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CRIMINAL JUSTICE MATTERS

VIOLENCE IN CONTEXT

Mental disorders and violence: the lessons of the inquiries

Jill Peay

Official guidance recognises that mentally disordered people are less likely to harm others than themselves. Research evidence indicates that the link between mental disorder and violent crime is spurious, other than in specific and limited circumstances. And, as Sayce (1995) poignantly illustrates, significantly more psychiatric patients die whilst taking neuroleptic medication, than kill in the absence of it. It is paradoxical, therefore, that the same NHS Guidelines (1994: para 34) require that an independent Inquiry be held in every case of homicide involving people who have been in contact with the specialist mental health services, a paradox compounded by the requirement that in cases of suicide, a local multi-disciplinary audit will normally suffice. Moreover, for homicides by other groups, for example those on parole, bail or probation, no such independent inquiry is deemed necessary. A coroner's verdict as to cause of death, without any examination of the preceding events, is likely, in the presence of a guilty plea, to constitute the only public exploration of those events.

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The independent Inquiries

The NHS Guidelines have led to a plethora of independent Inquiries (see, for example Blom-Cooper et al 1995; Davies 1995; Ritchie et al 1994). Although only five have so far reported, twenty four have been set up. Whilst the impetus for them lies in the desire to identify shortcomings and enhance resources in the community for the care of discharged patients, the Inquiries attract considerable publicity. Ironically, this tends to reinforce the resilient and pre-existing association in the minds of the public with respect to the link between mental disorder and the perpetration of violent crime upon strangers. This, in turn, can undermine the public's willingness to support 'care in the community', thus further alienating the mentally disordered offender from the very community to whom the guidelines look for safe and successful care.

Moreover, whilst the terms of reference frequently focus upon the quality and standards of care and control received by the aberrant ex-patients, the Inquiries themselves find it hard to avoid the dangers of what Grounds (1995) calls 'hindsight bias'. As he eloquently details, hindsight bias causes us selectively to focus on rare events, in these instances, deaths caused by psychiatric patients, and attempt retrospectively to identify the contributory factors. But, by implicitly asking the 'if only' question, we make such events appear predictable and risk concluding that they might have been avoided. It is arguable that the identification of such 'causal' factors should not be pursued at the expense of an examination of the day-to-day realities of patients' lives - for it is there that the real lessons have to be learnt.

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The lessons

What do the Inquiry reports tell us? The first lesson concerns the contrast between what we can't predict and what we should have known. The reports illustrate how we listen too little to those who know best - those, like families, who have genuine longitudinal knowledge - and we rely too much upon bureaucratic practices and documentation which can be inaccurate, absent or, as these reports powerfully detail, subject to erosion.

Secondly, the detailed histories of care and treatment the Inquiries provide constitute a catalogue of failure and missed opportunity. But is this a failure to care, a failure to know how to care or an inability to do so for those who know how? Care in the community is problematic in concept and practice. To be undertaken properly, and the Inquiry reports variously document how this might be achieved, care in the community is expensive and labour intensive. It requires co-ordinated teamwork; this can be difficult and stressful in the absence of an institutional base.

The final contrast is between what is and what might be. The picture of care by ill-equipped and under-qualified voluntary bodies, by reluctant GPs, all too ready to divest themselves of difficult patients, or of life on an acute ward, the kind of environment where Andrew Robinson, Christopher Clunis and John Rous could have spent their time as formal patients, is barren. It is a world where professionals seemingly react rather than being proactive in care.

Thus, the lessons to be learnt from these Inquiries are not about how to prevent or predict such tragic events - since by their nature they are largely unpredictable. Nor should we attribute too great a power of foresight or give too great a power to those we ask to prophesy. Rather, their value lies in focusing attention on the standards and quality of care provided for the great bulk of patients who have not been and probably will never be 'dangerous' and hence, are unlikely to attract public attention.

