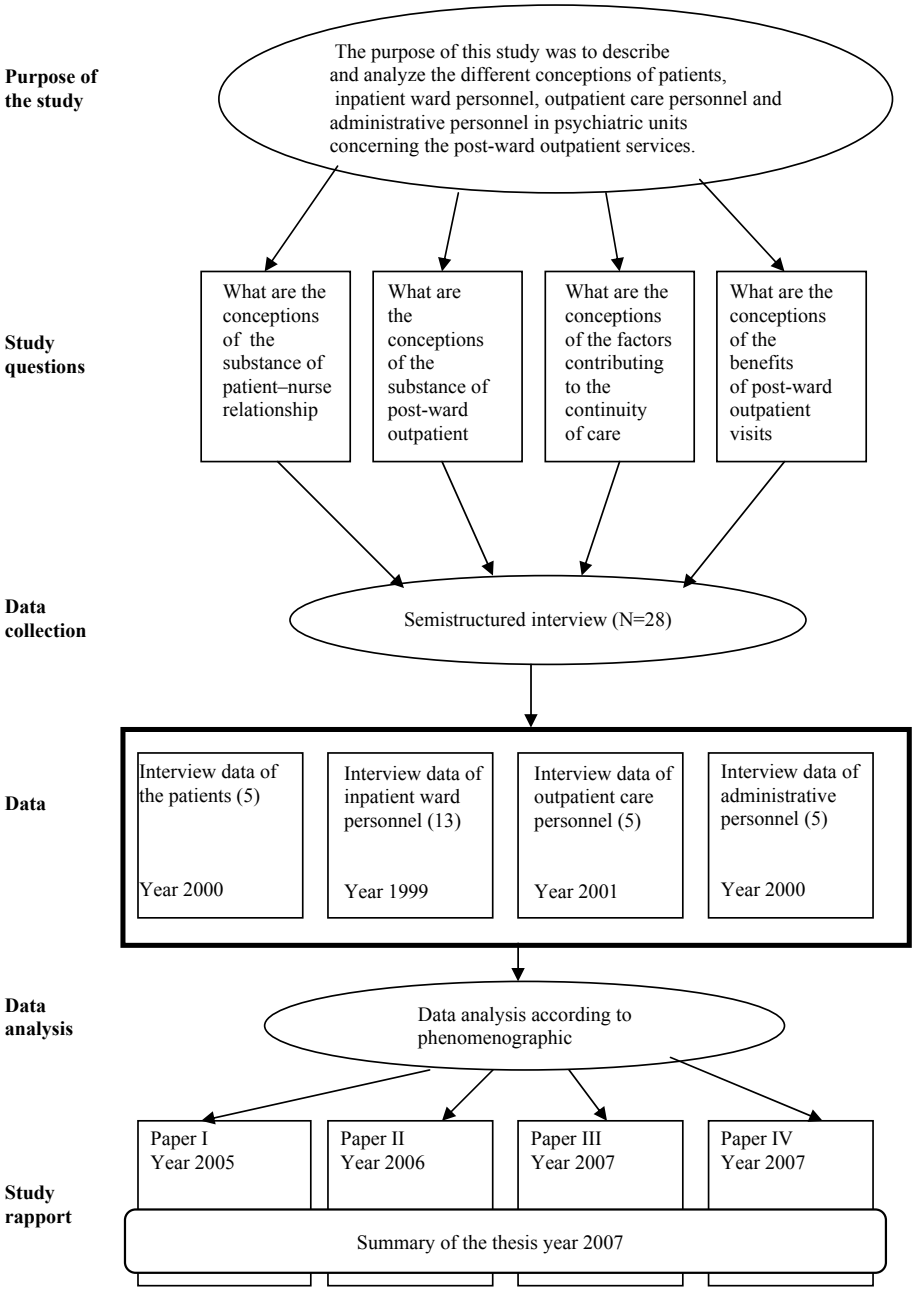

Figure 2. Phases of the study.

representatives to participate. There were 7 men and 16 women in the above-mentioned group of participants. They had on the average 6 years of experience in working within adult psychiatric post-ward outpatient services.

5.2 Data collection

The study material was collected by means of a semi-structured interview. A semi-structured interview is based on themes selected beforehand, but there is no clear formation or order to the questions in the interview (Hirsjärvi & Hurme 2001, Metsämuuronen 2003). This method of material collection enables interaction between the interviewer and interviewee, making it possible to use questions to widen the understanding of the participants' conceptions. (Marton 1981, 1988, Marton & Booth 1997.)

The method of material collection and interview themes were tested by interviewing one inpatient ward nurse. This preliminary interview indicated that the themes constructed on the basis of the research questions covered well the area of study and were able to provide profound information on the participants' conceptions of post-ward outpatient services. The themes also ensured that each area represented by a research question would be addressed. The preliminary interview was also included in the data.

I conducted the interviews with inpatient ward personnel in 1999, patients and psychiatric unit administration personnel in 2000 and outpatient service personnel in 2001.

Interviews with the patients took on the average 40 minutes. One of the patients was interviewed at the inpatient ward premises, one at outpatient care unit, three at the patients' homes. Interviews with the inpatient and outpatient ward personnel and psychiatric unit administration personnel took on the average 1 hour and 10 minutes. The participants were interviewed at their respective places of work in their own workrooms or other such premises reserved for doing the interview.

The aim of a study based on the phenomenographic approach is for the participants to thematise through reflection and make their own conceptions explicit (Francis 1995). Also in this study my role was to help the interviewees contemplate on and describe their conceptions as thoroughly as possible. The following are two examples selected from the data. The letter

"I" means the interviewer, which is, this author, and "W" an inpatient ward employee.

Ex. 1:
I: What, in your opinion, does a visit to a post-ward outpatient services consist of?

W: … there is free discussion, asking how the other is doing, and the patients often tell what life has been like at home, what they have been doing and how they have managed with the tasks that we have together appointed for them to do...

I: You said that you have mutually agreed on some tasks for the patients to accomplish. What kind of tasks are these?

W: …ordinary everyday things, such as managing grocery shopping, cooking meals and cleaning the house …

Ex 2:
W: ...the problem with these patients has mostly been that they do not attach to the care in any way. The continuity of care is one thing that it (post-ward outpatient services) aims at securing in order to provide the patient with at least something to be attached to during care…

I: You said that the patients have had difficulties with being attached to care? What do you think, then, why do the patients attach to care at the post-ward outpatient services?

W: I believe that the basis is that the patients feel that they have established a confidential relationship with someone, because many of our patients here at post-ward outpatient services have a, how should I put it… lack of trust caused by many disappointments. They have hard time believing that we sincerely want to help them and when they experience that we are genuinely here for them and want them to have a better life and better future, well, this is basically the factor that gets them to attach. Many patients have given us feedback that it feels safe to be attached to e.g. one's nurse.

According to Gröhn (1992), when the focus of interest is on conceptions, their appearance as actions is not sufficiently considered. Even though this study specifically investigates patients' and staff members' conceptions of post-ward outpatient services, the conceptions are

at the same time also descriptions of its functions. The most essential issue is for the participants to describe the functions in reality, and not just the ideal. This is why I, while doing the interview, attempted to constantly return to the participants' own conceptions of post-ward outpatient services and encourage them to speak about their own actions. In the examples below the letter "I" stands for the interviewer, i.e. this author, and "W" for an inpatient ward employee.

I: How do you react if one of your patients misses a post-ward outpatient visit?

W: It depends on the patient. I either send him a new appointment by mail, or, if the patient's situation is unstable I either make a home call or phone call and ask whether he has forgotten. I generally try to somehow contact them.

I: In what kind of situations do the patients miss a visit?

W: They may have forgotten about it and arrive the next day, or, for example, a patient receiving medicine injections has not been able to get a ride for the appointed date. Then there are also those patients that who in and say that they do not want to come or announce that they do not want any more medication and want to stop the care.

I: What do you do if a patient announces that he will not use the post-ward outpatient services any more?

W: …I try to encourage the patient to come for a visit or suggest that I can make a home call, in other words, I always make an effort to check on the patient. In situations where we have mutually agreed to end the visits I make sure the patient knows what to do if he later needs help.

In line with the practices of the phenomenographic approach, the interviews involve the risk of speaking about the issues in too general terms so that the connection, world and culture, i.e. the context related to the issue described by the informant, may remain unheeded (Marton 1995). The informant may be aware of knowledge and actions and the relationship between the two, but he does not speak of his own knowledge and actions but discusses post-ward outpatient services on a general level. This is why I made an effort to use concrete situations

and incidents as starting points for the interviews during the data collection period.

5.3 Data analysis

The purpose of the data analysis used in phenomenographic approach is to direct the stages that the researcher goes through when forming categories describing the data. According to Häkkinen (1996), the different stages of analysis generally proceed as follows: the data is used to form meaning units that are then compared with each other. Categories and their relations are then described. The process of data analysis in the present study proceeded through six stages: 1) transcribing the data into written form, 2) acquiring a general picture of the data, 3) searching the data for meaningful and adequate expressions from the point of view of the research question, 4) using the expressions to create meaning units, 5) comparing the meaning units for their similarity and diversity and 6) forming the final categories: subcategories and main categories (Papers I, II, III, IV).

In the first stage of the analysis I transcribed the data into text and also checked the uniformity between the written and spoken data.

In the second stage I concentrated on reading and listening through the interviews many times in order to form a good overall picture of their contents. It was during this stage that I first was able to outline the meaning content of the data. Larsson (1986) argues that the researcher should continue reading until the interviews almost exclusively fill his or her thoughts.

The third stage involved searching the data for meaningful and adequate expressions from the point of view of the research question. The expressions were formed on the basis of statements concerning post-ward outpatient services. In this stage I simplified and modified the found expressions into everyday language to facilitate their processing. Transforming expressions into everyday language enables one to recognise similar expressions later on (Kokko 1999).

In the fourth stage I formed meaning units out of the expressions. The purpose of analysing this stage is to reveal the conceptions concerning the phenomenon behind the linguistic expression (Marton 1988). Expressions are seen as conceptual entities, which is why it is essential not to break the conceptual connections between meaning units (Syrjälä 1994).

Defining meaning units in different contexts brings out the context-bound nature of analysis. In the present study this meant that I searched for the best possible interpretation for each expression in relation to the surrounding text.

The thus formed meaning units were compared with each other in the fifth stage. The categories gradually begun to take shape when I made comparisons between the similarities and differences of the meaning units. I grouped the meaning units into categories by gathering similar meaning units into one group and meaning units that were different from these but similar with each other into another group. Marton (1988) proposes that this is how rough, preliminary groups of meaning units can be gradually formed into more and more precise, clearly distinguishable categories.

In the sixth stage I formed the final categories: subcategories and main categories. I gave the categories their final names in which I attempted to use conceptions that would describe the data as well as possible. When applicable, I also used conceptions from previous studies or theories when they fulfilled the criteria set for categories formed on the basis of the data and could be used to describe the results of also this study (Uljens 1991).

The main categories of the studies are general categories, and they are presented as horizontally related to each other because they are of equal value. Some of the main categories consist of subcategories, which are vertically related to the main category and hence specify it (Uljens 1991).

According to Svensson and Theman (1983), the categories ought to rather be called abstracting than abstract, as the description is not restricted only to describing the contents of the conceptions on a general, abstract level, but it is also used to organise the data. The purpose of my study was not, however, to abstract away the concrete contents of the conceptions, but to find unique categories tied in with the contents of the data (Larsson 1986). The categories were found by dissecting and combining the data into entities. When describing the findings, I took up the central features of the categories and the structure of their interior elements.

