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.

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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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