The context of violence

These people should, nonetheless, be central to our concern. Violence occurs in a context. Although the context is more frequently substance abuse than psychiatric disorder, we should not dismiss the challenge that people suffering with psychiatric disorder pose. Their problems also occur in a context. This is partly systemic - frustration, over-stressed and under-resourced services and staff - and partly personal; those, for example, in the acute phase of a psychotic disorder who have previously acted out their fantasies and who make threats to kill should be treated with great caution. However, more

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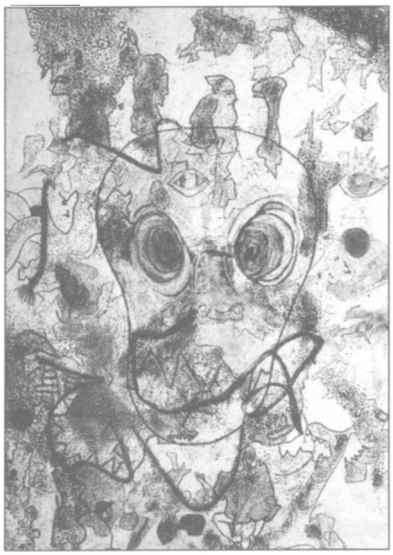

legislation, greater control, extended monitoring will focus on a select but possibly inappropriate few. For it is sad, but true, that we can neither know whether the deaths of, amongst others, Georgina Robinson, Jonathan Zito and Jonathan Newby could have been prevented nor whether the deaths of other, nameless, individuals have unwittingly already been avoided because of unheralded actions.

The way forward

Finally, it is important to stress that these Inquiries are preceded by personal tragedies. Although the events represent a tragedy for everyone involved they do not necessarily lead to a baying for blood by those most directly affected. Jayne Zito, Jonathan's widow, has been the driving force behind the establishment of the Zito Trust, which is working to improve the provision of community care for the severely mentally ill and establish a network of support for the victims of the failure of care. Her aim, as recorded in the *Clunis Report* (Ritchie et al 1994: para 2.1.5) is 'not to ensure that dangerous or potentially dangerous mentally ill people are locked up'. Jayne Zito wants them to have proper care so that they and the public may be safe. Then, she feels, her husband would not have died in vain.

Thus, we should concentrate our efforts on the mundane, not the exotic. For the latter will lead us to make provision for rare events, better avoided by quality care for all not expensive mopping-up. Think horses not zebras. ■

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Jill Peay is Senior Lecturer at Brunel University.

Purchasing Health Care for Mentally Disordered Offenders

Caroline Newman

The Mental Health Foundation is currently conducting a project to improve the purchasing and commissioning arrangements in the health and social services for mentally disordered offenders.

Over the last five years the Mental Health Foundation has been involved in developing policy, funding research and projects and generally raising awareness of the difficulties faced by professionals in the criminal justice system when they come into contact with mentally disordered offenders, either at police stations or at courts.

During this period it has become apparent that mentally disordered offenders who are assessed, either at courts or police stations, often need to be referred to the health or social services, but in many places too little attention has been given to commissioning the services they need. This is also a time of major change within both health and social services. Since 1991 managers in the health service have been required to purchase services from a range of providers.

More recently the same requirements have been made of social services. In addition local government is being reorganised and unitary authorities are being created. Social services are expected to provide a public service, at the same time as becoming more competitive. While these changes are taking place and systems are evolving, all parties are learning how best to operate the systems for the benefit of people who use the services.

During the 18 months of the project, materials will be developed, produced and disseminated. These will include examples of good practice and clear guidelines suggesting how services for mentally disordered offenders can be purchased and commissioned, the matters which ought to be covered in contracts and the standards of treatment and services which should be provided.

A very important element of the project will be the publication of a booklet specifically for professionals working in the criminal justice system explaining how the new 'market' arrangements in the health and social sectors. It will also inform professionals about how they can influence the services which are purchased and commissioned in their local areas. The booklet will be available from the Mental Health Foundation at the end of 1995.

Caroline Newman is Project Manager with the Mental Health Foundation.

37 Mortimer Street
London W1N 8PX
Tel: 0171 580 0145