Received Date : 11-Oct-2016

Accepted Date : 11-Oct-2016

Article type : Editorial

Editorial: The rising toll of homicide by psychiatric patients: have we reached 'peak community care'?

With a spring in his step, lecturer Jeroen Ensink left his suburban London home to post cards to his many friends around the world, announcing the arrival of his baby daughter. Seconds later his life was over. A young man had pounced, and in a state of frenzy, savagely stabbed his random victim (*Daily Mail*, 4 January 2016). As psychiatric patient Femi Nandap begins detention in a high-security institution, we should spare some thought for Jeroen's wife, and his only child.

'Lessons will be learned' is the typical response by health service managers to a homicide enquiry involving one of their patients Co-author JH, after the unprovoked killing of his father in Bristol in 2007, started a campaign for safer care of the mentally disturbed, and a more supportive and honest response to victims' families (hundredfamilies.org). Examining details of 1274 killings by people with mental illness, JH found the same failings repeated again and again. Lessons do not seem to be learned, and the dangerousness of a small but volatile subset of psychiatric patients is not taken seriously enough (Hundredfamilies, 2016a).

Myths around mental health policy persist. In ignorance of the creation of multidisciplinary locality teams and residential services, a simplistic notion tainted the perception of care in the

community in the 1990s. Scandals of patients 'slipping through the net', with tragic consequences, suggested that patients had simply been abandoned after the mental hospitals were closed. Yet much of the impetus for the shift from the former asylums to the community was from mental health campaigners, as a libertarian claim for rights, freedom and citizenship. This was a progressive development, not a penny-pinching exercise (with their economy of scale, mental hospitals were cheaper to run).

Community care policy had bad press in the early years, but opposition has declined over the last 10-15 years, partly because stigma and sensationalised media reporting have been challenged. However, this success has led to a censorial tendency. Three years ago a front page of *The Sun* newspaper (6 October 2013) declared '1200 killed by mental patients'. This figure was taken from the National Confidential Inquiry into Suicide and Homicide (2013), which has collated data on incidents involving people with mental illness annually since 1999, but it was criticised for including deaths at the hands of persons judged to be mentally unwell but not current psychiatric patients.

Services cannot be expected to prevent incidents by unknown people, but numerous cases were arguably preventable through better access to mental health care. Each fatality was a mother, father, son or daughter, many of whose families believe could still be alive today if their assailant had received timely and effective intervention. Mental health campaigners were enraged by *The Sun* headline, and an undermining commentary in *The Guardian* (7 October 2013) ended with the question: 'How would you want to see us reporting on mental health?' Hundreds of readers' comments condemned *The Sun* for allegedly provoking stigma, yet the article was reporting facts (the number of deaths was 1226, though incorrectly summed to 1216).

Much-needed reform of mental health services is being obstructed by a well-intended but perilous ideology of prioritising the battle against stigma over public safety. At a recent trial of a man with a long history of mental illness and violence accused of murdering a stranger, James Collins, a consultant forensic psychiatrist at Ashworth high-security hospital told the court (*Blackpool Gazette*, 14 July 2016):

> One of the things psychiatrists are encouraged to do is to not make a diagnosis of schizophrenia because of the stigma for the patient.

This approach is at odds with the scientific basis of psychiatry. No other branch of medicine would eschew its own taxonomic framework in this way. If a diagnostic category is avoided for reasons of sensitivity, the schizophrenic patient is unlikely to be treated as such. This contributed to a situation that left a vulnerable and dangerously volatile man without the care and medication he clearly needed on the day of the killing. Eventually diagnosed with schizophrenia after the murder, he is now serving a minimum of 23 years in custody as a result. The family of his victim remain devastated by their inexplicable loss.

It is often argued that people with mental illness are more likely to be a victim than a perpetrator of violence, yet evidence for this is unclear (Hundredfamilies 2016b). Paul Jenkins, when chief executive of the mental health charity Rethink, argued (politics.co.uk, 7 July 2010):

> The media often exaggerates the likelihood of homicide by a person with schizophrenia, when it is in fact very rare…You're more likely to be struck by lightning than killed by someone with schizophrenia.

However, a cursory look at the evidence shows this assertion to be completely unfounded. According to the Royal Society for the Prevention of Accidents, approximately three cases of death by lightning are recorded in the UK per year, compared to the National Confidential Inquiry (2016) attributing 34 killings to schizophrenic patients (a total of 369 in the period 2004 to 2014). In a documentary on the British television network ITV (*Tonight*, 15 September 2016), co-author JH interviewed Professor Simon Wessely of the Royal College of Psychiatrists, who claimed that the number of incidents is declining. Yet the data suggest the message is managed better than the hazard.

Recently JH sent Freedom of Information requests to all 57 National Health Service trusts with mental health services in England, seeking data on confirmed and suspected homicides involving psychiatric patients. In this extensive survey, all but three organisations supplied data. The results show a considerably higher number than the National Confidential Inquiry. Although there is fluctuation around an average of 50 cases per year, the latter data set shows a decreasing trend. However, these figures are limited to court convictions of recent patients known to secondary mental health services, and thus exclude instances of murder-suicide, and each case with multiple victims is only counted as one. The 12 victims of a shooting spree by Derrick Bird in Cumbria in 2010 are not recorded; psychiatric evidence at the inquest suggested he was mentally ill at the time of the offence *(Belfast Telegraph*, 22 March 2011). On this single factor, the National Confidential Inquiry is likely to underestimate by around 200 deaths over the least ten years.

