S58. Paternalism and autonomy: a Nordic study on the use of coercion in the mental health care system

Chairs: T.W. Kallert (D), C.-G. Westrin (S)

S58.1

Background and design of the 'Paternalism and Autonomy' Study

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In order to explore some of the problems related to the use of coercion in psychiatric care, a comprehensive Nordic study was launched in the mid-nineties. The core study, which was carried out in the same way in all of the five Nordic countries, focuses three main areas ("levels"). Level 1 addresses the justification for the use of coercion as reflected in the different mental health acts and legal documents, level 2 concerns the reliability and validity of public statistics on rates of involuntary hospitalization, while level 3 focuses on perceived coercion according to the patients' own experiences. All data is gathered in such a way that analyses across the three levels would be possible, as well as comparisons between the five Nordic nations. All consecutive admissions at thirteen hospitals were recorded over a fixed period of time in all countries (n=6078). A subsample of the patients were interviewed (n=995). The interview focused mainly the patients' experiences of coercion during the admission process. The paper presents details of the study design and describes methods applied in the study.

S58.2

How valid are statistics on civil commitment rates in the Nordic Countries?

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The objective of the study was to evaluate the validity of statistics on civil commitment in the Nordic countries.

Methods: Consecutive voluntary and involuntary admissions were included from 13 institutions in Denmark, Finland, Iceland, Norway and Sweden, and periods with deprivation of liberty during the stay in the institution were evaluated based on information from the medical files.

Results: 6078 admission were included, of those 1841 civil commitments and 4207 voluntary admissions. Significant differences between the countries regarding the induced deprivation of liberty during the admissions were exposed: the median length of stay after involuntary admission varied from 13 days to 29 days, deprivation of liberty during the stay was induced in 98.2% to 100.0% of the civil commitments, and in 3.6% to 20.8% of the voluntary admissions (preliminary analyses).

Conclusion: The validity of statistics on civil commitment in the Nordic countries are not very high, the burden of deprivation of liberty induced during stay after both involuntary and voluntary admission to hospital in the Nordic countries varies considerably. Official national statistics, if existing, must be evaluated in that context.

S58.3

Measurements of perceived coercion; methodological problems

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Denmark, Finland, Norway and Sweden have a special mental health act regulating involuntary psychiatric treatment. In Iceland civil commitment is regulated in the Act of Personal Competence. In Sweden the principal criterion for compulsory admission is serious mental disorder; in the other four countries, despite somewhat different expressions in the law texts, psychotic conditions. All countries allow involuntary treatment due to need for treatment and due to dangerousness to self or others. We studied the committed patient populations of centres with well-defined catchment areas using data collected in a structured way from patient files. Committed patients used in the analyses totalled 1651. In all the countries, schizophrenia-group diagnoses (F20–29) were the most common main diagnosis among the committed. The proportion of affective disorders as main diagnosis among the committed was greatest in Iceland. The proportion of substance use related diagnosis was greatest among the committed in Finland, and that of personality disorders in Norway. Male and female patients were equally represented among the committed in all the countries, but the mean age of the committed patients varied.

S58.4

Legal mode of admission and deprivation of liberty in psychiatric care in the Nordic Countries

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Legal status at admission has in several studies been found to be a poor measure of coercion. The objective was to study patients' perceptions of coercion in psychiatry in the Nordic countries in relation to the legal status at admission of the patients.

Methods: As part of the Nordic 'Paternalism and Autonomy' study 995 patients at one psychiatric clinic in Denmark, three in Finland, one in Iceland, four in Norway and four in Sweden were interviewed using the Nordic Admission Interview (NorAI).

Preliminary results: Of the legally committed patients, 77% in Denmark, 58% in Finland, 88% in Iceland, 51% in Norway and 68% in Sweden said they came to the hospital involuntarily. The ranges between centres were 56–61% in Finland, 39–59% in Norway and 70–74% in Sweden. The proportions of legally

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voluntarily admitted patients who said they came to the hospital involuntarily were 13% in Denmark, 8(3–18)% in Finland, 11% in Iceland, 17(8–21)% in Norway and 5(3–9)% in Sweden.

