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Carita Tuohimäki

THE USE OF COERCION IN THE FINNISH CIVIL PSYCHIATRIC INPATIENTS

A PART OF THE NORDIC PROJECT PATERNALISM AND AUTONOMY

*FACULTY OF MEDICINE,
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CARITA TUOHIMÄKI

THE USE OF COERCION IN THE FINNISH CIVIL PSYCHIATRIC INPATIENTS

A part of the Nordic project
Paternalism and Autonomy

Academic dissertation to be presented, with the assent of the Faculty of Medicine of the University of Oulu, for public defence in Community Centre of the Psychiatric Unity of the Vaasa Central Hospital (Sarjakatu 2), on September 14th, 2007, at 12 noon

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Abstract

Deprivation of liberty is always an infringement of a person's constitutional rights. During the past decades, Western countries have focused on their Mental Health legislation, in particular, by making changes concerning involuntary treatment. After all, little is known about the frequency and quality of involuntary treatment, yet this information is needed to modificate the phenomenon. The present thesis is a part of the Nordic study Paternalism and Autonomy. Two Finnish data have been used in this thesis: the register and the interview studies. The material of the register study comprises all admissions to the study hospitals (Tampere, Turku and Oulu) during a six-month period. The material of the interview study comprises the interviews of 50 patients admitted involuntarily and the interviews of the 50 voluntarily admitted patients following each involuntary admission. Both studies used a questionnaire based on previous studies.

In Finland the rate of involuntary treatment is high. The motivation for deprivation of liberty is, however, the interest of patients. Deprivation of liberty was predicted by a diagnosis of a psychotic disorder as well as previous involuntary treatment. Harmfulness to others-criterion as the motivation of involuntary treatment was rarely used. In this material, it was never used as the sole motivation of detainment. Agitation/desorientation was the common reason for seclusion/restraint. Actual violence was more frequently the reason for seclusion of female patients whereas threat of violence was the reason for seclusion/restraint of men. There were differencies among the study hospitals concerning the rate of seclusion/restraint: in Oulu mechanical restraint was used more frequently than in other study hospitals.

International comparison of deprivation of liberty is difficult because of the differences among countries in legislation and the paucity of the previous studies. Ward culture as well as the methods of registration vary in different countries, and, thus reliable comparison is restricted. The results of the current study confirm the notion that deprivation of liberty is more frequent in Finland that in many other countries.

Keywords: deprivation of liberty, involuntary treatment, psychiatry*,* seclusion/restraint

Tuohimäki, Carita, Pakon käyttö psykiatristen potilaiden sairaalahoidossa Suomessa. Osio yhteispohjoismaista projektia Paternalism and Autonomy
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Tiivistelmä

Vapauden rajoittaminen on aina kajoamista ihmisen perustuslailliseen oikeuteen ja siten tahdosta riippumaton hoito psykiatriassa on ongelmallinen alue. Länsimaissa on herätty keskustelemaan tästä aiheesta viime vuosikymmeninä ja tahdosta riippumatonta hoitoa on pyritty vähentämään lainsäädännöllisin keinoin. Jotta tahdosta riippumattoman hoidon ja toimenpiteiden käyttöön voidaan vaikuttaa, tarvitaan vertailukelpoista tietoa sen määrästä ja laadusta.

Tämä tutkimus on osa yhteispohjoismaista tutkimushanketta Paternalism and Autonomy – A Nordic Study on the Use of Coercion in the Mental Health Care System. Tähän väitöskirjaan on käytetty em. tutkimushankkeen kahta suomalaista aineistoa: rekisteritutkimusta ja haastattelututkimusta. Rekisteritutkimukseen kerättiin kaikki 6 kuukauden aikana tutkimussairaaloihin (Tampere, Turku ja Oulu) tulleiden potilaiden tiedot. Haastattelututkimukseen pyydettiin 6 kuukauden aikana 50 tahdosta riippumattomalla lähetteellä tullutta ja heille 50 vapaaehtoisesti tullutta verrokkia. Molemmissa tutkimuksissa käytettiin aiempiin tutkimuksiin pohjautuvia kyselylomakkeita. Rekisteritutkimukseen kerättiin sosiodemografiset taustatiedot, aiempi sairaalahoitohistoria ja ajankohtaisen hoitojakson vapauden rajoittamista koskevat tiedot sekä diagnoosit. Haastattelututkimukseen kerättiin tietoja potilaan kokemuksesta sairaalaantoimittamisesta ja mahdollisuudesta vaikuttaa toteutuvaan hoitoon. Potilaiden psyykkinen tila arvioitiin haastattelututkimusosiossa käyttäen standardoituja psykiatrisia arviointiasteikkoja.

Vapauden rajoittaminen psykiatriassa on Suomessa yleistä, tahdosta riippumattoman hoidon osuus on suuri. Vapautta rajoitetaan kuitenkin potilaan etua ajatellen (hoidon tarve ja potilaan vaarallisuus itselle). Psykoosi oli vapauden rajoitusta ennustava tekijä, kuten kuuluukin olla, koska psykoosi on tahdosta riippumattoman hoidon edellytys. Selittäväksi tekijäksi nousi myös aiempi tahdosta riippumaton hoito. Vaarallinen muille-kriteeriä käytettiin harvoin tahdosta riippumattoman hoidon perusteena, tässä aineistossa sitä ei käytetty yksinään sitovassa hoitopäätöksessä koskaan. Agitaatio/desorientaatio oli yleisin syy eristämiselle (eristys huoneeseen/leposide-eristys). Miehiä eristettiin hieman yleisemmin kuin naisia ja naisten eristys edellytti ajankohtaisen väkivaltaisuuden, kun miehiä eristettiin uhkaavan väkivallan vuoksi. Väestöön suhteutetut eristysluvut erosivat eri tutkimussairaaloiden välillä: Oulussa leposide-eristettiin muita sairaaloita yleisemmin. Eristystä ennusti parhaiten tutkimussairaala, mutta vapauden rajoituksen runsasta käyttöä ennusti aiempi tahdosta riippumaton hoito sekä ajankohtainen tahdosta riippumaton status.

Tahdosta riippumattoman hoidon samoin kuin eristysten yleisyyden kansainvälinen vertailu on hankalaa aiempien tutkimusten vähäisyyden ja eri maiden välisten lainsäädännöllisten erojen vuoksi. Luotettavaa vertailua vaikeuttavat myös erilaiset hoitokäytännöt sekä rekisteröintimenetelmät. Saadut tulokset tukevat käsitystä, että psykiatristen potilaiden vapauden rajoittaminen on Suomessa yleisempää kuin monissa muissa maissa.

Asiasanat: eristyshoito, psykiatria, tahdosta riippumaton hoito, vapaudenrajoitus

Motto:

- Älkää viisastelko. Oletteko kommunisti?
- Olen keksijä. Varsinainen ammattini on kyllä ollut käpyjen keräily, mutta pidän tiedettä kuitenkin pääasiallisena elämäntehtävänäni.
- Oletteko mielenvikainen?
- Herra kapteeni. Tällaista kysymystä ei epäilyksenalainen voi koskaan itse ratkaista. Sen asian määrittelee ympäristö.

Väinö Linna: Tuntematon sotilas

- Don’t try to be clever. I repeat: are you a Communist?
- I am an inventor. My actual occupation has been the collection of conifer-tree cones, yet I have always regarded the advancement of science as my chief mission in life.
- Are you insane?
- Captain, that is a question the individual suspected can never himself decide. It is his actions that dictate the answer.

Väinö Linna: The Unknown Soldier

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as a researcher and stood patiently by me in good and bad days of this study. Our deliberations gave strenght to finish this job. Words are not enough to thank you.

Abbreviations

BPRS	Brief Psychiatric Rating Scale
GAF	Global Assessment of Functioning
HCR-20	the Historical, Clinical, and Risk Management Scales
ICD-10	International Statistical Classification of Diseases, Injuries and Causes of Death, tenth revision
M1	Involuntary referral form
M2	Observation opinion form
M3	Detainment form
ETENE	The National Advisory Board on Health Care Ethics
OR	Odds Ratio
95%CI	95 percent confidential interval
SD	Standard deviation
MacCAT-CR	the MacArthur Competence Assessment tool for Clinical Research
BC	before Christ
AD	Anno Domini

List of original papers

The present thesis is based on the following original papers, which will be referred to in the text by the Roman numerals I-V.

I Tuohimäki C, Kaltiala-Heino R, Korkeila J, Protshenko J, Lehtinen V & Joukamaa M (2001) Psychiatric inpatients' views on self-determination. Int J Law Psychiatry 24: 61-9.

II Korkeila JA, Tuohimäki C, Kaltiala-Heino R, Lehtinen V & Joukamaa M (2002) Predicting use of coercive measures in Finland. Nord J Psychiatry 56: 339-45.

III Kaltiala-Heino R, Tuohimäki C, Korkeila J & Lehtinen V (2003) Reasons for using seclusion and restraint in psychiatric inpatient care. Int J Law Psychiatry 26: 139-49.

IV Tuohimäki C, Kaltiala-Heino R, Korkeila J, Tuori T, Lehtinen V & Joukamaa M (2003) The use of harmful to others-criterion for involuntary treatment in Finland. Eur J Health Law 10: 183-99.

V Tuohimäki C, Kaltiala-Heino R, Korkeila J, Tuori T, Lehtinen V & Joukamaa M (2004) Deprivation of liberty in Finnish psychiatric inpatients. Int J Law Psychiatry 27: 193-205.

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1 Introduction

Involuntary treatment and use of coercion in psychiatry is one of the classic problems where paternalism in medicine, and also the interest of society, has come into conflict with patient autonomy. Psychiatric care was centred upon hospitals until the early 1990s and the use of involuntariness and coercion was the common phenomenon. At that time many Western countries started to make changes in their legislation with a view to increase patients' autonomy, improve civil rights of mentally ill patients and reduce proportions of involuntary treatment. The number of beds in psychiatric hospitals was decreased markedly, and hospitalisation was increasingly replaced by day- or outpatient services throughout the Western world (Thornicroft *et al.* 1989, Korkeila 1998). However, in Finland deinstitutionalisation was accomplished later than in many other countries, e.g. in USA, UK and Italy. In Finland the number of beds in psychiatric hospitals was even increased until the late 1970s. Deinstitutionalisation started in the 1980s and in the early 1990s the number of beds decreased rapidly by the period of depression (Salokangas *et al.* 2000).

In the civil psychiatry, coercion can be used in two stages: firstly, when a patient is referred or admitted involuntarily to the hospital and detained there, and secondly, when a patient is controlled during the treatment. International literature has shown that aggressive behaviour during which a patient could be harmful to him/herself or to others, is the most widely accepted reason used as motivation for coercion both for hospitalising and controlling patients during treatment. In everyday life, however, it is seen that a patient's disturbed and/or disruptive behaviour is a common motivation for coercion (Fisher 1994, Kaltiala-Heino 1999a, Kaltiala-Heino *et al.* 2003). The Finnish forensic psychiatric organization has its own details (Eronen *et al.* 2000) but this thesis concentrates on civil psychiatry.

In the case of many somatic diseases, individuals can themselves influence the onset of a disease even if the liability is genetic, e.g. adult-onset diabetes with normal weight and exercise. In the case of mental disorders one's ability to influence the risk of becoming affected is usually insignificant; becoming mentally ill is commonly a result of biological, social and psychical factors. Thus, becoming mentally ill is usually not under the individual's own control even if using drugs is the well-known risk factor. When an individual becomes mentally ill, he/she should not be rejected or bypassed in the name of self-determination. The limits of self-determination are indistinct in many mental disorders. As a

welfare state we should take care of those who do not have enough energy or possibilities to look after their welfare, health or diseases (ETENE-julkaisuja, no 10 2004).

Involuntary treatment in psychiatry is not only deprivation of liberty; it can be seen as taking care of a patient who is unable to make decisions at that time. An interesting question ethically is when a patient is incapable of making decisions concerning him/her. Earlier there was a belief in medicine that mental illness automatically impaired patients' ability to make decisions (Appelbaum & Grisso 1995). The Finnish Mental Health Act gives some advice: "when an individual is mentally ill" and "other services are inadequate/insufficient". "Mentally ill" is interpreted as psychotic condition. The fact is that even if a patient is psychotic he/she could still evaluate some or all things concerning him/her, and psychotic state could thus not automatically be a reason for involuntary treatment. Unfortunately, other services can in practice be quite minimal and thus inadequate/insufficient, but lack of services seems ethically quite questionable as motivation for involuntary treatment. In 2005 the guarantee of medical care was taken in use in Finland. This guarantee is centred upon other medical care than acute treatment and its influence on psychiatric care has been rather small (Sosiaali- ja terveysministeriön oppaita, no 5 2005).

2 Review of the literature

2.1 Definitions

According to the Oxford English Dictionary (2005), *coercion* means the action of coercing, and coercing is defined as constraining, forcing as well as the application of force to control the action of a voluntary agent. Coercion can be divided into active and condition-depending coercion. In the first case some people are subjected due to physical force or threat from others, and in the second case the environment or conditions where people are living force them to act in a certain way. On the other hand, coercion can be divided into physical and non-physical form. Physical coercion is clearly against a person's wishes, because it comprises a causally sufficient and necessary condition of some incident. Non-physical coercion consists of threats and offers. The involuntariness of this form of coercion is relative, because a person could act against threats and offers within certain limits (Kirjavainen 1996). Coercion in psychiatric treatment can defined as follows: caretakers use power over the patient to force him/her to do something against his/her own will, or to prevent him/her from doing something he/she desires to do, to help/protect the patient or to control him/her (to protect others).

Paternalism is, defined by Oxford English Dictionary (2005), the policy or practice of restricting the freedoms and responsibilities of subordinates or dependants in what is considered or claimed to be their best interests. Paternalism can also be defined as others being able to make decisions referring to the individual's best interest: treatment is given in the name of helping the patient (Chodoff 1984). Paternalism can be divided into medical and social paternalism. Medical paternalism includes treatment when the aim is to protect the patient from harming him/herself, e.g. if the patient is suicidal, or if his/her psychotic symptoms would increase without treatment. Social paternalism is based on the logic that a mentally ill person cannot control his/her behaviour, and society must thus have the right to prevent the patient's harmfulness to others (Kjellin & Nilstun 1993).

Involuntary treatment in psychiatry means that a patient is treated either against his/her will or that he/she is treated even if he/she cannot express his/her opinion (treated non-voluntarily). The Oxford English Dictionary (2005) defines it in the following manner: "Not voluntary; done or happening without exercise or without co-operation of the will; not done willingly or by choice; independent of

volition, unintentional". Compulsory care/treatment can be used as a synonym for involuntary treatment. Involuntary treatment includes the process of hospitalisation as well as control measures during treatment. Treating patients involuntarily is an exception from the basic rule in Finnish health care that a patient is only treated in agreement with him/her. When patients are treated involuntarily, the decisions are still made by a doctor co-operating with patients (the Act on the Status and Rights of Patients (785/1992) and the Mental Health Act (1116/1991)). As far as possible, decisions should be made by listening to patients' opinions, but sometimes decisions can be made against patients' will. The Mental Health Act also gives the possibility to start involuntary treatment even if admission to hospital was voluntary in the first place: if a patient wants to discharge from hospital but a physician assesses that the patient needs treatment (the criteria of involuntary treatment fulfilled), the physician can decide to start an observation period (=involuntary treatment). This kind of situation is called "abduction". During involuntary treatment in hospital the patient can also be treated with coercive measures, e.g. with seclusion, forced medication and restraint. According to the law these measures should be used as little as possible and only as much as is absolutely needed, given the health and safety demands of the patient and others (the Mental Health Act, 1116/1991 and partially revision, 1423/2001).

Autonomy means a patient's right to accept or refuse the offered treatment (Pahlman 2003, p. 172). Oxford English Dictionary (2005) defines autonomy as liberty to follow one's will and personal freedom. Being a patient includes the right to have treatment even if one's own resources are so low that one cannot make decisions concerning treatment.

Seclusion means that a patient is isolated into a room alone without any furniture or into some other locked room that he/she cannot leave by him/herself. The Oxford English Dictionary (2005) defines it as condition when a person is apart from society. Sometimes the expression "seclusion" is used in cases where a patient is asked to stay or stays in his/her room under control of nurses. In this thesis the term "seclusion" is used only when a patient is isolated into a locked room.

Mechanical restraints mean bands or belts that are used for tying a patient onto a bed. In this case a patient cannot get up by him/herself. Bands or belts can be used around the body and/or upper and/or lower extremities. The manner of restraint using bands or belts varies between hospitals as well as situations.

Physical restraints include situations when a patient is restricted by holding by the hands, arms or shoulders. Sometimes a patient is held by many nurses at the same time, and physical restraint is commonly used when a patient is carried to a seclusion room or to mechanical restraints. However, therapeutic holding is a commonly used tool for the containment of aggressive behaviour in children (Lundy & McGuffin 2005).

The World Psychiatric Association approved the term "*informed consent*" in the declaration of Helsinki in 1964 (Lääkärin etiikka 2005). Informed consent means that when a patient approves a treatment he/she is aware of the content of treatment and that he/she understands the goals and risks of treatment. This term emphasises the autonomy of the patient. Consent can be seen as qualified when a patient has given consent without any pressure and with adequate information of treatment (Kaivosoja 1996). According to The Oxford English Dictionary (2005), "informed consent" in a medical context means consent to clinical treatment that has been given after all relevant information has been disclosed to the patient, or to his or her guardian; an instance of such consent. "Informed consent" can be given verbally, but the written form of consent is advisable, and in case of scientific research obligatory for the participants.

Deprivation of liberty in psychiatric treatment means a situation when a patient's freedom and autonomy is taken away by treating him/her without his/her co-operation. Deprivation of liberty should be considered from three viewpoints: medical, legal and ethical. The medical viewpoint emphasises the need of treatment, and includes the fact that a psychiatric disorder exists. The legal viewpoint gives guidelines for when deprivation of liberty (involuntary treatment as well as coercive measures) can be used. The Oxford English Dictionary (2005) defines *ethics* as "the science of morals and rules of conduct", and the word **"***moral***"** is defined as "concerned with character or disposition, or with the distinction between right and wrong." In other words: ethics means understanding of good and evil as well as right and wrong, and moral means the choices in everyday life made by an individual (Koskinen 1995). According to professional ethics, moral can be considered first in regard to society (culture, acts and norms), secondly in regard to an object as well as subject of moral action, and thirdly in regard to colleagues (Häyry & Häyry 1991). In order to behave in a moral way an individual needs the ability and possibility to consider different choices, and also the ability to empathise.

Medical justice concerns the legal questions related to medicine, public health care and health care personnel. Special interest is dedicated to the

relationships between a patient and a doctor and/or other health care personnel (Pahlman 2003, p. 30). In Finland the basic acts on medical justice are the Act on Patient Injury (585/1986) and the Act on the Status and Rights of Patients (785/1992). Both of these acts can be seen as being based on the agreement of human rights, and their spirit emphasises the status of the patient as subject and decision maker.

2.2 Brief history of coercion in psychiatric care

2.2.1 Brief history of coercion in the Western countries

Karl Menninger, cited by Szasz, summarised the history of psychiatry with these sad words: "Added to the beatings and chaining and baths and massages came treatments that were even more ferocious: gouging out parts of the brain, producing convulsions with electric shocks, starving, surgical removal of teeth, tonsils, uteri, etc" (Szasz 2003). To this list Szasz added the use of straitjackets, tranquillising chairs, confining chairs, cold baths, emetics, purgatives, Metrazol shock, inhalations of carbon dioxide, and even neuroleptic drugs. The fact is that a humane way to treat psychiatric patients is quite a new phenomenon, even though in ancient Greece treatment of mentally ill was gentle as seen in the next chapter. The very first notes on patients' rights were presented as early as after the French revolution (1789-99) (Shorter 2005). Those rights were actually taken into use only after World War II, when the regulation of Nuremberg (1947) and the declaration of the human rights by the United Nations (1948) were presented. Only two years later the European "Convention for the Protection of Human Rights and Fundamental Freedom" was signed (Council of Europe 1950). According to these presentations, the liberty of the individual, self-determination and autonomy form the basis of human rights. As late as in the 1950s psychiatry finally got the first effective medicine: chlorpromazine. However, effective medicines have not led to the total withdrawal of involuntary treatment methods such as seclusion or restraints even if they have decreased involuntary treatment. During the past decades the Western countries have started to discuss the rates of involuntary treatment in psychiatry, attempting to introduce jurisdictional changes to decrease it (Shorter 2005).

The treatment of mentally ill patients before the Middle Ages

Since the Middle Ages, coercive measures and isolation were for centuries basic treatment methods of psychiatric diseases. However, some cultures have also had tendencies to treat mental patients in a more human way as early as before the Middle Ages. The care that was given in the ancient Romans, Greeks and Arabs consisted of music, sedation with opium, good hygiene, activity and nutrition (Mental Health History Timeline 2005).

In Egyptian medicine, mental illness was seen as arising from ”the evil spirit”. This spirit was thought to have taken possession of the body of the mentally ill patient. Vomiting medicines, enemas and primitive surgery were used as physical treatment methods. An innovative form of treatment was temple sleep therapy, also called incubation. During incubation the patient spent the night in a holy place, e.g. a pyramid, and before falling asleep he/she was influenced by suggestions. It was hoped that suggestions would provoke dreams sent by the gods. Priests interpreted the dreams, and they also used them to get knowledge about mental illnesses and the ability to cure diseases. Medical herbs and substances were part of the treatment (Carlsson 2005).

In ancient Greece the aetiology of mental illness was seen as originating from an evil spirit or punishment from the gods. The treatments used included various cleaning methods or sleeping in a temple. In the latter method the patient slept in a temple, and a priest interpreted the patient’s dreams. The priests also gave instructions on how to eat or live to avoid illnesses (Hirvonen, 1987).

In the Roman empire mental illness was seen as a general disease, which affected both the cognition and the emotional life of the patient. The recommendations for treatment were work, sedative music, wine for insomnia and exercises for improving memory and the power of observation. Some cleansing methods were used in Rome, too, as treatment of mental illnesses (Vuori 1979).

The Arabs founded the very first mental hospital in the 9th century, and another in the next century, in Damascus. The atmosphere of these hospitals was relaxing, and baths, medicine, perfumes and therapy with music were used as treatment methods. Mentally ill patients could be revered as saints because lay opinion compared them to persons who could speak in many languages (Vuori 1979).

The treatment of mentally ill patients in the Middle Ages

There was no structured treatment for mentally ill patients in the Western countries until the Middle Ages. Psychiatric treatment was not the duty of societies, and no public assistance was given to mentally ill patients. In the Middle Ages, Christianity provided its own interpretation for the standpoint on mental illness. On the other hand, illnesses in general were conceptualised as the consequence of sins, but also as one of world's phenomena. Saint Augustinus divided illnesses into two groups: natural diseases and diseases caused by demons. Mental illnesses were included in the latter group. There was also a belief that some persons co-operated with demons on purpose, and many mentally ill patients were thus defined as sorcerers. Actual persecution of witchcraft started after the crusades, and continued until the new era. During these persecutions many mentally ill patients died at the stake. Mentally ill patients were also regarded as backsliders, and partly because of that they were treated badly. In Western Europe monasteries started to found the first aid places where patients were tied and locked in dirty, dark cells, and kept with the poor and leprosy patients. In Middle Europe patients were kept in special towers built for them. Exposure to extreme temperatures, making the patient vomit, burning the patient, immersion in water, whipping, putting in chains and coercive chairs were used as treatment methods (Foucault 1982). The purpose of the treatment was to get the patients to be afraid in a ”healthy way”. Mental illnesses were believed to be incurable. Patients were kept away from society, and the public opinion was that the patients could be harmful to general security. The mad and others incapable of taking care of themselves were mainly looked after by their families and those wishing to achieve merit through charity toward the helpless (Foucault 1982, Scull 1984).

The first public ways to take care of the mentally ill were founded in the late Middle Ages. In the 16th century, societies tried to eliminate all types of deriving profit from other's work, e.g. begging. As a result of this elimination systematic isolation of the mentally ill was started by setting up the so-called “ships of fools”**.** Mentally ill patients were driven away from the communities with these boats. In the 16th century Paracelsus defined mental illnesses as “Simili similibus curantur”: diseases caused by evil can only be cured with similar (=evil) measures (Kaila 1966, Salo 1996). In the same century German doctor Weyer presented that using coercive measures and torture as treatment of mental illnesses was wrong. His opinion was that a physician should be friendly and understanding when treating

mentally ill patients. However, his thoughts were opposite strongly by the contemporaries (http://www.mdx.ac.uk/www/study/mhhtim.htm).

The treatment of mentally ill patients in Europe after the Middle Ages

From the 18th century until the middle of the 20th century mentally ill patients as well as others who deviated in some way from "normal" people were increasingly locked up in madhouses, asylums and later on mental hospitals. When societies moved to the employer-worker system, mentally ill patients became the problem of the community: they were not capable of working full time, and they could not sell their working capacities. Psychiatry began to distinguish itself from professions treating people incapable of taking care of themselves for other reasons than "madness" (Foucault 1982, Scull 1984). Some physicians tried to be saviours in the 18th and partly the 19th century. Their view of mental illnesses was that mentally ill patients suffered from psychic incongruence and shocks, and they tried to cure patients with measures that brought about fears to the patients (Kaila 1966). In the late 1700s insanity was considered possession by demons. The insane were regarded as wild animals, and treatment was primarily punishment. Samuel Hahnemann (1755-1843) was one of the few physicians who perceived mental illness as a disease that required humane treatment. He opposed the practice of chaining mental patients, granted respect to them, and recommended simple rest and relaxation as treatment. Although this type of care may obviously seem important, it was revolutionary at the time (http://www.healthy.net/asp/templates/).