Excerpts from interviews coming up in the article (Paper I, II, III and IV) texts have been chosen in an attempt to describe the participants' conceptual entities. The purpose of this

effort is to convince the reader of that the researcher has not separated them from their original context to support her own interpretation (Uljens 1989, Ahonen 1994).

6 RESULTS

The purpose of this study was to describe and analyse different conceptions of patients, personnel in inpatient and outpatient care and administrative personnel concerning post-ward outpatient services. The study results are categories constructed on the basis of data analysis. Categories are created from the expressions by which participants describe their conceptions. The groups in the study are not compared with each other; in phenomenographic approach it is essential to describe the qualitative differences of conceptions. (Marton 1986.)

According to Uljens (1989), the categories formed through data analysis are abstract in three senses: they select, condense and organise the data. The results of this study are described as main categories, some of which have subcategories that help to clarify the matter. As the quality of a study is usually increased if the researcher is able to further combine the categories on a higher level, I have formed the integrated categories that explain the main categories on a more general level (e.g. Ahonen 1994, Kokko 2004). The four integrated categories are: good patient-nurse relationship as a basis to post-ward outpatient services (*Basis to PWOS*), varied services at post-ward outpatient visits (*Function in PWOS*), post-ward outpatient services enabling the continuity of care (*Facilitated by PWOS*) and the impacts of post-ward outpatient services (*Impacts of PWOS*). (Figure 3)

The results are presented in five main sections. The first section describes what are the conceptions of the substance of patient – nurse relationship (Paper III) and the second section describes what are the conceptions of the substance of post- ward outpatient visits (Paper II). What are the conceptions of the factors contributing to the continuity of care are described in the third section (Paper I) and the conceptions of the benefits of post-ward outpatient services in the fourth section (Paper IV).

While presenting the results, the terms 'nurse' or 'primary nurse' are used to refer to all employees, because the post-ward outpatient services are taken care of primarily by nurses (Table 1, Appendix 1, Table 4, Appendix 2).

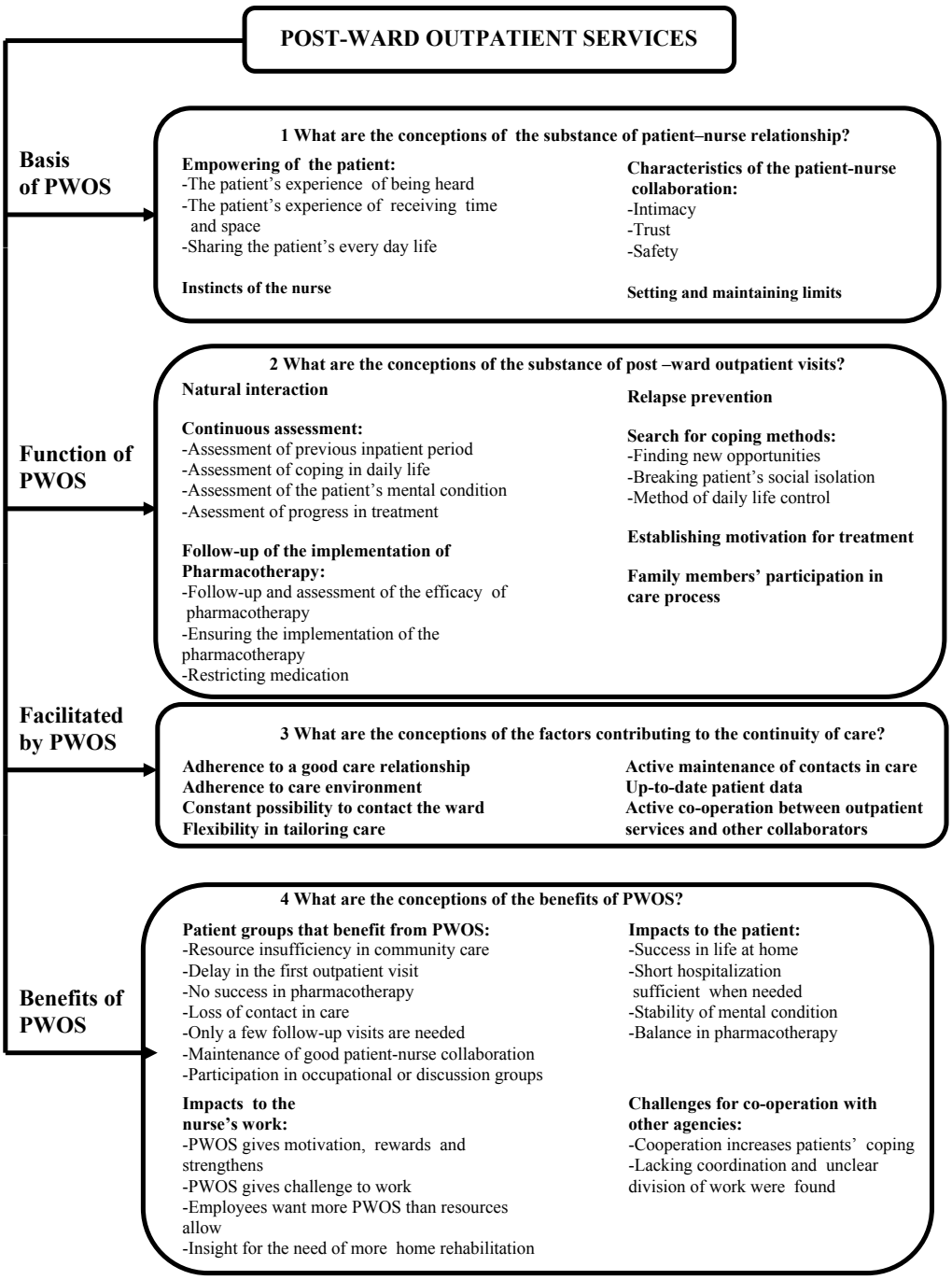

Figure 3. The conceptions of patients, inpatient ward personnel, outpatient care personnel and administrative personnel concerning the post-ward outpatient services

6.1 The substance of patient-nurse relationship

In this section the substance of patient-nurse relationship are described under the following four main categories: patient's appearance, behaviour and nonverbal expression, empowering the patient, characteristics of patient-nurse relationships and setting and maintaining limits (Paper III).

6.1.1 Patient's appearance, behaviour and nonverbal expression

The category titled "Patient's appearance, behaviour and nonverbal expression" represents the nurse's intuitive actions and use of silent knowledge when meeting the patient at a post-ward outpatient appointment. During the post-ward outpatient visit, the nurse assesses and observes the patient's situation professionally and holistically. The study participants related that, in addition to what the patient tells, the nurse also has to be able to observe meanings and signs that the patient is unwilling or unable to put into words.

The nurse will notice that a patient is not well if his or her behaviour or clothing significantly differs from previous visits. The patient may also have neglected his or her personal hygiene, which can be seen as, for instance, inappropriate clothing and unshaven appearance.

The nurse also needs to be able to 'read the patient between the lines', i.e. to hear words and sentences unsaid, which means that the patient's situation and well-being need to be observed more closely and that conclusions need to be made concerning the patient's ability to manage in outpatient care and at home.

6.1.2 Empowering the patient

The category "empowering the patient" includes the nurses' central helping methods which will help the patients to recover and achieve stability in their lives. A good patient-nurse collaborative relationship will strengthen the patient's self-esteem, reinforce his or her self-confidence and give resources for life. The category is divided into three subcategories: the patient's experience of being heard, the patient's experience of receiving time and space, and sharing the patient's everyday life.

The patient's experience of being heard refers to true, sincere listening to the patient, respect for the patient's own view, taking into account the patient's wishes and respecting the patient's own assessment of his or her condition. The nurses already begin to listen to the patient when, during the inpatient period, they first discuss the form and location of aftercare. Very often the patient wishes to receive aftercare with the nurse within post-ward outpatient services. The nurse's understanding attitude and the patient's feeling that he or she is being heard holistically and that his or her personal opinions are appreciated help the patient to improve his or her life situation.

The patient's experience of receiving time and space. The patient's post-ward outpatient visits are adjusted to his or her life rhythm as well as possible. The aim is to combine the post-ward outpatient visits with other visits to the hospital or health care centre. However, evening visits can be arranged for patients who are employed.

In case the nurse notices that the patient is showing signs of notable anxiety or distress during a post-ward outpatient visit, the time reserved for the visit is prolonged and more time is spent with the patient. The patient can also call the nurse between the visits if he or she feels that his or her condition has declined. On the other hand, the patient can also call e.g. when he or she is angry, only to unburden his or her mind.

Sharing the patient's everyday life. Many activities associated with the patient's coping in everyday life are shared by the nurse and patient. The patient and nurse together assess the patient's situation and consider his or her means of coping. The study participants said that sharing the patient's everyday life also means shared experiences.

Time is given to the patient during home visits: the patient and nurse may go shopping, outdoors, for a lunch, meal or coffee. Post-ward outpatients often have few friends or relatives. The nurse can e.g. accompany the patient to a funeral or help him or her find a new home, move in or find furniture.

6.1.3 Characteristics of the patient-nurse relationship

The category “characteristics of the patient-nurse relationship” is divided into the three following subcategories: intimacy, trust and safety. The experiences of intimacy, trust and

safety turned out to underlie the patient-nurse collaborative relationship in the study.

Intimacy. The patient and the nurse spend a lot of time together during the inpatient period. Sharing many things, including decisions concerning the patient's current life situation, brings them very close.

Intimacy means that the nurse takes interest in the patient's current life situation and resources, becomes committed to the patient and provides care. Intimacy in the collaborative relationship is important to the patient. Even after the relationship officially ends, the patient may wish to keep in touch with the nurse by, for example, sending postcards.

Trust. The building of trust already begins during the inpatient period. Many patients might have difficulties in learning to trust a nurse. If trust is established during the inpatient period through a good collaborative relationship, it will also carry the patient during the outpatient care. The patients generally want to continue working with the same person instead of breaking off the relationship and becoming another nurse's patient. In a trustful collaborative relationship, the patient is able to express feelings and, thus, find better possibilities for recovery.

Safety. In a collaborative relationship, it is essential to create a safe atmosphere. In a safe collaborative relationship, even delicate issues can be discussed. The patient's feeling of safety enhances openness and honesty in patient-nurse interaction.

The subjective feeling of safety requires the experience of feeling accepted and understood. Visits scheduled in advance and the possibility to contact the ward between post-ward outpatient visits were found to add to the patient's feeling of safety.

6.1.4 Setting and maintaining limits

The category “setting and maintaining limits” means that the patient cannot say ‘no’ endlessly by, for example, failing to show up for the agreed visits or refusing the pharmacotherapy given at the ward. Boundaries, conditions or requirements could be set for the patient to prevent his or her condition from declining or to ensure the continuity of care. Before the commencement of post-ward outpatient visits it was agreed with the patient how his or her

nurse will act if the patient would not keep the agreements made with and accepted by him or her.

6.2 The substance of post-ward outpatient visits

In this section the substance of post-ward outpatient visits is described under seven main categories: natural interaction, continuous assessment, implementation of pharmacotherapy, reacting to declining condition, search for coping methods, establishing motivation for treatment and family members' participation in care (Paper I).

