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Population rates over time of homicide by persons with schizophrenia

The findings of Flynn and colleagues[1] are important, but certain interpretations may be incorrect. It is potentially misleading to draw any conclusions on homicides by people with schizophrenia based on percentages of the total if overall rates show changes. The authors demonstrate that overall age-standardised homicide rates initially rose then have fallen over time in England and Wales. But there is no corresponding figure which shows rates over time among people diagnosed with schizophrenia. This is an important omission. An early study showed remarkably stable rates for mentally disordered homicide offenders in England and Wales over time, based on court adjudications.[2] Flynn and colleagues have better data to test this possibility. If rates for schizophrenia remained the same while the overall rates fell, it cannot then be concluded that substance misuse or any other unknown, complex factors had 'driven' anything. It would then mean their findings reflected, first, the failure of mental health services despite their changing configuration to have any impact whatsoever on homicide by persons with schizophrenia; and, second, decreasing willingness over time by psychiatrists to offer a bed when the offender appears in court, or to conclude that their responsibility is diminished. More persons with schizophrenia would then inevitably be sent to prison.

Unfortunately, persons with schizophrenia who have killed do not suit prevailing UK service provision of home treatment or early intervention. Courts require robust assurances that the public will be protected from them in future. There is also a worrying trend for secure services to return their patients to prison, where they are lost to follow-up. The authors rightly point out that it is difficult to obtain a secure bed in the first place. It could be that secondary diagnoses of substance misuse and personality disorder have increasingly provided the convenient excuses necessary to reject these patients for psychiatric treatment. Research findings on the impact of schizophrenia on violence and the role of substance misuse have been unhelpful to clinicians and are inconsistent, confusing multiple associations of an unspecified nature with causation.

The authors are to be complimented for not relying solely on diagnostic labels with doubtful temporal proximity to the homicide and, most importantly, for demonstrating that the large majority of persons with schizophrenia who killed had active psychotic symptoms at the time. These can be causative factors for violence,[3] whereas with diagnostic labels, it is impossible to tell.

Could they provide comparative population rates over time for persons with schizophrenia compared with all others? It might then be possible to infer whether population risk and protective factors for homicide perpetration are likely to be similar or very different.

Conflict of interest

None declared.

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MHTRs – orders without any home

The editorial by Taylor et al on the Sentencing Guidelines (2020) is welcome and rightly emphasises the availability of the Mental Health Treatment Requirement (MHTR) as an underutilised disposal for those whose culpability is diminished but not abolished by mental disorder, and whose longer-term mental health and recidivistic outcomes could be improved by a period of structured community supervision and treatment. Notwithstanding some problems that might exist with this order inherently (e.g. no review process for pharmacological treatment as directed, cf. a Mental Health Act Community Treatment Order; no form of review process as to ongoing suitability except in the context of a breach), one of the most challenging problems is whether there are going to be any mental health teams willing or structured to supervise it.

The NHS Long Term Plan and associated policy (e.g. The Community Mental Health Framework for Adults and Older Adults (2019)) is underpinning structural reorganisation of non-forensic community mental health services, whereby the community mental health team model is transforming to primary care network-embedded community teams with a much different remit in terms of long-term follow-up, being focused on interventions to improve quality of life and integration within services. Similarly, the care programme approach structure appears to be in the process of being 'phased out' in favour of an alternative, as yet unclear, structure.

Simultaneously, while the development of specialised community forensic teams is a welcome development, the gap in terms of not being universally commissioned to take on people with mental health problems released from prison, even if high risk, and indeed not all people discharged from secure services if the risk is deemed lower than threshold, is not likely to provide the supervision element of the MHTR.

My own experience of attempting to persuade both forensic and non-forensic mental health teams to take people under MHTRs is almost universally met with resistance, poor understanding of the framework and its uses, and a preference to 'let the CJS deal with it and if they want to engage they can'. The sentencing guideline is therefore helpful for sentencers, but without significantly improved awareness among non-forensic professionals *and* a specific clear remit of the new networked teams to work with such orders, I fear that they will be used no more and possibly less than historically.

Conflict of interest

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