The real treatment of psychiatric diseases started as late as in the 19th century. Until then mental patients were treated in an inhuman way. Before effective treatment measures there were still some doctors who tried to change the treatment culture into a more humane direction. The very first pioneers were Philippe Pinel (1745-1826), John Conolly (1787-1866) and William (1732-1822) and Samuel (1784-1857) Tuke. Pinel released mentally ill patients from chains in France, and at the same time Vinzenzo Chiarurgi in Italy and Johann Langermann in Germany tried to fight against the cruelty that was characteristic of the treatment of mentally ill patients. Pinel's work brought about positive changes, and his student Jean Etienne Esquirol (1772-1840) founded the first hospital that can be described as modern (Kaila, 1966). William and Samuel Tuke pointed at the conditions of a mental hospital called York Asylum, and as a result of their work large reforms were implemented in Britain. Conolly continued along the

Tukes' line, and in 1839 all coercive measures were forbidden in the hospital led by him (Kaila 1966).

In many countries the management of mentally ill patients was isolation from "normal" society. In the early part of the 19th century there were public county asylums together with some private madhouses. Lord Shaftesbury (1801-1885) tried to bring about a reform: he suggested that mentally ill patients (called pauper lunatics in the Victorian times) should be placed in "palaces". Lord Shaftesbury thought that a dramatically improved environment was curative. According to this view, the patients were given food, and their environment was warm and comfortable (Rollin 2003). Because of a desperate need of institutional places for the insane, asylums were crowded, uncomfortable and therapeutically stagnant, housing some 2,000 or more patients. These asylums were not only for mentally ill patients but also for *bona fide* patients, individuals with any kinds of problems (learning problems, pregnant single women who had been cast out by their relatives, vagrants, elderly people etc.): the asylums became society's dustbins (Rollen 2003).

From the beginning of the 19th century a gradual process of segregation took place. Poor people fit to work were sent to workhouses, but those who were unable to work, including those who were deemed insane and in need of incarceration, were sent to asylums. In those days the idea of madness was changing: it became recognised that even if a mentally ill patient lost his/her self-control, it did not mean a loss of humanity. The exposure of people in madhouses to brutal treatment thus changed, too: e.g. the use of mechanical restraint was abandoned.

2.2.2 History in Finland

In Finland the roots of the treatment of mentally ill people (called morons) are found in state hospitals. First the treatment of the mentally ill involved preservation with leprosy patients, and later with poor, mentally defective and generally abnormal individuals in houses for poor people (Sarvilinna 1938). The very first hospitals were founded at a time when Finland was a part of Sweden: Kronoby and Seili hospitals. When Seili hospital was founded in 1619 it was meant for both leprosy and mental patients. Healthy people shunned these two groups of patients, and so the location of Seili was on a small island: a place that was far away from other people and difficult to reach. Kronoby hospital was founded in 1631, and it was only meant for leprosy patients. In 1687 some of the

beds were reassigned for mentally ill patients, and the entire hospital was reserved for them approximately in 1764. Seili hospital was changed into a hospital for the mentally ill only in 1785 (Turunen & Achte 1976). In 1840 an imperial decree ordered province hospitals to set up separate wards for morons (Sarvilinna 1938). According to this imperial decree, the hospital in Kronoby was discontinued, and Seili hospital was transformed into a security centre (Sarvilinna 1938). Lapinlahti hospital in the vicinity of Helsinki was founded in 1841, and it was the first hospital that offered facilities for the whole principality (Achte 1974). The imperial decree of 1889 brought about a remarkable change: the concept of moron was rejected, and mental illness was defined as a disease (www.pmh.info/historian%20merkkipaaluja.pdf). Since 1889, municipalities received subsidies from the state to found psychiatric hospitals (Sarvilinna 1938). There are also the two state mental hospitals in Finland. Vanha Vaasa hospital was found about in 1765 and an institution for taking care of mentally ill people was opened in 1889. The Niuvanniemi hospital was opened in 1885 and it is the second oldest psychiatric institution in Finland (www.niuva.fi, www.vvs.fi)

Traditionally psychiatric treatment in Finland was centred around hospitals. Internationally, during one hundred years (1850-1950) the number of psychiatric hospitals increased more than ten-fold. In 1952 the Act on Mentally Ill Patients was established (1952/187). According to this Act, municipalities were responsible for the care of mentally ill patients. Finland was divided into 20 districts, which were to have a central psychiatric hospital as well as an office for psychiatric outpatients. So-called B-hospitals were founded for long-term patients (Salokangas *et al.* 2000). The number of beds increased in particular after this law came into effect: in 1955 there were 2.5 beds per 1,000 inhabitants, and the number of beds was at its highest in 1970 (4.3/1,000 inhabitants). The basic idea was that all mentally ill patients were placed in mental hospitals instead of old people's home (Salokangas 1997). This way it was made sure that patients got treatment, not only preservation. The deinstitutionalisation of psychiatric services has been influenced by international trends, but also by a number of plans and projects in Finland in the 1980s. The number of hospital beds in Finland decreased from 4.2/1,000 inhabitants in 1980 to 1.5/1,000 in 1993. In 2004 the figure is less than 1/1,000 (http://ec.europa.eu/health/). The Mental Health Act was partially reformed in 1977 (1977/521). The reformed Act was needed for the development of the entire psychiatric care organisation. In this Act new procedures of voluntary and involuntary hospitalisation were established, and one goal of the Act was to increase justice for involuntarily treated patients (Pahlman

2003, p.29-30). The report of the mental health committee was completed in 1984. The main point in this report was to develop psychiatric treatment regionally, and there were no proposals aimed at improving involuntary treatment in psychiatry. The new and still valid Mental Health Act (1990/1116) was adopted in 1991. This Act specified involuntary treatment procedures from referral to detainment. The Act defined that coercion can be used only as much as is necessary to treat patients because of mental illness during stay in hospital. These changes of mental health legislation were aimed at decreasing compulsory treatment by tightening the criteria for involuntary treatment, and according to patient census data, the use of commitment and detainment decreased greatly (Hakkarainen 1989, Korkeila 1998). The decrease in the number of hospital beds has been fast, and it has been difficult to develop sufficiently effective outpatient services at an equal speed (Korkeila 1998).

The latest revision of the Mental Health Act was taken into use in 2002 (2001/1423), and it includes a separate chapter concerning coercive measures during the observation period and involuntary treatment. This revision gives more precise instructions on using coercion in order to control a patient and to guarantee the safety of the patient or others, and of giving treatment independently of a patient's will (Pahlman 2003, p.30).

2.2.3 Psychiatric inpatient services in Finland today

The Primary Health Care Act (66/1972) and the Act on Specialised Medical Care (1062/1989) define psychiatric inpatient services in Finland.

For specialist level health services, Finland is divided into 20 health care districts. Within these districts, psychiatric inpatient services are provided by one or more psychiatric inpatient facilities. The administrative status of these facilities may vary (they may belong to university hospitals, central hospitals or local hospitals), but despite this a certain psychiatric facility (from now on referred to as psychiatric hospital) provides all psychiatric inpatient treatment for the working-aged population resident in certain municipalities. In some university cities, where the catchment area includes a major conurbation, the department of psychiatry in the city hospital (local hospital) additionally provides inpatient services for patients residing in the city. Thus, population living in the biggest (university) cities may alternatively be referred to the city hospital or the psychiatric hospital under the administration of a university hospital. However, it is always defined where a patient from a certain catchment area is to be admitted

when he/she requires psychiatric inpatient treatment. Admissions occur on the basis of domicile, and regarding to civil admissions of working-aged patients, psychiatric hospitals administered by university hospitals admit patients from their catchment areas like psychiatric hospitals administered by lower level services. An exception still exists in situations where a patient has travelled to another area temporarily: first aid should be given to all patients needing treatment that are staying in that catchment area. Furthermore, there are some special arrangements concerning forensic patients, child and adolescent psychiatry, geriatric psychiatry, and highly specialised assessment and treatment of rare conditions.

2.3 Health care legislation and patients' self-determination

2.3.1 Regulation of involuntary treatment and patient's self-determination in Finland

The most important provisions regulating health care in Finland are the basic human rights recorded in the Constitution (731/1999), the Act on the Status and Rights of Patients (785/1992), the Act on Health Care Professionals (559/1994), the Primary Health Care Act (66/1972) and the Act on Specialised Medical Care (1062/1989). A special law regulates psychiatric treatment: the Mental Health Act (1116/1991). In addition, many other statutes include norms on health care. Basic rights are anchored in the principle that all shall be equal before the law. Nobody shall be discriminated against on the grounds of sex, age, origin, language, religion, political or other opinion, or state of health, disability or other personal characteristics. The statutes on basic rights guarantee to everyone the right to life, personal freedom, bodily integrity and security. Public authorities are obliged to guarantee sufficient social and health services to everyone and to promote public health.

In Finland, a patient's right to make decisions regarding his/her treatment is provided for in the Act on the Status and Rights of Patients (785/1992). According to this Act, a patient should be treated in cooperation with him/her. Exceptions (when a patient can be treated against or without his/her will) are defined in the Mental Health Act as mentioned above, the Contagious Diseases Act (583/1986) and implementing decree (786/1986), the Act on Welfare for

Substance Abusers (41/1986), and the Act on Special Care for the Mentally Handicapped (519/1977).

2.3.2 The main purpose of mental health legislation

Three key elements of effective legislation are outlined: context, content and process – in other words, the "why", "what" and "how" of mental health legislation. It can be thought that the main aims of mental health legislation are to protect and improve the lives of mentally ill patients who are, or may be, vulnerable to abuse or violation of their rights. Besides having a hidden burden of stigmatisation and discrimination, mentally ill patients suffer from illness (Arboleda-Florez 2001, 2002). However, legislation itself is not always a guarantee of human respect and protection to mentally ill patients: if legislation is old (not recently updated) its focus is quite often on isolation of "dangerous" patients in the name of safeguarding the members of the society (WHO 2005).

In order for a law to have a positive effect on the lives of people with mental disorders, it must have realistic and attainable goals. An unrealistic law for which the state cannot deliver resources serves no purpose at all, and it can result in unnecessary expenses related to litigation, thereby diverting resources from service development (WHO 2005). Criteria for civil commitment have been substantially revised during the last three decades. Beginning in the United States, the process has to some extent been paralleled by similar reforms in many countries in Western Europe (Appelbaum 1997). Prior to 1969, most legal frameworks stipulated a given need for treatment as a standard criterion for compulsory admission. At that time, California adopted a new standard stipulating that a person had to be dangerous to her-/himself or to others to be considered for an involuntary placement. Since then, most states in the USA have passed similar acts (Hoge *et al.* 1989). Many psychiatrists argued, though, that a large number of the mentally ill in need of treatment would not qualify for commitment under these new standards, thus minimising their chance of receiving adequate care and increasing their chances of referral to the criminal justice system (Abramson 1982). Additionally it was criticised that restrictive commitment criteria might further entrench the chaotic living conditions of many chronically mentally ill individuals and contribute to the widespread homelessness among them (Lamb & Mills 1986). However, some evidence from empirical research refutes in part concerns about giving preference to the dangerousness criterion for compulsory admission. Some studies show that the

treatment of the seriously disturbed mentally ill who are not able to seek help on their own might be possible even while applying the dangerousness criterion (Hiday 1988). Emphasising the "dangerousness criterion" as a mandatory prerequisite for compulsory admissions might foster a strong public perception of the mentally ill people as being generally uncontrollable or dangerous persons, thus contributing to their stigmatisation (Phelan & Link 1998, Angermeyer & Matschinger 1999).

2.3.3 The content of the current Mental Health Act concerning involuntary treatment in Finland

Historically, admissions to mental hospitals were not voluntary. Only during the progressive era of the last century was voluntary admission included in legislation. Voluntary hospitalisation is today the dominant type of admission to mental facilities in developed countries.

Involuntary treatment in psychiatry is provided for in the Finnish Mental Health Act (1116/1991 and partial revision 1423/2001): the act regulates the use of all coercion in relation to referral, admission, stay, and treatment in psychiatric hospitals, and applies to all patients admitted to a psychiatric hospital. According to the Finnish Mental Health Act, involuntary psychiatric hospitalisation is allowed when the patient 1) is suffering from mental illness (a psychotic disorder), and 2) due to an illness is in need of treatment so that either a) lack of treatment would result in serious deterioration of his/her condition or b) would seriously endanger his/her health or safety or c) would seriously endanger other people's health or safety, and 3) no other mental health services are suitable or adequate enough to treat the patient. Several criteria from the second group (2 a-c) can apply simultaneously. Coercion during treatment must be used as little as possible, and only as much as needed for the patient's treatment. If a patient possesses substances that constitute a risk to the patient or others as well as substances that seriously hamper care, they can be seized by the unit. The contacts of the patient can be limited only by the chief physician in charge of the psychiatric treatment at the hospital, or a written decision must be made by a comparable physician. The patient as well as other persons concerned must be given an opportunity to be heard before making a decision in the matter. The decision on limitation of contacts must be made for a fixed period of time, and it may be in force for a maximum of 30 days at a time. An appeal may be lodged with the Administrative Court against taking possession of a patient's personal property or limiting a

patient’s contacts, and it must be lodged within 14 days of notification of the decision.

An established interpretation of the criteria written in the Act has been published by the Finnish Medical Association. First of all comes the interpretation of mental illness: a diagnosis must be based on an examination made by a physician, and the diagnoses established are psychotic and congruent conditions such as delirium, schizophrenia, bipolar disorder, psychotic depression, dementia and paranoid psychosis. According to this interpretation, maladjustment to laws and social norms, abuse or personality disorders are not classified as “mental illness”.

The involuntary admission process is initiated by a doctor independent of the hospital, who refers the patient to a psychiatric hospital with a referral (M1 form) for observation. In the referral the doctor describes the patient’s condition in a semi-structured form and states in a structured part which of the above-mentioned commitment criteria are likely to apply. On admission to hospital a psychiatrist (or a resident) decides whether the patient is to be placed under observation, in other words, if the criteria are still fulfilled. The observation period may last for a maximum of 4 days. The reasons for the observation period must be explained verbally to the patient. At the time of the termination of the observation period, a statement must be issued as to whether or not the commitment criteria are fulfilled (M2 form). The psychiatrist in charge then decides whether or not the patient is to be involuntarily detained. The decision (M3 form) is written, and it must be immediately presented to the patient, with instructions of how to appeal should the patient be dissatisfied. The decision (M3 form) includes a structured statement about the motivation for the detainment (the above-mentioned commitment criteria). Involuntary treatment has to be terminated as soon as the commitment criteria are no longer fulfilled. The decision is valid for a maximum of 3 months, after which a new observation period takes place, if further involuntary treatment is possibly required. The second order is valid for no more than 6 months. The second decision is subject to confirmation by the Administrative Court. If involuntary treatment is still considered necessary after the second detainment period, a new referral is needed to start the procedure anew. Patients can appeal against the detainment decision to the Administrative Court and if necessary to the Supreme Administrative Court.

Thus, the involuntary admission and detainment procedure in Finland does not automatically include legal control or evaluation by the legal profession unless the detainment is extended beyond 3 months (except in the case of minors

younger than 18 years old, for whom legal control is already included in the first detainment). However, if the patient is opposed to the involuntary treatment decision, he/she can appeal to the Administrative Court, and the legal grounds of the process will already be evaluated in the case of the first detainment. This evaluation is based commonly on paperwork, and no court hearing is included.

If a patient is admitted voluntarily to the hospital and he/she wants to be discharged, the psychiatrist in charge may place the patient under observation if the commitment criteria are likely to be fulfilled. The procedure will continue in a manner similar to the involuntary admission.

2.3.4 Coercion regulated by legislation in other countries

Legislation in the Nordic countries

Legislation concerning coercion in psychiatric treatment in the Nordic countries has quite a similar basic idea as in Finland, even if some differences do exist.

In Denmark there is a law from 1989 concerning involuntary treatment as well as involuntary measures in psychiatric hospitals (Lov om frihedsberovelse og anden tvang i psykiatrien, Sestoft and Engberg 2000). In Sweden there is a law concerning involuntary treatment in psychiatry (Lag om psykiatrisk tvångsvård), adopted in 1991. Forensic psychiatry has its own law, which was also adopted in 1991. In 1996 a new law was adopted concerning restrictions of visits during involuntary treatment. In Norway there is a law on psychiatric hospitalisation (Lov om etablering och gjennonforing av psykisk helsevern 1999 nr 62), adopted in 2001. There is no separate Mental Health Act in Iceland. The necessary legislation, e.g. for involuntary hospital admission, is included in the law on legal capacity. This ensures, among other things, the rights of patients to an appeal and an independent medical review. The latest legislation was enacted in 1990.

Denmark has specified by act the diagnosis used as motivation for involuntary treatment. In other Nordic countries the basic reason for involuntary treatment is “mental illness” or “severe mental illness”, but in Denmark it is “psychosis”. Additional criteria in Denmark and Norway are dangerousness to self or to others, whereas the dangerous criterion is not in use in Sweden. Sweden additionally emphasises a given lack of insight by the patient.

Legislation in other countries

European states have attempted to harmonise their psychiatric legislation to ensure the protection of human rights and dignity of involuntarily placed persons with mental disorders. The Committee of Minister's Working Party on Psychiatry and Human Rights under the authority of the Steering Committee on Bioethics (CDBI-H) presented a "White Paper" (2000) that draws up guidelines for a new legal instrument of the Council of Europe.

Many European countries stipulate a given and confirmed mental disorder as a major condition for detaining a person; additional criteria are heterogeneous across the European Union. Threatened or actual danger to oneself or to others is the most common additional criterion across the EU, but is not a prerequisite in Italy, Spain or Sweden (Salize & Dressing 2004). The dangerousness criterion is not applied in a similar manner across the European countries. Some countries only include only public threats in the definition, while others add possible harm to the patient him/herself. Mental disorder as a motivation for involuntary treatment varies from "psychosis" and "mental illness" to "psychopathic disorder", which is used in the UK. One third of the EU member states were able to provide diagnostic profiles of involuntarily placed persons, and Denmark, Ireland, Germany and the UK have specified diagnoses used as motivation for involuntary treatment (EU-report 2002, Salize & Dressing 2004).

Many states in the USA, Canada as well as Australia and New Zealand have their own acts concerning admissions into and detainments in psychiatric hospitals. The main reason for involuntary treatment is mental disorder, and the danger to self or to others criterion is commonly used as an additional criterion (Campbell 1994). In USA there are three types of involuntary community treatment for people who are mentally ill and at the same time also violent. About half of the states in the USA provide so-called outpatient commitment, and a few states provide so-called preventive commitment. Preventive commitment permits commitment of outpatients and in some cases of inpatients as well. The idea is that the patient does not meet the usual commitment criteria, but will most probably soon do so without treatment. The third type of involuntary community treatment is in use in some 40 states in the US. This type of treatment involves continued supervision of a person who has been released from a psychiatric hospital (Slobogin 1994).

Revisions of mental health legislation in the Western countries have recently often restricted the criteria for involuntary hospitalisation and extended

procedural safeguards. The purpose of these changes is to reduce involuntary hospitalisations, but still the direct impact of these reforms has been unclear. Studies have often found an immediate impact of decreased involuntary admissions to mental hospitals during the first year under new court rulings or new legislation, and sometimes involuntary treatment has decreased even before the latest law revision (Engberg 1990a, Kaltiala-Heino 1995). On the other hand, some studies have suggested an increase in the rate of civil commitment after adoption of law revisions aimed to reduce involuntary treatment (Lecompte 1995, Hiday 1996, Kessen 1997, Bloom *et al.* 1998). Further studies have also found a decrease in the length of stay of those committed and an increase in readmission by patients having shorter length of stay in psychiatric hospital. Law revisions may therefore produce unexpected changes in practices.

After all, involuntary treatment is not only influenced by legislation. It should also be kept in mind that other social forces operate prior to and concurrently with new statutory and judicial mandates. In some countries formal compulsory hospitalisations have declined over time without legislative changes (Karrstrom 1986, Hiday 1996).

2.4 Ethics of coercion in psychiatric treatment

In Western countries, legislation allows involuntary treatment of the mentally ill. Involuntary psychiatric treatment is motivated by either potential harm to others (for the good of society) or by the need for treatment and/or by potential self-harm (for the good of the patient). Two of the three widely used commitment criteria, need for treatment and dangerousness to self, are examples of medical paternalism. The third reason allowing involuntary psychiatric treatment, i.e. potential harm (dangerousness) to others, is based on the logic that a mentally ill person cannot control his/her behaviour, and that society has the right to prevent harm to others. This motivation applies social paternalism (Kjellin & Nilstun 1993). Green (2000) approached an ethical question in another way: right to mental health care. Patients should have a moral right to health care because this kind of action is based on benefits conveyed to the individual self and to society as a whole. However, confidentiality is embedded in the Western values of individuality and autonomy. This creates a moral and ethical dilemma.

2.4.1 The view of freedom as a basis of ethics

In this chapter the concept of ”freedom” is defined according to philosophers of different eras. The lifetime of each philosopher is mentioned after the name. Saarinen (1985), Wand and Klimowski (1998) as well as Sulkunen (1999) were used as references.

Freedom is one of the basic principles of ethics, and thus it needs a little more examination. Freedom is entirely opposite to the deprivation of liberty in psychiatry - or is it? Plato (427-347 BC) stated that an individual can be free, but not without limits. According to Plato, if an individual’s behaviour, based on free will, disturbs the life of others, the individual should be isolated from society. Aristotle (384-322 BC) thought that freedom is a prerequisite for action, and essential in this context is free argument of actions, in other words that an individual can give reasons for his/her actions in a free way. The ethics of Kant (1724-1804) is based on free will. According to him, a person has natural needs and desires like other creatures in this world, but a human being should also have the ability to consider and decide in what kind of way he/she could act to fulfil his/her desires. This is the autonomy of a human being: the ability to define the basis of his/her actions. According to this view, a human being’s free will is both free and limited at the same time. What is freedom of an individual or freedom of the society? Locke (1632-1704) presented that the basic human rights are freedom, equality and property. Rousseau’s (1712-1778) opinion was that when people were in a state of nature, they were free. In Locke’s society there is so-called negative freedom: an individual is free when not subjected to any limiting or coercion. In Rousseau’s society, freedom was positive: rights and freedom to do something, e.g. take part in politics. According to Hobbes (1588-1679), if there are no rules or even coercion in society, individuals will fight against each other by defending their existence, and freedom is thus limited only to the most powerful individuals. Sartre (1905-1980) and Foucault (1926-1984) defined freedom in the 20th century. According to Sartre, freedom is an individual’s right to make decisions in a free way, but he/she also has responsibility for his/her choices. Foucault thought that abnormality itself is a focus of punishment, and thus an individual cannot behave in a free way if his/her behaviour is deviant compared with the behaviour in society in general (Saarinen 1985, Want & Klimowski 1998, Sulkunen 1999).

In law texts, freedom as a concept includes three facets: jurisdictional, negative and freedom in fact (Pahlman 2003, p.13). Jurisdictional freedom means

that an individual can act without any limits imposed by the acts or authorities. Negative freedom means the right to act in a certain way without limits of justice or other people. Freedom in fact means freedom to act in the way the individual wishes. There could be a lack of freedom in fact even if the individual has jurisdictional or/and negative freedom. Jurisdictional freedom can exist even if an individual cannot in fact act in a free way, in other words an individual can have jurisdictional freedom even if he/she does not have freedom in fact. The lack of qualifications for economical, social or education welfare can limit freedom in fact (Karapuu *et al.* 1999).

Freedom in relation to mental health can be classified into two categories: psychological freedom (freedom from illness) and physical freedom. If freedom from illnesses (health) is more valuable than physical freedom, involuntary treatment and coercive measures in psychiatry could be justified to regain freedom, i.e. to become healthy again. On the other hand, if physical freedom is seen as the only true freedom, coercion in psychiatry can only protect others (Reiser 1980, Chodoff 1984, Hoaken 1986, Miller 1991).

2.4.2 The codes of medical ethics in Finland

As mentioned, the basic idea of ethics is individual freedom. Codes of ethics for medicine have existed since the time of Hippocrates. A code of ethics is another way to maintain standards, even if it cannot ensure ethical behaviour. Fulford and Bloch stated that ethical regulation should come from the individual with free will, and not be imposed from outside (Sarkar & Adshead 2003).

The central medical regulations in Finland are the oath of Hippocrates, the regulations of the Finnish Medical Association and the National Advisory Board on Health Care Ethics (ETENE) as well as the international code of medical ethics by the World Medical Association (WMA). All of these emphasize emphasise that a physician shall respect the rights of the patient, preserve human life and not harm the patient (Lääkärin etiikka 2005). In 2001 ETENE published a six-point list of ethical principles related to health care. Four of them are relevant for involuntary treatment. The first was patient's right to good care. This means that when needed, the care should be well informed and should be got without excessive delay. The next three points of this list include respect for a patient's humanity, autonomy (respecting self-determination) and equality/justice. The second point (respecting humanity) also states that a physician should treat patients as well as colleagues and staff with respect. According to the ethics of

medicine, involuntary treatment is treating a patient under compulsion. It is characteristic of involuntary treatment that forcing is closely argued by points of treatment. Physicians as well as other staff in psychiatric hospitals should be careful not to use threats and force hidden in treatment practices so as to avoid them becoming a part of everyday routines (ETENE-julkaisuja no 1 2001).

In a nutshell, the ethics of coercion in psychiatric treatment can be expressed as the following questions: Could the patient be treated voluntarily for his/her mental illness? Is the patient competent to consent (including the ability to understand the information given, to make decisions and to show it in an understandable way)? Could involuntary treatment and coercive measures be carried out showing respect to the patient?