Preliminary conclusion: The degree of discrepancy between legal status and patients' perceptions of coercion differed between countries and institutions within countries.

S58.5

Measurements of perceived coercion; methodological problems

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Several studies suggest that the patient's experience of being coerced during the admission to mental hospitals, does not necessarily correspond with their legal status. Instruments have been developed to measure perceived coercion, but their validity has not been thoroughly addressed. This paper compares two different ways of measuring perceived coercion used in a large scale study on the use of coercion in the Nordic countries. The instruments used in the study were the MacArthur perceived coercion scale, (which is a part of the frequently used Admission Experience Scale; AES) and a visual analogue scale, called the coercion ladder. The two ways of measuring perceived coercion are compared, and predictors of perceived coercion are determined for each of the two methods.

S59. Schizophrenia as a disorder of information processing

Chairs: C. Höschl (CZ), J. Libiger (CZ)

S59.1

The role of 5-HT activity in anti-psychotic treatment

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No abstract was available at the time of printing.

S59.2

Brain metabolism (PET) and cognitive performance in schizophrenia

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Patients with schizophrenia demonstrate cognitive dysfunction and the abnormalities in resting state of brain glucose metabolism. In order to determine whether the regional brain metabolism predicts the performance in neuropsychological tests we assessed patients (N=38) with schizophrenia with 18FDG positron emission tomography (PET) and neuropsychological tests. Regional brain metabolism was measured in the resting state and was tested for correlation with performance in neuropsychological tests and domains of psychopathology.

Total PANSS score negatively correlates with decrease of metabolism in insular regions, left caudatum and left dorsal temporal region. Positive symptoms are associated with the decrease of metabolism in basal ganglia and temporo-parietal cortex. Negative symptoms are mostly associated with the decrease of prefrontal and caudate metabolism. We found the association between the outcome in WCST and metabolism in dorsal prefrontal cortex, verbal fluency and prefrontal and fronto-temporal cortex and trail making test and frontal and dorsal cingular region.

Results are presented and discussed in the framework of a neuronal basis for cognitive dysfunction in schizophrenia.

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S59.3

Neuropsychological dysfunctions in the families of schizophrenic patients

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Abnormalities of information processing in schizophrenic patients are reflected in the results of neuropsychological tests measuring cognitive processes. Furthermore, these abnormalities have been reported to exist in a proportion of apparently healthy relatives of schizophrenic patients. The aim of this study was to compare the results of neuropsychological tests, measuring mainly the frontal lobe function in first-episode 21 schizophrenic patients, in both their parents (20 mothers and 20 fathers) and in 20 parents-matched healthy controls. Neuropsychological tests comprised the Trail Making Test (TMT), the Stroop color-word interference test, and the Wisconsin Card Sorting Test (WCST). There was a significant difference between the 21 patients and their healthy parents in the results of TMT and WCST but not in the Stroop test. On the other hand, a significant difference between parents and their matched controls was found in the Stroop B, and in two indices of the WCST (completed categories, CC and percentage of conceptual level responses, %CONC). A correlation was obtained between patients and their fathers in two indices of WCST (CC and %CONC), but not between patients and their mothers. The results obtained confirm those of other studies pointing to the presence of a significant impairment on neuropsychological tests in first-degree nonpsychotic relatives (parents) of schizophrenic patients, which may be used as an endophenotypic markers of genetic predisposition to schizophrenia.

S59.4

Computer-assisted rehabilitation of cognitive functions in schizophrenia

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Computers have become a part of rehabilitation of cognitive functions in schizophrenia. Computerized training programs are used to improve performance in hospitalized patients and serve as a sensitive measure of recovery. The paper discusses options of computer rehabilitation in a general psychiatric population with special focus on schizophrenia. We review the published studies on ecological validity and efficacy of computer-assisted rehabilitation.