Correspondence

EDITED BY LOUISE HOWARD

Predicting violence

Sir: Although the authors of the PRiSM Psychosis Study (November 1998) acknowledge that its quasi-experimental design militates against statistical generalisability, useful lessons can be learnt from its conclusions. One of these lessons is related to predictions about violent acts committed by people with severe mental illness. Public concern about this issue is rightly acknowledged in the third paper of the series (Johnson *et al*, 1998).

The quantitative characteristics of the performance of models that predict some rarely occurring outcomes are often poor. It could then be argued that the intensity of professional involvement with some patients is largely influenced by subjective predictions of such outcomes. In this context, we often act more vigorously when we are worried about a patient committing serious violence.

I will assume that this type of professional behaviour was reflected in the study. However, my assumption is questionable since the study conditions may have affected such behaviour.

The category 'currently viewed by staff as at risk of committing violent acts' (here, 'staff views') was used in the study, showing a frequency of 23 (21% of valid cases) in Nunhead, 9 (6%) in Norwood, and 32 (13%) overall. The frequency of the category 'episode of violent/threatening behaviour' was 18 (17%) in Nunhead, 6 (4%) in Norwood, and 24 (9%, 95% CI 6–13%) overall.

Assuming that 'staff views' entered the initial logistic regression model (not clarified in the paper), it was not included in its final model. This would indicate that this category is not helpful in prediction, and that predictions based on it would result in a high false positive rate.

Many of us envisage that recent Government initiatives and comments made about us by politicians will increase the shift towards professionals acting even more defensively, with a resulting further increase in false positive cases who will be more 'aggressively' treated. This professional attitude may complicate matters, since it has been suggested that intensive treatment increases the probability of some patients experiencing negative social outcomes.

To facilitate discussions on this topic, it would be helpful if the authors gave more details on the category 'currently viewed by staff as at risk of committing violent acts', such as its sensitivity, specificity, etc.

Johnson, S., Leese, M., Brooks, L., *et al* (1998) Frequency and predictors of adverse events. PRiSM Psychosis Study 3. *British Journal of Psychiatry*, **173**, 376–384.

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Homicide and failure of community care

Sir: Burns & Priebe (1999) say that "It has little impact to point out that the homicide rate by people with mental illness has been stubbornly unaffected by community care policies" and list, among the serious shortcomings of English services, "the excessive preoccupation with risk". Of interest is whether the rate has fallen. If not, despite vast expense and the remodelling of the entire psychiatric system, it may appear to offer neither value for money nor protection for the public. The relatively stable homicide rate may represent a balance between de-institutionalisation and the management of risk to others in the community, for instance by the use of compulsory detention.

Taylor & Gunn (1999) found that up to 11% of unlawful killings in Greater London and the Home Counties were by people with schizophrenia and other psychoses. If the prevalence of schizophrenia and other psychoses is taken as 0.25%, the risk of homicide is thus approximately 40 times that in the general population. If there are 40 deaths associated with 125 000 people with psychoses in the UK, using the comparison of 25 million drivers being associated with 3500–4000 road deaths, the rate of homicide is twice that of road deaths. Lower rates of psychosis would produce a relatively higher risk. If the figure of 300 deaths from dangerous, including drunken, drivers is used, then there are at least 20 times as many homicides per person with psychoses as road deaths per vehicle user through dangerous driving. Even if we decide what is an acceptable level of risk to others, society's attitudes to the numbers of road deaths and homicides by the mentally ill emphasises that there is a social construction to the concept of risk which figures alone will not dispel.

It will be fascinating to see whether a range of secure services, in-patient beds, 24-hour nursed care and good-quality community provision, including assertive outreach, will make an impact in respect of risk to others, including homicide, but we do not yet know (in east London we do not have the necessary services). As such things are not a research 'experiment' we may never know.

Burns, T. & Priebe, S. (1999) Mental health care failure in England. Myth and reality. *British Journal of Psychiatry*, **174**, 191–192.

Taylor, P. J. & Gunn, J. (1999) Homicides by people with mental illness: myth and reality. *British Journal of Psychiatry*, **174**, 9–14.

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Suicide in farmers in India

Sir: Farmers' high rates of suicide in India in mid-1998, together with the paper by Malmberg *et al* (1999), demonstrate that suicide in farmers is a public health problem having no borders. Some of the risk factors and methods of suicide (Hawton *et al*, 1998) among farmers in North America