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European Psychiatry 20 (2005) 321–326
EUROPEAN PSYCHIATRY
http://france.elsevier.com/direct/EURPSY/

Original article

Incipient offending among schizophrenia patients after first contact to the psychiatric hospital system

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Received 14 May 2004; accepted 11 January 2005

Available online 13 April 2005

Abstract

The study examines how age, sex and substance use disorder are associated with the risk of committing a criminal offence. The study explicitly examines the risk after the first contact to the psychiatric hospital system and after the diagnosis of schizophrenia for those with no previous criminal record; the association between previous non-violent criminality and later violent criminality is also analysed. The study sample comprised 4619 individuals ever diagnosed with schizophrenia. All solved offences were accessible. Data were analysed using Cox's regression. Schizophrenic men had twice the risk of schizophrenic women of committing both violent and non-violent offences. A registered substance use disorder increased the risk 1.9- to 3.7-fold, depending on the starting point for the analyses, while increasing age on first contact or when diagnosed with schizophrenia diminished the risk. Previous non-violent criminality increased the risk for later violent criminality 2.5- to 2.7-fold, depending on the starting point for the analyses. The results suggest that the psychiatric treatment system can play an active role in preventing criminality among individuals with schizophrenia. The preventive measures should be based on a thorough assessment including criminal history at intake and alertness toward young psychotic men with substance use disorders and especially if they also have a criminal history.

Keywords: Schizophrenia; Forensic psychiatry; Crime; Epidemiological factors; Substance-related disorders

1. Introduction

Persons with schizophrenia are more liable to commit crimes than the background population [8,14]. This is especially true for violent crimes [2,7,12,27]. No causal connection has been established yet, but studies indicate that the association partly derives from the psychopathology of the disease [28], when the psychotic individual acts violently on hallucinations or delusions [13] or associated affects [4], and partly from comorbid substance or alcohol abuse [31]. Attempts have been made to diminish the excess criminality [29] and the psychiatric treatment system has a possibility and an obligation to counteract the criminality among those known to the system.

Men generally commit more crimes than women do. This is true of both the general population and persons with schizophrenia; however, it has been shown that women with schizophrenia have a higher odds-ratio for violent and non-violent criminality than men when compared with the general population [7,8].

The older the schizophrenia patient has become without committing any crime, the less likely it is that he or she will ever offend. Wessely et al. [32] found that for each year the onset of schizophrenia was delayed, the overall risk for acquiring any lifetime conviction decreased by 5%, but they also found that schizophrenic individuals started to offend over a longer period of time than the non-schizophrenic mentally disordered control persons.

Substance use in people with schizophrenia significantly increases the risk for violence and aggression [21]. Substance use does, however, not explain all of the excess criminality committed by schizophrenia patients. In the Epidemiologic Catchment Area study a fourfold increase in violence was found among individuals with schizophrenia who did not have a comorbid substance use when compared to the violence in the general population [27].

A criminal record is strongly associated with the risk of new criminality [32] and a previous criminal history appears to have a strong association with criminal violence [5].

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doi:10.1016/j.eurpsy.2005.01.008

A common feature of the mentioned studies, however, is that new criminality committed was studied without any adjustment for whether crimes had been committed before first contact to the psychiatric hospital system and before the diagnosis of schizophrenia. Whether the schizophrenic individuals had committed crimes should, nevertheless, be taken into account, because studies have shown a positive correlation between prior and subsequent arrests [22] as well as a connection between the number of arrests before admission and subsequent arrests [25]. Crimes committed before first psychiatric contact may lead to psychiatric treatment, but may also result in a contact solely with the judicial system, offering an opportunity for early detection there [19].

Ideally, every patient should be risk assessed in the psychiatric setting. Given that schizophrenic patients commit more crimes than the general population, there are certain aspects the psychiatrists need to take into consideration, and many probably already do. When the psychiatrist becomes acquainted with the individual, the psychiatric treatment system must offer its share of knowledge and intervention to minimise new or repeated offending. The question is which features should be taken into account in an assessment and to what extent.