6.2.1 Natural interaction

Post-ward outpatient visits included informal discussion between the patient and nurse. Everyday matters related to the patient's home or incidents that had happened outside the home were discussed. The aim of the informal discussion was to bring up the patient's coping with his disorder. During the informal discussion the nurse observed the patient's behaviour and noticed possible changes towards better or worse.

6.2.2 Continuous assessment

Continuous assessment was an essential part of the substance of post-ward outpatient visits. The assessment was carried out with the help of goal-directed discussions. The main category of continuous assessment consisted of the following four subcategories: assessment of the previous inpatient period, assessment of coping in daily life, assessment of the patient's mental condition and assessment of progress in care.

Assessment of the previous inpatient period. The first post-ward outpatient visit included assessment of the previous inpatient period. Things that had been helpful during the inpatient care and possibly things the patients would have hoped to have been done differently were discussed with them. The purpose of going through the inpatient period was to help the patients plan their own continuity of care and set new goals for their lives.

Assessment of the coping in daily life means assessment of the patient's coping with everyday issues. During post-ward outpatient visits, the patients related to the nurse or other health care

professional their daily occupations; what they had done and how they had managed the everyday issues, such as buying groceries and cooking, cleaning and shopping, how they had managed to handle money and all the basic things in life. Also the patients' attendance to planned group activities and their experiences of and coping with these activities were evaluated.

Assessment of the patient's mental condition. Discussions with the patients and observing them during the discussions enabled the nurses to evaluate the patients' mental condition and managing since the last visit. Especially important topics of conversation were each patient's individual mental problems. It was possible to assess the patients' mental condition by using symptom control methods. The method was used to find out how the patient's condition had been since the last visit. Based on the mental condition, the frequency and sufficiency of the visits were also assessed.

Assessment of progress in treatment. The progress in treatment was also constantly assessed. The assessment was carried out by each patient's nurse either alone or together with a physician or a working group. The progress in post-ward outpatient services was also assessed in care consultations which were attended by the patients and their nurses, but also by the attending physician and, if necessary, also by the patient's family members and possibly colleagues from other units that participate in the patient's treatment. The latter could include employees of home nursing, home help services and social services. The Mental Health Act (1116/1990) requires the progress in treatment of long-term patients to be evaluated at six-month intervals.

6.2.3 Follow-up of the implementation of pharmacotherapy

The implementation of pharmacotherapy was found to be one of the main reasons for patients to attend their post-ward outpatient visits. The implementation of pharmacotherapy was divided into the following three sub-categories: follow-up and assessment of the efficacy of pharmacotherapy, ensuring the implementation of pharmacotherapy and restricting medication.

Follow-up and assessment of the efficacy of pharmacotherapy. The efficacy of mental patients' medication was observed and assessed, primarily, on the basis of the patient's

mental condition, but also by measuring the serum drug concentration. The use of psycho pharmaceutical drugs was related to many fears and emotional attitudes. It was essential that the pharmacotherapy was integrated with the other aspects of treatment, such as a confidential patient-nurse relationship and the psychosocial modes of treatment. Post-ward outpatients' pharmacotherapy had been either started or changed during the inpatient period. Pharmacotherapy was usually started with small doses and then gradually increased. At the post-ward outpatient visits, the suitability and dosage of both injected and oral medication were observed and evaluated.

Ensuring the implementation of pharmacotherapy was important, because many patients omitted medication directly after the inpatient period, which resulted in the aggravation of symptoms and, often, readmission to the hospital. At the post-ward outpatient visits the patients were motivated to continue their pharmacotherapy and use medication according to the physician's orders. If necessary, drug injections were given to the patient regularly at the post-ward outpatient visits. Each drug injection visit was connected with the possibility to discuss with the nurse or some other ward employee and meet with other patients.

Restricting medication. On occasion, also medication had to be restricted. In these cases the patients filled up their drug dosers by themselves at the ward where their drugs were kept. Restrictions in medication were imposed especially on patients with self-destructive behaviour.

6.2.4 Relapse prevention

The nurses were active and prepared to act in acute situations. If a patient failed to turn up for an appointment at the post-ward outpatient services, they acted in different ways depending on the patient's situation. This was possible because the nurses were familiar with their post-ward outpatients. Some patients were mailed the time for a new appointment. In some cases, the nurse personally contacted the patients, their family, or someone else from the patient's network – the contact persons were agreed upon with the patient in advance – to find out why the patient had not come and to book a new appointment or make other arrangements. If the patient's mental condition was unstable and the employee had a reason to suspect that the patient might harm himself or others, the employee would immediately make a house call or, if necessary, make a request for executive assistance in order to bring the patient directly to

the ward.

If the employee noticed that the patient's mental condition had declined, they contacted the ward physician or the attending psychiatrist, who evaluated whether the patient was in need of hospitalisation or whether he or she could manage at home. It was also possible to shorten the intervals between the post-ward outpatient visits until the patient's condition improved.

If the patients did not recognise their declining condition, the situation was more complicated. In these cases, the patient's family member or neighbour often contacted the ward. If the patient also was a client of home nursing services, the home nurse would contact the ward when noticing a decline in the patient's condition.

6.2.5 Search for coping methods

The category "search for coping methods" consisted of the following three sub-categories: finding new opportunities, breaking the patient's social isolation and methods of daily life control.

Finding new opportunities. At post-ward outpatient visits, the patient and nurse together tried to find out what new opportunities there would be for the patient to cope until the next visit and later in life. If, for example, the patient had not attended a previously agreed upon group activity, the discussion would focus on what would help him or her to participate the next time. The patient and nurse together considered potential ways to act in different situations and discussed how to prevent hospitalisation in cases of declining condition.

Breaking the patient's social isolation. The patients of post-ward outpatient services were often socially isolated, and especially the long-term patients had low self-esteem. Psychiatric patients frequently felt themselves different from other people. The patients' problems may have originated from their earlier interaction with family members or health care personnel. Other negative experiences in the patients' living environment may also have caused withdrawal and isolation. If the employees had, during the inpatient period, found out the patient's tendency to isolate and have difficulties in getting out of the home to perform his or her personal errands, it was agreed that the nurse would accompany the patient. The patient was also helped and guided to look for stimuli in different groups or classes.

Method of daily life control. The interviewees pointed out that the post-ward outpatients who had been inpatients for a long time had problems in controlling their daily life. If the patients had problems with shopping or going to the bank or the social services office, they could first practice these skills together with the nurse. The ward staff also helped patients by showing them how to fill in forms related to the patients' everyday lives.

6.2.6 Establishing motivation for treatment

Helping the patient to find motivation for the treatment was an essential part of post-ward outpatient services. At the post-ward outpatient visits, the patients were motivated and encouraged to visit their nurses, discuss with them, or use another chosen form of aftercare long enough. The interviews revealed the importance of the patients having a care contact and not isolating themselves from the society. That is why plenty of time was used to motivate the patients to use aftercare. During post-ward outpatient visits, both the positive and negative aspects of treatment were discussed and the positive points emphasised. The patients were motivated to participate in rehabilitation, in group activities organised by different organisations, and in social interaction.

6.2.7 Family members' participation in care process

The meetings with the patient's family members were already organised during the inpatient period. The family also attended care consultation when the patient was discharged if the patient so wished. Family members were informed about the possibility to contact the nurse or the ward. Meetings with family members were organised and, if necessary, the family would attend post-war outpatient visits and house calls as well as care consultations held during the post-ward outpatient services. If necessary, the care consultations took place at the patient's home.

6.3 The factors contributing to the continuity of care

As a result of the analysis, seven main categories describing the factors contributing the continuity of care were formed: adherence to a good co-operative relationship, adherence to the care environment, flexibility in tailoring care, active maintenance of contacts in care,

constant possibility to contact the ward, up-to-date patient data and active co-operation between the outpatient services and the other collaborations (Paper 1).

6.3.1 Adherence to a good co-operative relationship

A confidential care relationship between the patient and the nurse and the patient's adherence to the nurse improve the patients' commitment to care and, thus, improve the continuity of care. During the inpatient period preceding post-ward outpatient services, the patient and the nurse have a possibility to develop a close relationship, which enables the continuity of a co-operative relationship in post-ward outpatient care. The interviewees expressed that the co-operative relationship at the ward usually becomes very important. In a good co-operative relationship, the patient experiences that he or she and his or her needs are taken seriously, and that he or she is able to commit her or himself to the treatment. This means that the patient comes to the post-ward outpatient visits with the nurse and follows the care plan. A good co-operative relationship with the nurse encourages the patient and his or her immediate social network to contact the nurse in case the patient has problems between the visits.

6.3.2 Adherence to the care environment

The patients also adhere to the care environment: the ward, its atmosphere, the other patients, and the employees. The experience of developing belonging to a community during hospitalisation helps the patient to become committed to post-ward outpatient services. This is especially true of long-term patients. Adherence to the care environment is to be seen in, for instance, the fact that some patients want to spend some time at the ward and meet the inpatients before their post-ward outpatient visit. For some patients, the ward is actually the only place where they meet other people. There is also another aspect in meeting hospitalised patients: the post-ward outpatient shares with the inpatients his or her experiences of being at home and in outpatient care. Good experiences of some post-ward outpatients concerning, for instance, pharmacotherapy motivate the other patients to carry on. Apart from the nurse, other ward employees also play a central role in making the patients feel themselves accepted in the community. Post-ward outpatients also feel the ward safe because there are personnel on duty day and night. This makes it easy to contact the ward when problems occur or when the patient's condition declines.

6.3.3 Flexibility in tailoring care

Flexibility in tailoring post-ward outpatient services supports the continuity of care. Before discharge, a preliminary agreement is made with the patient about the number and frequency of visits. This agreement is then assessed during the post-ward outpatient services and, if necessary, altered. The patient's wishes are taken into account when planning the schedule of visits. The post-ward outpatient visits are adjusted to the patient's life circumstances. For instance, evening visits with the nurse can be arranged for outpatients who are employed. The location for the visit is also discussed with the patient; the visits can take place in or outside the ward. Some of the visits are house calls. The patients ask for house calls of their own accord, or the arrangement is made in co-operation with the patient, if the patient's disorder or life circumstances require so.

6.3.4 Active maintenance of contacts in care

The visits require mutual commitment: the patient must arrive on time and the nurse has to be available as agreed. The patient's commitment to post-ward outpatient services is enough to ensure the continuity of care, but the nurse must also be committed to the patient's care and well-being. A close contact with the patient enables both the continuity of care and the patient's adherence to outpatient care and care in general. The visit schedule that has been discussed with the patient in advance is kept. At every post-ward outpatient visit and house call, it is made sure that the patient knows when the next visit will take place. It is also discussed in advance with the patient how to act if the patient does not turn up at the next post-ward outpatient visit. Should this happen, the nurse will see to the situation. If the patient is reached and if the reason for not appearing is, for instance, that the patient forgot about the visit, a new visit is booked. If the patient cannot be reached or, for example, the family reports that the patient's condition has deteriorated, the nurse makes a house call. During the house call, it is decided whether the patient is in need for hospitalisation or whether he or she can still manage at home.

6.3.5 Constant possibility to contact the ward

It is possible for the post-ward outpatients and their families to contact the ward if the patient's condition declines. There are employees at the ward at all hours, and it is possible to

contact the ward even in the evening and at night. If necessary, the patient is granted a "walk-in" permission, which means that they can come straight to the ward if their condition declines. When the patient arrives at the ward, it will be assessed whether the patient needs hospitalisation or can manage at home. These patients also have a possibility to stay overnight and the patient's situation is then re-assessed in a care consultation the next morning. During their inpatient period, the patients become acquainted not only with the nurse but also with the other employees, and the employees get to know the patients. Thus, the patients can also discuss their problems with the other employees in case the nurse is not in duty.