2.4.3 The ethical way to treat mentally ill patients – does it exist?

It has recently been discussed in some countries that coercion in psychiatry cannot be based on treatment alone, but on the welfare of society as well (Stastny 2000, Brown 2003, Austin *et al.* 2004, Tannsjo 2004). According to the authors mentioned above, patients with personality disorders as well as patients with psychotic disorders must be treated involuntarily. The argument for this recommendation is that patients with severe mental illness, including personality disorders, commit crimes more often than individuals without severe mental illness, and thus they should be kept in hospital in the name of welfare of society even though "evidence-based" treatment of personality disorders does not exist. This issue is so far only the topic of discussion, and in most Western countries mental health legislation does not define personality disorders as a reason for involuntary treatment.

The codes of medical ethics emphasise the autonomy of the patient – not only the right to accept treatment but to refuse it as well. The ambiguity around mental illness has given rise to some interesting debate in society around the ethical treatment of individuals who show symptoms of a disputed disease. On one hand, every human being has certain human rights that have been guaranteed by governing bodies around the world, including the right not to be involuntarily treated. On the other hand, psychiatric treatment needs to be given to improve the quality of life of persons suffering from a treatable illness and of the people who live with that person. The Canadian Medical Association's Code of Ethics is a guide to the ethical behaviour of physicians, and it contains 49 clauses. Two of them are interesting in this context: "An ethical physician will recognise that the

patient has the right to accept or reject any physician and any medical care recommended to him/her" and furthermore, "an ethical physician will, when the patient is unable, and an agent unavailable, to give consent, render such therapy as he/she believes to be in the patient's interest." Using these two clauses together it is understandable that the attending physician respects the right of the patient to accept or refuse the treatment offered, but intervenes therapeutically when the patient is unable to give or refuse consent (Cahn 1982).

Olsen (1998) presented different kinds of categories of persons under consideration for coerced treatment: these categories included the three basic issues dangerousness, capacity and presence of a mental disorder, and combinations of these issues. Firstly it was summarised that involuntary treatment should exist when an individual with mental illness is dangerous and lacks the capacity to make decisions concerning his/her life. Secondly, when treating a patient it should be kept in mind that treatment should be the most therapeutic and at the same time the least restrictive one. Green (2000) linked ethics and political activity, and emphasised the importance of translating moral values into political realities in the way that all individuals have the right to be treated when needed. One of the most important tasks of physicians is to relieve suffering: in this light it is ethical to treat involuntarily patients who are in patent or overt distress because of an illness (Cahn 1982).

2.4.4 Informed consent and its assessment

Informed consent means that when a patient approves treatment he/she is aware of the content of treatment and that he/she understands the goals and risks of the treatment; in other words, has rational autonomy. A fundamental value concerned with rational autonomy is the presence or absence of competence. The Oxford English Dictionary (2005) defines "competency" as a sufficiency of means for the necessities and conveniences of life. "Competency" was at first a legal concept, and all individuals were presumed by law to be competent until otherwise determined in a judicial hearing. The practical reality of psychiatric care is that psychiatrists are required to make their own assessment of whether a patient is competent or not (Appelbaum & Roth 1981). Even if mental illness is seen as a factor that makes the psychiatric patient incompetent, some previous studies have shown that psychiatric, even psychotic, patients have some competence left, at least a modest understanding of information presented (Grisso & Appelbaum 1991, Cournos 1993, Appelbaum & Grisso 1995). Thus, competence and

autonomy in psychiatric patients must be evaluated as a continuum and not as simplistic all-or-none phenomenon.

The degree of competence of patients, all of whom are certified as "competent" by a psychiatrist, may vary from patient to patient. Autonomy is predicated on a rational determination free of coercion, not just coercion by a physician but also by the overall circumstances. Although mental illness may be a cause of incompetence, many people who experience mental illness retain competence and should therefore live by the same rules as other people (Behr *et al.* 2005). After all, the assessment of capacity to consent is still to some extent insufficient. Only two of the published measures (the MacArthur Competence Assessment tool for Clinical Research [MacCAT-CR] and the Informed Consent Survey) are designed to evaluate four commonly recognised dimensions of capacity to consent to research (understanding, appreciation, reasoning, and expression of a choice) (Wirshing *et al.* 1998, Appelbaum & Grisso 2001). Palmer *et al.* (2005) introduced a 3-item questionnaire that includes cognitive functioning and decisional capacity as well as capacity to understand. Other screening methods focus exclusively on the understanding of disclosed material. Appelbaum & Grisso (1995) defined the structure of competence to consent to treatment as follows: 1) ability to communicate a choice, 2) ability to understand relevant information, 3) ability to appreciate the situation and its likely consequences, and 4) ability to manipulate information rationally. Kumakura (1994) wondered how issues of fundamental rights such as informed consent can be assessed with numerical scores (quantitative value). In his opinion, "capable-incapable" is a continuum, and it thus needs its own assessment system. Hamilton (1983) argued that "Informed consent" is impossible: without an adequate background of information, it is impossible to understand explanations about disease and treatment. The author was sceptic and thought that this term is a lawyers' myth.

2.5 Empirical research on coercion in psychiatry

2.5.1 The scope of involuntary treatment – the size and burden of psychoses

According to two large American community surveys, the Epidemiological Catchment Area study (ECA, data collected in 1980-5) and the National

Comorbidity Study (NCS, data collected in1990-2), 32-49% of adult population had some kind of psychiatric disorder in their lifetime. According to a recent review of 27 European studies the 12-month prevalence of psychotic disorders was 0.2-2.6% (mean 0.8%) among working-age people (18-65 years old). This means that altogether almost four million individuals suffer from psychosis in EU member states (Wittchen & Jacobi 2005). In a large national survey (National Psychiatric Morbidity Survey) conducted in the UK it was found that one-year prevalence of psychotic disorder was 0.4% (Jenkins *et al.* 1997). A recent German survey names a 12-month prevalence rate of 26 cases and a lifetime prevalence of 45 cases for having any psychotic syndromes per 1,000 population of 18-65 years (Rössler 2005).

According to two large Finnish community surveys, Mini-Suomi and UKKI, the prevalence of psychotic disorders was 2% (Lehtinen *et al.* 1991a). The UKKI study showed that there were longitudinal changes in a population cohort: the prevalence of psychoses increased from 1.1% to 3.5% (studied as 0, 5 and 16 years) (Lehtinen *et al.* 1991b). According to a recent study (Suvisaari *et al.* 1999), the incidence of schizophrenia in Finland seems to be diminishing: each successive cohort shows a decline from 0.79 to 0.53 per thousand males, and from 0.58 to 0.41 per thousand females. According to Perälä *et al.* (2007) lifetime prevalence of all psychotic disorders was 3.06% and when register diagnosis of the nonresponders were included the prevalence rose to 3.48%. The lifetime prevalences were as follows: 0.87% for schizophrenia, 0.32% for schizoaffective disorder, 0.07% for schizophreniform disorder, 0.18% for delusional disorder, 0.24% for bipolar I disorder, 0.35% for major depressive disorder with psychotic features, 0.42% for substance-induced psychotic disorders, and 0.21% for psychotic disorders due to a general medical condition.

After all, the burden of mental illnesses, especially psychotic disorders, is not only about the prevalence of illness. Being usually chronic, maybe life-long disorders, psychoses cause huge direct and indirect costs to society: according to Wittchen *et al.* (2005), the healthcare costs caused by psychotic disorders come to almost euros, and total costs are over 35 billion euros .The burden of psychosis is extensive and multifaceted: it includes mortality, disability associated with physical and mental conditions as well as degree of dependency, i.e. the need for daily assistance from another person. Furthermore, psychotic disorders are encompassed by the loss of productivity through impairment, disability and premature death as well as the risk of some legal problems. (Rössler *et al.* 2005).

2.5.2 The perceived coercion in psychiatric inpatient

A patient's perception of being forced into treatment does not necessarily coincide with his/her legal status (Westrin *et al.* 1994, Lidz *et al.* 1995, Kaltiala-Heino *et al.* 1997). A review by Monahan *et al.* (1996) found that approximately 10% of voluntary patients perceived coercion during treatment. Studies in the 1970s emphasised that involuntarily admitted patients had more negative experiences of hospitalisation that voluntarily admitted patients, whereas studies in the 1980s found that both involuntarily and voluntarily admitted patients had similar views toward hospitalisation (McKenna *et al.* 1999). McKenna *et al.* (1999) found that involuntarily admitted patients had a stronger sense of coercion, and if a patient was angry at the time of admission he/she had a greater sense of coercion compared to voluntarily admitted patients. When comparing voluntary, committed, and detained (voluntarily admitted and later detained) patients Poulsen (1999) found that committed patients commonly perceived coercion, and detention after voluntary admission predicted perceived coercion. Gardner *et al.* (1999) interviewed patients at admission and after discharge, and they found that over a half of patients who said that they did not need hospitalisation at admission changed their views at the follow-up interview. The same study shows, however, that perceptions of coercion were stable, and patients' attitude toward hospitalisation did not become more positive. One Finnish study did however find that patients' attitudes changed to more negative from admission to discharge (Kaltiala-Heino & Salokangas 1990). This finding was supported by Kaltiala-Heino (1995): those patients who felt coercion by admission also felt worse about the treatment and perceived the outcome as poorer. Perceived involuntariness was associated with involuntary legal status, less insight and poorer psychic status (Kaltiala-Heino 1995). However, one study concluded that perceived coercion neither increases nor decreases psychiatric inpatients' medication adherence or use of treatment services after discharge (Rain *et al.* 2003).

There are a few studies concerning the competency of adult psychiatric patients when they are admitted to psychiatric hospital. In the early 1980s Appelbaum *et al.* (1996) developed a 15-item questionnaire comprised of a number of previously recognised components of competency. The patients were interviewed within 24 hours after voluntary admission into the hospital. Only 50 percent of the patients thought that they were in need of psychiatric treatment; 50 percent did not know that they had a possibility to refuse treatment, e.g. medication. Furthermore, half of the patients did not know that the hospital could

not hold them against their will. Casimir and Billick studied involuntarily admitted patients and found that 53% of these patients thought that they were in need of psychiatric treatment. Twenty percent of these involuntarily admitted patients were unsure of whether the hospital could hold them against their will (Casimir & Billick 1994). Rogers *et al.* (1993) compared patients who felt their voluntary admission to be genuine with patients who felt that their admission was not genuine. Of the patients who felt their admission to be genuine, 21% reported some degree of coercion, while 80% of the patients who felt their admission not to be genuine felt coercion when they went into hospital.

Patients' awareness of their legal rights and implication of committal is poor: according to Toews *et al.* (1981), only 11% of patients had been informed, and 66% wished to have their rights explained. Patients' knowledge of their legal rights increased over time: Toews *et al.* (1986) found that initially only 14%, but after 3 months up to two-thirds of involuntarily admitted patients knew their legal status. Two studies support the findings of Toews *et al.*: Stender and Aggernaes (1992) as well as Simonsen (1992) found that only a minority of patients were unaware of legal processes, and felt they had not been properly informed about their rights. However, one study found that 58% of the patients were satisfied with the information given on the committal process (Conlon *et al.* 1990).

2.5.3 Involuntary hospitalisation – admissions and detainments

Voluntary hospitalisation is the dominant type of admission to psychiatric hospital in developed countries today. In Europe, the earlier figures on involuntary admissions in the 1970s and 1980s vary from one percent in Spain to over 50 percent in parts of Switzerland (Riecher-Rossler & Rossler 1993). A recent EU committee report (Salize & Dressing 2004) found that the figures vary between a mere 6 and 218/100,000 inhabitants as seen in Table 1. The involuntary admission rates vary according to type and administrative status of the admission facility (Hoyer 1988, Vestergaard 1994, Hiday 1996). Furthermore, the figures vary quite a lot when comparing statistical information and rates in literature as seen in Table 1.

Table 1. The figures of annual involuntary treatment in different countries in international literature and statistical information from the EU committee report.

Country	Author	Period	Rates/100,000 inhabitants
Austria	Salitze and Dressing 2004	1999	175
Belgium	Salitze and Dressing 2004	1998	47
Finland	Salitze and Dressing 2004	2000	218
France	Salitze and Dressing 2004	1999	11
Ireland	Salitze and Dressing 2004	1999	74
Italy	Barbato and D'Avanzo 2005	1996-7	26
Luxembourg	Salitze and Dressing 2004	2000	93
The Netherlands	Salitze and Dressing 2004	1999	44
Portugal	Salitze and Dressing 2004	2000	6
Sweden	Kärrström 1986	1982	248
	Salitze and Dressing 2004	1998	114
Norway	Hoyer 1984	1982	109
	Central bureau of statistics, Oslo	1990	136
Denmark	Hoyer 1984	1982	26
	Engberg 1992	1988	24.4
		1990	28.4
	Salitze and Dressing 2004	2000	34
Greenland and Faroe Islands	Engberg 1991	1984-88	19-44
Germany	Rieher *et al.* 1991	1970-80	9.4-109
	Riecher-Rössler and Rössler 1993	1984-86	18.8
	Salitze and Dressing 2004	2000	175
United Kingdom	EU report 2002	1998	93
		1999	48
Canada (Newfoundland and Labrador)	Malla and Norman 1988	1975-78	42

The possibilities to compare the results of these studies are limited: findings suffer from reduced availability and reliability of data. Varying definitions or methods adopted by national health departments or statistical bureaus contribute to sometimes dramatic differences in compulsory admission rates or quotas, and time series are especially scarce (Riecher-Rossler & Rossler 1993). When available, changes over time seem to indicate that rates or quotas are subject to a broad set of influencing factors, including changing legal frameworks, varying administrative routines and differences in quality standards of national or regional mental health care systems (Salize & Dressing 2004). The scarcity of data and the variety of controversial research results may be attributed to a complex set of

poorly understood legal, political, economical, social, medical, methodological and other factors interacting in the process.

In the search for predictive factors for compulsory admission rates, some socio-demographic characteristics, such as ethnicity and age, have been identified as increasing the risk of being placed involuntarily, although some of the findings are contradictory (Gove & Fain 1977, Szmukler *et al.* 1981, Nicholson 1988, Sanguineti *et al.* 1996). Availability of both inpatient and outpatient mental health services, social deprivation, urban/rural environments and attitudes as well as beliefs of the population all have effect on commitment figures (Soothill *et al.* 1981a, Malla & Norman 1988, Engberg 1991, Sytema 1991). Many studies confirm correlations between reforms of legal frameworks and changes in commitment rates as mentioned earlier in Chapter 2.3.5. Some studies have found that large regional differences in the commitment rates of a country might occur even though the same criteria are used (Spengler & Böhme 1989 Engberg 1991, Riecher-Rössler & Rössler 1993). Malcolm (1989) reported a positive correlation between the rates of compulsory admissions and the number of psychiatric beds, whereas areas giving priority to comprehensive outpatient care showed fewer frequent involuntary placements. This variety of somewhat controversial research findings suggests that a complex set of still poorly understood legal, political, economical, social, and medical as well as multiple other factors seem to interact in the process of involuntary placement (Faulkner *et al.* 1989). Thus, it would be rather short-sighted to trust in simple mechanisms (e.g. simply changing the criteria) in order to change the rate of commitment (Roth 1989).

2.5.4 Coercive measures

Coercion can be used in various forms during the treatment episode: to help the patient (coercive treatment) and to control the patient (coercive measures) (Kaltiala-Heino 1999a). Seclusion and restraint are methods used in the psychiatric treatment of disruptive and violent behaviours. It has been discussed whether these methods reduce or prevent aggressive behaviour of serious mentally ill patients in practice. Seclusion has been the focus of much political, professional, clinical, ethical and moral debate and argument in recent years. As a complex and often emotive process, its use has been advocated by those who consider it as either therapeutic or necessary in the control of the violent and the disturbed, and opposed by those who consider it a relic of the past, potentially punitive, and lacking in therapeutic benefits. Coercion during treatment is divided

into three forms: clear-cut coercion, hidden coercion, and no-option coercion (rotten choices). Hidden coercion as well as rotten choices were not studied. Hidden coercion included measures that are hidden in ward routines, and all patients are more or less subjected to these “rules”. Rotten choices include situations where a patient e.g. takes oral medication after lengthy negotiation or after having been given a choice between oral and injected medication (Kaltiala-Heino 1999b). According to one Finnish study restriction or isolation were considered helpful in 36% of the interviewed psychiatric inpatients (Vartiainen *et al.* 1995). Sailas and Fenton (2003) made a systematic (Cochrane) review of articles concerning these coercive measures. According to them there were no studies on the effect of seclusion or restraint for those with serious mental illness. However, their conclusion was that other alternative ways to treat unwanted or aggressive behaviour needed to be developed because of reports of adverse effects of seclusion and restraint.

Use of coercive measures may cause severe unwanted outcomes: more harm than help. Implementation of alternative methods for preventing assault and harm to oneself or others has not been widely used in clinical practice (Sailas 1999). Some of the previous studies indicate areas of intervention, planning and screening in order to decrease the use of seclusion and restraint (Brown & Tooke 1992, Fisher 1994, Bensley *et al.* 1995). Bensley *et al.* (1995) actually found that a considerable proportion of assaults by patients on staff might be related to situations that are amenable to less restrictive interventions than seclusion and restraint. There is also evidence that applying targeted programmes can decrease the use of coercive measures (Forster *et al.* 1999). A randomised controlled trial setting seems to have rarely used in many of these studies.

Comparing the use of coercive treatments/measures in psychiatric treatment internationally is difficult because publications are scarce and have not always focused on the same features. Some studies have been concerned with clear-cut coercion. Of the admitted patients in Denmark about 15% are subjected to coercion or at least restrictions (Andersen & Hansen 1991, Schröder & Christensen 1992). According to a study conducted in 23 mental hospitals in New York State, on average 2.9% (0.4-9.4%) of the patients were secluded (Way & Banks 1990). In Newcastle (Britain) less than 5% of patients were secluded (Thompson 1986). Studies in the USA have found higher figures: seclusion was as often as in 31% of treatment periods (Swett 1994). According to a study at a university hospital, seclusion was used in 10.5 percent of admissions over an eight-month period, and involuntarily admitted patients were significantly more

likely to be secluded (Hiday 1996). Okin (1986) reported that in a state-wide study of state mental hospitals 32 percent of all admitted patients were placed in seclusion or restraint at some time of their hospital stay, but the length of being secluded or restrained was short, averaging only one percent of mean hospital stay.

According to a review by Swett (1994), seclusion was associated with the patient's young age, borderline diagnosis and irritability and with multiple symptoms in general. According to a review by Soloff and his colleagues there was great variation in the use of restraint/seclusion (from 22% to 66% of patients). The variation could be associated with both patient characteristics and treatment ideologies (Soloff *et al.* 1985). Okin suggested that the use of seclusion is not determined by the patient population but by treatment ideologies (Okin 1985). One study linked the risk of seclusion to frequent earlier hospitalisations and being black, but not to diagnosis (Soloff & Turner 1981). There are also a few studies that support the idea that the use of coercion is not defined by patient characteristics but by treatment sites, ward milieu, ideologies and attitudes (Brown & Tooke 1992, Betemps *et al.* 1993, Cangas 1993, Fisher 1994). Some authors have suggested that staffing ratio and experience may have an effect on seclusion rates. In the early 1980s the possibility of seclusion use as a result of staff's sadistic tendencies was even discussed; however, later studies have not found support for this view (Johnson 1997). In addition, Betemps *et al.* linked the use of coercion to legislation and treatment routines. A tendency to seclude has also been associated with inadequate medication, both too little and too excessive (Soloff *et al.* 1985, Chiles *et al.* 1994).

2.5.5 The motivations of involuntary treatment

Deprivation of liberty in psychiatric treatment is defined by legislation in Western countries. The three basic criteria (need for treatment, dangerousness to self, and dangerousness to others) appear in different combinations in different mental health acts (Appelbaum 1997). Involuntary treatment in psychiatry has been motivated by the need to treat, help or cure the patient (medical paternalism), and to control him/her (social paternalism) (Chodoff 1984, Kjellin & Nilstun 1993). Until the late 1960s the need for treatment was the "main" motivation for involuntary treatment, but later the dangerousness criterion has been emphasised (Aviram 1991, Appelbaum 1997, White Paper 2000). A stereotypical association of danger with mental illnesses has grown stronger during the past 50 years (Phelan & Link 1998, Link *et al.* 1999). Media representation of violence by

people with mental disorders emphasises images of random, serious violence to strangers. Studies of general psychiatric patients do not support this representation; they include few cases of serious or homicidal violence (Johnston & Taylor 2003).

Swanson *et al.* (2002) examined the prevalence and correlates of violent behaviour by individuals with severe mental illness. They found that violence of these individuals is related to multiple variables with compounded effects over the life span. According to them, interventions to reduce the risk of violence should be targeted to specific subgroups with different clusters of problems related to violent behaviour (Swanson *et al.* 2002). Risk assessment of violent behaviour has mostly been studied among criminal offenders (Tiihonen *et al.* 1995, Eronen *et al.* 1997, Grann *et al.* 1999, Sjostedt & Langstrom, 2001). There are only a few similar studies concerning civil admissions motivated by the "harmful to others" criterion. However, there are some facts known to suggest that a patient may be liable to violence: previous violent behaviour, severe mental illness, such as schizophrenia or manic-depressive disorder, severe mental illness with active symptoms, abuse of drug or alcohol and personality disorders, especially psychopathic disorder (Reed 1997). Only a few studies have discussed violence *vice versa*: the prevalence of violent victimisation against a mentally ill patient. According to a recent study by Walsh and colleagues, in the 1980s one third of patients discharged from psychiatric hospital and living in hostels had been victims of crime in the preceding year. Recently, 16% of psychiatric patients reported being violently victimised (Walsh *et al.* 2003). The recent study found that in USA more than one quarter of persons with severe mental illness treated in the community had been victims of a violent crime in the past year. This rate is more than 11 times higher than the general population rates (Templin *et al.* 2005).

In Denmark, somewhat more than half of involuntary patients were deprived of their liberty by referring to the "dangerousness to oneself" criterion (Engberg 1990a, 1991). In Sweden, Keiland *et al.* (1983) reported that of all the involuntary patients, 13% were detained mainly to prevent injury to others (in their material, several motivations could apply simultaneously). In the UK, Soothill *et al.* (1990 a) classified a third of committed patients as being significantly dangerous to others at the time of the committal, judged by their case histories.

The most widely accepted indication for seclusion/restraint is intervening in a case of actual or threatening violence when other means are inadequate. "Threatening violence" has been shown to be a controversial and indefinite concept (Angold 1989, Fisher 1994, Swett 1994). Some studies have however

found that agitation as well as problems in cooperation can be motivations for seclusion (Soloff & Turner 1981, Walsh & Randell 1995). Of the patients 58-75% believe that seclusion is used as punishment, even if rather frequently the secluded patients do not know the reason for it (Brown & Tooke 1992, Fisher 1994). According to staff's opinion there is too little privacy provided for the patients when a ward is overcrowded and when there are too many noisy and restless patients in a ward at the same time: seclusion/restraint is more easily used (Cangas 1993).

2.5.6 Summary of the empirical literature

During the past decades, legislation concerning involuntary treatment in psychiatry has been revised in many countries. Revision of the law has commonly involved a tightened criterion of involuntary treatment. More attention has also been paid to patients' rights and possibilities to influence their treatment.

The rates of involuntary treatment as well as coercive measures in psychiatry vary internationally and nationally. The differences in these rates between countries may be due to differences in mental health legislation. However, variation within a country cannot be explained by legislation, and little is known about the impact of mental health legislation on the use of coercion. Comparing the rates of involuntary treatment and coercive measures in psychiatry between countries is difficult also due to differences in registration practices. The figures of involuntary treatment are commonly so-called census-day figures, and they do not give realistic annual rates of compulsory care in psychiatry. However, realistic annual rates of involuntary treatment and coercive measures are more needed nowadays when EU tries to standardise mental health services as well as legislation in all member states.

Studies dealing with patients' perception of coercion have shown differing results in different decades. According to the latest studies, psychic condition as well as knowledge of rights and the committal process seems to influence perceived coercion. However, perceived coercion have no effect on psychiatric inpatients' medication adherence or use of treatment services after discharge. The legal status is not a good indicator for perceived coercion, even if it has been used in most previous studies. However, little is known about factors that could predict perceived coercion. Patients' knowledge of their legal rights has been poorly studied, and the factors that influence knowledge are unknown.

The motivations of involuntary treatment and coercive measures have been studied, and the results vary internationally: some countries emphasised the good of the patient, whereas other countries emphasised the good of society by using dangerousness to others as motivation for treatment. There are only a few similar studies concerning civil admissions motivated with the "harmful to others" criterion, even though the dangerousness criterion has been emphasised in recent years.

Involuntary treatment in psychiatry has not been studied earlier in this context in Finland. The subject is however important: the structure of Finnish psychiatric care has changed markedly during the past two decades. The number of beds in psychiatric hospital has decreased and hospitalisation has been replaced by outpatient services. Treatment periods in psychiatric hospitals have become shorter, and the few hospital beds should be kept in use as effectively as possible. Simultaneously these changes in psychiatric care have led to more attention on patients' rights to influence their treatment.

