

Correspondence

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Time to start taking an internet history?

Young people are turning increasingly to the internet to meet their educational, entertainment and social networking needs, and in times of emotional or psychological difficulty, they may likewise seek information online. The scope for anonymity, information, interaction, and sometimes fantasy, without fear of repercussion, makes the web an obvious choice for young people who are reluctant to disclose their difficulties to parents or professionals.

In the aftermath of the Bridgend suicides, recognition of the dangers of life online was recently highlighted by a government pledge to strengthen the Suicide Act 1961 by specifying the illegality of any internet activity which encourages suicidal behaviour.¹ The move comes in response to public concern over internet safety, particularly for young and vulnerable groups, who may access websites or online communities that promote suicide or self-harm. In this context, and with approximately 170 000 adolescent self-harm hospital presentations per year,² the revised legislation is an important and timely step.

A new diagnosis of 'internet addiction' has been proposed³ and much of the current research into this problem comes from Asia, where cardiopulmonary-related deaths and even game-related murders in internet cafes are now regarded as serious public health issues. In the West, most psychiatrists share the general population's ignorance and minimisation of internet-related psychopathology.

Eliciting a careful and sensitive internet history as part of routine psychiatric history taking may prove invaluable in assessing young people at risk of self-harm and suicide and in uncovering other aspects of psychopathology associated with excessive or unhelpful internet use. Above all, further research into the relationship between online activity and mental health among adolescents and the general population is crucial if we are to manage risks associated with internet use and also take advantage of potential benefits of new technologies.

- 1 Ministry of Justice. *Suicide and the Internet – Updating the Law*. TSO (The Stationery Office), 2008 (<http://www.justice.gov.uk/news/newsrelease170908a.htm>).
- 2 Oldershaw A, Richards C, Simic M, Schmidt U. Parents' perspectives on adolescent self-harm: qualitative study. *Br J Psychiatry* 2008; **193**: 140–4.

- 3 Block J. Issues for DSM–V: internet addiction. *Am J Psychiatry* 2008; **165**: 306–7.

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Homicide due to mental disorder

The article by Large *et al* describes the rise and fall in homicides attributed to mental disorders in England and Wales over the past 50 years.¹ Since 2000, the rate of homicide due to a mental disorder in England and Wales has been 0.07 per 100 000 or lower. Encouraged by the authors, we examined the rate of homicides due to a mental disorder in The Netherlands. Dutch law considers responsibility for crimes to be diminished if there is a causal relationship between a mental disorder and the crime committed. Five degrees of responsibility are defined (i.e. complete responsibility, slightly diminished, diminished, considerably diminished, and total absence of responsibility). A severe psychiatric disorder, usually of a psychotic nature, is a necessary condition for a 'total absence of responsibility' finding.

From 1212 cases of homicide between 1 January 2000 and 31 December 2006, 1020 (84.2%) defendants were psychiatrically assessed pre-trial. Of these, 58 (5.7%) were considered to have total absence of responsibility. Furthermore, 63 (6.2%) were found to have considerably diminished responsibility, 239 (23.4%) diminished responsibility, 309 (30.3%) slightly diminished responsibility, and 259 (25.4%) complete responsibility. A psychotic disorder was diagnosed in 115 (11.3%) people, which is in line with earlier studies.² The rate of homicide due to mental disorder would be 0.11 per 100 000 when individuals with a total absence of or strongly diminished responsibility are included. If individuals with a diminished responsibility are also included, this would be 0.32 per 100 000.

The difference between England and Wales and The Netherlands may be explained by a different view on the issues of a diminished responsibility.³ This may also explain the rise and fall of homicides due to mental disorders in England and Wales over the past 50 years.

- 1 Large M, Smith G, Swinson N, Shaw J, Nielsen O. Homicide due to mental disorder in England and Wales over 50 years. *Br J Psychiatry* 2008; **193**: 130–3.
- 2 Taylor PJ, Gunn J. Homicides by people with mental illness: myth and reality. *Br J Psychiatry* 1999; **174**: 9–14.
- 3 Dell S. The mandatory sentence and Section 2. *J Med Ethics* 1986; **12**: 28–31.

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A conclusion in the abstract of Large *et al*¹ is illogical. If the same sociological factors causing increase in 'other' homicides up until the 1970s had caused the increase among the mentally ill, then they should have continued to have exerted this effect, with a continuing rise corresponding to 'other' homicides instead of a fall. Similarly, if the subsequent decline in homicides among the mentally ill were due to improvements in psychiatric treatment and service organisation as the authors suggest, then the rise in their rates prior to that period must have been due to the converse: a deterioration in quality of treatment and service organisation. The obvious explanation (which is now politically incorrect) is the closure of mental hospitals and rehabilitation at that time because of almost non-existent community care.