6.3.6 Up-to-date patient data

Up-to-date patient data are necessary to ensure the continuity of care. The general situation and condition of a post-ward outpatient are registered in the care plan after a visit. It is important also to register the medication and the possible collateral symptoms. The registering helps everybody involved to recall the patient's previous visit. It is important to have up-to-date data of the patients, should the patient have a visit with someone other than the nurse. The patient might leave unsaid or tell something contrary to what was agreed upon, unless the other employees also have the same information as the nurse. The patient's data on, for instance, medication may be requested when the patient moves into another care unit. Post-ward outpatient visits are summarised, and when the outpatient care at the ward ends, the summary is sent to the possible following care institution.

6.3.7 Active co-operation between outpatient services and other collaborators

Many aspects of the active co-operation between outpatient services and other collaborators support the continuity of care. During hospitalisation, all existing contacts with the outpatient services are maintained. Especially the existing good therapy relationship in outpatient services is supported to maintain it. In the care consultations before discharge, the division of work between the collaborators is settled. Especially for primary service users, it is agreed upon where particular services are available. Should it be discovered during the post-ward outpatient care that the patient's care is too dispersed; a new discussion on centralising the services will be arranged. When the patient ultimately moves from post-ward outpatient services to outpatient services, the nurse at the ward and the outpatient services employee work in an overlapping manner; the patient gets to know the outpatient services' employee

and the employee's work place and simultaneously has post-ward outpatient visits with the nurse. When the patient has moved to outpatient services, the co-operation is maintained as follows: when the outpatient services employee is off duty, the patient meets the ward nurse, and should the patient feel too much anxiety about the weekend, he or she can call the nurse or other employees at the ward to feel safe. If the patient is in need for extra support after the care periods, then both the nurse and the outpatient services employee make house calls to help the patient manage in outpatient care.

6.4 The benefits of post–ward outpatient services

As a result of the data analysis, the conceptions of the benefits of post–ward outpatient services are classified into four main categories and seventeen subcategories (Paper IV). The main categories were as follows: patient groups that benefit from post–ward outpatient services; impacts to the patient; impacts to the nurse's work, and challenges for co-operation with community care.

6.4.1 Patient groups that benefit from post-ward outpatient services

As a result of the analysis, seven main categories describing the patients to be treated with post-ward outpatient services were formed: resource insufficiency in community care, delay in the first outpatient visit, no success in pharmacotherapy, loss of contact with care, only a few follow-up visits are needed, maintenance of good patient-nurse collaboration and participation in occupational or discussion groups.

Resource insufficiency in community care The interviewees' conceptions also revealed situations where community care services did not have enough resources for sufficiently intensive care. The patients would already have managed at home after inpatient care with the help of supportive visits, but for instance, it was not possible to arrange two visits a week for them. In these cases, aftercare was arranged so that the patient would get post-ward outpatient services either through visiting the nurse who was responsible for his or her care during the inpatient period, or the nurse would visit the patient at his or her home.

Delay in the first outpatient visit When a patient's first visit in an outpatient unit was too far after discharge, the patient would receive aftercare with post-ward outpatient services for a

limited time. Post-ward outpatient visits ensured the patient's coping in outpatient care until he or she had the possibility to see a member of the regular outpatient personnel.

No success in pharmacotherapy Post-ward outpatients were patients for whom successful implementation of pharmacotherapy had not been attained in any other way. They were, in most cases, long-term patients who had been willing to have injections at an outpatient care unit or had not let the home nurse give them injections during the home visits. Without appropriate medication as part of the post-ward outpatient services, the symptoms of these patients always worsened, resulting in new inpatient periods.

Loss of contact with care Patient's who had not consented to any other form of care and would otherwise have remained without any contact with health care staff, were involved in post-ward outpatient services. The patients in this group had either not had any earlier contact with an outpatient care unit or had had contact but had refused to continue there. There were also patients who were not committed to their care and did not feel themselves ill. When a possibility to choose between care units was given to the patients, they did not wish to be transferred to another unit. However, since they needed intensive aftercare, they were allowed admission to post-ward outpatient services. Patients may find it difficult to attend aftercare at their local mental health centre or the local health centre in a small municipality. Many patients were found to prefer travelling a longish distance to a hospital.

Only a few follow-up visits are needed For patients who only needed a certain number of follow-up visits after their inpatient care and did not need further outpatient contacts after that, aftercare was organised as post-ward outpatient service. These follow-up visits were carried out through post-ward outpatient services when the ward employees did not want to burden outpatient service. Such cases involved the follow-up of a patient after a short inpatient period when the goal was to ensure that the patient's return to home would be successful.

Maintenance of good patient-nurse collaboration One reason for post-ward outpatient visits was the aim to not to interrupt the good patient-nurse relationship established during the inpatient period. It was often the patient's own wish to not start over with a new employee as the relationship with the familiar nurse at the ward was safe and close. The decision was often made by the patient and nurse together. They had established a good and confidential

collaborative relationship during the inpatient period and wanted to continue it. Especially for long-term patients, it was really difficult to establish new relationships and contacts with the outpatient care staff. It was therefore only natural that their collaboration continued in post-ward outpatient services.

Participation in occupational or discussion groups Post-ward outpatient services can also include participation in occupational and discussion groups organised on the ward. Within outpatient care, the emphasis of these patients' care was in a rehabilitation home or in a mental health centre, but it was useful for them to participate in sports groups or symptom control groups organised on the ward.

6.4.2 Impacts to the patient

The category "impacts to the patient" was divided into four subcategories: success in life at home, short hospitalisation sufficient when needed, stability of mental condition and balance in pharmacotherapy.

Success in life at home. The greatest benefit of post-ward outpatient services was achieved when the patient was able to live and manage at home after a long inpatient period. Post-ward outpatient services did not always exclude all the need for help or make the patient fully independent. In order to enable the patient to live at home, home help services and home nursing were often needed. The main goal was, however, to enable living at home even for the patients who had been hospitalised for a long time.

Short hospitalisation sufficient when needed. Another important benefit for patients in post-ward outpatient services was that if the patient needed hospitalisation, the inpatient period was short. With the help of post-ward outpatient services, the patients managed for longer periods of time without the need of inpatient periods. For some patients, the inpatient periods were called interval periods: the point of time and the length of the inpatient period were agreed upon in advance. In post-ward outpatient services, possible deterioration of the patient's condition was quickly attended to. The patient's mental condition was monitored through post-ward outpatient services and also together with the patient and his or her family. This policy helped to lower the threshold for the patient to come to inpatient care. The patient's mental condition did not get so bad as to necessitate involuntary admission, but

admissions took place in mutual understanding with the patient.

Stability of mental condition. Post-ward outpatient services helped the patients to become committed to care, which kept their mental condition more stable.

Balance in pharmacotherapy. An essential benefit of post-ward outpatient services was that it enabled the monitoring and implementation of the patient's pharmacotherapy.

6.4.3 Impacts to the nurse's work

The category "impacts to the nurse's work" was divided into the following four subcategories: motivation, rewards and strength, challenge to work, willingness to do post-ward outpatient services more than resources allow and insight for the need of more home rehabilitation.

Motivation, rewards and strength. The patients who are admitted into psychiatric inpatient wards and remain there are often severely ill but are discharged relatively soon. As the nurses mostly worked with severely ill patients on the ward, it was delightful for them to also encounter patients who could cope with their disorder and were able to lead a normal life and even enjoy it. Post-ward outpatient services were experienced as a natural continuity to inpatient care. During home visits, the nurses saw the patients and their families in everyday circumstances. It was important for them to see that the patients really had recovered well enough to manage at home. As the nurses had contributed to the patients' recovery, they now felt empowered by being able to witness their well-being in everyday life.

Challenge to work. Work in post-ward outpatient services was independent and responsible but assisted by the essential support of a working group. The work included acute situations and, during post-ward outpatient visits or home visits, occasionally also emergency situations had to be solved and difficult decisions made. Work in post-ward outpatient services was mostly lonely and full of responsibility, but also very interesting. While working in post-ward outpatient services, all available possibilities could be used and creativity and imagination were allowed, too. If something particular occurred concerning the condition of a post-ward outpatient, the working group at the inpatient ward was there to help. After the patient had visited the ward or the nurse had visited the patient at home, the nurse had a possibility to

discuss the situation with a physician or some other member of the team.

Willingness to do post-ward outpatient services more than the resources allow. The number of patients in post-ward outpatient services had to be limited because of insufficient resources. The ward nurses who worked in post-ward outpatient services were simultaneously responsible for the inpatients on the ward. Each nurse also had his or her personal inpatients to take care of. The nurse participants were motivated to work in post-ward outpatient services and would have liked to take more patients. Post-ward outpatient services had to be integrated to the work done on the ward, and the number of personal patients in post-ward outpatient services hence had to be restricted due to insufficient resources.

Insight for the need of more home rehabilitation. Another factor restricting post-ward outpatient work was the shortage of time available for intensive home rehabilitation. There were post-ward outpatients who needed more home rehabilitation, which means that these patients should be visited more often at home. Long-term patients would benefit more from intensive home rehabilitation and support for living at home. To carry out this work, other modes of outpatient care, such as home help services and home nursing, would have to be involved.

6.4.4 Challenges for co-operation with community care

In post-ward outpatient services, multiple clientship was one of the major challenges in the co-operation with outpatient care. This main category divided into two subcategories: Co-operation increases patients' coping and lack of coordination and clear division of work.

Co-operation increases patients´ coping. When a patient was hospitalised, the ward nurses maintained the existing contacts with community care. The patient's nurse has an active role in summoning the patient's network together. As for large-scale consumers of services, it is agreed upon with the different parties what their tasks are and what observations each will make. It is also agreed how to contact another party, and of which matters each should be notified. When different parties participate in this way, everyone gets the most vital information about the patient's care and its development. If necessary, the network is summoned together again if the agreements made in a network meeting have not materialised, or if the patient has acted in a way to cause a need to revise the agreements. The study

participants had noticed how rewarding it is for all parties to be in contact with different collaborators. Their professional confidence increased, as did their knowledge of how different partners work. At its best, co-operation was constructive and helped to support the patient in coping in outpatient care.

Lacking coordination and unclear division of work were found. These situations occurred when the patient's care was not jointly agreed upon with the network participating in the care. There were situations where the patient's nurse in post-ward outpatient services was not sure of whether the patient still had a contact with the mental health centre staff. For instance in one case, the home help services withdrew their participation in halfway of the care of a patient and his asocial family, and the responsibility for the family's coping fell on the post-ward outpatient services nurse’s shoulders. In larger municipalities, collaboration was hindered by, for instance, the frequently changing personnel in home help services. There was a patient whose matters were scattered about since there were uncoordinated participating in his or her care; the patient was tossed around between these units, she got prescriptions from different units, and there was no coherent care plan. It was not until after several network meetings that the matter was settled: the patient's treatment and especially his or her pharmacotherapy were supervised by the post-ward outpatient services staff.

7 DISCUSSION

7.1 Discussion of the results

The purpose of my study was to describe and analyse the participants' different conceptions of the psychiatric post-ward outpatient services. The phenomenographic approach makes a distinction what something is and how that something is conceived to be. In the first case, interest is directed towards the phenomenon as such, which is known as the first-order perspective. In my study I am interested in the way the participants conceived post-ward outpatient services in reality which is known as second-order perspective. This means that I did not aim at describing post-ward outpatient services and their essence as such, but rather orientated on participants' conceptions of post-ward outpatient services and made conclusions based of them. It is the second-order perspective that is unique to phenomenographic approach. (Marton 1981.)