3 The aims of this study

The aims of this study were to investigate the following:

1. How do acutely admitted inpatients perceive their admission, and do they know their legal status and right to decide about their treatment? What kinds of factors influence the awareness? (I)
2. How much involuntary treatment and coercive measures exist, are there differences in the population-based rates between different hospitals, to what extent are working-age psychiatric patients subjected to coercion during the hospitalisation process and during care, and is there regional variation in the use of these measures? (III, V)
3. How to the treating agents motivate involuntary admission, detainment, and coercion during treatment, and particularly, what is the rate of dangerousness to others in decisions concerning hospitalisation and the use of coercion? (II, IV, V)

4 Material and methods

4.1 The Nordic Paternalism and Autonomy project

The Scandinavian Study Group on Ethics, Law and Psychiatry is a group of social psychiatric researchers from the Nordic countries interested in studying coercion in psychiatry. The group has planned and carried out a three-dimensional Nordic Paternalism and Autonomy project since 1992. At the beginning, ethical norms reflected in legislation concerning involuntary treatment in the Nordic countries were studied (Level 1). Secondly, information of compulsory treatment was collected from medical and nursing files concerning every treatment period in the study hospitals during a six-month period aiming to study the epidemiology of involuntary treatment (Level 2). Thirdly (Level 3), the analysis of compulsory treatment was widened to comprise the experiences of patients by interviewing a sub-sample of patients who were included in the Level 2 study. As a whole, this project studied how the ethical norms of legislation are reflected in treatment practices and in patients' experiences.

The project included all Nordic countries and there were one to three study sites in every country. The study was approved by the ethical committees of the participating university hospitals according to research legislation of the participating countries.

This thesis is based on the Finnish data of the Levels 2 and 3 of the Nordic Paternalism and Autonomy project. The ethical committees of the participating hospitals and the Ministry of Social Affairs and Health approved the Finnish study.

4.2 Material

In Finland the study was carried out in psychiatric university clinics of Oulu, Tampere and Turku, and in Oulu City Hospital and Kupittaa Hospital (Turku). These hospitals were responsible for the treatment of all working-age psychiatric inpatients from their catchment areas. In Oulu data were collected from the populations of eight municipalities and one city. In Tampere the catchment area comprised one city, one town and one municipality. In Turku the hospitals served the population of one city. The total working-age population (18-64 years) of the catchment areas was 112,200 in Oulu, 137,700 in Tampere and 107,200 in Turku. In accordance with the study design, material was gathered in Finland on two

levels. In Level 2 (hereafter called register study), data from hospital databases concerning all admissions to the study hospitals during a six-month period were used. In Level 3 (hereafter called interview study), the researchers interviewed 50 consecutive involuntarily admitted patients at each centre and for a comparison group, 50 voluntarily patients admitted next to each included involuntary patient. The flow chart of the samples in these studies is seen in Figure 1.

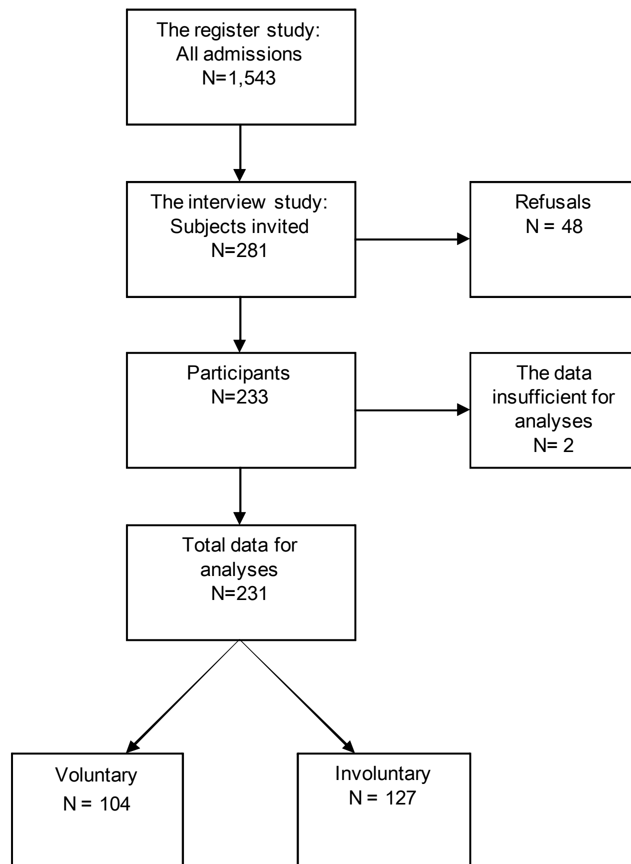

Fig. 1. Flow chart of the samples in the register and interview study.

4.2.1 The material of the register study

The material of the register study comprises all admissions of 18- to 64-year-olds to the hospitals during a six-month period in 1996 (February-July in Tampere, March - August in Turku and March, May-August and October in Oulu). The admissions were identified from the hospital databases. The study design was a retrospective chart review.

The medical and nursing files and medication schedules of all admissions and local registers for coercive measures during the study period were reviewed by using a structured questionnaire. There were altogether 1,543 admissions: 53% were male and 47% were female. The mean age of the patients was 40.4 years (SD=11.2). Of the patients 32% were married, 45% unmarried and 23% divorced. Almost half of the patients belonged to the lowest socio-economic class (48%), while 17% had the highest socio-economic status when using a three-point classification. The register study was used in four articles (II, III, IV and V) in this thesis.

4.2.2 The material of the interview study

Consecutive patients admitted involuntarily during the study period were asked to participate in an interview concerning this hospitalisation within 3 days from the admission. To gather a comparison group, the next voluntarily admitted patient following each involuntary admission was invited to participate in the same interview. Structured interviews completed with some open-ended questions were used. Patients were invited to the interview only once during the study period even though they could have more than one admission to hospital. New patients were recruited until 50 involuntarily and 50 voluntarily admitted patients were involved at each centre. In Oulu, however, the sample was somewhat smaller because during the first weeks of data collection, only involuntary patients were invited. Patients with organic damage or alcohol/drug related diagnoses as the only reason for hospital treatment were excluded from the interview study. The patients' mental status was assessed by the Brief Psychiatric Rating Scale (BPRS) (Overall 1974) and the Global Assessment of Functioning Scale (GAF) (Endicott 1976). BPRS assesses the severity of mental illness by rating a variety of symptoms. The variable is continuous; the higher the score, the more severe the mental illness. GAF assesses how functional a patient is despite his/her symptoms.

GAF is also a continuous variable, but the higher GAF score, the better the patient functions.

Of the 281 patients invited, 233 (83%) participated in the study. The data of two participants were insufficient for analyses. Therefore 231 participated cases are analysed as seen in Figure 1. Participation was equal in all three centres. Of the patients participating in the study 51% were female, 30% were married or cohabiting and 45% belonged to the lowest social class. The patients were on average 39.5 years old (SD 11.3). Involuntarily admitted patients accounted for 55%, and 26% were admitted for the first time. Of the patients 49% had had previous involuntary treatment periods, and 64% of them suffered from psychotic disorders. Their mean GAF score (SD) was 36.2 (11.4) and mean BPRS score (SD) 23.2 (9.2). The voluntarily and involuntarily admitted patients did not differ in relation to sex, age, marital status or social class, or in relation to previous treatment history (admissions/no admissions).

Those who refused to participate in the interview study did not differ from the participants in terms of sociodemographic background, such as gender, age, marital status or social class. However, among those who refused to participate there was a higher proportion of involuntary admitting (81% vs. 55%, $p<0.005$), psychotic disorders (83% vs. 64%, $p<0.05$), and previous involuntary treatments (68% vs. 49%, $p< 0.05$). The GAF score was obtained from 50% of the refusals, too. The GAF score was significantly lower among them than among participants (19.9 (7.4) vs. 36.2 (11.4), $p<0.001$).

The interview study was used in one article in this thesis (I).

4.3 Methods

A structured form of data collection for the register study and another for the interview study were created. The forms of this study by the Nordic study group based on their previous studies (Kjellin *et al.* 1993, Kaltiala-Heino 1995). For the Finnish study the forms were devised by authors and tested in a pilot study in Tampere and Turku. Both forms are shown (Appendix 1 and 2).

4.3.1 The variables of the register study

Table 2 presents all the register study variables collected for the Nordic data. In Finland, however, some additional variables concerning coercion during treatment periods were also collected.

Table 2. The variables of the register study and their use in the original articles of this thesis. The variables collected only in Finland are marked with 'F'.

Variable	Classification	Articles
Study hospital	Tampere	II,V
	Turku	
	Oulu	
Sex	Male	II,III,IV,V
	Female	
Age	Continuous variable according to the birth and admission date	II,III,IV,V
Marital status	Married	II,III,IV,V
	Co-habiting	
	Single	
	Divorced	
	Widowed	
Socio-economic status	Classified according to patient's education and occupation into four classes	II,III,IV,V
Diagnoses and the main diagnosis separately	According to the ICD-10 from the medical files	II,III,IV,V
The date of referral	Continuous variable	
Referral for admission from	Primary health care	V
	Private doctor	
	Psychiatrist or other professional in psychiatry	
	No referral	
	Transfer from other hospital	
	Other (e.g. planned interval treatment)	
Legal status during referral	Voluntary	II,IV,V
	Involuntary	
F: Reasons for the involuntary referral	Need for treatment	IV,V
	Harmfulness to self	
	Harmfulness to others	
Legal status on admission	Voluntary	II,IV
	Involuntary	
F: Observation period	Yes	V
	No	
Detainment	Yes	IV,V
	No	
F: Reasons for the detainment	Need for treatment	IV,V
	Harmfulness to self	
	Harmfulness to others	
Number of admissions	First-ever admission	II,IV,V
	Readmission	

Table 2 continued.

Variable	Classification	Articles
Previous commitments	Yes	II,IV,V
	No	
F: Coercive measures during hospitalisation	Seclusion	II,III,IV,V
	Restraints	
	Forced medication	
	Physical holding	
	Restrictions in leaving the ward	
	Other (e.g. restrictions in phone calls or having visitors)	
F: Reasons for coercive measure	Open question	III
Length of stay	Days	II,III,IV,V
Length of involuntary stay	Days	II,III,IV,V
Discharge to	Home	V
	Other psychiatric hospital	
	Other hospital	
	Other institution (establishment)	
	Somewhere else	
	No discharge during study period	
Index: was there any involuntary period during hospitalisation	Yes	IV,V
	No	

Legal status at referral was recorded from referral for observation (M1) or voluntary referral where it is stated in a structured way. Legal status at admission was recorded from case history (whether or not the patient was placed under observation at admission). Possible observation period later during the detainment and motivation for that were recorded from the formal decision written at the end of an observation period (M3). Furthermore, data on the length of the observation period and involuntary stay were collected, as was information in detail of coercion during treatment.

Age was classified into two categories in article II: under and over 30 years. In articles IV and V classification was into three categories: in article IV 18-25, 26-45 and 46-64 years old and in article V 18-40, 41-50 and 51-64 years old. The classes were formed so that all groups were almost the same size. *Socio-economic status* was classified into three or four classes. In article II four-stage classification was used: I: management, senior officials, independent entrepreneurs/II: small-business persons, officials, foremen, farmers/III: lower-level white-collar workers, skilled workers, farmers with small farms/IV:

unskilled workers, students etc. In articles IV and V a three-stage classification was used where managerial, independent entrepreneurs, business people, officials and foremen belonged to the highest class (class I), skilled workers formed the second class, and the lowest class (class III) comprised unskilled workers. *Marital status* was categorised into three classes: married, unmarried and divorced in articles IV and V, but in article II a two-fold classification was used: having (married or co-habiting) or not having (single, divorced or widowed) a relationship at the time. *Diagnoses* (commonly main diagnosis) were dichotomised: psychotic disorders (F00-09, dementia or delirium caused by organic disease; F10-19.4, delirium caused by drugs and/or alcohol; F20-29, schizophrenic/schizoaffective disorders; F30.2, manic with psychotic symptoms; F31.2, F31.5, bipolar disorder with psychotic symptoms; F32.3, F33.3 depression with psychotic symptoms (the first or recurrent episode), and non-psychotic disorders (other diagnoses) in articles IV and V. In articles II and III, five- and six-fold classifications were used: in article II six classes: (1) organic psychiatric syndromes and somatic diagnoses, 2) substance-use-related disorders, 3) schizophrenia, 4) affective disorders, 5) personality disorders and 6) other psychiatric disorders), and in article III the personality disorders group was linked into other psychiatric disorders. However, due to the small size of the ”heavy use” groups in article II, the diagnoses were regrouped into four classes: 1) schizophrenia (F20-29), 2) affective disorders (F30-39), 3) substance-use-related disorders (F10-19), and 4) all other diagnoses.

For article III, after collecting the motivation for using seclusion and/or restraint as defined by the staff from patient files and local seclusion registers, the authors of this article (RK-H, CT, JK and VL) classified independently the recorded reasons for seclusion/restraint into six categories: 1) violence, 2) threatening violence, 3) breaking property, 4) threatening to break property, 5) agitation/disorientation, and 6) unclassifiable. These categories were formed based on pre-existing knowledge provided by the previous studies. The classification is further clarified in the following.

1. Violence: The category comprises completed/ongoing violent acts targeted at a person, or behaviour clearly indicating that violence was about to occur (the patient was about to attack somebody but was stopped before he/she had time to touch the person).

2. Threatening violence: This category includes verbal threats of violence, e.g. the patient said that he/she was going to kill or hit someone or cut him/herself etc.
3. Breaking property: The category comprises completed or ongoing events of intentionally breaking property by hitting, kicking, crushing etc. If there was evidence of both breaking property and being agitated/disorientated, breaking property was recorded.
4. Threatening to break property: This includes verbal threats of breaking property by hitting, kicking, throwing, crushing etc., or ongoing attempts of doing so that were prevented by prompt intervention before the patient broke anything.
5. Agitation/disorientation: This category includes situations where the patient is secluded/restrained because of behaving in an agitated/disorientated manner: the patient behaved in an agitated, excited, restless way; pacing around; reacting to communication in a strained way, or the patient behaved in a disorientated, confused, or chaotic manner; doing irrelevant things; being noisy; soiling; undressing in public; displaying uncontrolled sexual behaviour etc. In these cases the patient does not use verbal threats of violence or commit acts of violence.
6. Unclassifiable: All motivations written in the seclusion records could not be classified into the five categories defined. These motivations were defined as unclassifiable in the current analysis.

Furthermore, seclusion/restraint periods were categorised into five groups: 1) the first episode, 2) the second episode, 3) the third episode, 4) from 4 to 10 episodes, and 5) eleven or more episodes.

In article II, the variable “heavy use” of seclusion/restraint was defined, meaning either 1) use of seclusion or restraints three times or more, or 2) a cumulative duration of seclusion or restraints of 24 hours or more during a treatment period. The concept of ”heavy use” was derived from the material of Level 2.

4.3.2 The variables of the interview study

The background variables were collected as seen in Table 3.

Table 3. The background variables of the interview study.

Variable	Classification
Study hospital	Tampere
	Turku
	Oulu
Ward type	Acute/long term
	Male/female/mixed
Number of places in the ward	Continuous variable
Age	Continuous variable
Sex	Male
	Female
Marital status	Married
	Cohabiting
	Single
	Divorced
	Widowed
Socio-economical status	Classified according to patient's education and occupation
The date of admission	Continuous variable
The date of interview	Continuous variable
Legal status at the time of interview	Voluntary
	Involuntary
Medication at the time of interview	Name and dose of effective substance
Diagnoses	According to ICD-10
Number of previous admissions (from the register study of interviewees)	First Readmissions
Number of previous commitments (from the register study of interviewees)	First Recommitment
BPRS (Brief Psychiatric RatingScale)	Continuous variable from 1 to 108
GAF (Global Assessment of Functioning)	Continuous variable from 1 to 100

In article I, age was classified into three categories: 18-29, 30-49 and 50-64 years old. Similarly, marital status was categorised into three groups: single/having a relationship/divorced. Socio-economical status was also classified into three classes: I: managerial, officials, independent entrepreneurs, small-business persons, foremen, farmers/II: lower-level white-collar workers, skilled workers, farmers with small farms/III: unskilled workers, students etc. Diagnoses were

dichotomised: psychotic disorders (F00-09, dementia or delirium caused by organic disease; F10-19.4, delirium caused by drugs and/or alcohol; F20-29, schizophrenic/schizoaffective disorders; F30.2, manic with psychotic symptoms; F31.2, F31.5, bipolar disorder with psychotic symptoms; F32.3, F33.3 depression with psychotic symptoms (the first or recurrent episode) and non-psychotic disorders (other diagnoses).

In the interview, the participants were asked about their experiences of the hospitalisation process with structured questions of the interview form. The questions were concerned with satisfaction with being admitted, knowledge of their legal rights and perceived coercion during the admission process (in detail in Appendix I).

In article I, the patients' knowledge of their decision-making power was tested with two questions about whether they thought they could discharge themselves from the hospital whenever they wanted or not (question 1: "Are you able to leave the hospital when you want or do you need to ask for permission?" If the patient answered that she/he needs to ask for permission, question 2 was asked: "Do you mean that you may not yourself decide about stopping treatment, or that although you decide yourself it would be good to agree about the matter?"). The patients were further asked to state their legal status ("Are you therefore now in voluntary or involuntary care?").

According to the consistency of the perceived legal status and perceived possibility to decide about treatment, the patients were classified into four categories:

1. Consistent perceived voluntary (classifies her/himself as voluntarily admitted, believes s/he can decide about discharge)
2. Consistent perceived involuntary admission (classifies her/himself as involuntary, believes others decide about discharge)
3. Inconsistent (either classifies her/himself as voluntarily admitted, nevertheless believes others decide; or classifies her/himself as involuntarily admitted; however, believes s/he can decide about discharge
4. Uncertain (cannot define legal status or does not know who decides, or both).

After the interview the mental status of the subjects was assessed using two psychiatric rating scales. The Brief Psychiatric Rating Scale (BPRS) (Bech *et al.* 1993) is a symptom scale assessing the severity of psychotic disorders with 18 items. The questions of BPRS have five specific symptom areas: thought disorders, emotional withdrawal, anxiety-depression symptoms, aggressiveness

and agitation. This scale is a semi-structured and goal-directed interview. Every item is graded from 0 to 6, where 0 is defined as "no symptom". The Global Assessment of Functioning Scale (GAF) (Bech *et al.* 1993), GAF, is a functioning scale. It rates social functioning as well as severity of symptoms in psychiatric patients. A researcher filled in this scale on the basis of total assessment during an interview. GAF score is from 0 to 100, and level 0 means total lack of social functioning in the patient. The scores of both scales are continuous, and the scores were classified into three categories: in BPRS the lowest quartile, sum score up to 15 points/the intermediate quartile, 16-30 points/the highest quartile, over 30 points; in GAF the classes were up to 27, 28-39 and 40+.

4.4 Statistical methods

Pearson's chi-square test was used in the case of categorical variables. In the case of continuous variables variance analysis was used. Logistic regression analysis was used to study multivariate dependencies. Statistical analysis was done by using the SAS program package in articles I, II, IV and V, and in article III by using the SPSS program package.

4.4.1 The statistical methods of the register study

In article II, Poisson regression analysis was used to calculate the differences between the population-based traits. The chi-square test was used to describe the bivariate associations between categorical variables. The stepwise logistic regression model was used to calculate odds ratios (OR) for factors predicting "heavy use" of these interventions. In the stepwise logistic regression analyses, the following were used as outcome variables: 1) use of seclusion (none vs. one or more episodes), 2) use of restraints (either none or one or more episodes), 3) use of either seclusion or restraints (either none or one or more episodes), 4) having less than three, or three or more incidences of either intervention, and 5) having a cumulative duration of use or either intervention of less than 24 hours, or 24 h or more. In the stepwise logistic regression models sex, age, socio-economic status, marital status, main diagnosis, prior treatment history, hospital and legal status according to the referral were used as independent variables.

In article III, differences between recorded reasons for using seclusion and restraints were studied with chi-square test. In analysing the reasons used to motivate seclusion/restraint according to sex and the diagnosis of the patient

concerned, the type of admission to the treatment period studied (voluntary/involuntary) and the ordinal number of seclusion/restraint episode, seclusion and restraint were combined since according to the literature, mostly similar indications are given for both.

In article IV, differences between patients whose involuntary treatment was motivated by harmfulness to others and patients whose involuntary treatment was motivated by other reasons were studied with chi-square test. The analyses were conducted in three different ways for assessing the associations of the “harmful to others” criterion. The dependent variable was motivation for involuntary referral (harmfulness to others used vs. not used in M1) and detainment (harmfulness to others used vs. not used in M3) both alone and together with other motivations. The independent variables used were sex, social class, marital status, diagnoses and potential self-harm.

In article V, the response variable was any deprivation of liberty and the independent variables used were marital status, social class, catchment area, source of referral, main diagnosis, and where the patients discharge to. The estimates of the annual incidence figures for involuntary admissions and detainments were calculated in relation to 100,000 of general working-age population (18-64 years of age); 95% confidence intervals are given. The length of stay was studied with variance analysis.

4.4.2 The statistical methods of the interview study

In article I, to assess which patients can accurately define their legal status, the patients classifying themselves correctly were compared with those having any inconsistencies, uncertainty or making a mistake by using the chi-square test. A logistic regression analysis was made with the variables significantly associated with awareness of legal status and rights in separate analyses (BPRS, GAF, psychotic disturbance).

5 Results

5.1 The patients' view on self-determination (I)

Of the legally voluntary patients, 80% defined their treatment period as voluntary. Of the involuntary patients, 48% defined themselves as involuntary patients. The patients' knowledge about discharge varied between those who defined themselves voluntary/involuntary and those who were legally voluntary/involuntary patients, as seen in Table 4. In all groups, despite who in them defined themselves as involuntary patients, over one tenth (13-15%) were uncertain as to who decides on discharge.

Table 4. The patients' knowledge about discharge compared to patients' legal as well as self-defined status (%).

	The patients who defined themselves as voluntary %	The patients who defined themselves as involuntary %	Legally voluntary patients %	Legally involuntary patients %
Patient decides about discharge him/herself	38	8	38	12
Others decide about discharge	49	88	47	76
Uncertain	13	5	15	12

Compared to the factual legal status, 43% of the patients were correctly and consistently aware of their legal status and its implications in relation to discharge. Of the involuntary patients, 37% were able to state that they were involuntarily treated and others would decide about their discharge, while of the voluntary patients, 49% knew they were being treated on a voluntary basis and could themselves decide about terminating the treatment.

Non-psychotic patients were better able to report their legal status and rights correctly than psychotic patients. The fewer symptoms the patient had, the better was the awareness of his/her situation: the patients who had the lowest quartile of the BPRS sum score and the highest quartile of the GAF sum score had better perception of their legal status. When the BPRS and GAF scores and psychotic disturbance were entered in logistic regression simultaneously, only psychotic disturbance persisted as a significant variable (OR 2.4, 95% CI 1.3-4.5), and the

result was that the patients who had a psychotic disorder had deficient awareness of their legal status and rights.

5.2 Involuntary hospitalisation and the use of coercive measures (II, III, V)

5.2.1 Involuntary hospitalisation

Involuntary referral was involved in 27% of the cases and an observation period in 26% of the cases. Involuntary detainment concerned 17% of the patients. Altogether, at least some form of deprivation of liberty was used with 36% of the patients. A flow chart concerning the patients and their involuntary treatment is seen in Figure 2.

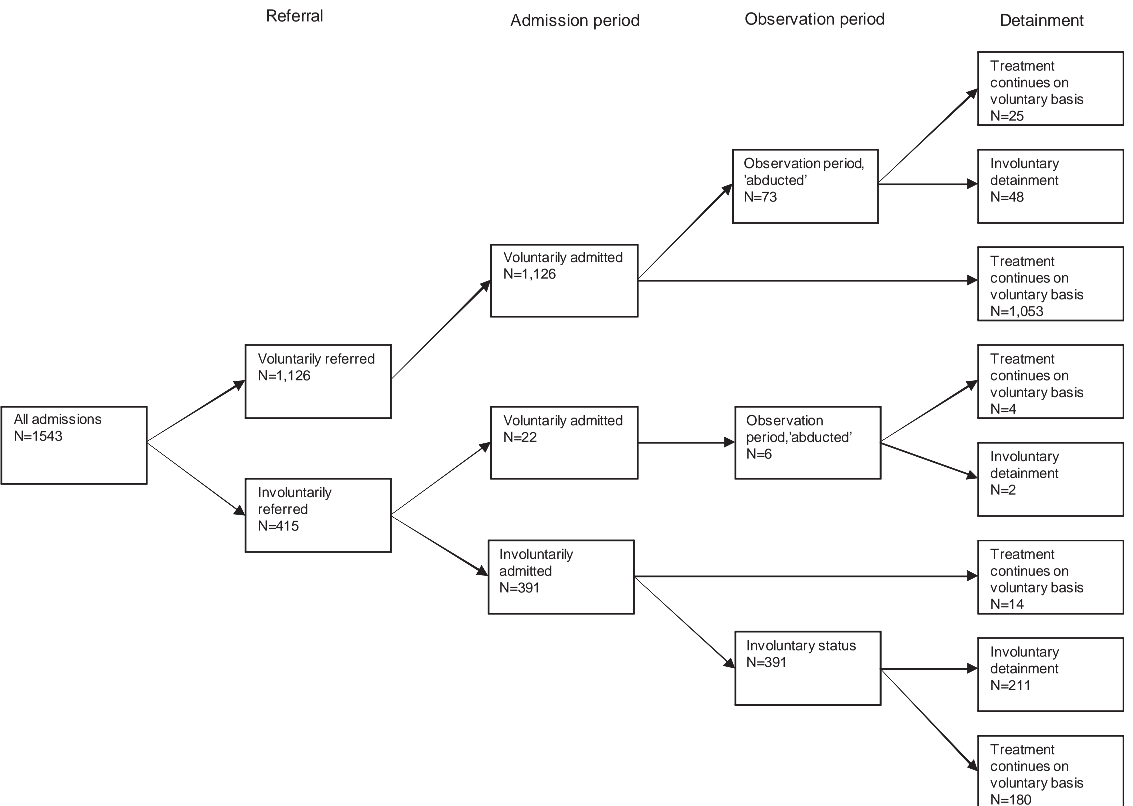

Fig. 2. The process of involuntary treatment, a flow chart. Of all admissions the data were incomplete in two cases, and are therefore not enclosed later in this figure.

