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Editorial

The interface between general and forensic psychiatric services

General adult and forensic psychiatric services interface primarily concerning the care of individuals with schizophrenia (or schizoaffective disorder). Most patients in forensic services are men with schizophrenia. In the past 20 years, evidence has accumulated to show that persons with schizophrenia are at increased risk, as compared to the general population, to commit non-violent crimes, at higher risk to commit violent crimes, and at even higher risk to commit homicide [1,2,4,11]. The proportion of crimes attributable to persons with schizophrenia varies by type of offence, by time period, and by country, but the increase in risk for violent offending that is conferred by schizophrenia is similar across studies and countries [3,5,7].

Preventing violent offences by persons with schizophrenia would lower violent crime rates anywhere from 5 to 11% [2,3]. Further, studies indicate that the rates of violent crime reflect an elevated rate of physically aggressive behaviour towards others among individuals with schizophrenia [6].

This evidence of an elevated risk of aggressive behaviour among persons with schizophrenia is known to professionals working within forensic psychiatric services. But, it is largely unknown to many professionals working within general psychiatric services, and to a few it is considered to be untrue or irrelevant. In this special issue, Mullen and Ogloff discuss a strategy to overcome this lack of knowledge that acts as a barrier to collaboration between forensic and general psychiatric services.

The patients who most frequently are transferred to forensic services are those who presented conduct problems since childhood. Many already have a conviction for a violent crime before their first episode of psychosis which is usually treated in general psychiatric services [6,8]. The combination of antisocial attitudes and behaviours that have been present since childhood plus hostility, irritability, and a lack of insight seriously limit their collaboration with clinicians and engagement with treatment. Yet, this sub-group of patients require intensive treatments to reduce psychotic symptoms, aggressive and antisocial behaviours including substance misuse, and to increase pro-social behaviours. At the present time, general adult services care for most of these patients. A few are transferred to forensic services usually after many years of treatment in general psychiatric services during which time they continued to commit criminal offences [8,9].

Forensic services differ from general psychiatric services in that treatment focuses not only on reducing the symptoms of psychosis, but also on reducing aggressive behaviour and antisocial attitudes and behaviours. In the only study to compare outcomes among men with schizophrenia treated in general and forensic psychiatric hospitals, the patients treated by forensic services displayed lower levels of symptoms, substance misuse, and aggressive behaviour throughout a 2-year follow-up period in the community [10]. Similarly, in this special issue, Crocker and Côté report that in Quebec, patients with a history of crime in general psychiatric services as compared to those in forensic services showed elevations in risk factors associated with future violence.

Forensic services are generally better resourced than general services, assessments are more comprehensive, inpatient stays are longer, treatments often include multiple components that address the combinations of problems presented by these patients, and discharge is dependent on engagement in treatments likely to bring about positive change in both the primary illness and aggressive behaviour. Further, unlike general psychiatric services in Europe that do not have the option of using court-orders to enforce compliance with community treatment, forensic hospitals discharge patients to the community under orders to participate in various treatments and services. These differences with general psychiatric care are dramatic and each has implications for the care of patients with schizophrenia who engage in aggressive behaviour towards others.

In recent decades, the treatment of people with schizophrenia has changed to include neuroleptic medications and community care interspersed with short stays in hospital during acute episodes. Once these changes had been implemented, the numbers of forensic psychiatric beds increased in most European countries [9]. Three papers in this special issue use national statistics from Austria, the Czech Republic, and Denmark in an effort to understand the link between the number of forensic beds and policies and practices in general psychiatric services. While findings indicate a somewhat different situation in each country, conclusions are remarkably

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similar. Schanda et al. argue that in Austria there is ''an increasingly inadequate provision of comprehensive care for 'difficult', but not extremely dangerous, psychotic patients living in the community.'' Vevera et al. note that ''Whilst in the Czech Republic, a decrease in the number and length of hospitalizations is an appropriate goal for the majority of patients, inpatient care should still be provided to those with a history of criminogenic factors such as housing problems, living in poverty, lack of social support, and treatment non-compliance''. Kramp and Gabrielsen studying Denmark demonstrate that ''over time the (negative) growth rate in number of consumed beds is significantly correlated with the (positive) growth rates for forensic patients, homicide and arson. Social and community psychiatry have little effect... These patients are not only offenders, but also the victims of an inadequate treatment system''.

These conclusions suggest that the care currently provided by general psychiatric services to a sub-group of patients with schizophrenia is failing to reduce criminal activities. Hodgins et al. investigated the treatments provided to patients with severe mental illness by general psychiatric services over a 2-year period. The findings showed that general psychiatric services limited their care to the reduction of symptoms of the primary illness and took no account of patients' histories of aggressive behaviour. Even substance misuse that has been strongly linked to aggressive behaviour [4,11] went untreated in the great majority of cases. These findings support the call by other authors for more specific intensive treatment for a sub-group of patients engaging in antisocial behaviours.

The paper by Bjørkly et al. shows that in Norway this problem is being dealt with head-on by developing a brief instrument that can feasibly be administered in acute wards to assess the risk of aggressive behaviour. The screening tool identifies patients requiring a more comprehensive examination to assess for multiplicity of co-morbid disorders and problems. These more detailed assessments would necessitate collaborations with mental health professionals with expertise in the forensic field either to train colleagues in general services to conduct these assessments or to undertake the assessments. Either way, the next challenge will be to provide the broad array of effective treatments that patients with increased risk of violent behaviour require.

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