The summary of results of the analysis is presented in Figure 3. The post-ward outpatient services were studied from as many points of view as possible. The participants in the study include post-ward outpatients and hospital ward personnel that take care of post-ward outpatients. Also psychiatric outpatient personnel who work in close co-operation with hospital ward personnel were interviewed for the study. While the duties of outpatient care traditionally include the aftercare of patients discharged from the hospital, they also occasionally treat post-ward outpatients in co-operation with hospital ward personnel and also admit hospital ward patients from post-ward outpatient services. The directors of the psychiatry are responsible for both psychiatric outpatient care and hospital care; they also control post-ward outpatient services and take care of the necessary resources.

The results in my study can be considered new in Finland because post-ward outpatient services have so far not been studied from this point of view. In this chapter I compare my study results to other studies in the field of psychiatric care and nursing.

Basis of post-ward outpatient services. Continuing care at the post-ward outpatient services is always preceded by a period of varying length at the inpatient ward. The establishment of a close, reliable and safe relationship between the patient and nurse during the inpatient period is a prerequisite not only for care at the inpatient ward but also for outpatient care. A good

cooperation relationship helps the patient to adhere to the continuing care at the post-ward outpatient services and also to his or her own care. A good relationship, and along with it, good knowledge of the patient, helps the outpatient nurse to sense and recognise changes in the patient's condition on the basis of the patient's presence and behaviour even when there are not yet any concrete signs of deteriorating condition. A cooperation relationship that the patient experiences as safe and reliable also makes it possible for the nurse to restrict the patient's actions in situations when this is necessary for the care. (Paper III)

The patient-nurse relationship was found to be of essential significance in successful patient care. A good patient–nurse relationship creates the basis on which the post-ward outpatient services can be constructed. Patients' resources were empowered by nurses' listening to them, giving to patient time and space and patients' sharing the incidents of everyday life with the nurse. Some important characteristics of the cooperation were intimacy, trust and safety. A good patient– nurse relationship was shown to help the nurse to interpret the patient's behaviour and non-verbal communication and also enabled her or him to set and maintain limits to the patient if it was needed.

Previous studies have also shown that the central dimension in psychiatric care and psychiatric nursing is the relationship between staff and patients (Peplau, 1952, 1992, Madden, 1990, Heifner, 1993, Wilson & Hobbs, 1995, O'Brien 1999), and collaboration has been considered a central intervention (Gastmans, 1998, Anthony, 1999, Kitson, 1999, Kokko, 2004). 'The patient-nurse relationship' has also been called 'client–nurse relationship' (e.g. Hörberg et al. 2004), 'nurse–patient relationship' (e.g. Heifner 1993), nurse-client relationship (e.g. Forschuk 1992, 1994), 'therapeutic partnership' (e.g. Wilson & Hobbs 1995), 'therapeutic alliance' (e.g. Madden 1990) and 'patient-nurse collaborative relationship' (e.g. Munnukka 1993). Peplau's (1988, 1992) model is described as a "therapeutic interpersonal process between a nurse and a patient".

The results of my study are in line with a number of other studies, some (Munnukka 1993, Gilbert 1995, Wilson & Hobbs 1995, Aspvik 2003, Kokko 2004) of which emphasise the importance of providing the patient with the possibility to meet his or her resources with the help of adequate professional support. Patients have been found to appreciate nurses' understanding and their listening ability, and also giving time and space and doing things together (Heifner 1993, Forchuk & Reynolds 2001, Falk & Allebeck 2002, Hyvönen 2004,

Kokko 2004, Schröder & Ahlström 2004), as well intimacy (Munnukka 1993, Suonsivu 1993), trust (Forchuk et al. 1998a, Hellzen at al. 1995, Schröder & Ahlström 2004, Schröder et al. 2006) and safety (Falk & Allebeck 2002, Hörberg et al. 2004, Schröder et al. 2006).

The good patient-nurse relationship, good patient-other nurse relationship and good patient-team relationship and their importance to patients' life also as qualitative aspect has been presented in different studies (e.g. Johansson & Eklund 2003, Siponen & Välimäki 2003).

Also the study by Kokkola et al. (2002) emphasised intuition and ability to detect and understand the multiple types of messages and hidden meanings in patients' behaviour as central characteristics of a good nurse. According to both Gilbert (1995) and Wilson and Hobbs (1995), in order to support patients and maintain a dialogue with them a nurse is required to possess sensitivity, good professional skills and knowledge of self and one's personal resources.

One of the results concerned the aspect observed in the patient-nurse relationship entitled "setting and maintaining limits". Similar observations were only found in Suonsivu (1993): she considered it unprofessional for a primary nurse to try to please a patient, especially in situations where setting limits to the patient's behaviour would have been the most important act in order to improve recovery. According to Välimäki (2000), respect for the patients' self-determination does not mean that they are left without help in situations where they cannot take care of themselves because of their deteriorated condition. However, the need for coercive measures must be considered carefully, as patients may find restricting measures to undermine their dignity.

Function of post-ward outpatient services. The contents of the post-ward outpatient visits are quite varied. After an opening small talk the contents at the post-ward outpatient visit are very structured. The visit includes varied evaluation of the patient's coping with everyday life, his mental well-being and overall situation in life. A further issue belonging to post-ward outpatient services is the follow-up and maintenance of pharmacotherapy. Suitable pharmacotherapy supports the patients' possibility to manage at home and with outpatient services. It is essential to make efforts to prevent the deterioration of the patient's condition within post-ward outpatient services, for if neglected, it may lead to a new, sometimes long inpatient period. The nurses co-operate with the patient, finding new solutions for her or him

to manage social relationships and everyday life. A well-functioning relationship with the patient's family and close ones not only assists the patient's coping, but also helps the family members to cope with the situation.

My study revealed the contents of a visit to post-ward outpatient services to be quite varied, including discussion of everyday incidents, many-sided assessment of the patient, medication monitoring, prevention of deterioration of health, supporting management with everyday life and recognising the needs of family members. (Paper II.)

The complex substance of community care visits is also emphasised in other studies. Salokangas et al. (2000) point out the need for paying especial attention to the contents of psychiatric outpatient care. The success of outpatient care is furthered by a confidential patient-nurse relationship, paying attention to the patient's medication, teaching the patient to manage with symptoms and practicing social skills. Special attention must be paid on the care of patients with a history of repeated hospitalizations and, in particular, on monitoring their medication in outpatient care (Salokangas et al. 2000). Crowe et al. (2001) found that patients appreciate the community psychiatric nurse for the following reasons: receiving care in their own homes, receiving help in developing strategies for coping, receiving practical support and for the fact that the nurse is accessible and observes signs of changes for the worse in the patient's condition. According to Gibson (1999), supporting community care services may include e.g. continued staff-patient interaction, scheduled day activities, day treatment, case management, medication monitoring and scheduled follow–up visits with a psychiatrist.

Also some other studies have emphasised the importance of involving family members in the patient's care and rehabilitation (Gibson 1999, Stengård 2005). Family members need information about the patient's illness and about the care and guidance in problematic situations (Stengård 2005).

Facilitated by post-ward outpatient services. Post-ward outpatient services enable the realisation of the continuity of care. For some patients it means a long co-operation relationship with the nurse, for some it involves only a few visits to the post-ward outpatient services after an inpatient period. A factor significantly contributing to the continuity of care is a good cooperation relationship between the patient and the nurse. During inpatient care, the patient also becomes attached to the care environment at the ward, other patients and

members of the ward team, which makes it easier for him or her to contact the ward if needed and do post-ward outpatient visits. Other factors promoting the continuity of care include flexible organisation of services, nurses' active participation in taking care of post-ward outpatients and keeping the patients within care. All of the above also presupposes that each person participating in patient care have the same, up-to-date knowledge of the patient and his or her situation. The continuity of care is also reinforced by active co-operation between other partners. (Paper I)

My study revealed a number of factors in post-ward outpatient services that supported the continuity of care. Such factors were e.g. commitment to a good patient-nurse relationship and the care environment at the ward. Other essential factors were the possibility of the patients to contact the ward, personal care and personnel reacting to a patient missing a post-ward outpatient visit. Also up-to-date information about the patient and co-operation with other care participants were found to be factors contributing to the continuity of care. (Paper I)

Previous studies have suggested that the focus of psychiatric outpatient care development ought to be on the continuity of care of difficult long-term patients and on re-involving the patients that have dropped out of care (Honkonen 1995, Salokangas et al. 2000).

The making of home calls is especially important immediately after a patient fails to attend a meeting in order to ensure the continuity of care and determine the possible need for intensifying it (Salokangas et al. 2000). The principal goal of assertive community treatment (ACT) is to maintain contact with patients even if they refuse the care for a long-time (Sytema 2007).

According to Aaltonen et al. (2000), a requisite for the continuity of care is the care personnel's ability to flexibly move within, and if need be, also outside the organisation according to the patients' and their families' needs. Patients' ability to manage at home can be supported by providing the family members with a phone number to the care unit or nurse who to contact in case of need. Also the Schröder and Ahlström (2004) point out the need for easy access to care services.

The results of a project titled Integrated Care of Acute Psychosis indicate that the

centralisation of the responsibility to one care unit from the beginning to the end of the care of a patient (for patient care from beginning to end to one care unit) is the best means to ensure the continuity of care (Aaltonen et al. 2000).

Benefits of post-ward outpatient services. According to the findings of my study, the psychiatric post-ward outpatient services provide continuing care after inpatient care to seven different patient groups. Post-ward outpatient services are utilised by patients who would otherwise remain without care. These patients are unwilling to seek care in other outpatient units. There are also patient groups to whom the post-ward outpatient services can be the most effective alternative. Some of these patients need more frequent outpatient visits than the resources of outpatient services allow while to some patients the delay between discharge and the first visit to outpatient services is too long. Furthermore, with some patients it is not appropriate to cut off the contact with primary nurse when only a few aftercare visits are needed. For some patients continuing the good co-operation relationship established during the inpatient period is a central issue for continuing care at the post-ward outpatient services. Also patients in need of different group activities in order to manage visit the post-ward outpatient services. (Paper IV.)

The post-ward outpatient services were of assistance and support to those patients who had previously not been committed to using follow-up care provided by primary health care units or psychiatric outpatient units or were not committed to the prescribed medical treatment. Without the close patient-nurse relationship in the post-ward outpatient services they would have dropped entirely outside care or would have to be repeatedly admitted to inpatient care. Post-ward outpatient services also took care of the patients who would otherwise have been forced to wait for admittance to outpatient care and of those who needed more support than the outpatient units were able to provide. A patient transferred from a hospital into outpatient services often first needs intensive support and services that assist in his or her managing with the everyday life (Harjajärvi et al. 2006).

At best, the post-ward outpatient services improve the patient's situation in life so that he can manage at home and in outpatient care. If a post-ward patient needs hospital care, the care period is generally short, because the outpatient services nurse is able to quickly detect the deterioration in the patient's situation. The patient can also more easily contact the primary nurse or the ward team if he or she feels his or her situation is becoming worse. Post-ward

outpatient services help to stabilise the patient's mental health, one of the related factors of which is the realisation of pharmacotherapy as planned. (Paper IV.)