Many patients with schizophrenia, entering the psychiatric hospital system for the first time, already have a criminal record [19] and it has been shown that both criminality and substance use are associated with the recognition of mental disorder among persons with schizophrenia [18]. Criminal mentally disordered persons who start their contact with the criminal justice system instead of the psychiatric treatment system have a progressively increasing possibility of being channelled into the criminal justice system on following contacts in contrast to criminal mentally disordered persons who start their contact within the psychiatric hospital system [6]. Since the psychiatric treatment system is unaware of these individuals until they enter the psychiatric hospital system for the first time, all that can be done is to emphasise the need for an early detection scheme in the judicial system.

However, the majority of individuals later diagnosed with schizophrenia enter the psychiatric hospital system without a criminal record, and the psychiatric hospital system has a responsibility to minimise the risk for these individuals of getting one. This should be done by offering relevant treatment, social support, continuity in care, and by working with insight and treatment compliance in these patients [3].

Most likely the psychiatrist will be more likely to risk assess the patient who already has a diagnosis of schizophrenia, but many of the patients later diagnosed with schizophrenia are not diagnosed as such on first contact [15]. Factors associated with the risk of offending after first contact to the psychiatric hospital system are therefore relevant.

In a large scale register-based study we examined to what extent sex, age and substance use had an association with whether persons began to offend or not after the first contact with the psychiatric hospital system and after the diagnosis of schizophrenia was given. We also examined the association between previous non-violent criminality and subsequent violent criminality.

2. Materials and methods

Three national registers were used in this register-based study: PCR, The Danish Psychiatric Central Research Register, NCR, The Danish National Crime Register and CRS, The Danish Civil Registration System.

The PCR holds information on inpatient contacts to Danish Psychiatric Hospitals since 1905 and on all outpatient contacts to secondary health services since January 1, 1995. It has been electronic and nationwide since 1969 and satisfies the demands confronting registers for research purposes [16].

The NCR has been described as probably the most thorough and comprehensive in the Western World [35], and since November 1, 1978, when it was made electronic, all charges and decisions on any reported offence in Denmark have been registered with only 1 or 2 days of delay. The minimum age of criminal responsibility is 15 years of age in Denmark; hence no crimes committed before the age of 15 are registered. Conversely, all solved crimes committed are registered even when committed by psychotic or schizophrenic patients. In Denmark the court first gives a verdict of guilty or not guilty. An offender whom the court has found psychotic (often based on a forensic report), is viewed as guilty but not punishable [9]. Hence a sentence is passed on a crime even though the offender is psychotic. The sanction imposed, however, will be a sentence to psychiatric treatment instead of imprisonment if the court detects the psychotic disorder. A sentence to psychiatric treatment implies involuntary psychiatric hospital treatment as an in- or an outpatient [20].

Everyone living in Denmark for more than 3 months has a civil registration number. The CRS holds information on the time of death, disappearance or emigration on all. The civil registration number is unique and consists of the date of birth and a serial number, making linkage across registers and time very accurate.

The Danish Psychiatric Central Research Register [17] revealed that 5184 Danes born after November 1, 1963 had ever received a diagnosis of schizophrenia. In Denmark the diagnoses were based on ICD-8 until December 31, 1993 [33] and on ICD-10 after January 1, 1994 [34]. A diagnosis was registered on every hospital contact.

The NCR was searched for criminal records of every identified individual, and for every verdict of guilty the sentence was recorded with the date of the crime and the most serious offence leading to the sentence. The violent crimes covered: homicide, attempted homicide, aggravated and common assault (including threats and attempts), arson, other violence against the person, rape and attempted rape, other sexual offences and robbery. The non-violent crimes covered: malicious damage to property, drug offences, burglary and theft, other misappropriations against property, culpable homicide or bodily harm by negligence, other sections in the penal code and other special acts.