Related to the population, the annual rate of any deprivation of liberty in psychiatric care was 273/100,000 (95% CI 256-290) among working-age inhabitants. The commitment rate (arrival on involuntary referral) was 233/100,000 (95% CI 217-249), the rate of deprivation of liberty in the form of observation period 226/100,000 (95% CI 210-241) and the rate of involuntary detainment 146/100,000 (95% CI 134-159).

There were no differences between involuntarily and voluntarily treated patients with regard to gender, age or marital status. However, the patients treated involuntarily belonged to the lowest socio-economical class more commonly (p=0.005) than other patients. The involuntarily treated patients had longer episodes of hospital treatment than the patients treated voluntarily, mean 49.4 days (SD =54.5) vs. 22.1 days (SD =32.8, p=0.0001).

In logistic regression analysis, psychotic disorder (OR 10.3; 95% CI 7.2-14.6, p=0.0001) and earlier involuntary treatment (OR 3.0; 95% CI 2.0-4.6, p=0.0001) were the factors that predicted deprivation of liberty during the treatment period. If the index hospitalisation was readmission, the risk of deprivation of liberty was lower (OR 0.2; 95% CI 0.2-0.4, p=0.0001).

5.2.2 The use of coercive measures

There were altogether 482 episodes of restraint or seclusion during the study period. Of a total of 1,543 admissions seclusion was applied in 102 (6.6%) and restraints in 58 (3.8%) cases. In 14 (0.9%) admissions the patient was subjected to both seclusion and restraints.

The overall risk of seclusion was predicted by having previous commitments (OR 2.2; 95% CI 1.3-3.8, p<0.01), and involuntary legal status on admission (OR 14.0; 95% CI 7.7-25.0, p<0.001). The overall risk of restraints was predicted by the diagnostic group of substance-use-related disorders (OR 4.0, 95% CI 1.3-12.0, p=0.01), involuntary legal status on admission (OR 5.6, 95% CI 3.0-10.4, p<0.001) and by being treated in Oulu (OR 10.6, 95% CI 4.1-27.7, p<0.001). In stepwise logistic regression analysis, where the dependent variable was the use of either seclusion or restraints, significant predictive factors were having previous commitments (OR 2.3, 95% CI 1.5-3.6, p<0.001) and involuntary legal status on admission (OR 9.8, 95% CI 6.3-15.3, p<0.001).

”Heavy use” of seclusion and restraint was associated with previous commitments (OR 2.2, 95% CI 1.3-3.8, p<0.01) and involuntary legal status on admission (OR 14.0, 95% CI 7.7-25.0, p<0.001). Even if the overall use of

restraints was predicted by the diagnostic group of substance-use-related disorders, ”heavy use” was more common among episodes of treatment with a schizophrenia group diagnosis than with any other diagnosis (3.3%, other diagnostic groups ranged from 0.5% to 1.2%, $p<0.01$). In the stepwise logistic regression model, the factors predicting ”heavy use” were having previous commitments and involuntary legal status on admission.

5.2.3 Regional variation of coercion in the study hospitals

At first, when only percentages of all admissions were studied, Turku seemed to use more coercion. This was, however, explained by the fact that population-standardised rates for voluntary admission and treatment were lower in Turku than in the other two centres. Standardised for the general population, the differences in deprivation of liberty between the three centres in proportions of admitted patients disappeared. All forms of deprivation of liberty were equally commonly used in all three centres.

There were marked, statistically significant differences in the rates of use of seclusion and restraints between the centres. Turku had the highest population-based level of use of seclusion, whereas Oulu had the highest figures of use of restraints. Still, ”heavy use” was more likely to occur in Turku than in Oulu or Tampere (respective percentages: 5.4%, 1.0% and 0.7%, $p=0.001$). In the stepwise logistic regression model the centre of Turku predicted ”heavy use” in the form of multiple seclusion or restraints, but Turku did not predict ”heavy use” in the form of the cumulative duration of use of seclusion or restraints.

5.3 The motivations of involuntary treatment and coercive measures (III, IV, V)

5.3.1 The motivations of involuntary treatment

Need for treatment was the most commonly reported criterion (91%) for involuntary referral. In 77% of the involuntary referrals potential harmfulness to self was stated as the criterion, but potential harmfulness to others was involved in only 31%. The same tendency was seen in the criteria reported for involuntary detainment: need for treatment was mostly used (98%). Potential harmfulness to self was used in 78%, and potential harmfulness to others in 21% of the cases.

When comparing the centres the only difference was in the use of the criterion “potential harmfulness to self” for detainment: in Oulu it was used in 64% of detainment decisions, whereas the proportions in Tampere and in Turku were 86% and 83%, respectively. Harmful to others was used as the only motivation for involuntary treatment in two cases in involuntary referral (M1), and never in detainment (M3).

The patients whose involuntary referral/detainment was motivated by the harmful to others criterion solely or combined to other criteria did not differ from other patients referred/detained involuntarily pertaining to sociodemographic background (age, marital status, and socio-economical status), diagnoses, coercion during treatment (defined as seclusion, mechanical restraint, forced medication, physical holding and restrictions in leaving the ward) or treatment history (first treatment/readmission; first involuntary treatment/redetainment). The “harmful to others” criterion was used more commonly for male patients (involuntary referral: OR 2.52, 95% CI 1.63-3.92, $p=0.0001$, and involuntarily detained patients: OR 2.23, 95% CI 1.26-3.94, $p=0.0012$).

Use of the “harmful to others” criterion in involuntary referral did not predict a longer length of stay or a longer involuntary period, whereas using “harmful to others” in detainment predicted a longer treatment episode (69 vs. 46 days, $p=0.003$) as well as a longer involuntary period (60 vs. 30 days, $p<0.0001$).

5.3.2 The motivation of coercive measures

The most frequently (43.6%) recorded motivation for seclusion/restraint was agitation/disorientation. A total of 11.2% of the seclusion/restraint episodes took place because of actual violence, and in 25.1% of the episodes the motivation was threatening violence. About 2.1% of the episodes occurred due to the patient breaking property, and 0.6% due to the patient threatening to break property. Of the reasons for seclusion/restraint, 5.9% could not be classified, and in 12.2% of the recorded episodes, the motivation had not been written in the case history or in the local seclusion register, even though this is required whenever seclusion/restraint occurs.

The motivation for seclusion/restraint differed between male and female patients. Women were more commonly secluded because of actual violent behaviour (17.6%) and because of agitation/disorientation (66.0%), whereas men were more commonly secluded/restrained due to threatening violence (40.5%) ($p<0.0001$).

Actual violence as well as agitation/disorientation of the patient was a common reason for mechanical restraint, whereas threatening violence was the reason for seclusion in seclusion room ($p<0.0001$). When actual violence was the reason for seclusion/restraint, violence was mainly targeted towards the staff (35.2%) and towards other patients and visitors (33.3%). In 20.4% of these cases the target of violence was the patient him/herself. The target of aggression was not reported in 11.1% of the actual violence-related episodes. When the reason for seclusion/restraint was threatening violence, the target of the threats was most commonly the patient him/herself (51.2%). In 44.6% of the seclusion/restraint episodes motivated by threatening violence the target was staff, and only 1.9% of the episodes were targeted towards other patients and visitors. The target was not specified in 2.5% of recorded episodes of seclusion/restraint due to threatening violence.

From the first to tenth episodes of seclusion/restraint, agitation/disorientation was the most commonly used motivation (1st: 76.8%, 2nd: 52.6%, 3rd: 50.0%, and 4th - 10th: 46.8%). If there were 11 or more episodes of seclusion/restraint, the most common motivation was threatening violence (86.7%).

6 Discussion

6.1 The study design, material and methods

Coercion in psychiatric treatment is a diversified issue: perceived coercion is not the same as the legal status. On the other hand, the tightening of the criteria for involuntary treatment by changing laws has not automatically decreased the figures of involuntary treatment. The present study evaluated both perceived coercion and the proportion of involuntary treatment and use of coercion measures in psychiatry in Finland. This study also attempted to illuminate some factors associated with coercion in psychiatric hospital treatment.

The study was limited to the working-age population and civil admissions because the study hospitals provided all the psychiatric inpatient treatment for this age group in their catchment areas. However, the proportion of treatment with coercion is higher when the whole population is taken together: elderly patients are also treated in other institutions than the hospitals of the present study, and when patients under 18 years need treatment it must take place in wards meant especially for adolescent patients, but some of them are still treated in adult wards. Forensic patients from the study area are commonly treated in other facilities than the study hospitals. The figures given on this study concern only treatment of working-age civilian patients and are thus likely to be somewhat low compared to all psychiatric treatment.

Methodologically, a retrospective chart review with structured forms is systematic and does not risk interfering with routines in the ward. All use of coercion in the centres studied in the present thesis must be recorded in the case histories, and use of seclusion and restraint was additionally recorded in a special register kept in the hospital during the study period. As a result of the revision of the Mental Health Act in 2002 these special registers should be sent to the State Provincials Offices. Furthermore, to ensure that all information was obtained, nursing files were also included in the study. However, long negotiations before a patient consents e.g. to take his/her medication or to come to hospital etc. may be perceived as coercive by the patient and the staff/relatives, but these events may not be recorded as involuntary treatment/coercive measures, because the patient finally ”chooses” the alternative given by the relatives/staff. A previous study where the data were gathered by interviewing patients, staff and/or relatives has given higher figures of coercive interventions than this study (Kaltiala-Heino

1995). The methodology used in this study is thus more likely to underestimate rather than overestimate the use of coercion in psychiatric inpatients.

Even if a retrospective chart review is reliable as a method in detecting episodes of seclusion and restraint, there are limitations. A limitation of this method is that concerning seclusion/restraint situations, researchers were restricted in analysing motivation as documented by the staff and therefore could not reach the nuances in situational correlates of the seclusion/restraint episodes. A more detailed analysis of situational correlates requires qualitative research methods, preferably observation techniques (Silverman 1997, Kaltiala-Heino 1999). However, such methods are extremely resource-consuming and may even alter the treatment practices. A possibility to avoid that kind of bias is to use a retrospective research design, like in the present study. Further, in this study, the reliability of the results is increased by the blind rating by four researchers of the written documentation of reasons for using seclusion/restraint. In this study it was possible to link the reasons for using seclusion/restraint with a number of patient-related variables.

Yet another limitation of this study is the fact that the diagnoses were not based on structured interviews. Diagnostic assessment in Finnish psychiatric hospitals has, however, been shown to be reliable, especially as to differential diagnosis of psychotic disorder (Isohanni *et al.* 1997). Poikolainen (1983) and Keskimäki and Aro (1991) demonstrated that the accuracy of a diagnosis made in the hospital was good: 85%-95% of the data are accurate. On the other hand, Taiminen *et al.* (2001) found that the agreement on diagnosis between clinicians and researches was low, especially for patients with schizophrenia admitted for the first time. Sex differences in the diagnostic practice in schizophrenia have also been suggested: in female patients there is a longer latency period between the first admission and the diagnosis of schizophrenia (Hoye *et al.* 2000). These problems in the diagnostic process may have influenced the analysis made in this study in relation to the independent impact of schizophrenia in respect to the use of involuntary treatment/measures. A plausible effect is that the diagnosis of schizophrenia could be an underestimate also in this study. To avoid the bias caused by this, we have mostly used the diagnoses in a dichotomised way: psychotic/non-psychotic conditions.

The strength of this study is that the data were collected during a six-month period, and the annual rates of this study are based on this six-month admission sample. Previous studies from different countries have commonly used the information of involuntary treatment from one-day census data, and reports from

Finland have used census data similarly as well. However, census data recording a patient's legal status only on a given day (commonly the 31st of December) and this one-day patient census are influenced e.g. by the general shortening of (involuntary) psychiatric inpatient treatment periods. Furthermore, the one-day census will miss the previous involuntary status of a patient who, at the time of the census, is continuing the treatment on a voluntary basis. Although seasonal variation in the involuntary treatment/use of coercion is very unlikely to affect figures when the inclusion period was so long, 95% confidence intervals have been used to improve the reliability of annual rates.

To measure perceived coercion involves many problems, such as what is considered to be coercive by an individual patient and to what extent the answers of the patients are valid. On the other hand, the subjectivity of the interviewer can influence the patient's answers, or at least the interpretation of the answers. Previous studies have shown that the patient's answers correlated better with "what actually happened" than the answers of the clinicians or the relatives, and discrepancies between officially reported coercion and the patients' statements (Lidz *et al.* 1997, Kjellin & Westrin 1998, Poulsen 1999). People subjected to involuntary psychiatric hospitalisation and treatment often feel victimised in much the same way as do wives (less often husbands) who are abused by their spouses (Szasz 2003). However, the best strategy for studying the role of coercion may be to seek the views of the patients themselves on their experiences concerning their admission to hospital (Monahan *et al.* 1995, Hoyer, 1999).

In this study the patients' mental status was assessed by using the BPRS (Overall 1974) and GAF (Endicott 1976) scales. Both scales have been used in many studies, and their validity has been verified (Bech 1993). To improve the reliability of the researchers they all assessed a series of the same patient's (N=6) mental status with both BPRS and GAF before the study began.

7 Results

7.1 Psychiatric inpatients' view on self-determination (I)

The results of this study showed that the patients know their legal status as well as their rights poorly. It is rather striking that only a half of the voluntarily admitted patients and roughly a third of involuntarily admitted subjects were able to state their legal status correctly and whether they had the right to decide themselves about their discharge. Furthermore, 5-16% of the patients were uncertain. These results are parallel with the results of previous studies (Toews *et al.* 1981, Bradford *et al.* 1986, Simonsen 1992, Stender & Aggernaes 1992).

In this study, awareness of legal status was enquired from the patients during the first 72 hours in hospital. Toews *et al.* (1986) noted that patients' knowledge of their legal rights increases over time. Initially only 14%, but after 3 months up to two thirds of committed patients knew their legal status. In Sweden, 16% of inpatients (both voluntary and committed) interviewed at discharge did not know what their legal status had been during the stay (Candefjord 1989). This is understandable as patients have more time to orientate and also to recover from their acutely worsened mental status. Some studies have shown that patients revised their beliefs about the necessity of hospitalisation, but their attitude towards this kind of treatment still remained negative, or became even worse (Kaltiala-Heino & Salokangas 1990, Gardner *et al.* 1999).The discouraging results in the present study that 80% of the legally voluntary patients but only 48% of the legally involuntary patients defined themselves correctly as voluntary/involuntary may be partially due to the interviews taking place at an early stage of the treatment.

According to Lidz *et al.* (1995), patients' perceptions of coercion were independent of demographic factors, but perceived coercion was associated with the way the patients were treated. If the patients were treated with respect, concern and fairness during the admission process, they accepted involuntary treatment more easily than when they were being negatively pressured. Comparing to the findings of this study, voluntarily admitted psychiatric inpatients were quite well aware of their legal status, but they had very poor awareness of their possibilities to decide about discharge. The results of this study are parallel with the results of the study of Lidz *et al.* (1995) concerning perceived coercion: there were no demographic differences between the

voluntarily and involuntarily admitted patients. Unfortunately, the patients' perceived coercion was not assessed similarly in these two studies, and direct comparison is thus impossible.

Knowing one's rights regarding discharge might be a clearer indicator of whether the patient is aware of his/her situation. Only half of the voluntary patients thought they would be able to discharge themselves, and one fourth believed they would not be allowed to decide for themselves. Are the voluntary patients uninformed about their rights, or is the voluntary legal status a superficial and untrue classification? The patients' problems with understanding despite information can also be due to anxiety, which is commonly associated with hospitalisation even if the patient is admitted voluntarily. Almost two thirds of the involuntary patients knew they could not discharge themselves. In Finland patients are informed about the observation period at its beginning, but only verbally. Thus, the mistake made by a fifth of the involuntary patients who thought that they could discharge themselves may be due to both misunderstanding because of only verbal explanation, and to denial.

A correct view of the legal status was more likely among patients suffering from a non-psychotic disorder and with fewer symptoms as measured by the BPRS as well as better ability to act measured by the GAF. However, awareness among the patients with less severe illness was not good. The modern approach to assessing competency to consent/to refuse treatment includes that during the assessment the patient is carefully informed about the issue s/he should decide on (Appelbaum *et al.* 1998). The severity of illness may not be an excuse for not trying to inform patient. The Patients Right Act states that a patient must be treated with co-operation, but how can a patient participate in planning or make decisions concerning his/her treatment if he/she does not get adequate information? Respect for the patient's autonomy obliges the treating agents to inform the patients about their situation even if it is a fact that the patient is not allowed to decide about her/his stay (Välimäki & Leino-Kilpi 1998). Information needs to be repeated frequently and clearly enough, so that severely ill patients will be able to process it. Uninformed patients are not necessarily incompetent to decide about their treatment (Zaubler *et al.* 1996). In the present study it was not possible to confirm to what extent and how the patients had been informed about their legal status and discharge issues. It is possible that the patients' ignorance of their status and rights was partially due to not having been properly informed, even though the most severely ill patients' inability to understand the information provided is also likely to play a role.

Less than half of the involuntary patients defined their treatment as involuntary. It is known that a patient's perception of being forced into treatment does not necessarily coincide with her/his legal status (Spence *et al.* 1988, Simonsen 1992, Westrin *et al.* 1994, Monahan *et al.* 1996, Kaltiala-Heino *et al.* 1997). In various studies, 40-60% of committed patients have been seen to accept their hospitalisation (Bradford *et al.* 1986, Persson *et al.* 1988, Conlon *et al.* 1990, Simonsen 1992, Stender & Aggernaes 1992, Kaltiala-Heino 1995), and they have perhaps even desired it. It has even been suggested that some of the involuntary admissions may happen due to convenience reasons, such as avoiding hospital fees or transportation fees, or to ensure a bed (Miller 1978). In Finland, however, only the last one of Miller's reasons for involuntary admission is possible. This study did not include a follow-up, and thus patients' opinions on the reasons for involuntary admission are not available.

7.1.1 Involuntary hospitalisation and the use of coercive measures (II, III, V)

The rate of involuntary treatment is high in Finland, higher than in most other countries. International comparisons of the extent to which involuntary treatment takes place are difficult because of differing legislation, practices and registration methods. In previous studies the rate of involuntary treatment varies from 6/100,000 inhabitants in Portugal to 248/100,000 inhabitants in Sweden (Malla & Norman 2004). The highest Swedish rate was based on the 1982 figure; in 1998 the rate was significantly lower, 114/100,000 inhabitants. Also in Finland a census-day rate of involuntary treatment in 2000 was 218/100,000 inhabitants (Salize & Dressing 2004). Compared with these figures, the figures of this study (annual involuntary detainment rate: 146/100,000 and annual rate of any deprivation of liberty 273/100,000 working age inhabitants) seem to be strikingly high, but direct comparison is not possible because of different registration as well as assessment methods.

Different types of legislation result in different figures regarding involuntary treatment. In Finland, the commitment criteria are broad, emphasising the need for treatment as a criterion for commitment. However, in Denmark, where the need-for-treatment criterion has also been adopted, the commitment figures are much lower than in Finland. This draws attention to the treatment culture. Our results showed also that despite the same legislation, there are still differences between centres: there were differences in percentages of involuntary admissions

and inpatient periods even if the rates of involuntary treated patients did not differ between the three Finnish centres. This difference was explained by a lower rate of all admissions in one centre. The rate of psychotic disorders was similar in every centre, so the suggestion is that the explanation for this is the treatment and/or referral culture.

In this study the use of seclusion was applied in 6.6% of psychiatric inpatients and restraint in 3.8%. In Norway Höyer and Drange studied the use of coercive measures in psychiatric treatment at the end of the 1980s and the beginning of the 1990s. When the figures were compared between Norway and Finland (in relation to population), the use of coercive measures in Norway seemed to be one-fifth of that found in Finland (Höyer & Drange 1991,1994, Kaltiala-Heino 2000). In Denmark, Reisby evaluated the use of seclusion, restraint and forced medication. The figures were one half of those presented in Finland (Reisby 1983). Schepelern *et al.* (1993) also included restrictions on leaving the ward and suggested figures that corresponded to less than a half of the Finnish figures. There is also study where the figures are lower still (Schröder & Christensen 1992). Nevertheless, the Finnish figures were quite similar compared with figures of previous studies, and even lower than some figures from the USA (Okin 1986, Way & Banks 1990, Swett 1994, Hiday 1996). However, the results of these studies are not comparable because of different size of data as well as methodological differences.

There were significant differences in the population-based rates of using seclusion and restraint between the centres. The choice between use of either seclusion or restraint and the pattern of using them differed according to the centre. This may be in contradiction with the aims stated in the Mental Health Act: a clinician-based individual evaluation of need for coercive measures, and use of coercive measures to a minimal extent. Ray and Rappaport (1995) suggested that the observed variations in the use of seclusion and restrain between institutions may prevail as long as there are different kinds of clinical perspectives on the advisability and limited possibilities for comparative monitoring of seclusion and restraint. In this study there were differences in patient population between the centres, and it is possible that some of the observed differences in the use of coercion can be explained by the differences in clinical features of the patients in the Finnish centres.

Unfortunately, no symptom-rating scales were included in these analyses. For instance, previous studies found that a high score on the BPRS scale was positively correlated with the use of seclusion and restraints (Yesavage 1984,

Kasper *et al.* 1997). Previous studies also found that some clinical factors and other factors such as staff-patient ratio, use of psychotropic drugs and the educational level of staff could influence and be predictors for restrictive measures (Yesavage 1984, Klinge 1994, Ray & Rappaport 1995). This study found, however, that patients with a substance-used-related disorder were at a risk of being subjected to restraint.

Some previous studies have found that certain race and ethnicity predict overrepresentation of hospital admission and even of involuntary treatment (Cochrane 1977, Carpenter & Brockington 1980, Dean *et al.* 1981, Koffman *et al.* 1997). In this study it was not possible to collect data on race or ethnicity. The most important reason for lack of data of race and ethnicity is that the Finnish legislation prohibits the gathering of that kind of information. On the other hand, the proportion of people from different ethnicities is so small in Finland that examination with the methods used in this study was impossible.

7.1.2 The motivation of involuntary treatment and coercive measures (III, IV, V)

According to this study, deprivation of liberty in psychiatric care is almost exclusively because of “the good of the patient” (need for treatment and/or protection of the patient from hurting her/himself). Studies with comparable methodology in other Nordic countries have shown a great emphasis on the “dangerousness to self” criterion. In Denmark, slightly more than half of the involuntarily treated patients were deprived of their liberty by referring to the “dangerousness to self ”criterion (Engberg 1990a,1991). Keiland *et al.* (1983) reported in Sweden that of all involuntary patients, 13% were detained mainly to prevent injury to others. Soothill *et al.* (1990a) found that a third of committed patients were defined as dangerous to others at the time of committal; the decision was based on case histories. Paternalistic motivation for the use of coercion may well be intertwined with social control, even the desire to punish, even though the conscious and explicit aim is to help and protect the patients (Kjellin & Nilstun 1993, Kaltiala-Heino 1999). This study suggests that in the Finnish commitment process, the paternalistic justification of deprivation of liberty is preferred to social control.

In Finland, commitment decisions are for the most part based on a philosophy of paternalistic doctor-patient relationships: the doctors assess the good of the patient from their own viewpoint, without considering the values and the

life-style of the patient. Although patients are seemingly not left totally without treatment, we should consider whether the very problems the patient experiences as most relevant are left untreated by giving treatment based on our values and our opinions of the desirable goal.

The “harmfulness to others” criterion as a motivation for involuntary treatment was rarely used in involuntary referral and detainment with other motivations (need for treatment and harmfulness to self), and never as the sole motivation. Risk assessment of violence (harmfulness to others) is always an estimation, and it is not based on any structured interview or assessment for compulsory treatment. Previous studies have shown the poor reliability of attempts to predict violent behaviour (Buchanan 1997). However, some studies have showed that both the HCR-20 (the Historical, Clinical, and Risk Management Scales) and BPRS were strong predictors of in-violence (Grey *et al.* 2003). A previous study indicated that hospitalisation before patients develop violent behaviour is perhaps used in excess in psychiatric care, even if it is not known whether they will actually become violent (Kaltiala-Heino *et al.* 2000). This study may support the finding that patients are also referred to psychiatric care at the time when they are not violent. Substance-use-related disorders seem to play a central role in violence (Eronen *et al.* 1996, Steadman *et al.* 1998). This study showed, however, that the “harmfulness to others” criterion was used similarly in all diagnostic groups.