Post-ward outpatient services are motivating and rewarding for the nurses and provide them with resources for their work. Post-ward outpatient services also pose new kinds of challenges and responsibilities to the nurses; for instance, they will have to act without help from the team during a home visit and make independent decisions. Nurses view post-ward outpatient services as patient-oriented and feel that it is a good model for helping the patient in everyday life both at home and at work. This is why the nurses would be willing to provide more services than the personnel resources at the ward allow. The nurses have experienced that post-ward outpatient services have also clearly shown the need for more resources in home rehabilitation. (Paper IV.)

There are also other official parties involved in post-ward outpatient services. There are many others beside the post-ward outpatient nurses helping the patients to manage their everyday life. Good co-operation among all of the actors involved with patient's care improves his or her abilities to get through the difficulties, while the lack of coordinated co-operation and unclear sharing of responsibilities decreases them. (Paper IV.)

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The study by Rasinkangas et al. (1997) reports results similar to the ones described above. Tuori (1994) suggests that deficient resources in outpatient care may result in the hospitalization of patients that could, with the help of sufficiently intensive patient-nurse relationships, have managed without inpatient care. One of the major reasons for re-

admittance to a hospital is deterioration of the patient's mental health preceded by discontinuation of medication (Hoffman 1994, Kent & Yellowlees 1994, Salokangas et al. 2000). Sometimes the person with a mental illness is unmotivated or unable to participate in a community care system after discharge from hospital, which further promotes the revolving door pattern (Gibson 1999).

Some studies (Forschuk et al. 1998b, Reynolds et al. 2004, Forschuk et al. 2005.) describe the transitional discharge model (TDM) in which the inpatient staff continue to work with the discharged patient until a working relationship is established with a community care provider. The supportive relationship with hospital staff is generally lost during the discharge and Forchuk and Brown (1989) report it to take possibly several weeks before a working relationship with community staff can be established.

It appears that previous studies do not mention the following groups of patients cared with post-ward outpatient services that emerged in the course of my study: Those who only needed a few follow-up visits after discharge from hospital; those who did not wish to discontinue a good patient-nurse relationship established at the ward and, finally, those patients who, even after discharge, participated in activities and different types of group meetings organised at the ward (Paper IV).

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I have found in my study that post-ward outpatient services were useful to the patients who reflected positively on the nurses' work but the study also highlighted the lack of personnel resources and need for more at-home rehabilitation. As post-ward outpatients may also be patients in other social and health service units, co-operation and co-ordination between units arose as an essential factor for the patients' managing in outpatient care.

To date there are no Finnish studies on the effectiveness or benefits of post-ward outpatient services. However, Reynolds et al. (2004) discuss the effects of a transitional discharge model for psychiatric patients. Individuals participating in above mentioned research report fewer symptoms, better levels of function and higher quality of life and are less likely to have been re-admitted to hospital.

Other forms of care than hospitalisation have been proved much better tolerated by patients and their relatives (Ruggeri et al. 1995). However, many of the severely mentally ill patients are in need of long-term support and repeated hospitalisations are in some cases necessary (Korkeila 1998).

Psychiatric post-ward outpatient services require co-operation between psychiatric personnel and other authorities participating in patients' care. One of the findings of my study was that good cooperation enabled the patients to manage in outpatient care. Also a number of other studies address the need to further develop cooperation between different professional groups: specialised health care, primary health care, social services, voluntary services and patients' family members (Korkeila 1996, 1998, Taipale 1996, Lassila 1998, Immonen et al. 2003, Hyvönen 2004, Hyvönen et al. 2004, Kärkkäinen 2004, Tuori 1994, Stengård 2005).

There was lack of psychiatrists in psychiatric community care and in hospitals during this study process - which is the case even today. Due to this lack responsibility of care of psychiatric patients has been shifted to other professionals especially to nurses. The lack of psychiatrists makes it difficult to realize and systematically assess the care and rehabilitation plans according to the Mental Health Act. The psychiatrists have the central role in planning and implementation of patients' pharmacotherapy. The nurses in post-ward outpatient services received support from their own team and from their charge nurse. The important duty of charge nurse was to enable post-ward outpatient services with adequate shift planning.

According to Thornicroft and Tansella (2003), there is no compelling argument or scientific evidence that would favour a mental healthcare model based on hospital care alone. On the other hand, there is also no scientific evidence that community services alone can provide satisfactory comprehensive care. Available evidence and accumulated clinical experience in many countries support a balanced care model that includes elements of both hospital and community care. Nevertheless, local communities may have strong views on developing such mental health services in their midst.

The data of my study was gathered in 1999-2001. I find the results of the study valid and applicable also in the psychiatric care and nursing of today, since they describe a patient oriented functional model. The benefits of the post-ward outpatient services compared to the traditional community care according to the results of the study appear to consist of recommitting those patients back to the care who have missed to commit themselves in the pharmacotherapy and other forms of community care. Furthermore, the post-ward outpatient services are flexible, easily available, accessible round the clock and sensitive to deterioration of the patient's condition.

The results must, however, be considered in terms of wider perspectives of organising mental health services. Firstly, can this kind of function be considered in this extent to be the duty of specialised health care? The post-ward outpatient services supported in many ways the patients to manage in community care but it was provided by hospital wards. The positive characteristics of post-ward outpatient services and the features supporting the management of the patient can and should in the future be also applied to community care and other basic services. The specialised health care could act in training and developing role for community care and basic services. Thus the positive characteristics could be applied in the community

care also before a patient's inpatient care. In community care there is a need for more individualised, activating, diverse, mobile, on-duty services that are integrated into the patients' everyday life (Korkeila 1998, Harjajärvi et al. 2006).

Secondly, there is need to consider from the continuity of care point of view whether there are patients within post-ward outpatient services whose further care after intensive inpatient care period could however be carried out by the same ward team (Tuori 1987,1990, Aaltonen et. al. 2000). Salokangas et al. (2000) suggest that psychiatric hospitals should be developed to meet the needs of the changed patient composition and short inpatient periods.

Third aspect to be considered is whether the patients who obtain post-ward outpatient services become too much committed to the care organisation (Tuori 1990). In the planning and implementation of patients' care and services we must not forget that the patient must have the possibility to come fully out of the care system and the role of the patient (Nikkonen 1996).

7.2 Credibility of study

This chapter discusses the credibility of the study first in the light of concepts describing the credibility of qualitative research as put out by Fridlund (1998). The said concepts have been used to evaluate the credibility of studies applying the phenomenographic approach by e.g. Arvidsson et al. 2000, Arvidsson et al. 2001, Björkman 2002, Jormfelt et al. 2003, Svedberg et al. 2003, Skärsäter et al. 2003a, Skärsäter et al. 2003b, Högberg et al. 2004, Svedberg et al. 2004 and Schröder and Ahlsröm 2004.

Secondly, this chapter discusses the credibility of study by evaluating the interaction between the researcher and the participants and the researchers' role during the research process. It is worth noticing that the lack of attention to these issues have previously been criticised. (Uljens 1991, Francis 1993, Marton 1995, Häkkinen 1996, Ahonen 1994.)

According to Fridlund (1998), there are four concepts that are of general importance for scrutinising an study: applicability, concordance, security and accuracy. When applying a qualitative method, such as the phenomenographic approach, this means using and explaining other concepts such as identification, reasonableness, trustworthiness and conscientiousness

in order to produce valid results (Fridlund 1998, Fridlund & Hildingh 2000).

Identification. Phenomenography is an approach with high applicability for identifying different human conceptions of a phenomenon (Marton & Booth 1997). To ensure identification, the participants were purposefully chosen to obtain a broad knowledge of post-ward outpatient services (Larsson 1986, Uljens 1989). The participants to the study were patients, inpatient ward personnel, outpatient care personnel and administrative personnel. A more detailed description of the selection of participants can be found in Chapter 6.1.

Reasonableness means that the object of study remains the same as was intended (see Fridlund 1998). To ensure reasonableness, I formed the themes that served as basis for the interviews on the basis of the four research questions. I pre-tested the themes in an interview with one nurse in the ward, and as it turned out that the themes would not have to be modified, also this interview was included in the actual research data.

Trustworthiness. By the careful, systematic and detailed description of the analysis and the fact that the categories are illuminated by means of quotations, the security of data collection can be considered trustworthy. The security of data collection can be further improved by having one person to conduct all of the interviews (e.g. Svedberg et al. 2003). This is why all of the interviews of the present study were conducted by this researcher.

Conscientiousness. The systematic and careful handling of data ensures conscientiousness (e.g. Arvidsson et al.2001). I read through the research data repeated times during the analysis process in order to be able to study the statements and distinguish their similarities and differences. I confirmed the data by a continuously moving back and forth between the data as a whole and its smaller constituents. According to Sjöström and Dalgren (2002), the core question of credibility in a phenomenographic study is that of the relationship between empirical data and the categories for describing ways of experiencing a certain phenomenon. The researcher has to show that a chosen way of describing differences and similarities is well supported by the empirical data. To ensure accuracy (Paper I-IV), the data analysis was also evaluated by both the second and third author.

Uljens (1991) points out that when assessing the credibility of the phenomenographic approach, the focus is on data collection, data analysis and theoretical validity of the study.

Ahonen (1994) observes that credibility is based on the validity of data and conclusions, which has two dimensions: the data must correspond to the participants' thoughts (authenticity) and it must also be related to the theoretical starting point of the study (relevance). According to Lincoln and Cuba (1985) and Miles and Huberman (1994), the assessment of the consistence of research process and analysis refers to the reliability of the research results (dependability).

Authenticity of data presupposes, according to Ahonen (1994), two things. First, the participants should express their conceptions on precisely the phenomenon under study and that they express what they really think and not what they think the researcher would like them to express (see also Ashworth & Lucas 2000). Second, the authenticity of data is dependent on the researcher's and participants' intersubjective understanding. To prove this, the researcher has to describe the context of the data collection process, explain how she built the confident relationship between herself and the informant and present enough transcribed excerpts from the data.

I have attempted to ensure the authenticity of data collection by the following means: the research data was collected through semi-structured interviews. The themes used in the interviews were created on the basis of the research questions. The questions I posed to the interviewees followed these themes and I made an effort to ask them as explicitly as possible. I am under the impression that the participants understood the questions I posed to them, and their appropriate responses further support this view. The purpose of the study was to produce information on post-ward outpatient services. The participants described their experiences and conceptions for the most part as based on their own actions, that is, they explained how certain incidents had taken place or how they themselves had acted. It is thus my understanding that the participants related to me their own conceptions of post-ward outpatient services.

The interviews were conducted either in a peaceful location reserved for interview purposes or in the workers' own workrooms. The interviews went on undisturbed apart from an interview with an inpatient ward staff member that was interrupted by a telephone call, and a meeting with a psychiatry administrative staff member, interrupted by an individual coming to ask for instructions. In my opinion, these two separate interruptions did not affect the course of the interview as a whole. Because the research data was collected through

interviews, both the researcher and participants were able to ensure understanding what the other party meant. The participants were able to specify my questions and I their responses.

It was easier to create a confidential relationship with the participants because while collecting the research data I worked as the head nurse in psychiatry and was thus well known to the personnel at the inpatient and outpatient wards and psychiatric unit administration that participated in the study. The patients participated in the study through being asked by the nurses, who provided them with information on the researcher. Each informant chose for her or himself whether to participate in the study or not. Järvinen (1990) argues that voluntary participation increases the authenticity of the data. I also made an effort to build confidence in the participants by beginning the interview sessions with informal discussion. I also explained to each informant at the beginning of the session why I took on studying post-ward outpatient services and what I am trying to accomplish and improve with my study.