As a lecturer in mental health nursing, co-author NM has observed a growing tendency for assertive airing and passive acceptance of extreme stances at professional conferences. Since qualifying in 1990, NM has been a proponent of care in the community, but he now worries about the direction of travel. At the recent Royal College of Nursing mental health conference, as well as positive messages about empowerment, some speakers bluntly called for withdrawal of all restrictive practices. Patrick Callaghan (2016), in an abstract of a forthcoming talk at University of Nottingham on the 'myth of mental illness', declared: 'by classifying individuals as risky we are giving the stamp of scientific approval to society's prejudices and fear.' Some radical scholars and activists disapprove of any control of patients, whether by formal powers of the Mental Health Act, tranquillising injection or seclusion. Instead of valuing such action as a sometimes necessary element of care, they perceive oppression or abuse.

Mental health practitioners have a difficult role, which they perform with skill and intuition. Most have a practical rather than ideological bent, but they are also influenced by the perverse incentives of the system. Risk assessment, as deplored by Callaghan, is an everyday concern for community practitioners, but they are more likely to underestimate the likelihood of harm. A practitioner who rates risk as high is tempting fate, and possible disciplinary investigation into why nothing was done. Another factor is patients' rights to read their notes, which may inhibit candid description and interpretation of behaviour.

The development of mental health care is not a straightforward linear trajectory from 'dark ages' to enlightenment. There are cyclical patterns too. Indeed, mistakes from the past may be repeated if policymakers and practitioners lack a broader historical perspective (McCrae &

Nolan, 2016). Inevitably, the dramatic decline of inpatient facilities will begin to reverse, as the danger of excessive reliance on community services is realised. At the cutting edge of psychiatry are home treatment teams, which conduct several visits to each patient daily, checking first that he is still alive, and secondly that he takes his medication. Many entrants to these caseloads ought to be in a safe environment with 24-hour care. This replacement of hospital may be a bridge too far.

The threshold for admission is now so high that only the most disturbed cases are admitted to psychiatric wards; the turnover is so rapid that patients are discharged before they are well enough. Treatment is simply tranquillising medication, with insufficient time or resources for meaningful therapeutic engagement. On returning home, patients with psychotic disorder may receive more potent dosage than would be needed on a ward. Community Treatment Orders, introduced in response to tragic incidents, are a useful instrument, but they should not be used primarily as a means of reducing hospital provision. Meanwhile, unsupervised patients on the cusp of psychotic relapse do not always receive the attention they or their families seek.

Arguably, we are approaching 'peak community care'. Mental health workers often attribute problems to resource limitations, yet treating an acutely disturbed patient at home rather than in hospital is an ideological option. This could become another example of counterproductive liberalism: by overstretching a good idea, the ultimate outcome is the opposite of that intended. If fighting stigma is prioritised over safety, a backlash will surely arise. It would be better for policy-makers to turn the corner now, before they are forced to act by a resurgence of public hostility. Larry Gostin, the great mental health reformer, has spoken of his journey

from ‘civil libertarian to sanitarian’. Activists should hear his wise words. Tragic incidents cannot always be predicted, but a more robust system is needed. Lives matter.

Niall McCrae, King’s College London

Email: nmccrae@kcl.ac.uk

Julian Hendy, hundredfamilies.org

References

Belfast Telegraph (22 March 2011): Gunman ‘had delusional beliefs’.

Blackpool Gazette (14 July 2016). Killer’s delusions for 20 years. http://www.blackpoolgazette.co.uk/news/crime/killer-s-delusions-for-20-years-1-8012618

Callaghan P (2016): *Dangerous Liaisons?: The Myth of Mental Illness and Risk.* Abstract for lecture, University of Nottingham. 10 October.

Daily Mail (4 January 2016): University lecturer who was stabbed to death on his doorstep had just had a baby with his wife 10 days before.

Daily Telegraph (5 October 2013): Truth about dangerous mental patients let out to kill.

Gostin L (2010): *From a Civil Libertarian to a Sanitarian: ‘a Life of Learning’*. Presidential address for the Faculty Convocation, Georgetown University, Washington, DC. 3 March.

Hundredfamilies (2016a): *The Victims*. http://www.hundredfamilies.org/the-victims/

Hundredfamilies (2016b): *Victims not Perpetrators.* http://www.hundredfamilies.org/victims-not-perpetrators/

McCrae N, Nolan P (2016): *The Story of Nursing in British Mental Hospitals: Echoes from the Corridors*. London: Routledge.

National Confidential Inquiry into Suicide and Homicide (2013): *Annual Report*. http://research.bmh.manchester.ac.uk/cmhs/centreforsuicideprevention/nci/reports/NCIAnnualReport2013V2.pdf

National Confidential Inquiry into Suicide and Homicide (2016): *Annual Report*. http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf

politics.co.uk (7 July 2010): Rethink - fewer mental illness homicides.

The Guardian (7 October 2013): The Sun says 1,200 people have been killed by 'mental patients' – is it true?

The Sun (6 October 2013): 1200 killed by mental patients: shock 10-year toll exposes care crisis. https://www.thesun.co.uk/archives/news/1052064/1200-killed-by-mental-patients/

Tonight (15 September 2016): *Care or Crime?* ITV.