The practical motivations for using seclusion/restraint have been surprisingly little studied. The most frequently reported reason for the use of seclusion or restraint in this study was agitation/disorientation. Involuntarily admitted patients were not mainly secluded because of violence or threatening violence, but due to agitation/disorientation. When the patients had initially been admitted voluntarily seclusion/restraint was mostly motivated by threatening violence; in over half of the cases the target of aggression was the patient him/herself. Violence was the reason for seclusion mainly in episodes occurring after numerous previous seclusion episodes, not in the early stages of the treatment. Violence, however, does not have a logical connection to seclusion/restraint (Angold 1989, Brown & Tooke 1992, Fisher 1994). Violent behaviour is the reason for seclusion/restraint in 15-35% of the cases, but agitation or behaviour difficult to control is the reason for seclusion/restraint in 25-40% of episodes (Convertino *et al.* 1980, Soloff & Turner 1981, Hammil *et al.* 1989, Walsh & Randell 1995). An interesting finding was that in fewer than 5% of seclusion/restraint episodes the reason was difficulty in co-operation reported by staff (Walsh & Randell 1995). It could be thought that

the patients were secluded in a ward before the development of violent behaviour, but it is not known whether the patients would actually have become violent. A previous study (Kaltiala-Heino *et al.* 2000) indicates that coercion and restrictions are perhaps used in excess, even prematurely, in psychiatric care. All in all, patients with previous commitments and involuntary legal status on admission may be at risk of being subjected to both types of coercive measures. Seclusion is not, however, used in the treatment of acutely admitted violent patients in emergencies, but violence as a reason for seclusion/restraint is associated with chronic situations and organic disorders.

There were differences between the sexes: actual violence was used more commonly as the reason for seclusion/restraint in female patients. This is interesting, because men in general and also male patients actually commit more violent acts than females (Eronen *et al.* 1998). The explanation for this phenomenon could be that men were more frequently secluded/restrained due to threatening violence than women. This finding emphasises the findings of a previous study: Soloff and Turner (1981) found that violence of male patients is a more alarming possibility, and action is thus taken by staff at an earlier stage than when women are concerned.

Substance-use-related disorders appeared as the only significantly predictive diagnostic group for the use of restraint. “Heavy use” of coercive measures such as seclusion and restraint in the form of three or more episodes of use was more common during episodes of treatment with schizophrenia group diagnosis than with any other diagnosis. Swett (1994) found that patients with personality disorders have a higher risk of being subjected to seclusion/restraint than patients with psychotic disorders, and only the patient’s irritability on admission as estimated by the staff was a predictive factor for seclusion/restraint, whereas severity of the patient’s psychiatric disorders or proportion of symptoms was not. Soloff and Turner (1981) found also that the patient’s diagnoses or psychic condition had no correlation with the number or length of episodes of seclusion/restraint. Okin (1985) found that different kinds of patient-related factors (e.g. sex, age, ethnicity, legal status, diagnosis) did not constitute predictive factors to seclusion/restraint. Other previous studies have shown contradictory results: seclusion/restraint has been connected to male as well as female sex, young age as well as middle-age, psychotic as well as non-psychotic disorders, legal status during treatment and ethnic group (commonly non-white) (Soloff & Turner 1981, Okin 1985, Angold 1989, Way & Banks 1990, Fisher 1994, Engberg 1992, Swett 1994, Walsh & Randell 1995). In Finland, previous

studies have shown that seclusion/restraint has a connection with psychotic disorder and male gender, but above all with involuntary status during treatment (Kaltiala-Heino & Laippala 1997, Kaltiala-Heino 1997). Our results can thus not be supported or overruled by the heterogeneity of international studies, and comparisons are not meaningful. However, our results have similarities with previous Finnish studies.

8 Conclusions

1. The involuntarily treated patients' views on their legal status and its implications are deficient. A patient can hardly actualise the legal rights if s/he is unaware of them. To enhance psychiatric patients' self-determination and to encourage active participation in the formulation of a treatment plan, more attention should be paid to informing psychiatric inpatients about the legal nature of their treatment.
2. The figure of deprivation of liberty in psychiatric treatment is high in Finland. The figures of compulsory treatment are high when compared to international statistics. When comparing coercive measures such as seclusion and restraint with international statistics the figures were similar or even low.
3. The main motivations for involuntary treatment were the need for treatment and harmfulness to self. Harmfulness to others is a rarely used motivation for involuntary treatment. The involuntarily treated patients motivated by harmfulness to others were not found to have any specific characteristics except for male gender. Coercive measures were not used more regularly with these patients than with involuntarily treated patients motivated by other criteria, and the "harmfulness to others" criterion used in involuntary referral was not a reason for a long length of stay. These results suggest that psychiatry has not accepted the role of social control in Finland. However, more attention should be paid to using the "harmfulness to others" criterion: patients who are violent due to their actual mental illness, need to be treated instead of being given a sentence.
4. Seclusion and restraints were commonly motivated by agitation/disorientation of the patient, even if seclusion/restraint is theoretically in the first hand justified by the need of treating violent patients in emergencies. Previous commitments and involuntary legal status on admission were only predictive factors for "heavy use" of seclusion and restraint. These results show that the motivation for seclusion and restraint is to treat the symptoms of disease. More attention should be paid to treatment culture: to encourage attempts to find alternative ways of treating agitation/disorientation.
5. There were no differences in involuntary treatment between the three centres in Finland. However, there were significant differences in the population-based rates of using seclusion and restraints. These differences cannot be

explained by legislation; treatment culture also varies between the study hospitals.

8.1 Recommendations and clinical implications

The findings on patients' perception of their legal status and possibility to decide about discharge are discouraging. Perception was the more deficient the higher the points of the BPRS score and the lower the points of the GAF score; in other words, when the mental illness was severe. However, the severity of a patient's illness may not be an excuse for not trying to inform her/him, because despite impaired ability to make autonomous decisions, the decision should be left with her/him. Awareness of their rights enables patients to participate in the planning and decision-making concerning their psychiatric treatment, which is the explicit goal of psychiatric treatment. Thus more attention should be paid to the idea that psychiatric patients should be informed about their legal status and rights in a more understandable way.

It seems that even though the figures on involuntary treatment are high in Finland in an international comparison, the basic idea behind the motivation of treatment is still the best of patient – the need for treatment in involuntary treatment and agitation/disorientation in the case of seclusion and restraints. In Finland coercive treatment in psychiatry does not include social paternalism; potential harmfulness to others is very rarely used as motivation of involuntary treatment. Even though it seems that involuntary treatment as well as coercive measures is motivated with psychiatric reasons - need for treatment and agitation/disorientation - attention should be paid to all use of compulsion in psychiatry. Coercive measures as well as involuntary treatment itself are always emergency situations in psychiatry. Decisions on compulsion must thus commonly be done quickly and with a lack of staff. It is important to look over these situations afterwards with both the patient and staff.

Furthermore, it seems that even if involuntary treatment and coercive measures in psychiatry were defined by the same legislation in Finland, there were differences between study hospitals as to how treatment is accomplished. Thus it is important to pay attention to practices used in wards. Sometimes some practices come into use slowly and stealthily, but a lot of work is needed to change them. There are good results from psychiatric wards where the staff has paid strict attention to the practices concerning the use of coercive measures in

the ward, and the use of seclusion and restraints has decreased without any revisions of the law or instructions.

Previous involuntary treatment as well as psychotic disorder was predictive of deprivation of liberty. These results can be interpreted in such a way that patients with the most difficult symptoms or/and the most severe disease are likely to be treated with coercion, but these results can also indicate that some kind of stigmatisation takes place when a patient has undergone compulsory treatment for the first time. The use of involuntary treatment should thus be carefully considered every time, but especially when it is being considered for the very first time.

Not only involuntary treatment but also seclusion/restraint practices differ from the guidelines accepted internationally for mental health care. On the administrative level, the present findings emphasise the need for clearer instructions to the staff regarding seclusion and restraint. The latest revision of the Mental Health Act provides detailed instructions on the use of coercion during the treatment period. The need for clearer guidelines on mental health care, especially involuntary treatment in psychiatry, calls for further research.

8.2 Implications for further research

The latest revision of the Mental Health Act defines the rules for using coercive measures in Finland. This revision marked a significant change in legislation on involuntary treatment: earlier the Mental Health Act gave general instructions on involuntary treatment in psychiatry, and coercive measures were only mentioned in that coercion should be used only as much as it is necessary. It is an important topic of future research to study how these regulations work and how coercive measures are used in different hospitals in the country.

Internationally standardised and annually updated involuntary placement rates on a national level (detailing the number of basic items, such as regular or emergency admissions as well as socio-demographic and diagnostic characteristics) are fundamental to the evaluation of national as well as European-wide policies.

This study found that there were differences in the use of coercion between study centres, even though every centre follows the same legislation. However, legislation is only one dimension of the treatment: also culture and money influence. There is a crucial need for further observational studies to assess how

services deliver care to people with severe mental illness: patients should be treated equally under the same legislation.

9 Summary

9.1 Background and aims of the study

Involuntary treatment and coercive measures in psychiatry is one of the classic problems where paternalism in medicine has come into conflict with patient autonomy. Patients' right to participate in decision-making concerning their treatment is increasingly more emphasised in modern Western societies. Involuntary treatment and coercive measures are limited to specific situations, and these situations are commonly defined by law. The rates of involuntary treatment as well as coercive measures in psychiatry have varied dramatically between countries, but also within individual countries. However, international comparison has many limitations due to different legislation, registration and treatment cultures. The aims of this study were to examine the rates of involuntary treatment and coercive measures such as seclusion and restraint and the motivations to use them. One aim was to study how psychiatric inpatients are aware of their legal status and possibilities to decide about their discharge.

9.2 Materials and methods

This study is part of the Nordic project ”Paternalism and autonomy”. The material used in this study included two stages: 1) register study and 2) interview study. The material of the register study was collected during a 6-month period 1996. The data comprise all admissions of participants aged 18-64 years to the three study hospitals in Finland (Tampere, Turku and Oulu) during the study period. The admissions were identified from the hospital databases. This study design was a retrospective chart review. The material of the interview study was collected in each centre by interviewing 50 involuntarily admitted patients and their voluntarily admitted controls. The participants were interviewed within 72 hours from the admission.

Both the register and the interview study had its own data collection form created by the Nordic study group based on their previous studies. These structured forms were tested in a pilot study. Sociodemographic background information as well as previous treatment history and diagnoses according to ICD-10 was collected. Furthermore, in the interview study the patients' mental

status was assessed by the Brief Psychiatric Rating scale (BPRS) and Global Assessment of Functioning Scale (GAS).

9.3 Results, discussion and conclusions

Of the legally voluntary patients, 80% defined their treatment period as voluntary, and 48% of legally involuntary patients defined their treatment period correctly. Less than half of voluntarily treated patients knew their legal status correctly, and were aware of the possibility to decide about discharge from hospital. Of the involuntarily treated patients only 37% had a correct perception about their legal status.

The rate of involuntary treatment as well as coercive measures such as seclusion and restraint was high. The motivation for involuntary treatment was almost exclusively "the good of patient", such as need for treatment and protection of the patient from hurting him/herself. The "harmful to others" criterion was rarely used as a motivation for involuntary treatment. Psychotic disorders were a major predictor of involuntary treatment, but previous compulsory care also predicted deprivation of liberty. There were significant differences in the population-based rates of using seclusion/restraint among the centres. The motivation for seclusion/restraints was commonly agitation/ disorientation. Involuntary treatment was used similarly between genders, but males were overrepresented in the seclusion/restraint rates. Females were more likely to be secluded/restrained because of actual violence, whereas males were secluded/restrained due to threatening violence.

Compared to previous studies, these results differ in some points. The patients' awareness of their legal status during the treatment period was quite similar as in previous studies. Deprivation of liberty is distinctly high compared to other Western countries. Violence had been the main reason for seclusion/restraint in previous studies, whereas these results showed that agitation/disorientation was commonly used in Finland. Compared to other studies in Finland, the "harmful to others" criterion was used more rarely as a motivation for involuntary treatment.

A limitation of this study is that the diagnostic assessment was not based on structured interviews, and to avoid a bias the diagnoses were commonly dichotomised into psychotic/non-psychotic conditions. The study is limited to the civil psychiatric treatment of working-aged population, because the study hospitals provide the care for this age group in their catchment areas. However,

geriatric and forensic patients are also likely to be subjected to coercion in psychiatry, geriatric patients even in a medical setting, too. Thus, the results of this study may be lower than they would have been if all psychiatric treatment received by the populations in these catchment areas had been under study. In the interview study the refusals were more likely to have a diagnosis of psychotic disorder and be treated involuntarily, and they had also commonly had previous compulsory care. It is thus possible that the refusals are even more unaware of their legal rights than the participants, and the results of this study can therefore be underestimates in terms of the knowledge about the legal status of the treatment.

The strength of this study is that as a method, a retrospective chart review is reliable in detecting periods of involuntary treatment and episodes of seclusion/restraint because these phenomena, as they were collected, are clear-cut and not a matter of interpretation. This study included all admissions during a period of 6 months in well-defined catchment areas. The study hospitals occupied comparable positions in the Finnish mental health system, and no administrative or legislative changes took place during the study period. Thus the study period can be suggested to be representative of the involuntary admission pattern seen in the area as well as the representative of the Finnish psychiatric inpatient care in general. Commitment documents are supervised by legal authorities and they included information about the motivation of involuntary referral/detainment in a structured form that could not be biased through interpretation by the researchers. The information of the documents can thus be considered complete and reliable.

These findings emphasise the fact that the use of deprivation of liberty in psychiatry in Finland is distinctly high, and motivated by "the good of patient", such as need for treatment and/or protection of patient from hurting him/herself. Psychotic disorder as well as agitation/disorientation is predictive of deprivation of liberty, which is the spirit of the Mental Health Act. Nevertheless, ways of reducing the figures of involuntary treatment as well as coercive measures should be found. At the same time, it should be kept in mind that the figures of suicidality are also very high in Finland; is deprivation of liberty applied to the right patient group? The staff working in mental health care should have more education concerning both types of involuntariness in psychiatry.

References

Abernethy V (1984) Compassion, control, and decisions about competency. Am journal of psychiatry 141 (1): 53-58.
Abramson M (1982) The criminalization of mentally disordered behaviour. Hosp Comm Psychiatry 23: 101-105.
Achté K (1974) Satakolmekymmentä vuotta psykiatriaa. Kustannusosakeyhtiö Otavan painolaitokset, Keuruu.
AIHV (2004) http://www.aihw.gov.au/publications/aus/ah04/ah04-c12.pdf
Andersen B & Hansen E (1990) Patientrådgivere og tvang i psykiatrien. Ugeskr Laeger 152: 2292-4.
Angermeyer MC & Matschinger H (1999) Lay beliefs about mental disorders: a comparison between the western and the eastern parts of Germany. Soc Psych Psychiatr epidemiology 34 (5): 275-81.
Angold A (1989) Seclusion. Br J Psychiatry. 154: 437-44.
Appelbaum PS & Roth LH (1981) Clinical issues in the assessment of competency. Am J Psychiatry 138 (11): 1462-1467.
Appelbaum PS & Bateman AL (1985) Competency to consent to voluntary psychiatric hospitalization: a theoretical approach. Bulletin of the AAPL 7 (4): 390-399.
Appelbaum PS & Grisso T (1995) The MacArthur treatment competence study I. Mental illness and competence to consent to treatment. Law and human behavior 19 (2): 105-125.
Appelbaum PS (1997) Almost a revolution: an international perspective on the law of involuntary commitment. J Am Acad Psychiatry and Law 25: 135-147.
Appelbaum B, Appelbaum P & Grisso T (1998) Competence to consent to voluntary psychiatric hospitalization: a test of a standard proposed by APA. American Psychiatric Association. Psychiatr Serv 49(9): 1193-6.
Appelbaum P & Grisso T (2001) MacCAT-CR: MacArthur competence assessment tool for clinical research. Sarasota, Fla: Professional Resource Press.
Arboleda-Florez J (2001) The state of the evidence: Stigmatization and human rights violations. In Mental Health: A call for action by World Health Ministries. World Health Organization, Geneva.
Arboleda-Florez J (2002) What causes stigma? World Psychiatry 1(1): 25–26.
Austin W, Bergum V & Nuttgens S (2004) Addressing oppression in psychiatric care: a relational ethics perspective. Ethical Hum Psychol Psychiatry 6(1): 69-78.
Autonomia ja heitteillejättö – eettistä rajankäyntiä. (2004) ETENE-julkaisuja: no 10,. ISBN 952-00-1458-6.
Aviram U (1991) Care or Convenience? On the Medical-Bureucratic Model of Commitment of the Mentally Ill. Int J of Law Psychiatry 13: 163-177.
Barbato A & D'Avanzo B (2005) Involuntary placement in Italy. Br J Psychiatry 186(6): 542 - 543.

Bech P, Malt U, Ahlfors U, Elgen K, Lewander T, Lundell A, Simpson G & Lingjarde O (1993) Scales of assessment of diagnosis and severity of mental disorders. Acta Psych Scand 372 (87 Suppl): 35, 60.

Behr G, Ruddock J, Benn P & Crawford M (2005) Zero tolerance of violence by users of mental health services: the need for an ethical framework. Br J Psychiatry 187: 7-8.

Bensley L, Nelson N, Kaufman J, Silverstein B & Shields JW (1995) Patient and staff views of factors influencing assaults on psychiatric hospital employees. Issues Ment Health Nurs 16(5): 433-46.

Betemps E., Somoza E & Buncher C (1993) Hospital characteristics, diagnoses and staff reactions associated with use of seclusion and restraint. Hosp Comm Psychiatry 44: 367-71.

Bloom JD, Williams MH, Land C, McFarland B & Reichlin S (1998) Changes in public psychiatric hospitalization in Oregon in the past two decades. Psychiatric Services 49(3): 366-369.

Bradford B, McCann S & Merskey HA (1986) Survey of involuntary patients´ attitudes toward their commitment. Psych J University Ottawa 11:162-165.

Brown J & Tooke S (1992) On the seclusion of psychiatric patients. Soc Sci Med 35: 711-21.

Brown JD (2003) Is involuntary outpatient commitment a remedy for community mental health service failure? Ethical Hum Sci Serv 5(1): 7-20.

Buchanan A (1997) The investigation of acting on delusions as a tool for risk assessment in the mentally disordered. Br J Psychiatry Suppl 32: 12-6.

Cahn CH (1982) The ethics of involuntary treatment. Can J Psychiatry 27: 67-74.

Candefjord IL (1989) Studier av psykiatrisk vård, särskild tvångsvård, I två svenska län: De psykiatriska patienternas upplevelser av tvångsvård. Nordisk Psykiatrisk Tidsskrift 43: 353-356.

Cangas J (1993) Nursing staff and unit characteristics: do they affect the use of seclusion? Perspect Psychiatr Care 29: 15-22.

Campbell T (1994) Mental health law: institutionalised discrimination. Australian and New Zealand J Psychiatry 28: 554-559.

Carlsson L (2005) Schizophrenia throughout the history – the prehistoric times. http://www.hubin.org/facts/history/history_schizophrenia_en.html

Carpenter L & Brock A (1980) A study of mental illness in Asians, West Indians and Africans living in Manchester. Br J Psychiatry 137: 201-5.

Casimir KC & Billick SB (1994) Competency in adolescent inpatients. Bull Am Acad Psychiatry Law 22(1): 19-29.

Chiles J, Davidson P & McBride D (1994) Effects of clotsapine on use of seclusion and restraint at a state hospital. Hosp Comm Psychiatry 45: 269-71.

Chodoff P (1984) Involuntary Hospitalization of the Mentally Ill as a Moral Issue. Am J Psychiatry 141: 384-389.

Cochrane R (1977) Mental illness in immigrants to England and Wales: an analysis of mental hospital admission 1971. Social Psychiatry 12: 25-35.

Conlon P, Merskey H, Zilli C & Frommhold K (1990) The attitudes towards committal of patients hospitalised in a psychiatric facility for the first time. Can J Psychiatry 35: 324–327.

Convertino K, Pinto R & Fiester A (1980) Use of inpatient seclusion at a community mental health center. Hosp Comm Psychiatry 31(12): 848-50.

Cournos F (1993) Do psychiatric patients need greater protection than medical patients when they consent to treatment? Psychiatric quarterly 64 (4): 319-29.

Dean G,Downing H & Shelley E (1981) First admissions to psychiatric hospitals in south-east England in 1976 among immigrants from Ireland. Br Med J (Clin Res Ed). 282(6279): 1831-3.

Endicott J (1976) The global assessment scale. Arch Gen Psychiatry 33: 766-771.

Engberg M (1990 a) Frihedsberovede psykiatriske patienter. Ugeskr Laege 152: 2914-2916.

Engberg M (1990 b) Commitments to mental hospitals in Denmark 1971-1987. Nordisk Psykiatrik Tidsskr 44: 323-328.

Engberg M (1991) Involuntary commitment in Greenland, the Faroe Islands and Denmark. Acta Psych Scand 84: 353-356.

Eronen M, Hakola P & Tiihonen J (1996) Mental disorders and homicidal behavior in Finland. Arch Gen Psychiatry 53(6): 497-501.

Eronen M, Tiihonen J & Hakola P (1997) Psychiatric disorder and violent behaviour. Int J Psych Clin Practice 1: 179-188.

Eronen M, Angermeyer M & Schulze B (1998) The psychiatric epidemiology of violent behaviour. Soc Psych Psychiatr Epidemiol 33(Suppl 1): 13-23.

Eronen M, Repo E, Vartiainen H & Tiihonen J (2000) Forensic psychiatric organization in Finland. Int J Law Psychiatry 23(5-6): 541-6.

EU-report: Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States. Research Project - Grant Agreement No. SI2.254882 (2000CVF3-407). Final Report. Mannheim, Germany, May 15, 2002.

Faulkner L, McFarland B & Bloom J (1989) An empirical study of emergency commitment. Am J Psychiatry 146(2): 182-6.

Finnish legislation. http://www.finlex.fi/

Fisher W, Pierce G & Appelbaum P (1988) How flexible are our civil commitment statutes? Hosp Comm Psychiatry 39: 711-712.

Fisher W (1994) Restraint and seclusion: a review of literature. Am J of Psychiatry 151: 1584-91.

Forster P, Cavness C & Phelps M (1999) Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. Arch Psychiatr Nurs 13(5): 269-71.

Foucault M (1982) Madness and civilization: A history of insanity in the age of reason. London, Tavistock. (Primary: Histoire de la Folie, 1961).

Gardner W, Lidz C, Hoge S, Monahan J, Eisenberg M, Bennet N, Mulvey E & Roth L (1999) Patients' revisions of their beliefs about the need for hospitalization. Am J Psychiatry 156 (9): 1385-91.

Gove W & Fain T (1977) A comparison of voluntary and committed psychiatric patients. Arch Gen Psychiatry 34: 669–676.

Grann M, Langstrom N, Tengstrom A & Kullgren G (1999) Psychopathy (PCL-R) predicts violent recidivism among criminal offenders with personality disorders in Sweden. Law Hum Behav 23(2): 205-17.

Green S (2000) An ethical argument for a right to mental health care. Gen Hosp psychiatry 22: 17-26.

Grey N, Hill C, McGleishA, Timmons D, MacCulloch M & Snowden R (2003) Prediction of violence and self-harm in mentally disordered offenders: a prospective study of the efficacy of HCR-20, PCL-R, and psychiatric symptomatology. J Consult Clin Psychol. 71(3): 443-51.

Grisso T & Appelbaum P (1991) The MacArthur Treatment Competence Study. III Abilities of Patients to consent to psychiatric and medical treatments. Law and human behaviour 19 (2): 149-174.

Hakkarainen A (1989) Changes in the psychiatric patient population: A theoretical model and its application in Finland. Health Services Research by the National Board of Health in Finland 48.

Hamilton M (1983) On informed consent. Br J Psychiatry 143: 416-18.

Hammill K, McEvoy J, Koral H & Schneider N (1989) Use of inpatient seclusion at a community mental health center. Hosp Comm Psychiatry 31(12): 848-50.

Harrison G, Ineichen B, Smith J & Morgan H (1984) Psychiatric hospital admissions in Bristol II. Social and clinical aspect of compulsory admission. Br J Psychiatry 145: 605-611.

Häyry H & Häyry M (1993) Oikeuksien ja velvollisuuksien rajapintoja lääkintä- ja hoitotyössä. Ammattien ja ansaitsemisen etiikka.Toim. Timo Airaksinen. Yliopistopaino, Helsinki 2003: 130-172.

Hiday VA (1988) Civil commitment: A review of empirical research. Behavioral Sciences and Law 6: 15–44.

Hiday VA (1996) Involuntary commitment as a psychiatric technology. Int J Technology assessment in health care 12(4): 585-603.

Hirvonen, L (1987) Lääketieteen historia. ISBN 951-9221-09-3. Recallmed oy. Hangon kirjapaino Oy.

Hoaken P (1986) Psychiatry, Civil Liberty, and Involuntary Treatment. Can J Psychiatry 31: 222-226.

Hoge SK, Appelbaum PS & Greer A (1989) An empirical comparison of the Stone and dangerousness criteria for civil commitment. Am J Psychiatry 146: 170–175.

Holstein J (1988) Court ordered incompetence: Conversational Organization in Involuntary Commitment Hearings. Social Problems 35: 458-473.

Hoye A, Hansen V & Olstad R (2000) First admission schizophrenic patients in northern Norway, 1980-95: Sex differences in diagnostic practice. Nord J Psychiatry 54: 319-25.

Höyer G (1988) Grounds for involuntary hospitalisation according to the opinion of Norwegian psychiatrists. Int J Law Psychiatry 11: 289-303.

Höyer G & Drange H (1991) Bruk av tvangsmidler i norske psykiatriske institusjoner. Tisskr Nor Laegeforen 111: 1709-13.

