the columns

correspondence

Homicide is impossible to predict

Sir: I agree with Szmukler (*Psychiatric Bulletin*, January 2000, **24**, 6–10), about difficulties inherent in predicting rare events. This is especially so when attempting to predict homicide. The results of the National Confidential Inquiry (Shaw *et al*, 1999) suggested that 15 homicides by people with schizophrenia who have had contact with psychiatric services occur each year. If we estimate that 80% of people with schizophrenia have contact with psychiatric services at some point during their lives this would suggest that the incidence of homicide by people with schizophrenia is about 0.094 per 1000 per year.

I am not aware of any instrument devised to identify patients at high risk of committing homicide, but those designed to detect violent incidents report their sensitivity and specificity to be around 0.8. If these figures were applied to an instrument for predicting homicide it would have a positive predictive value 0.0002. This value is the "proportion of patients with positive test results who are correctly diagnosed" (Altman, 1991). In other words, for everyone identified correctly, 5000 people will be identified as being at high risk of committing a homicide but will not do so.

The rarity of homicide suggests that even highly sensitive methods for detecting risk fail to adequately distinguish those who commit homicide from the vast majority who will not. While risk assessment is an important part of providing high quality of care to all patients in contact with mental health services, thinking about patients in terms of the likelihood of their committing homicide is not.

ALTMAN, D. G. (1991) *Practical Statistics for Medical Research*. London: Chapman and Hall.

SHAW, S., APPLEBY, L., AMOS, T., *et al* (1999) Mental disorder and clinical care in people convicted of homicide: national clinical survey. *British Medical Journal*, **31**, 1240–1244.

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Sir: Szmukler (*Psychiatric Bulletin*, January 2000, **24**, 6–10) and Maden (*Psychiatric Bulletin*, January 2000, **24**, 37–39) make thoughtful comments on the need for external independent inquiries following homicides by those known to the psychiatric services. As someone who has chaired such an inquiry (Prins *et al*, 1998) a few additional comments come to mind. First, the need for official and widespread dissemination of findings from the numerous inquiries that have been conducted so far. This is not to undervalue recent unofficial accounts such as those compiled by Reith (1998) and by the Zito Trust. Second, although Szmukler and Maden comment on the stress experienced by those being scrutinised and the impact on relatives, there is also the strain felt by inquiry panel members who try to establish a sense of 'fair play' for all parties. Third, it is important to remember the degree of arbitrariness that exists in the setting up of these inquiries. There is no similar mandate for an external independent inquiry into homicides committed by non-psychiatric patients, for example, those who may be under supervision by the probation service. Finally, it is a well recognised fact that whether an assault ends in the death of a victim may depend upon a degree of serendipity, for example, the thickness of a victim's skull, their general health or the availability of emergency services. I understand that the Department of Health has a working group considering the future of homicide inquiries. I await their report with interest.

PRINS, H., ASHMAN, M., STEELE, G., *et al* (1998) *Report of The Independent Inquiry into the Treatment and Care of Sanjay Kumar Patel*. Leicester: Leicestershire Health Authority.

REITH, M. (1998) *Community Care Tragedies*. Birmingham: Venture Press.

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Sir: George Szmukler makes some excellent points in his article (*Psychiatric Bulletin*, January 2000, **24**, 6–10). It is indeed impossible to predict rare events like homicide, for the sound mathematical reasons he quotes. The phenomenon of retrospective distortion should be understood by everyone who is tempted to be wise with hindsight. Inquiries are very probably, as he says, a waste of time and money, repeated time and again and no more useful than an obsessional symptom to a patient with a neurosis.

In one sense, however, it is our own fault. It is easy for psychiatrists to fall into the trap, to collude with the illusion that we are effective in preventing individual tragic outcomes. The threat of such events is, after all, about the only shroud-waving potential that the subject possesses, in the battle for funds. The unit where I work is one of the most modern and attractive buildings in the country, yet its closure as part of the rationalisation of services, has produced scarcely a murmur of protest. I suspect it might be different, if the public believed it was full of dangerous people, who were only prevented from committing crimes by the skills of those looking after them.

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Greater support for senior house officers

Sir: The paper by Dewar *et al* (*Psychiatric Bulletin*, 2000, **24**, 20–23) makes a very interesting read and triggered memories of a suicide I faced as a senior house officer in training. I had seen a young man in the accident and emergency department while on call. He expressed suicidal ideas and had a primary diagnosis of personality disorder. A decision was taken to discharge him to his general practitioner's care after discussion with a senior consultant. Unfortunately he committed suicide seven weeks later.

I was unprepared for my own reaction, a mixture of surprise, disbelief and guilt. I had been the last professional in contact with the patient and I was required to prepare a report and appear in the coroner's court. Over the next six months I was fraught with fears and anxiety. I received no support from colleagues and seniors and the only person who was any

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help was the solicitor instructed by my trust to defend me in court.

Having read the paper by Dewar *et al*, I feel I would have benefited from some training for the consequences or the organisational procedures following suicide. I feel I should have had a mentor or a similar senior person to open up to.

Senior house officers are the most vulnerable doctors, owing to their relative inexperience and the fact that it is often the first time they come across suicide. There should be a better support network when something on these lines occurs.