According to Eskola and Suoranta (1996), trust ought not to be thought of as self-evident (see also Säljö 1994), but the researcher ought to pay attention to building trust by considering norms directing interaction and also appropriately reporting on the study and its significance to different parties.

When using qualitative methods, such as the phenomenographic approach, the humanistic paradigm is the guideline, and thus it highlights the fact that both the investigator and the participants are necessary in the exchange of information, therefore demanding a good and honest relationship (Fridlund 1998). An interview is an interactive situation, characterised by a pre-planned structure and the fact that it is initiated and directed by the interviewer. The interviewer usually has to motivate the interviewee and maintain his motivation. Furthermore, the interviewer is aware of his role and the interviewee must be able to rely on that the information provided will be treated confidentially. (Hirsjärvi & Hurme 2001, Metsämuuronen 2003.)

Chapter 6.2 describes two interview situations which, I feel, are well conducted. The transcribed interview data includes a few instances which I presume to be examples of situations described by Ahonen (1994), where I as a researcher have directed the informant. The following are two examples of instances where I expect to have directed an informant. These have not, however, affected the formation of categories. The letter ”I” stands for the

interviewer and ”W” for a worker participating in the study.

Example:
I: Going back to discussing co-operation, what is your impression of the co-operation with psychiatric outpatient care, considering that post-ward outpatient services also belong to outpatient care?

W: …perhaps they at first felt that we are taking over their jobs, but I don't suppose there are any more such views, I don't know.

I: You mean that post-ward outpatient services have now reached a fixed status as one mode of operation among the others?

W: Yes, yes, but I do, however, think that first we have to consider the other options and only then resort to the post-ward outpatient visits if no other outpatient care options are possible.

Example:
W: When the patient is at the ward also the other team members see him and can assess his situation, while during a home visit one has to do this alone.

I: Yes, that is true. I presume it is important to have the team there?

W: Yes, it is something that one keeps in mind, that one does not just toil away on one's own or so.

Relevance of data does, according to Ahonen (1994), involve things such as whether the researcher is able to deepen the interview with the help of questions, whether she keeps to the issue under study during the interviews and how the researcher is able to portray the conceptual uniformity of the study.

Examples 1 and 2 in Chapter 6.2 describe how I evaluate my success in deepening the interview by posing further questions. The interview themes arising from the research questions guided me in keeping to the studied topic while conducting the interviews. Even though the order of discussion themes may have changed in the course of the interviews, I

made sure each theme was covered. I have attempted to give a logical description of the data collection and data analysis processes. I have presented the results separately for each research question and compiled them into a clarifying summary. It is my impression that I have been able to provide the reader with a coherent picture of the conceptual unity between my study and its results.

Authenticity of conclusions, or, as in a study in the phenomenographic vein, the authenticity of category formation, presupposes that the participants' expressions provide enough material for the categories devised by the researcher. If the author presents the excerpts from interviews in whole units of interpretation, the reader can be convinced that the researcher has not separated the expressions from their original context to support her own interpretations or lapsed into over-interpretation. While assessing the authenticity of the categories, the researcher must also specify the difficulties related to interpreting the meanings (Ahonen 1994, Häkkinen 1996). It is central to the phenomenographic approach that the categories describe and correspond to the participants' conceptions and interpretations in the best possible way (Uljens 1991, Tynjälä 1991, Järvinen & Järvinen 1995).

The principles of analysing phenomenographic data are described in Chapter 5.1 where I present the phenomenographic approach and in Chapter 6.3 where the process of data analysis is described. From the point of view of the researcher, the value of the phenomenographic approach lies in the conceptions' qualitative differences and not in their number or representativeness in a certain group. This is why a category in the data is sometimes supported by only one expression with its meanings, sometimes with a number of them. When presenting the results (Papers I-IV) I attempted to select the direct quotations from the interviews so that they would be entire units of interpretation. This has not, however, always been possible, mainly because the number of words in the original publications is quite strictly defined. For the same reason, for each formed category there is only one excerpt. Larsson (1986) argues that the researcher ought to present two excerpts, one describing the category perfectly and the other more insufficiently. He also suggests that excerpts be not used excessively, as too wide-ranged quotes do not make reading the results interesting. In the present study a difficulty associated with interpreting the meanings was mostly that many quotes described several research questions and matched various categories.

Relevance of conclusions presupposes that the categories are connected with research

questions and theoretically described. The categories that emerged as a result of data analysis are presented separately for each research question in Chapters 7.1-7.4, and their summary in Chapter 7.5 includes some theoretical descriptions.

As related to assessing the reliability of phenomenographic research, there has been some discussion on the significance of parallel categorisation. Parallel categorisation has not been seen especially relevant for this kind of qualitative research. According to Uljens (1991), the most significant result of a phenomenographic study is a category description. The researcher forms a description from the original data, but a person doing the parallel categorisation works the other way around from the categories towards the original data, which is why he is not necessarily able to guarantee that the category description presented as a result of this process really matches the original data (Uljens 1989, 1991, Säljö 1994, Järvinen 1990). The present study attempts to indicate similarity with the original data by presenting original quotes in the category descriptions (Papers I-IV). The purpose of the original quotes is also to make the issue more concrete (Sandelowski 1994).

7.3 Assessment of the phenomenographic approach in this study

Phenomenographic approach is a qualitative research method which aims to describe, analyse and understand human beings' experiences of different phenomena in the surrounding world (Marton 1981, 1992, 1994). The phenomenographic approach originates from educational research (Marton 1986), but is now accepted and used frequently in health care research (Barnad et al. 1999, Frilund & Hidingh 2000).

The application of a phenomenographic approach to nursing research would instead aim to deal with and emphasise the differences between how different patients experience their condition and needs. The clinical implications of such an emphasis on differences would mean that professionals in health care would be prepared to take different ways to fulfil the needs of different patients. (Sjöstöm & Dahlgren 2002.)

In the context of health care, it is also a fact that patients react to diseases and injuries, to medication and other kinds of treatment in different ways. In many cases this excludes any routine-based dialogues with and treatment of patients. Rather, it is important that examination, diagnosing and treatment of all patients are based on considerations of the vast

differences between people. (Sjöstöm & Dahlgren 2002.)

The phenomenographic approach may supply the disciplines of nursing and nursing education with knowledge about variations in how patients, nurses and students think, but especially the structural and content aspects of how phenomena are experienced in nursing situations. The availability of content-related descriptions of a group of people's perceptions of core professional setting is in itself a resource for enhancing awareness. (Sjöstöm & Dahlgren 2002.)

The phenomenographic approach was a reasonable choice for the purposes of the present study as the aim was to describe and analyse the different conceptions of post-ward outpatient services by the patients, hospital ward personnel, outpatient care personnel and administrative personnel. The phenomenographic approach enabled me to keep to the original data during data analysis, which will be of significance when applying the study results in developing the care and nursing of psychiatric patients.

7.4 Ethical considerations

Issues of ethical consideration are related to the choice of research topic, the relationship between the researcher and the participants and between the researcher and the organisation under study (e.g. Vehviläinen- Julkunen 1997, Wagstaff & Could 1998).

The first issue requiring ethical consideration is the choice of research topic – why is the study undertaken and by whose conditions? I have explained the choice of topic of the present study and the reasons for carrying it out in Chapter 2.3. I made choices that are in line with the practices of the phenomenographic approach in allowing the participants' voices to be heard (Hirsjärvi & Hurme 2001). These I have explained in Chapter 5 when discussing the choice of participants and data collection process.

Another ethical consideration is connected with the relationship between the researcher and the participants. The relationship between the researcher and the participants is important; because the participants have the right to know what will ensure if they agree to participate in the study. Related factors are the questions on the voluntariness of participation, participants' awareness of the purpose of the study and preservation of the participants' anonymity. An

informed content from the participants is a presupposition for the study. (Benoliel 1988, Capron 1991, Feinlieb 1991, Sheinin 1991, Burns & Crove 1993, Blackburn 1994, User & Holmes 1997, Vehviläinen- Julkunen 1997, Latvala 1998, Vuokila-Oikkonen 2003.)

The starting point for interviews used in the present study was the participants' voluntariness and agreement. Each of them signed a written permission including information on who would carry out the study, for what purpose, and what the gained information would be used for. I told the same things to each informant at the beginning of each interview. I also informed the participants that the interviews would be recorded and that they were free to break off the interview if they so wished.

Scientific studies must not harm the participants (Laki lääketieteellisestä tutkimuksesta 1999). Patients participating in studies are a vulnerable group. Koivisto et al. (2001) point out that psychiatric patients are able to make decisions concerning their own care, but they may have difficulties in understanding details related to the study. Patients' voluntariness must involve the patient being oriented to time and place, able to communicate and aware of the purpose of the study (Laki potilaan asemasta ja oikeuksista 1992). This was accounted for in the present study by the fact that each of the participants was able to manage with outpatient care, because they were post-ward outpatients. Furthermore, nurses working at the inpatient wards familiar with the patients helped with choosing the participants for this study.

Välimäki et al. (1996) argue that on one hand, psychiatric patients are willing to participate in research projects; while on the other hand, it is difficult to encourage them to participate. Only one patient enrolled to participate in the study upon receiving my letter asking for patients' willingness to participate in the research project, the four other participants joined only after the nurse asked them to.

I took account of the preservation of the participants' anonymity by explaining to them that the researcher is bound to professional secrecy and that I carefully preserve the information data. I also told them I will dispose of the information data once the research report is ready. The tapes and transcripts were physically destroyed when the study was finished. Three of the interviews were transcribed by me, while the remaining twenty-five interviews were transcribed by a professional transcriber. She received the interviews marked with codes, and only I knew whom they referred to. The code marks were also needed in case I would have

needed later on to discuss with an informant about an issue emerged during the interview. The transcription process involved the deletion of names of persons, wards and locations. When selecting excerpts from the interviews for the research report I made sure not to include statements that could have revealed the identity of an informant.

Acquiring research permission is related to the relationship between the researcher and the organisation. The research plan for the present study was approved of by the Oulu University Faculty of Medicine Researcher Training Commission on the 17th of November 1998. The study was also approved of by the Ethics Committee of Central Ostrobothnia Health Care District on the 15th of December 1998.

8 CONCLUSIONS AND SUGGESTIONS FOR FURTHER RESEARCH

The purpose of my study was to describe and analyse the post-ward outpatient services from the points of view of the patients and the staff at the hospital and outpatient clinics using the phenomenographic approach. The following presents the conclusions made on the basis of the study results and some implications for future research.

The post-ward outpatient services at ward in psychiatric hospital offer aftercare of both long and short duration to different patient groups. Post-ward outpatient visits are especially important to those patients that have not previously been committed to follow-up care in other outpatient units after their inpatient period or are continuously re-admitted to the hospital owing to having discontinued their medical treatment.

Post-ward outpatient services relieve the workload of other psychiatric outpatient units and facilitate the patients' moving to outpatient care in cases where the outpatient care resources are limited and there is no intensive support available to patients after their inpatient period. Hence, when evaluating psychiatric care and psychiatric nursing in the future, there is a need to consider which patient groups are really being served by the post-ward outpatient services and whether there are patient groups or individual patients whose follow-up care after inpatient period will always and exclusively be realised by hospital staff or on the contrary the outpatient staff take care of inpatient care as well.