Höyer G & Drange H (1994) Utviklingen av tvangsmidlerbruk i norske psykiatriske institusjoner. Tisskr Nor Laegeforen 114: 585- 8.
Höyer G (1999) Clients' perception of coercion: a research perspective. Research in Community and Mental Health 10: 101-121.
http://www.healthy.net/asp/templates/article.asp?PageType=Article
http://www.mdx.ac.uk/www/study/mhhtim.htm
http://www.pmh.info/historian%20merkkipaaluja.pdf
http://ec.europa.eu/health/ph_information/dissemination/echi/echi_4_en.print.htm
Ineichen B, Harrison G & Morgan G (1984) Psychiatric hospital admissions in Bristol I. Geographical and ethnic factors. Br J Psychiatry 145: 600-604.
Isohanni M, Mäkikyrö T, Moring J, Räsänen P, Hakko H, Partanen U, Koiranen M & Jones P (1997) A comparison of clinical and research DSM-III-R diagnoses of schizophrenia in a Finnish national birth cohort. Social Psych Psychiatr Epidemiology 32: 303-308.
Jenkins R, Bebbington P, Brugha T, Farrel M, Gill B, Lewis G, Melzer H & Petticrew M. (1997) The national psychiatric morbidity surveys of Great Britain – strategy and methods. Psychol Med 27: 765-774.
Johnson D (1997) Factors in the continuance and discontinuance of Seclusion in a Special Hospital http://www.fnrh.freeserve.co.uk/report2.html
Johnston I & Taylor PJ (2003) Mental disorder and serious violence: the victims. J Clin Psychiatry 64(7): 819-24.
Kaila M (1966) Psykiatrian historia lääketieteen yleiskehityksen ja kulttuurihistorian valossa. Werner Söderström osakeyhtiön kirjapaino, Porvoo.
Kaivosoja M (1996) Pakko auttaa. Sosiaali- ja terveysministeriön julkaisuja. Sosiaali- ja terveysministeriö, Helsinki.
Kaltiala-Heino R & Salokangas R (1990) Potilaiden kokemukset tahdosta riippumattomasta psykiatrisesta hoidosta. Suom Lääkäril 28: 2446-2453.
Kaltiala-Heino R (1995) Involuntary psychiatric hospitalization. Academic dissertation. Acta Universitas Tamperensis ser A vol 466. Vammalan kirjapaino, Vammala.
Kaltiala-Heino R, Salokangas R & Laippala P (1997) Impact of coercion on treatment outcome. Int J Law Psychiatry 20: 311-322.
Kaltiala-Heino R (1999) Eristys ja lepositeet psykiatrisessa hoidossa. Mielen valtaa, psykiatrian lukemisto. Toim. Ilkka Taipale. WSOY – Kirjapainoyksikkö, Juva, 1999. (A)
Kaltiala-Heino R (1999) Methodological issues in measuring coercion in psychiatric care. In: Morrissey J & Monahan J (eds) Research in community and Mental Health vol 10. Coercion in Mental Health Services. Stanford, Connecticut. JAI Press. (B)
Kaltiala-Heino R, Korkeila J, Tuohimäki C, Tuori T & Lehtinen V (2000) Coercion and restrictions in psychiatry inpatient treatment. Eur Psychiatry 15: 213-9.
Kaltiala-Heino R, Välimäki M, Korkeila J, Tuohimäki C & Lehtinen V (2003) Involuntary medication in psychiatry inpatient treatment. Eur Psychiatry 15: 213-9.
Karapuu H (1999) Right to Employment and Freedom of Livelihood. In Hallberg P, Karapuu H, Scheinin M, Tuori K & Viljanen V. Basic Rights. Juva 1999.

Karrstrom JM (1986) Psychiatry, compulsion and legal security: A report from the social affairs commission in Sweden. Int J Law Psychiatry 8: 327-33.

Kasper J, Hoge S, Feucht-Haviar T, Cortina J & Cohen B (1997) Prospective study of patients' refusal of antipsychotic medication under a physician discretion review procedure. Am J Psychiatry 154(4): 483-9.

Keskimäki I & Aro S (1991) The accuracy of data on diagnoses, procedures and accidents in the Finnish Hospital Discharge Register. International Journal of Health Sciences 2: 15-21.

Keiland V, Lassenius B & Östman O (1983) Den psykiatriska tvångsvården på kraftig tillbakagång. Läkartidningen 80: 4749-4751.

Kessen C (1997) Emergency commitment and legislative reform in New Jersey. Am J Orthopsychiatry 67(1): 123-133.

Kirjavainen H (1996) Moraali, motivaatio ja yhteiskunta. Kirjakas/RT-paino, Pieksämäki.

Kjellin L (1997) Compulsory psychiatric care in Sweden 1979-1993. Social Psych Psychiatr Epidemiol 32: 90-96.

Kjellin L & Nilstun T (1993) Medical and social paternalism. Regulation of and attitudes towards compulsory psychiatric care. Acta Psych Scand 88(6): 415-419.

Kjellin L, Westrin C-G & Eriksson K (1993) Coercion in Psychiatric Care: Problems of Medical Ethics in a Comprehensive Empirical Study. Behavioral Sciences and the Law 11: 323-334.

Kjellin L & Westrin CG (1998) Involuntary admissions and coercive measures in psychiatric care. Registered and reported. Int J Law Psychiatry 21(1): 31-42.

Klinge V (1994) Staff opinions about seclusion and restraint at a state forensic hospital. Hosp Comm Psychiatry 45(2): 138-41.

Koffman J, Fulop N, Pashley D & Coleman K (1997) Ethnicity and use of acute psychiatric beds: one-day survey in north and south Thames regions. Br J Psychiatry 171: 238-41.

Korkeila J. (1998).Perspectives on the public psychiatric services in Finland. Evaluating the deinstitutionalisation process. Research report 93, STAKES. Gummerus printing, Jyväskylä 1998.

Koskinen L (1995) Mikä on oikein. Etiikan käsikirja. Suom. Torsti Lehtinen. Helsinki, Lasten keskus.

Kumakura N (1994) The patient as “subject” and capacity to give informed consent. Jpn J psychiatry neurol 48(suppl): 45-51.

Lääkärin etiikka (2005) Editor: Saarni Samuli. Suomen Lääkäriliitto. ISBN 951-9433-49-x. Punamusta OY, Joensuu.

Lamb HR & Mill MJ (1986) Needed changes in Law and procedure for the chronically mentally ill. Hosp Comm Psychiatry 37: 475-480.

Lecompte D (1995) The paradoxical increase in involuntary admission after the revision of the Civil Commitment Law in Belgium. Medicine and Law 14: 53-57.

Lehtinen V, Veijola J, Lindholm T & Väisänen E (1991a): Childhood and primary family - related determinants of good mental health. Results from the longitudinal UKKI study in Finland. In Psychiatric Disorders in the Social Domain. Contributions to a Scientific Basis for Understanding and Action Edited by: Sorensen T, Abrahamsen P & Torgersen S. Oslo: Norwegian University Press: 141-149.

Lehtinen V, Lindholm T, Veijola J, Väisänen E & Puukka P (1991b) Stability of prevalences of mental disorders in a normal population cohort followed for 16 years. Soc Psych Psychiatr epidemiol. 26(1): 40-6.

Lidz CW, Hoge SK, Gardner W, Bennet NS, Monahan J, Mulvey EP & Roth LH (1995) Perceived coercion in mental hospital admission. Pressures and process. Arch Gen Psychiatry 52: 1034-39.

Lidz C, Mulvey E, Hoge S, Kirch B, Monahan J, Bennet N, Eisenberg M, Gardner W & Roth L (1997) The validity of mental patients' accounts of coercion-related behaviors in the hospital admission process. Law Hum Beh 21(4): 361-76.

Link B, Phelan J, Bresnahan M, Stueve A & Pescosolido B (1999) Public conceptions of mental illness: labels, causes, dangerousness, and social distance. Am J Public Health 89(9): 1328-33.

Lundy H & McGuffin P (2005) Using dance/movement therapy to augment the effectiveness of therapeutic holding with children. J Child Adolesc Psychiatr Nurs 18(3): 135-45.

Malcolm LA (1989) Decentralisation trends in the management of New Zealand's health services. Health Policy 12(3): 285-99.

Malla A & Norman R (1988) Involuntary Admissions in a Canadian province: the influence of geographic and population factors. Social Psych Psychiatr Epidemiology 23: 247-251.

McKenna B., Simpson A., and Laidlaw T (1999). Patient perception of coercion on admission to acute psychiatric services. The New Zealand experiences. Int J Law Psychiatry 22 (2): 143-153.

Mental Health History Timeline, 2005. http://www.mentalhealth.org.uk/page.cfm?pagecode=IZTL

Mill J (1917) On Liberty. Bernhard Tauchnitz, Leipzig

Miller RD (1978) Voluntary "involuntary" commitment the briar-patch syndrome. Bull Am Acad Psych and Law 8: 305-312.

Miller RD (1991) Law, Psychiatry and Rights. Medicine and Law 10: 327-333.

Mills M (1988) Civil commitment. Arch Gen Psychiatry 45: 770-772.

Monahan J, Hoge S, Lidz C, Roth L, Bennet N, Gardner W & Mulvey E (1995) Coercion and commitment: understanding involuntary mental hospital admission. Int J Law Psychiatry 18: 1-15.

Monahan J, Hoge S, Lidz C, Eisenberg M, Bennet N, Gardner W & Roth L (1996) Coercion to inpatient treatment: initial results and implications for assertive treatment in the community. In D.L. Dennis and J. Monahan (Eds.), Coercion and aggressive community treatment: a new frontier in mental health law: 13-28. New York, Plenum.

Narrow WE, Rae DS, Robins LN & Regier DA (2002) Revised prevalence estimates of mental disorders in the United States: using a clinical significance criterion to reconcile 2 surveys' estimates. Arch Gen Psychiatry 59(2): 115-23.

Nicholson RA (1988) Characteristics associated with change in the legal status of involuntary psychiatric patients. Hosp Comm Psychiatry 39: 424 -429.

Okin R (1985) Variation among state hospitals in use of seclusion and restraint. Hosp Comm Psychiatry 36: 648-51.

Okin R (1986) The relationship between legal status and patient characteristics in state hospitals. Am J Psychiatry 143(10): 1233-7.

Olsen D (1998) Toward an ethical standard for coerced mental health treatment: least restrictive or more therapeutic? J Clin ethics 9(3): 235-246.

Overall J (1974) The brief psychiatric rating scale in pharmacological research. In: Pichot P (Ed) Modern problems of psychopharmacopsychiatry: 67-78. Basel: Karger.

Pahlman Irma (2003) Potilaan itsemääräämisoikeus. Edita Prima Oy, Helsinki 2003.

Palmer B, Dunn L, Appelbaum P, Mudaliar S, Thal L, Henry R, Golshan S & Jeste D (2005) Assessment of capacity to consent to research among older persons with schizophrenia, Alzheimer disease, or diabetes mellitus. Arch Gen Psychiatry 62: 726-733.

Persson R, Ohrt T, Hogner U, Sjödin I d'Elia G & Thorell L-H (1988) Psykiatrisk tvångsvård – konverterade och icke-konverterade patienters attityder. Läkartidningen 85: 2535-2537.

Perälä J, Suvisaari J,Saarni S, Kuoppasalmi K, Isometsä E, Pirkola S, Partonen T, Tuulio-Henriksson A, Hintikka J, Kieseppä T, Harkanen T, Koskinen S & Lönnqvist J (2007) Lifetime prevalence of psychotic and bipolar I disorders in a general population. Arch Gen Psychiatry 64(1): 14-6.

Phelan JC & Link BG (1998) The growing belief that people with mental illnesses are violent: the role of the dangerousness criterion for civil commitment. Soc Psych Psychiatr epidemiol 33(suppl 1): 7-12.

Pierce G, Durham M & Fisher W (1985) The impact of broadened civil commitment standards on admission to state mental hospitals. Am J Psychiatry 142: 104-107.

Pilgrim D & Rogers A (1999) A sociology of mental health and illness. Second edition. Open university press, Buckingham and Philadelphia.

Poikolainen K (1983) Accuracy of hospital discharge data: five alcohol-related diseases. Drug and Alcohol Dependence 12: 315-322.

Poulsen H (1999) Perceived coercion amond committed, detained and voluntary patients. Int J Law Psychiatry 22 (2): 167-75.

Rain SD, Williams VF, Robbins PC, Monahan J, Steadman HJ & Vesselinov R (2003) Perceived Coercion at Hospital Admission and Adherence to Mental Health Treatment After Discharge. Psychiatr Serv 54: 103-105.

Ray N & Rappaport M (1995) Use of restraint and seclusion in psychiatric settings in New York State. Psychiatr Serv 46(10): 1032-7.

Reed J (1997) Risk assessment and clinical risk management: the lessons from recent inquiries. Br J Psychiatry Suppl 32: 4-7.

Reisby N (1983) Registrering af tvangsanvendelse. Ugeskr Laeger 145: 1801-5.
Reiser S. (1980) Refusing treatment for mental illness: historical and ethical dimensions. Am J Psychiatry 137: 329-331.
Riecher A, Rössler W, Löffler W & Fätkenheuer B (1991) Factors influencing compulsory admission of psychiatric patients. Psychol Med 21: 197-208.
Riecher-Rossler A & Rossler W (1993) Compulsory admission of psychiatric patients: An international comparison. Acta Psych Scand 87: 231-36.
Robertson L & MacCreadie R (1991) Admission rates, detention rates and socioeconomic deprivation Br J Psychiatry 159: 733-734.
Rogers A, Pilgrim D & Lacey (1993) Experiencing psychiatry: Users' views of services. London: Macmillan.
Rollin H (2003) Psychiatry in Britain one hundred years ago. Br J Psychiatry 183: 292-298.
Rosenhan D (1973) On being sane in insane places. Science 179: 250-258.
Rössler W, Salize H, van Os J & Rieher-Rössler A (2005) Size of burden of schizophrenia and psychotic disorders. Eur Neuropsychopharmacology (15)4: 399-409.
Roth LH (1989) Four studies of mental health commitment.Am J Psychiatry 146(2): 135-7.
Rowlands RP (2001) Auditing first episode psychosis: giving meaning to clinical governance. Int J Clin Pract 55(10): 669-72
Saarinen E (1985) Länsimaisen filosofian historia huipulta huipulle Sokrateesta Marxiin, Werner Söderström Osakeyhtiö, Helsinki.
Sailas E (1999) Seclusion and restraint in psychiatric care. Psych Fennica 30: 205–13.
Sailas E & Fenton M (2000) Seclusion and restraint for people with serious mental illnesses. Cochrane Database Syst Rev.2:CD001163.
Salize H & Dressing H (2004) Epidemiology of involuntary placement of mentally ill people across the European Union. Br J Psychiatry 184: 163-168.
Salokangas R (1997) Psykoosien hoidon haasteet 2000-luvun suomessa. Psykoosi ja sen hoito, editors. Achte K & Tamminen T. ISBN 951-9221-83-2. Gummerus Kirjapaino Oy, Jyväskylä. 274-285.
Salokangas RKR, Stengård E, Honkonen T, Koivisto A-M & Saarinen S (2000) Sairaalasta yhteiskuntaan. Seurantatutkimus sairaalasta kotiuttamisen vaikutuksista skitsofreniapotilaan elämään ja hoitotilanteeseen, Stakes, Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskus. Raportteja 248, Saarijärvi.
Salo M (1996) Sietämisestä Solidaarisuuteen. Mielisairaalareformit Italiassa ja Suomessa. Vastapaino, Tampere.
Sanguineti VR, Samuel SE, Schwartz SL and Robeson MR (1996) Retrospective study of 2,200 involuntary psychiatric admissions and readmissions. Am J Psychiatry 153(3): 392-6.
Sariola E & Ojanen M (1997) Hoito vai pakkohoito, miten autan skitsofreniapotilasta. Kustannusosakeyhtiö Otava, Helsinki. Otavan kirjapaino, Keuruu.
Sarkar SP & Adshead G (2003) Protecting altruism: a call for a code of ethics in British psychiatry. Br J Psychiatry 183: 95-7.
Sarvilinna A (1938) Mielisairaanhoidon kehityksestä Suomessa vuoteen 1919. Yliopistollinen väitöskirja. Vakka-Suomen Kirjapaino, Uusikaupunki.

Scheff T (1974) The labelling theory of mental illness. Am Sociol Review 39: 442-452.
Schepelern E, Aggernaes K, Stender A & Raben H (1993) Tvang utfört på psykiatrisk afdelning, Fredriksberg Hospital, för og erter indförelse af den nye psykiatrilov. Ugeskr Laeger 155: 553-7.
Schröder P & Christensen N (1992) Tvang i psykiatrien. Ugeskr Laeger 154: 1826-30.
Scull A (1984) Decarceration, (2nd edn), Polity Press, London.
Segal S (1989) Civil commitment standards and patient mix in England/Wales, Italy and the United States. Am J Psychiatry 146: 187-193.
Sestoft D & Engberg M (2000) Law and mental health in Denmark. Int J Law Psychiatry 23: 533-540.
Shorter E (2005) Psykiatrian historia. ISBN 952-5154-57-2. Hakapaino, Helsinki.
Silverman, David (Ed.) (1997) Towards an Aesthetics of Research. In Qualitative Research. Theory, Method and Practice. SAGE Publications, London-Thousand Oaks-New Delhi.
Simonsen E (1992) Compulsory admission for treatment--an interview study of patients. 2. Rights, guardianship and attitudes to commitment. Ugeskr Laeger 154 (26): 1835-8.
Sjostedt G & Langstrom N (2001) Acturial assessment of sex offender recidivism risk: a cross-validation of the RRASOR and the Static-99 in Sweden. Law Hum Behav 25(6): 629-45.
Slobogin C (1994) Involuntary community treatment of people who are violent and mentally ill: A legal analysis. Hosp Comm Psychiatry (45)7: 685-689.
Soloff P, Gutheil T & Wexler D (1985) Seclusion and restraint in 1985: a review and update. Hosp Comm Psychiatry 36: 652-7.
Soloff P & Turner S (1981) Patterns of seclusion. A prospective study. J Nerv Ment Dis 269: 37-44.
Soothill K, Adserballe H, Bernheim J, Dasananjali T, Harding T, Pinto Ribeiro R, Reinhold F & Soueif M (1981 a) Social control of deviants in six countries. Medicine, Science Law 21: 31-40.
Soothill K, Harding T, Adserballe H, Bernheim J, Erne S, Magdi S, Panpreecha C & Reinhold F (1981 b) Compulsory admissions to mental hospitals in six countries. Int J Law Psychiatry 4: 327-344.
Soothill K, Kupituksa P & MacMillan F (1990 a). Compulsory hospital admissions: dangerous decisions? Medicine Science Law 30: 17-25.
Soothill K, Kupituksa P, Badiani D & MacMillan F (1990 b) Compulsory admissions to mental hospitals. A replication study. Int J Law Psychiatry 13: 179-190.
Spence N, Goldney R & Costain W (1988) Attitudes towards psychiatric hospitalisation: a comparison of involuntary and voluntary patients. Australian Clinical review: 108-116.
Spengler A & Böhme K (1989) Epidemiologic aspects of the psychiatric management of immediate commitment. Nervenarzt.60(4):226-32.
Stastny P (2000) Involuntary psychiatric interventions: a breach of the Hippocratic oath? Ethical Hum Sci Serv 2(1): 21-41.

Steadman H, Mulvey E, Monahan J, Robbins P, Appelbaum P, Grisso T, Roth L & Silver E (1998) Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry 55(5): 393-401.

Stender AK & Aggernaes KH (1992) Compulsory admissions at the Frederiksberg hospital during the period 1 November 1987 to 30 September 1989. 2. Patients' assessment and experiences of the admissions. Ugeskr Laeger 22; 154(26): 1844-7.

Sulkunen P (1999) Johdatus sosiologiaan – käsitteitä ja näkökulmia.2.painos. ISBN 951-0-22285-2. WSOY, Juva.

Suvisaari J, Haukka J, Tanskanen A & Lönnqvist J (1999) Decline in the incidence of schizophrenia in Finnish cohorts born from 1954 to 1965. Arch Gen Psychiatry 56: 733-740.

Swanson JW, Swartz MS, Essock SM, Osher FC, Wagner HR, Goodman LA, Rosenberg SD & Meador KG (2002) The social-environmental context of violent behavior in persons treated for severe mental illness. Am J Public Health 92(9): 1523-31.

Swett C (1994) Inpatient seclusion: desription and causes. Bull Am Acad Psychiatry Law 22: 421-30.

Sytema S (1991) Social indicators and psychiatric admission rates: a case register study in the Netherlands. Psychol Medicine 21: 177-184.

Szasz T (2001) Mental illness: psychiatry's phlogiston. Med Ethics 27(5): 297-301.

Szasz T (2003) The psychiatric protection order for the "battered mental patient". Br Med J 327: 1449-1451.

Szmukler G, Bird A & Button E (1981) Compulsory admissions in a London borough: I. Social and clinical features and a follow-up. Psychol Med 11(3): 617-36.

Taiminen T, Ranta K, Karlsson H, Lauerma H, Leinonen K, Wallenius E, Kaljonen A & Salokangas RK (2001) Comparison of clinical and best-estimate research DSM-IV diagnoses in a Finnish sample of first-admission psychosis and severe affective disorder. Nord J Psychiatry 55(2): 107-11.

Tannsjo T (2004) The convention on human rights and biomedicine and the use of coercion in psychiatry. J Med Ethics 30(5): 430-4.

Templin L, McClelland G, Abram K & Weiner D (2005) Crime victimization in adults with severe mental illness: comparison with the National Crime Victimization Survey. Arch Gen Psychiatry 62(8): 911-21.

Teplin L, Abram K, McClelland G, Dulcan M & Mericle A (2002) Psychiatric Disorders in Youth in Juvenile Detention. Arch Gen Psychiatry 59: 1133-1143.

Thompson P (1986) The use of seclusion in psychiatric hospitals in the Newcastle area. Br J Psychiatry 149: 471-4.

Thornigroft G, Bebbington P & Leff J (1989) Outcomes for Long-Term Patients One Year After Discharge From a Psychiatric Hospital. Psychiatr Serv 56: 1416-1422.

Tiihonen J, Hakola P & Eronen M (1995) Homicidal behaviour and mental disorders. Br J Psychiatry 167(6): 821

Toews J, El-Guebaly N & Leckie A (1981) Patients' reactions to their commitment. Can J Psychiatry 26: 251-4.

Toews J, El-Guebaly N, Leckie A & Harper (1986) Change with time in patients' reactions to committal. Can J Psychiatry 31: 413-5.
Terveydenhuollon yhteinen arvopohja, yhteiset tavoitteet ja periaatteet. ETENE-julkaisuja: no 1, 2001. ISBN 952-00-1076-9.
Turunen S & Achté K (1976) Seili hospital in 1619-1962. Psych Fennica: 13-20.
Vaillant G (2003) Mental health. Am J Psychiatry 160(8): 1373-1384.
Välimäki M & Leino-Kilpi H (1998) Preconditions for and consequences of self-determination: the psychiatric patient's point of view**.** J Adv Nurs 27: 204.
Vartiainen H, Vuorio O, Halonen P & Hakola P (1995) The patients' opinions about curative factors in involuntary treatment. Acta Psych Scand 91(3): 163-6.
Vestergaard J (1994) The Danish mental health act of 1989: Psychiatric direction and the new legalism. Int J Law Psychiatry 17: 191-210.
Vuori H (1979) Lääketieteen historia. ISBN 951-20-1790-1. Gummerus, Jyväskylä.
Wand C & Klimowski A (1998) Kant vasta-alkaville ja edistyville. ISBN 951-887-141-8. Kustannus OY Jalava. Helsinki.
Walsh E & Randell B (1995) Seclusion and restraint: What do we need to know? J Comm Psychiatr Nurs 8: 28-40.
Walsh E, Moran P, Scott C, McKenzie K, Burns T, Creed F, Tyrer P, Murray R & Fahy T (2003) Prevalence of violent victimisation in severe mental illness. Br J Psychiatry 183: 233-238.
Way B & Banks S (1990) Use of seclusion and restraint in public psychiatric hospitals: patient characteristics and facility effects. Hosp Comm Psychiatry 41: 75-81.
Westrin CG, Kjellin L, Axelsson-Östman M, Candefjord I, Ekblom B, Johansson K, Knorring L, Lindström E, Lindström L, Nordström M, Palmstierna T, Wallsten T & Ängfors G (1994) Större respekt för anhöriga. Läkartidningen 91: 129-132.
White Paper of EU-committee (2000) http://www.ijic.org/docs/psychiatry.pdf#search=%22white%20paper%20psychiatry%22
WHO: Resource Book on Mental Health, Human Rights and Legislation (2005). ISBN 92 4 156282 X. China.
Wirshing D, Wirsching W, Marder S, Liberman R & Mintz J (1998) Informed consent: assessment of comprehension. Am J Psychiatry 155: 1508-1511.
Wittchen HU & Jacobi F (2005) Size and burden of mental disorders in Europe – a critical review and appraisal of 27 studies. Eur Neuropsychopharmacology (15)4: 357-376.
Yesavage J (1984) A study of mandatory review of civil commitment. Arch Gen Psychiatry 41(3): 305-8.
Yhtenäisen kiireettömän hoidon perusteet. Sosiaali- ja terveysministeriö. Oppaita 2005:5. ISBN 952-00-1654-6. Yliopistopaino. Helsinki
Zaubler T, Viederman M & Fins J (1996) Ethical, legal, and psychiatric issues in capacity competency, and informed consent: An annotated bibliography. Gen Hosp Psychiatry 18: 155-172.

