Homicide, inquiries and scapegoating

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Homicide

Homicide is in the news and community care is being blamed, a view not justified by the facts. Much has been written about the homicides of Johnathan Zito and Georgina Robinson and there has rightly been considerable public and professional concern. There have been other reports on the murder of Johnathan Newby in October 1993 and William Bennett in July 1994. Yet another case is currently the subject of an inquiry and again the press is expressing indignation and horror. The anxiety and concern are natural but the reactions are not justified.

This has encouraged me to bring together the figures for homicidal patients admitted to the Special Hospitals since 1972 (Table 1), and the total national figures for homicide in these same years. The term homicide includes those committed to a Special Hospital for both murder and manslaughter, since many may have been regarded as having shown diminished responsibility as a result of their mental disorder.

Table 1. Offences[1] initially recorded by the police as homicide by current classification[2] in England and Wales

Year	Offences initially recorded as homicide[2]	Offences no longer recorded as homicide[2]	Offences currently recorded as homicide		Special Hospital patients convicted of murder or manslaughter[3]
			Number[2]	Number per million population[2]	
1972	480	71	409	8.3	51
1973	465	74	391	8.0	32
1974	599	73	526	10.7	36
1975	508	65	443	9.0	34
1976	565	77	488	9.9	25
1977	484	66	418	8.5	19
1978	535	64	471	9.6	25
1979	629	83	546	11.1	32
1980	621	72	549	11.2	33
1981	556	57	499	10.1	30
1982	618	61	557	11.2	25
1983	552	70	482	9.7	31
1984	619	82	537	10.8	31
1985	625	89	536	10.7	33
1986	660	94	566	11.3	33
1987	686	86	600	11.9	42
1988	645	96	549	10.9	38
1989	626	101	525	10.4	33
1990	663	105	558	11.0	35
1991	726	95	631	12.4	44
1992	682	88	594	11.6	39
1993	675	69	606	11.8	—

1. A separate offence is recorded for each victim of homicide, so that in an incident in which several people are killed, the number of homicides counted is the total number of persons killed.
2. As at 5 August 1994; figures are subject to revision as cases are dealt with by the police and by the courts, or as further information becomes available (*Criminal Statistics: England and Wales 1993*, 1994).
3. Patients with diminished responsibility (SHAS, 1994).

Sheppard (1995) has produced, for the Zito Trust, a very useful report summarising 39 of the inquiries held since the Ely inquiry in 1969 until 1994; the majority are in hospitals for those with mental illness or learning disabilities. In the earlier years, most of the inquiries were considering the ill treatment or neglect of patients, the occurrence of an unusual number of suicides or severe administrative difficulties. Only one inquiry considered the homicide of a nurse in Tooting Bec hospital in 1974 and in 1988 there was an inquiry into the case of a social worker killed in her hospital office. The first inquiry into a killing by a discharged patient took place in 1991 and, since then, there have been at least four further inquiries. The number of patients admitted to the Special Hospitals having committed homicide has not increased. Figures supplied by the Special Hospitals Service Authority (SHAS, 1994) show that the number of people charged with homicide and subsequently admitted to the Special Hospitals between 1972 and 1992 has remained remarkably constant (Table 1). There are differences in the total number of homicides committed in England and Wales in the same period, and these show a considerable increase.

It is difficult to compare these figures with those obtained by the Steering Committee of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People (1995) which had a different remit; this was to identify killers who had been in contact with a psychiatrist in the 12 months before the homicide took place. In the three years 1991, 1992, and 1993, only a total 34 cases were identified where there had been such psychiatric contact in the preceding 12 months. The report concluded that "homicide committed by psychiatric patients is very rare indeed, in relation to the numbers of such persons who are admitted to hospital." One is not anxious to suggest that the relative rarity of these homicidal events, which grab public attention, makes them any less serious or distressing to the families and friends of the victims and, in some cases, of the assailant.