A good patient-nurse relationship creates the basis for post-ward outpatient services, which is why the nurses and other staff working within the field of psychiatry must be able to participate in continuous education and receive supervision of work.

The contents of post-ward outpatient visits are varied. The patient's situation in life and his or her abilities to manage in community care are evaluated from multiple points of view. The services also enable the staff to visit the patient at home. It is of essence to be familiar with the patient's living environment to understand his or her overall situation in life and to better plan the rehabilitation program.

The post-ward outpatient services are in an important position also in promoting the continuity of care. Individually planned post-ward outpatient services involve consideration

of the patient's situation in life. The possibility to contact the inpatient ward at any time increases the patient's sense of security and will, in part, prevent the patient from seeking to the public health care or specialised health care emergency duty units.

The quick reaction of nurses, participating in post-ward outpatient services, to a patient missing an agreed appointment enables them to quickly intervene in deteriorations in the patients' condition. There is a need for short, well-planned care periods in cases where the patient's situation has deteriorated in outpatient care. This can prevent or reduce the inpatient periods that otherwise tend to begin as emergency cases, often in a drastic way.

The post-ward outpatient services of psychiatry hospital wards is an identified but not a recognised enough form of care within the psychiatry care system. At present there are post-ward outpatient services and they are considered important, but there are no official guidelines to direct the services. It was found in the present study that for the most part, post-ward outpatient services were realised by nurses. The division of work between physicians and nurses is a point of discussion in Finland, partly because of the continuous lack of physicians, partly as part of a better and more flexible re-organisation of services. The clarification of the responsibilities and duties of nurses would support the establishment of post-ward outpatient services into patient-oriented form of activity within psychiatry. It is also of essence to guarantee sufficient resources for these services.

There still remains a lack of different forms of care that would be diverse in nature and serve the needs of various patient groups, located between the psychiatric inpatient care and outpatient care. Psychiatric care system still needs more systematic organisation and coordination of services in order to create more community care based, need oriented, sustaining, regional and local service systems.

This study was directed to investigating the post-ward outpatient services at the psychiatry hospital wards of one hospital district. There is no information available on the extent of post-ward outpatient services at psychiatry hospital wards. In order to study this issue university hospitals and central hospitals should be contacted to survey whether they offer post-ward outpatient visits and if so, how many of them there are per year, whether they are registered as outpatient services or inpatient services and which patient groups they serve.

I found in my study that the study participants felt that post-ward outpatient visits supported the patients' managing in outpatient care. There is a need for future studies on the long-term effects of the provided services. There is also need to study the severity of symptoms, changes in the patients' level of functioning, quality of life and readmissions in connection with post-ward outpatient services.

The present study did not gather information on the costs related to post-ward outpatient services. Another relevant issue to study would be to define their economic efficiency and effectiveness in relation to other forms of psychiatric outpatient care.

This study described the contents and central characteristics of post-ward outpatient services. The main categories and subcategories presented here can be operationalised in future studies and their verification in practise can be studied in quantitative terms more comprehensively and in different functional environments with patients and nurses working with post-ward outpatient services.

It would also be interesting to compare the contents and special characteristics of post-ward outpatient services to case management models.

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Appendix 1.

Table 1. Post-ward outpatient services in psychiatric wards in 1994 - 1998

Type of visit	1994	1995	1996	1997	1998	Total
Visiting primary nurse	319	661	787	714	933	3414
Visiting doctor *)	0	0	61	100	149	310
Home visits*)	0	33	72	108	120	333
Family visit	7	15	20	29	23	94
Net meeting *)	0	3	6	12	50	71
Telephone contact **)	0	0	4	18	29	51
Total	326	712	950	981	1304	4273 ***)

*) Statistics since 1995
**) Statistics since 1996
***) Post ward care need assessments are not included

Table 2. The amount of psychiatry ward patients attending to post-ward outpatient services and their percentage of all psychiatry ward patients in 1994-1998.

Year	The amount of patients	Percentage of all ward patients
1994	79	18,8
1995	127	33,3
1996	154	37,1
1997	168	41,0
1998	203	48,7
Total	731	35,8

Table 3. Visits to psychiatric outpatient care and post-ward outpatient visits of ward patients in 1994-1999

Year	**P**sychiatric outpatient	Post-ward outpatient visits	Percentage
1994	18573	351	1,8
1995	17593	737	4,1
1996	14338	986	6,8
1997	13057	1046	8,0
1998	13009	1378	10,5
1999	12838	1653	12,8

Appendix 2.

Table 4. Patients with ten or more visits at the post-ward outpatient services in 1998

Visits	
Primary nurse	695
Doctor	58
Home visit	85
Family visit	7
Telephone contact	23
Net meetings	23
Total	898
Number of visits	
10-14 visits	19
15-19 visits	16
20-24 visits	7
25-29 visits	2
30-34 visits	3
35-39 visits	1
40-44 visits	1
Total	49
Patients	
Women	25
Men	24
Total	49
Age range of patients	
Average age	39,2
The oldest patient	75
The youngest patient	19

Patients' ages	
0-14	0
15-24	4
25-34	15
35-44	13
45-54	12
55-64	3
65-74	1
75-84	1
85 –	0
Total	49

Appendix 3.

Table 5. Sociodemographic data of patients who have been inpatients in psychiatric wards in 1998 and who have ten or more post-ward outpatient visits.

Age	Female	%	Male	%	Total	%
15-24	1	4,0	3	12,5	4	8,2
25-34	9	36,0	6	25,0	15	30,6
35-44	5	20,0	8	33,3	13	26,6
45-54	9	36,0	3	12,5	12	24,5
55-64	0	0,0	3	12,5	3	6,1
65-74	0	0,0	1	4,2	1	2,0
74-85	1	4,0	0	0,0	1	2,0
Total	25	100,0	24	100,0	49	100,0
Marital status						
Single	12	48,0	14	58,3		
Married	5	20,0	5	20,8		
Divorced	7	28,0	5	20,8		
Widower	1	4,0	0	0,0		
Total	25	100,0	24	100,0		
Social status						
Managing position	0	0,0	1	4,2		
Other officer, foreman	4	16,0	5	20,8		
Skilled worker	7	28,0	9	37,5		
Unskilled worker	5	20,0	3	18,5		
Housewife	1	4,0	0	0,0		
University student	1	4,0	0	0,0		
Other student	2	8,0	2	8,3		
No vocation	5	20,0	4	16,7		
Total	25	100,0	24	100,0		
Dwelling companion						
Living alone	16	64,0	7	29,2		
Spouse	5	20,0	5	20,8		
Children (no spouse)	3	12,0	1	4,2		
Parents	1	4,0	6	25,0		
Siblings) (no parents	0	0,0	0	0,0		
Other person	0	0,0	0	0,0		

Appendix 3.
(Continue)

Rehabilitation home or small service home	0	0,0	5	20,8	
No residence	0	0,0	0	0,0	
Total	25	100,0	24	100,0	
Employment					
Working or in military service	3	12,0	1	4,2	
More than 1 month disability pension	3	12,0	4	16,7	
Retired	12	48,0	10	41,7	
Unemployed	2	8,0	4	16,7	
Other or no employment	5	20,0	5	20,8	
Total	25	100,0	24	100,0	

Appendix 4.

Table 6. Patients according to diagnostic groups (Ten or more visits in post-ward outpatient services in 1998)

Diagnosis	Patient	%
F00 – F09 Organic, including symptomatic, mental disorders	1	2,0
F10 – F19 Mental and behavioural disorders due to psychoactive substance abuse	1	2,0
F20 – F29 Schizophrenia, schizotypal and delusional disorders		
F 20.0 Paranoid schizophrenia	6	12,2
F 20.1 Hebephrenic schizophrenia	1	2,0
F 20.2 Catatonic schizophrenia	3	6,1
F 20.3 Undifferentiated schizophrenia	3	6,1
F 20.5 Residual schizophrenia	5	10,2
F 20.9 Schizophrenia, unspecified	3	6,1
F 23.3 Other acute predominantly delusional psychotic disorder	2	4,0
F 25.0 Schizoaffective disorder, manic type	2	4,0
F 25.1 Schizoaffective disorder, depressive type	1	2,0
F 25.2 Schizoaffective disorder, mixed type	2	2,0
F30 – F39 Mood (affective) disorders	9	18,4
F40 – F49 Neurotic, stress-related and somatoform disorders	6	12,2
F60 – F69 Disorders of adult personality and behaviour	4	8,2
Total	49	100,0

Appendix 5. Original publications I – IV. (Printed with the permission of the copyright holders.)

Kuopio University Publications E. Social Sciences

E 127. Korhonen, Heikki. Tietojärjestelmät suun terveydenhuollon ohjauksessa ja johtamisessa Suomessa 1972-2001.
2005. 219 s. Acad. Diss.

E 128. Ryttyläinen, Katri. Naisten arvioinnit hallinnasta raskauden seurannan ja synnytyksen hoidon aikana: naisspesifinen näkökulma.
2005. 216 s. Acad. Diss.

E 129. Kinnunen, Juha & Lindström, Kari (toim.). Rakenteellisen ja toiminnallisen muutoksen vaikutukset HUSin johtamiseen ja henkilöstön hyvinvointiin.
2005. 278 s.

E 130. Pättiniemi, Pekka. Social enterprises as labour market measure.
2005. 50 s. Acad. Diss.

E 131. Kouri, Pirkko. Development of maternity clinic on the net service – views of pregnant families and professionals.
2006. 114 s. Acad. Diss.

E 132. Sirviö, Kaarina. Lapsiperheiden osallisuus terveyden edistämisessä - mukanaolosta vastuunottoon: asiakastilanteiden arviointia sosiaali- ja terveydenhuollon työntekijöiden ja perheiden näkökulmista.
2006. 178 s. Acad. Diss.

E 133. He, Hong-Gu. Non-Pharmacological Methods in Children's Postoperative Pain Relief in China.
2006. 160 s. Acad. Diss.

E 134. Löfman, Päivi. Itsemääräämisen edistäminen. Osallistavan toimintamallin kehittäminen reumapotilaiden hoitotyöhön.
2006. 118 s. Acad. Diss.

E 135. Saaranen, Terhi. Promotion of school community staff's occupational well-being in co-operation with occupational health nurses – participatory action research in Eastern Finland in 2001–2004.
2006. 105 s. Acad. Diss.

E 136. Jansen, Ilona. An Archaeology of Philosophical Anthropology - A Reconstruction of the Historical Philosophical Background of Ethnography and Consequences for Nursing Science.
2006. 149 s. Acad. Diss.

E 137. Waldén, Anne. Muurinsärkijät - Tutkimus neurologisesti sairaan tai vammaisen lapsen perheen selviytymisen tukemisesta.
2006. 312 s. Acad. Diss.

E 138. Klemola, Annukka. Omasta kodista hoitokotiin. Etnografia keskipohjalaisten vanhusten siirtymävaiheesta.
2006. 145 s. Acad. Diss.

E 139. Willberg, Mirja. Millä perusteella kilpailuttamaan? Tutkimus sosiaali- ja terveyspalvelujen kilpailuttamisen ja sen toimijoiden tietoperustasta ja preferensseistä.
2006. 192 s. Acad. Diss.

E 140. Pirskanen, Marjatta. Nuorten päihteettömyyden edistäminen. Varhaisen puuttumisen malli koulu- ja opiskeluterveydenhuoltoon.
2007. 132 s. Acad. Diss.