Appendix 1

Perushaastattelu

Taso 3: Pakon käyttö potilaan kokemana

Taustatiedot Oulu

1. Numero 2:3:__:__:__:
2. Nauhurin käyttö
    1. Kyllä
    2. Ei
3. Tulopäivä :__:__:__:__:__:__:
4. Ikä :__:__:
5. Sukupuoli :__:
    1. nainen
    2. mies

KL 1 ammatti ____________

koulutus ____________

siviilisääty :__:

1. naimisissa
2. avoliitossa
3. naimaton
4. eronnut
5. leski

6. Sairaala :__:

1. TAYS
2. TYS
3. Turun kaupunginsairaala
4. Oulun yliopistollinen sairaala

7. Osasto :__:__:__:__:
8. Osaston koko (paikkojen lukumäärä) :__:__:
9. Osastotyyppi a) :__:
    1. akuutti
    2. pitkäaikais
    3. sekä akuutti että pitkäaikais
    4. oikeuspsykiatrinen (akuutti/pitkäaikais)
    5. muu
10. Osastotyyppi b) :__:
    1. avo
    2. suljettu
    3. sekamuotoinen

11-15. Lääkitys haastattelupäivänä (1=kyllä, 2=ei) Kirjaa viivoille lääkitys:

11. neuroleptit	1	2	________________________
12. antidepressantit	1	2	________________________
13. anksiolyytit	1	2	________________________
14. unilääkkeet	1	2	________________________
15. muut	1	2	________________________

jälkikäteen koodataan lääkitys vertailukelpoisina annoksina

neuroleptiannos ________________________

antidepressanttiannos ______________________

bentsodiatsepiiniannos _______________________

unilääkeannos ____________________________

16. Maa :__:

D F I N S

Haastatteluosa:

17. Milloin tulit sairaalaan tälle hoitojaksolle?

____ päivää sitten tai päivänmäärä :__:__:__:__:__:__:

en osaa sanoa = 999999

ei vastausta = 000000

18. Tulitko yksin vai oliko joku saattamassa? :__:

1. yksin
2. joku saattamassa
9. en osaa sanoa
0. ei vastausta

jos tuli yksin, hyppää kohtaan 20.

19. Kuka oli saattamassa sinua? :__:

vapaa vastaus, valitse oikea(t)

1. tulin yksin
2. omainen
3. poliisi
4. ystävä(t), naapuri(t), työtoveri(t)
5. oma terapeutti, muu terveydenhuollon työntekijä, sosiaalityöntekijä
6. joku muu

7. useampi edellä mainituista
9. en osaa sanoa
0. ei vastausta
huom ___________________________________

20. Oliko sinun vai jonkun muun ajatus, että tulisit nyt sairaalaan? :__:
1. kokonaan minun
2. kokonaan muiden
3. sekä minun että muiden
9. en osaa sanoa
0. ei vastausta
huom ___________________________________
jos oli kokonaan potilaan idea, hyppää kohtaan 23

21. (jos muiden) Keitä nuo muut olivat, joiden ajatus tämä sairaalahoitosi oli? :__:
1. lähiomainen (puoliso/lapset/vanhemmat)
2. muu sukulainen
3. poliisi
4. ystävä(t), naapuri(t), työtoveri(t)
5. oma terapeutti, muu terveydenhuollon työntekijä, sosiaalityöntekijä
6. joku muu
7. ei relevantti (kys. 20 vastaus 1= kokonaan minun ajatus)
8. useampi edellä mainituista
9. en osaa sanoa
0. ei vastausta
huom ___________________________________

22. Vaikka toiset olivatkin aloitteentekijöinä sairaalaan tulossasi, olitko itse samaa mieltä, että sinun pitäisi tulla? :__:
1. kyllä
2. en
3. ei relevantti (tulo oli potilaan idea)
9. en osaa sanoa
0. ei vastausta
huom ___________________________________

23. Oletko siis nyt tullut sairaalaan vapaaehtoisesti vai pakolla? :__:

1. tahdosta riippumatta, pakolla
2. vapaaehtoisesti, omasta tahdosta
9. en osaa sanoa
0. ei vastausta

huom ____

24. (Jos muut ehdottivat sairaalahoitoa) Sanoivatko (mainitse edellä nimetyt henkilöt) sinulle, miksi sinun piti tulla sairaalaan? :__:

1. kyllä
2. ei
3. ei relevantti (tulo oli kokonaan potilaan idea)
9. en osaa sanoa
0. ei vastausta

Minkä he sanoivat syyksi?

____

____

25. Mikä on oma mielipiteesi? Miksi tulit tälle sairaalahoitojaksolle?

____

____

____

26. Oliko tarpeen tulla sairaalaan? :__:

1. kyllä
2. ei
9. en osaa sanoa
0. ei vastausta

27. A) olisitko mieluummin halunnut jotain muuta hoitoa? :__:

1. kyllä (mene kohtaan 27 B)
2. en (mene kohtaan 27 C)
9. en osaa sanoa
0. ei vastausta

B) (Jos piti muuta hoitoa parempana) Mitä muuta hoitoa olisit mieluummin halunnut? :__:

1. avohoidon yksilöterapiaa
2. lääkitystä avohoidossa
3. sairauslomaa
4. tukea perheeltä
5. tukea yhteiskunnalta ja viranomaisilta
6. jotain muuta (mitä?____________)
7. useampaa edellä mainituista
8. ei relevantti (kohdassa 27 A vastaus EN)
9. en osaa sanoa
0. ei vastausta

C) (Jos EI kohdassa 27 A) Eli onko niin, ettet olisi tarvinnut mitään hoitoa, vai niin, että sairaala oli sinusta hyvä vaihtoehto? :__:

1. en tarvinnut mitään hoitoa
2. sairaala oli paras vaihtoehto
8. ei relevantti (kohdassa 27 A vastaus KYLLÄ)
9. en osaa sanoa
0. ei vastausta

28. Onko ihmisarvoasi loukattu sairaalaan tulon yhteydessä? :__:

1. kyllä
2. ei
9. en osaa sanoa
0. ei vastausta

29. Oletko ensimmäistä kertaa psykiatrisessa sairaalahoidossa? :__:

1. kyllä, ensimm. kertaa tässä tai muussa psyk. sairaalassa
2. ensimmäistä kertaa täällä, mutta aiemmin hoidettu muussa psyk. sairaalassa
3. olen ollut täällä ennenkin
9. en osaa sanoa
0. ei vastausta

30. (Jos ollut ennekin hoidossa) Oletko aikaisemmilla hoitokerroillasi koskaan ollut pakkohoidossa? :__:

(tätä kertaa ei siis lasketa tässä, vaikka olisi tahdosta riippumaton)

1. on ollut ainakin kerran tahdosta riippumattomassa hoidossa
2. ollut vain vapaaehtoisessa hoidossa
8. ei relevantti (potilas ei aiemmin ole ollut psyk. sairaalahoidossa)
9. en osaa sanoa
0. ei vastausta

31. Haluaisitko lähteä sairaalasta pois nyt? :__:

1. kyllä
2. en
9. en osaa sanoa
0. ei vastausta

32. A) Vaikka nyt haluatkin vielä olla sairaalassa / Haluaisit siis lähteä pois nyt (valitse oikea aloitus edell. vastauksen mukaan) onko sinulla mahdollisuus lähteä milloin haluat vai onko kysyttävä lupa jostakin? :__:

1. voin lopettaa sairaalahoidon koska haluan
2. minun on kysyttävä lupa (mene kohtaan 32 B)
9. en osaa sanoa
0. ei vastausta

B) Sinun siis pitäisi pyytää lupa. Tarkoitatko, että et saa päättää hoidon lopettamisesta itse vai että vaikka päätätkin itse, olisi toki hyvä sopia asiasta? :__:

1. päätösvalta on minulla
2. päätösvalta on muilla
3. irrelevantti kysymys (vastasi A-kohdassa, ettei tarvitse kysyä lupaa)
9. en osaa sanoa
0. ei vastausta

33. Oletko siis nyt hoidossa vapaaehtoisesti vai tahdostasi riippumatta? :__:

1. olen pakkohoidossa, tahdosta riippumatta
2. olen vapaaehtoisessa hoidossa
3. epävarma
0. ei vastausta

huom ____

34. Onko vapauttasi rajoitettu tällä hoitojaksolla, esim. oletko ollut ilman vapaakävelyä tai muuta vastaavaa? :__:

1. kyllä
2. ei
9. en osaa sanoa
0. ei vastausta

35. Kun nyt ajattelet tilannettasi, oliko sairaalaan tulo oikea ratkaisu? :__:

1. kyllä
2. ei
9. en osaa sanoa
0. ei vastausta

36. Monenlaiset asiat vaikuttavat siihen, että joku tulee potilaaksi psykiatriseen sairaalaan. Joskus potilaaseen kohdistuu painetta valita tämä ratkaisu, tai hänet jopa fyysisesti pakotetaan sairaalaan, kun taas toisinaan potilas hakeutuu sairaalaan täysin omasta aloitteestaan ja halustaan.
Toivon sinun nyt miettivän omaa tuloasi tälle hoitojaksolle: tulitko kokonaan omasta toivomuksesestasi vai vaikuttiko tuloosi pakko, uhka, taivuttelu tai ylipuhuminen. Merkitse alla olevaan tikapuukuvioon, missä määrin sinusta tuntuu, että tulit sairaalaan omasta tahdostasi tai pakolla. Esim. jos tulit täysin omasta halustasi, laita merkki ykkösen kohdalle, jos taas sinut pakotettiin, merkitse 10.:__:

10 Minut pakotettiin tulemaan vastoin omaa tahtoani
9
8
7
6
5
4
3
2
1 Tulin täysin omasta halustani

Lopuksi luen sinulle neljä väittämää. Mieti niitä suhteessa omaan tuloosi tälle sairaalahoitojaksolle. tuntuvatko ne olevan tosia sinun tilanteessasi? Pyydän sinua vastaamaan jokaiseen erikseen, vaikka ne saattavatkin kuulostaa samanlaisilta.
1=kyllä
0=ei

37. Minulla oli mahdollisuus sanoa, halusinko tulla sairaalaan	1	0
38. Sain sanoa mielipiteeni sairaalaantulosta	1	0
39. Kukaan ei näyttänyt haluavan tietää, halusinko minä tulla sairaalaan	1	0
40. Minun mielipiteelläni sairaantulosta ei ollut väliä	1	0

Huom! Väitteistä 37–40 on olemassa Ruotsissa validoidut kysymysversiot. Ellei haastateltava potilas pysty hahmottamaan näitä kohtia väitteinä, voit käyttää väitteiden sijasta kysymyksiä. KYSYMYKSET OVAT KUITENKIN TOISSIJAINEN VAIHTOEHTO.

37. Oliko sinulla mahdollisuus sanoa, halusitko tulla sairaalaan?	1	0
38. Saitko sanoa mielipiteesi sairaalaan tulosta?	1	0
39. Haluavatko toiset tietää sinun mielipiteesi sairaalaan tulosta?	1	0
40. Kuunneltiinko sinun mielipidettäsi sairaalaan tulosta?	1	0

Haastattelun päivänmäärä
:__:__:__:__:__:__:

Appendix 2

Taso 2: Pakon käytön rekisteröinnin validiteetti ja reliabiliteetti; pakon käytön vertailu Pohjoismaiden välillä

3. Numero 2:3:__:__:__:
4. Sairaala :__:

1. TAYS
2. TYS
3. Turun kaupunginsairaala
4. Oulun yliopistollinen sairaala

3. Syntymäaika (vv,kk,pp) :__:__:__:__:__:__:
   (huomaa, että tässä eri merkitsemistapa kuin haastattelussa)

4. Sukupuoli :__:

1.mies
2. nainen

KL 0 ammatti ____________
koulutus ____________
Sosiaaliryhmä :__:
(täytetään jälkikäteen ja laitetaan sitä varten nyt ylös ammatti ja koulutus, sikäli kun sairaskertomuksesta ilmenee)

siviilisääty :__:

6. naimisissa
7. avoliitossa
8. naimaton
9. eronnut
10. leski

5. Psykiatriset diagnoosit. (sairauskertomuksesta, uloskirjoitusdg tai dg:t 6 kk hoidon kohdalla)

:__:__:__:__:
:__:__:__:__:
:__:__:__:__:
:__:__:__:__:

6. Päädiagnoosi (sairauskertomuksesta, uloskirjoitusdg tai dg:t 6 kk hoidon kohdalla – tutkijat määrittävät, mikä diagnooseista oli päädiagnoosi; vakavin tähän hoitokertaan johtanut tila)

:__:__:__:__:

7. Lähetteen päivänmäärä (vv,kk,pp) :__:__:__:__:__:__:
8. Sisäänkirjoituspäivä (vv,kk,pp) :__:__:__:__:__:__:
9. Uloskirjoituspäivä (vv,kk,pp) :__:__:__:__:__:__:

10. Lähettäjä :__:__:

1. terveyskeskus tai ei-psykiatrinen yksityisvastaanotto
2. psykiatri tai vastaava (MTT:n lääkäri, ylioppilaiden mielenterveyspalveluiden lääkäri, yksityisen psykiatrikeskuksen lääkäri)
3. muu ammattilainen psykiatrian alalta (psykologi, sosiaalityöntekijä…)
4. ilman lähetettä
5. tuomioistuin (mielentilatutkimukseen tai syyntakeettomana hoitoon määrättynä tulevat)
6. siirto toisesta psykiatrisesta sairaalasta
7. siirto somaattisesta sairaalasta
10. muu (______________________)
11. ei tiedossa

11. Laillinen asema lähetettäessä

0. vapaaehtoinen
1. tahdosta riippumatta

12. Jos tahdosta riippumaton lähettäminen, millainen :__:

1. mielenterveyslain mukaiset käytännöt
2. muu _____________________ (esim. oikeuden päätös)
8. ei relevantti (oli vapaaehtoinen)
9. ei tiedossa

KL 1 M1-kriteerit

1= käytettiin
0= ei

hoidontarve	1	0
vahingollisuus itselle	1	0
vahingollisuus muille	1	0

13. Laillinen asema sisäänkirjoitettaessa :__:

0. vapaaehtoinen
1. tahdosta riippumatta (tarkkailu aloitettiin/jatkettiin tai hoitopäätös oli jo)
2. ei otettu sisään
3. muu
9. ei tiedossa

14. Jos tahdosta riippumaton sisäänkirjoitus, millainen :__:

1. mielenterveyslain mukaiset käytännöt
2. muu ______________________ (esim. oikeuden päätös)
8. ei relevantti (oli vapaaehtoinen)
9. ei tiedossa

15. Jos siirto, oliko alkuperäinen sisäänkirjoitus :__:

0. vapaaehtoinen
1. tahdosta riippumatta
8. kyseessä ei ollut siirto
9. ei tiedossa

16.Minne uloskirjoitettiin :__:

1. kotiin (myös kuntoutuskoti ja asuntola)
2. muuhun psykiatriseen sairaalaan
3. somaattiseen sairaalaan
4. muuhun laitokseen (?__________________________)
5. muualle (?__________________________)
8. ei uloskirjoitettu tutkimusaikana (hoito jatkui yli 6 kk)
9. ei tiedossa

17.Laillinen asema uloskirjoitettaessa :__:

0. vapaaehtoinen

1. tahdosta riippumaton (esim. kriminaalipotilas koeajalle, joka sisältää pakollisen avohoidon; osassa Pohjoismaita on koeaikoja ja avopakkohoitoja ei-kriminaalipotilaillekin)

8. ei uloskirjoitettu

18. Jos sairaalasta järjestettiin uloskirjoittamisen jälkeisiä pakkotoimia, mitä :__:

1. pakollinen avohoito
2. muu (?________________________)
8. ei relevantti (ei järjestetty pakkotoimia)

19. Sisältyikö sairaalahoitoon ajanjaksoja, jolloin potilas oli sairaalassa tahdostaan riippumatta (tarkkailu, hoito hoitopäätöksellä, mielentilatutkimus, oikeuden määräämä hoito kriminaalipotilaalla) :__:

0. ei
1. kyllä

KL 2 Tarkkailu (huom! vuosi, kuukausi, päivä)

alkoi :__:__:__:__:__:__:

päättyi :__:__:__:__:__:__:

lopputulos :__:

1. hoitopäätös
2. vapautus
3. ei M3
8. ei relevantti

alkoi :__:__:__:__:__:__:

päättyi :__:__:__:__:__:__:

lopputulos :__:

1. hoitopäätös
2. vapautus
3. ei M3
8. ei relevantti

alkoi :__:__:__:__:__:__:

päättyi :__:__:__:__:__:__:

lopputulos :__:

1. hoitopäätös
2. vapautus
3. ei M3
8. ei relevantti

KL 3 Tahdosta riippumaton hoito

alkoi :__:__:__:__:__:__:

päättyi :__:__:__:__:__:__:

M3 kriteerit (1=käytettiin, 0=ei käytetty)

hoidontarve	1	0
vahingollisuus itselle	1	0
vahingollisuus muille	1	0

alkoi :__:__:__:__:__:__:

päättyi :__:__:__:__:__:__:

M3 kriteerit (1=käytettiin, 0=ei käytetty)

hoidontarve	1	0
vahingollisuus itselle	1	0
vahingollisuus muille	1	0

alkoi :__:__:__:__:__:__:

päättyi :__:__:__:__:__:__:

M3 kriteerit (1=käytettiin, 0=ei käytetty)

hoidontarve	1	0
vahingollisuus itselle	1	0
vahingollisuus muille	1	0

Mahdollisten tahdosta riippumattomien jaksojen alku- ja loppupäivänmäärät (vv,kk,pp). Tässä kirjataan samaksi jaksoksi kaikki peräkkäinen tahdosta riippumaton aika. Ellei potilaalla ole tällaista jaksoa, koodataan alku- ja loppupäivänmääräksi 888888.

Esim. potilas tulee tarkkailulähetteellä 1.1. ja asetetaan tarkkailuun. Pakkopäätös tehdään 4.1. Hänet otetaan uudelleen tarkkailuun 1.4. ja pakkopäätös tehdään 4.4. Pakkopäätös puretaan 22.4. Kirjataan kohtaan 19a alkupäivä 1.1. ja loppupäivä 22.4.

19a 1. jakso alkoi :__:__:__:__:__:__:

päättyi :__:__:__:__:__:__:

19b 2. jakso alkoi :__:__:__:__:__:__:

päättyi :__:__:__:__:__:__:

19c 3. jakso alkoi :__:__:__:__:__:__:
päättyi :__:__:__:__:__:__:

19d 4. jakso alkoi :__:__:__:__:__:__:
päättyi :__:__:__:__:__:__:

KL 4 Tahdosta riippumattomien päivien lukumäärä :__:__:__:

20. Sisältyikö hoitoon pakollisia avohoitojaksoja? Kirjataan alku- ja loppupäivänmäärät (vv,kk,pp)

Tähän kirjataan ylös, jos esim. potilas välillä ikään kuin koeuloskirjoitettiin velvoitehoitoon ja otettiin sitten taas sairaalaan, tai jos sairaalahoidosta uloskirjoitettaessa määrättiin pakollinen avohoito; uloskirjoituksen jälkeisen pakollisen avohoitojakson pituus pitäisi selvittää kyseisestä hoitopisteestä

20a 1. jakso alkoi :__:__:__:__:__:__:
päättyi :__:__:__:__:__:__:

20b 2. jakso alkoi :__:__:__:__:__:__:
päättyi :__:__:__:__:__:__:

21. Indeksitapahtuma: sisälsikö potilaan sairaalahoito minkäänlaista lakiin perustuvaa tahdosta riippumatonta ajanjaksoa (Suomessa tarkkailulähete, tarkkailu, tahdosta riippumaton hoitopäätös, mielentilatutkimus, kriminaalipotilaan hoito oikeuden määräämänä, kriminaalipotilaan velvoiteavohoito) :__:

0. ei, koko hoitojakso oli juridisesti vapaaehtoinen
1. kyllä, joku lakiin perustuva vapaudenrajoitus tapahtui

22. tapahtuiko vapaudenrajoituksia, jotka eivät perustu lakiin (esim. aloitettiinko tarkkailu, joka ”raukeni” ilman asianmukaisia papereita; kirjattiinko sairauskertomukseen, että tarkkailu aloitetaan heti, jos potilas toivoo uloskirjoitusta)

:__:

0. ei todettavissa
1. kyllä

23. Jos tapahtui, millaisia?

____

____

____

KL 5- KL 10 Muut pakkotoimet ja rajoitukset sairaalahoidon aikana

KL 5 Eristys :__:

1. käytettiin
0. ei käytetty

episodien lukumäärä :__:__:

aika tunteina

1. episodi :__:__:

miksi eristettiin? _______________________________________

2. episodi :__:__:

miksi eristettiin? _______________________________________

3. episodi :__:__:

miksi eristettiin? _______________________________________

4. episodi :__:__:

miksi eristettiin? _______________________________________

5. episodi :__:__:

miksi eristettiin? _______________________________________

kokonaiseristysaika :__:__:__: tuntia

KL 6 Lepositeet :__:

1. käytettiin
0. ei käytetty

episodien lukumäärä :__:__:

aika tunteina

1. episodi :__:__:

miksi? _______________________________________

2. episodi :__:__:

miksi? _______________________________________

3. episodi :__:__:

miksi? ____

4. episodi :__:__:

miksi? ____

kokonaisleposideaika :__:__:__: tuntia

KL 7 Fyysinen kiinnipitäminen :__:

1. käytettiin
0. ei käytetty

episodien lukumäärä :__:__:

tilanteiden kuvaus

1. ____
2. ____
3. ____

jne ____

KL 8 Vapaakävelyn rajoitukset :__:

1. käytettiin
0. ei käytetty

KL 9 Pakkolääkitys :__:

1. käytettiin
0. ei käytetty

episodien lukumäärä :__:__:

1. kerta
   - neuroleptit :__:
   - antidepressantit :__:
   - anksiolyytit :__:
   - muut :__:
2. kerta
   - neuroleptit :__:
   - antidepressantit :__:
   - anksiolyytit :__:
   - muut :__:
3. kerta

neuroleptit :__:
antidepressantit :__:
anksiolyytit :__:
muut :__:

4. kerta
   neuroleptit :__:
   antidepressantit :__:
   anksiolyytit :__:
   muut :__:

KL 10 Muut pakkotoimet ja rajoitukset :__:
(kirjataan tähän vierailu- ja puherajoitukset, lomakiellot, poliisin virka-avun käyttö, pakkoruokinta ja muu mahdollinen pakon ja rajoitusten käyttö)

1. käytettiin
0. ei käytetty

kuvaus____
____
____

24. Oliko kyseessä ensihoito psykiatrisessa sairaalassa? :__:

0. kyllä
1. ei, uusintahoito
9. ei tiedossa

25. Oliko potilas aiemmin ollut pakkohoidossa (sair.kert. perusteella; lasketaan dokumentoidut tarkkailujaksot ja hoidot hoitopäätöksellä) :__:

0. ei
1. kyllä
9. ei tiedossa

26. Pitäiskö tämän sairaalahoitokerran normaalien rekisteröimiskäytäntöjen mukaisesti kirjautua tahdosta riippumattomaksi johonkin rekisteriin? :__:

Tähän kohtaan laitetaan kyllä, jos on tapahtunut sellaisia vapaudenrajoituksia, joiden mainitsemiseen on kohta STAKESin hoitoilmoituslomakkeessa

0. ei
1. kyllä
9. tällaisen tapauksen osalta ei ole määritelmää

27. ja KL 11-14 täytetään jälkikäteen HILMO:n perusteella

27. Kirjautuiko tämä sairaalaantulo tahdosta
riippumattomaksi :__:

0. ei
1. kyllä

(Tähän kysymykseen vastataan Hilmo-rekisteristä saatujen tietojen perusteella: Kyllä= HILMO:ssa on maininta tarkkailulähetteestä tai tahdosta riippumattomista päivistä tai oikeusturvakeskuksen määräämästä hoidosta tai tutkimuksesta

KL 11 Kirjautuiko tämä sairaalajakso tahdosta riippumattoman hoidon osalta kansalliseen rekisteriin oikein, sellaisena kuin sairauskertomuksesta ilmeni? :__:

0. ei
1. kyllä
9. tieto puuttuu

KL 12 Jos virhekirjautumista tahdosta riippumattoman hoidon osalta, mitä

lähetetyyppi	1	2
tahdosta riippumattomien päivien määrä	1	2

KL 13 Kirjautuivatko toteutetut pakkotoimet oikein, sellaisena kuin sairauskertomuksesta ilmeni? :__:

0. ei
1. kyllä
9. tieto puuttuu

KL 14 Jos virhettä pakkotoimien kirjaamisessa, mitä

eristys	8	1	2
lepositeet	8	1	2
fyysinen kiinnipitäminen	8	1	2
pakkolääkitys	8	1	2

Original papers

I Tuohimäki C, Kaltiala-Heino R, Korkeila J, Protshenko J, Lehtinen V & Joukamaa M (2001) Psychiatric inpatients' views on self-determination. Int J Law Psychiatry 24: 61-9.

II Korkeila JA, Tuohimäki C, Kaltiala-Heino R, Lehtinen V & Joukamaa M (2002) Predicting use of coercive measures in Finland. Nord J Psychiatry 56: 339-45.

III Kaltiala-Heino R, Tuohimäki C, Korkeila J & Lehtinen V (2003) Reasons for using seclusion and restraint in psychiatric inpatient care. Int J Law Psychiatry 26: 139-49.

IV Tuohimäki C, Kaltiala-Heino R, Korkeila J, Tuori T, Lehtinen V & Joukamaa M (2003) The use of harmful to others-criterion for involuntary treatment in Finland. Eur J Health Law 10: 183-99.

V Tuohimäki C, Kaltiala-Heino R, Korkeila J, Tuori T, Lehtinen V & Joukamaa M (2004) Deprivation of liberty in Finnish psychiatric inpatients. Int J Law Psychiatry 27: 193-205.

Original publications are not included in the electronic version of the dissertation.

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