But there seems to be a very different view of an inquiry on a hospital patient and on a patient discharged to the community. There is a frequent suggestion that these incidents have increased due to the implementation of community care. Yet the data deny this. Has there been a change in the behaviour of psychiatric patients, or is it a change in the attitudes of the public, the media and the professionals? Sayce (1995) points out that while people tend to recognise the names of homicidal patients they do not know the names of those who have died in Broadmoor. Perhaps it is another expression of the fear that parents are said to have that the world is a more dangerous place for their children then it was in their own childhood. Certainly the media do not give reassurance about psychiatric homicide. But in spite of assurances that the world is no more dangerous than it was, parents were not convinced and the fear may be the result of a lost sense of shared social order. Perhaps it is the same with psychiatric homicide.

Other possibilities are that people and the press have become aware of community psychiatry since the enactment of the National Health Service and Community Care Bill in 1990 or the realisation that the large 'water-tower' psychiatric hospitals are being closed. The public seem to believe that these unfortunate homicides could be prevented if community care was better financed. Others hope and believe, unrealistically, that all would be well if patients were returned to live in a hospital and made to take their maintenance doses of medication. This tends to confirm Menzies Lyth's (1988) view that hospitals and other institutions can be seen as a defence against the public's anxiety.

Inquiries

The inquiries reflect a shift in public feeling and concern that the psychiatric over-control of patients demonstrated in the earlier inquiries has shifted to the under-control suggested in the more recent reports.

Inquiries are useful when they indicate shortcomings and we must take them seriously. They are often essential to conciliate the relatives of victims and to reassure the public. But they raise important issues especially in regard to the coordination of, and communication between, staff members, between services and between districts. There are defects in the assessment of dangerousness and the issue of confidentiality, especially as it concerns the involvement of family members and other carers, is not addressed. Yet we have to accept that there are and will be occasions, in both hospital and community, when people for whom little positive action can be planned will escape the attempts that are made and perform quite unpredictable homicidal or suicidal actions. Of course there will be failures too of staff to appreciate the risk or take appropriate action. It can be argued that this should not protect any service from inquiry (Grounds, 1995) but the disadvantages are less commonly considered.

Such inquiries cause distress to perfectly harmless individuals who may be suffering from depression or anxiety and feel that they will be regarded as potentially violent. It also has an effect on psychiatric staff in whom it may generate an attitude of defensive psychiatry, and make problems of confidential communication even more difficult. Finally, there is the cost of these enquiries. Justice Sir John Donaldson wrote in 1987 (Daniels & Sabin, 1995) that since

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resources are finite it is a difficult balance to decide "whether we should be using up NHS resources by requiring the (Health Authorities) to stop doing the work for which they were appointed and to meet the complaints of their patients" and, one might add, the public. Community care has to work on the basis of personal relationships rather than on the production of a mass of bureaucratic paperwork. It is not possible here to consider all the questions about violence by psychiatric patients, nor all the issues raised by these inquiries. Surely what is needed is more training and a consideration of the 300 concerns raised and recommendations made in previous inquiries (Sheppard, 1995). Who has read all the inquiry reports or can take account of them in their daily practice, in spite of the very considerable cost of each inquiry?

Scapegoating

In the last five years what impresses one is not the stigma of mental illness, but the increased willingness, particularly by the press (Philo *et al*, 1993), to scapegoat the mentally ill. There has been *no increase* in the number of homicides admitted to Special Hospitals when care and treatment in mental hospitals has been transferred to the community. The value of repeated inquiries is also considered, for they do little to lessen scapegoating. As Williams (1956) said "We see then in the fantasies of patients and of others in the community the individual who is set apart, marked sinful, not to be associated with; the 'scapegoat' described by Sir James Frazer, as the animal or human being on whom are loaded every year the evil desires and acts of the community, who is sent away or abandoned, taking the evil away from a community relieved of its sins."

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