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Experience of community treatment orders

Sir: We wish to reply to Moncrieff & Smyth's paper on community treatment orders (CTOs) (*Psychiatric Bulletin*, November 1999, **23**, 644–646). We write as British psychiatrists working in Melbourne where CTOs have been in use since 1987. In our service 161 adults (18–65 years) out of a total catchment area population of 225 000 are subject to a CTO. CTOs are regarded as part of good clinical facilitating treatment in the least restrictive environment many lasting for only a few months after hospital admission.

The CTO enables the clinician to insist on clinic attendance and the patient's acceptance of oral or intra-muscular medication. If the patient refuses to comply then the CTO may be revoked and the patient admitted to hospital, usually for a very brief period. This ultimate sanction is rarely required. The CTO is only one part of a comprehensive biopsychosocial care plan. An order may alter the dynamics of care, but the clinician–patient relationship is usually remarkably well preserved. In our clinical experience, CTOs are most helpful if some sort of therapeutic alliance has been established. This alliance can be continually developed and improved particularly by psychoeducation sessions.

We dispute Moncrieff & Smyth's surprising statement that CTOs would increase the amount of medication administered and, therefore, side-effects. In our experience, doses as low as 20 mg of flupenthixol depot monthly are sufficient to spare an insightless patient the indignity of regular compulsory admissions to hospital with all the extra medication and restrictions that these inevitably entail. A prolonged symptom-free period may demonstrate the benefits of psychiatric care to a person with a recurrent psychotic illness.

The introduction of CTOs in Victoria was an integral part of the state-wide development of community care. They are not now, and never were, intended to be a means by which psychiatry could control antisocial behaviour.

The efficacy of CTOs has not been established, but having practised with them and without them we feel that they have an important part to play in good clinical care. We agree with Burns (*Psychiatric Bulletin*, November 1999, **23**, 647–648) and wish to move the debate away from the issue of prevention of violence towards the provision of humane, community-based care.

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Sir: The issue of community treatment orders (CTOs) continues to create difference within the College, but Moncrieff & Smyth (*Psychiatric Bulletin*, November 1999, **23**, 644–646) have added nothing new to the debate. Rather, by drawing the issue away from the practical question of how to help a small group of vulnerable people, towards vaguely defined issues of social control, they may be doing psychiatry a disservice. They have been selective in their references, avoiding the many articles evaluating CTOs in other countries, for example the USA and Australia. Most of their arguments are as relevant to any kind of compulsory treatment as to that specifically located in the community.

The notion, furthermore, that it was "concern for patient rights that underscored the move away from the asylums" is only partially true. There were certainly concerns about institutionalisation, recognised by numerous hospital inquiries, but the impacts of modern medication and of the resource implications of an ageing real estate were just as powerful. The rising demand for medium secure unit beds reflects the way in which the asylums are returning, in another form, while the rising level of Mental Health Act sections reflects the distress of a number of chaotic, relapsing individuals for whom current community provision is simply inadequate.

One of us recalls a rather angry argument in the 1970s, about the introduction of car seat-belts, in which a senior physician suggested that it was a gross infringement of personal rights to be ordered to wear a belt. Yet the impact of a seat-belt law, in terms of reduced head injury and general morbidity and reduced mortality, has been immense. With the appropriate legal safeguards, the use of enhanced tribunals or other legal agencies to monitor community treatment, and reversion of psychiatrists to their proper role (as therapists rather than turnkeys), it would seem to us that history can inform the usefulness of the CTO approach.

We strongly concur with Burns (*Psychiatric Bulletin*, November 1999, **23**, 647–648) that these orders are not about bad behaviour, but about therapy and treatment for people with limited insight who have a right to such treatment. The challenge to psychiatry lies in educating the public that untoward behaviour will always occur, even with CTOs in place. The problem with the language of 'social control' is that it makes it very easy to be a bad Samaritan.

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Survey of supervised discharge of mentally ill people

Sir: A postal survey was conducted (April 1996–June 1997) to determine the attitudes of consultant psychiatrists working with adult, adolescent or psychogeriatric patients in the Wales Region towards the new legal powers.

After 12 weeks there had been a 31% (107/300) response rate. Only six patients in total were placed on supervised discharge by three of the 107 respondents. Twenty-eight of the 107 respondents stated that they had considered using the new legislation regarding supervised discharge, although 53 had reservations.

Three aspects caused concern when the respondents were asked about the factors that influenced the decision to recommend supervised discharge. Supervised discharge would generate an increased workload, for which resources are not available (5/107); there was no sanction on the patient if he or she did not comply (30/107); and, properly resourced community care could be used instead of supervised discharge (27/107). Several respondents commented that the legislation was insufficient in its powers and that the legislation would not be appropriate for patients lacking insight.

Respondents felt that confusion existed while processing the paperwork and the forms need to be simplified and clarified in order to avoid unnecessary time consumption.

Although the Act introduces a new somewhat convoluted system of procedures for supervised aftercare, and has serious implications for both human rights and the relationship between care professionals and their service users, it is difficult to see it as an improvement on the possibilities for intervention under

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