Quality Assurance in Forensic Psychiatry as Crime Prevention: Homicide in Auckland, New Zealand 1990-1992

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Introduction

This paper will introduce the principles of quality assurance as it relates to forensic psychiatry, before discussing in some detail the structure and functioning of the Regional Forensic Service, Mental Health in Auckland, New Zealand.

A brief discussion on recent referral trends is followed by a discourse on some aspects re specific pathways of individuals referred between Justice and Mental Health. An examination of the clinical profile starts with specific profiles of individuals referred to the Acute Assessment and Admission Medium Secure Unit (Kauri) before profile patterns of individuals referred to the whole of the service are presented.

Principles of Quality of Service and Assurance are debated in relation to its relevance to the Auckland situation, specifically to the presented clinical review of all individuals referred over the last three years (and since then sentenced). Consumer and service-related issues are discussed in some detail before connections are suggested between some of the review's findings on the one hand and the assessment of dangerousness on the other hand.

Finally, the summary will highlight some of the more relevant findings in relation to individuals referred and our service.

Method

All available correspondence; (clinical and other files) in relation to all 55 individuals (49 male, about 89 per cent; 6 female, about 11 per cent) charged with homicide (using the wider approach taken by Community Service Orders, Department of Justice, Wellington 1984; Submission, Department of Justice, Wellington, 1986; New Zealand Police, Auckland 1992; Conviction and Sentencing, Department of Justice, Wellington, 1992) and referred for a psychiatric assessment to the Regional Forensic Service, Mental Health, Auckland between the three years of 1990-1992 inclusive, were reviewed, with specific emphasis on court reports and caption sheets. The clinical admission book in the Kauri Unit, (Mason Clinic) was consulted regarding specific parts of the review that is the recommendations and the outcome. In selected cases court, police and justice files were available as a matter of routine clinical work.

Results

The following is not intended to be a comprehensive account of the actual presentation, but is a selection of specific areas which might be of particular interest.

Both quality of service and assurance has become an integral part in medicine today. This is of particular importance
during the changes currently happening in the provision of medical and related services in New Zealand where a split into purchasers and providers has major implications for health service in New Zealand (Department of Health, 1992; Jenkins 1990, pp. 500-514).

The Mason Report 1988 set the scene for a total reorganisation of psychiatric services in Auckland and for that matter, New Zealand (Psychiatric Report 1988). The Regional Forensic Service, Mental Health in Auckland has since its inception in 1988 been in the forefront in New Zealand to comply within a culturally appropriate context with the report's recommendations. Within the context of offering a readily accessible and efficient service the Regional Forensic Service sees some of its objectives in the reduction of the incidents of mental disordered offenders, reduce reoffending, relapse and readmission as well as preventing re-entry into the criminal justice system of individuals with a mental disorder. Meaningful indicators for the various activities are currently being developed. This paper will address some of the early trends and results.

The Forensic Service itself has about 150 employees, (including four psychiatrists), with a budget of $NZ7 million and currently serves about 1.3 million people in the northern part of the North Island of New Zealand. The service receives about 2,000 referrals per year - about 10 per cent of all referrals to general psychiatric services in Auckland. The service has 60 beds, divided into acute and sub-acute, medium-secure facilities, a minimum-secure rehabilitation service and an `open' hostel within the hospital grounds.

Recent trends show that the increasing number of referrals to the newly established Court Liaison Service (1,000 per year) coincides with a decrease in the number of prison referrals, possibly indicating a `filtering out' of mentally disordered (alleged) offenders in court and referring relevant individuals to more appropriate placement than prison.

Specific research into the pathways of individuals charged with homicide over the last three years show that 29 individuals (nearly 53 per cent) out of a total of 55 individuals between 1990-1992 are referred to prison for a psychiatric report in custody, while 26 individuals (about 47 per cent) are sent to the Regional Forensic Service for a psychiatric assessment in hospital. Virtually all referrals to hospital were by most staff involved deemed to be of an acute and urgent nature.

In this context it is interesting to examine the admissions of all individuals under section 121 (2) (b) (ii) of the Criminal Justice Act 1985 (1986) sent to the Acute Assessment and Admission Kauri Unit of the Mason Clinic for a psychiatric assessment during the first twelve months since its opening in May 1992. It is notable that charges of violence against persons (excluding sex offences) were the most common charges, (34 cases or 50 per cent of the total of 68 admissions). In 23 cases (nearly 68 per cent) assault was the most common charge, while homicide featured in five cases, or about 14 per cent. Excluding individuals with a personality disorder, the most common psychiatric diagnosis overall (n=34) was schizophrenia in 12 individuals (just over 35 per cent) with the most common charge of all individuals suffering from schizophrenia being assault in 9 cases (75 per cent). Both the individuals charged with murder and manslaughter suffered from schizophrenia; one of the three individuals charged with attempted murder also suffered from schizophrenia.

Psychiatric diagnosis in this context relates to Axis I, DSM III-R diagnosis only (DSM III-R 1987). It excludes Axis II diagnosis, for example personality disorders unless mentioned otherwise.

The most frequent clinical and epidemiological variables made up the clinical profile of all (55) individuals referred to the whole of the forensic service between 1990-
1992. It suggests the following pattern: being a relatively young, unemployed male person (around the age of 30) charged with having murdered a person known to him, usually during the weekend and following an argument. The most frequently used weapon was a knife (which would include machetes). The clinical reason for the initial referral was a question of a psychotic illness in the widest sense (27 out of 55 individuals - 49 per cent). The final diagnostic formulation in 15 individuals (about 27 per cent) related to a personality disorder, followed by ‘no formal major psychiatric diagnosis’ in 14 individuals (26 per cent) of the total number of all individuals referred. Schizophrenia (as per DSM III-R Axis I) was noted as the most common diagnosis in 11 individuals, (20 per cent of all individuals referred) (DSM III-R, 1987). Six individuals suffering from schizophrenia (about 55 per cent) were charged with murder.

The most likely contributing factor to any motive for the offence (all n=55, and sentenced in various forms at this stage) would have been a preceding argument in 25 cases, (45 per cent). In other words, a common denominator at the time of the offence related to the individual suffering from an acute exacerbation of a long-standing, usually stress-induced situation or emotional problem at the material time. The offenders described their behaviour at the time as an attempt to solve an insoluble situation (of both intra-and inter-personal turmoil), most of the time aggravated by the concurrent use of drugs, particularly alcohol. Both or one of these substance(s) were used or abused at the material time by 38 individuals (out of 55 persons referred - about 69 per cent), and by 8 out of the 19 individuals suffering from an Axis I-DSM III-R disorder (about 41 per cent).

The most frequent weapon used during the offence was a knife (including a machete) in 30 out of 55 incidents (55 per cent). In only three cases were firearms used (about 6 per cent), but 36 out of the 40 individuals I had direct contact with would have preferred a firearm (90 per cent), if it were available.

About 4 per cent of individuals referred were made ‘Special Patients’, s. 115 1 b Criminal Justice Act, that is, they were acquitted on grounds of insanity.

No copy-cat features were noted, nor was there any support for a recent Dutch study on crime in major western countries which showed that homicide might be related to gun ownership, rather than aggression (this information relates to reports through the media; the actual Dutch study is not available in New Zealand).

Discussion

Interpreting figures relating to homicide statistics can be an interesting exercise for many reasons (Bowden, 1990, p. 510; Crimes Act 1961, pp. 703-715). The following are selected areas of interest which might be of particular interest for ensuing discussion.

While our service is in the process of developing meaningful indicators of the quality of service provided against a background of quality assurance, we can so far document the following:

All individuals referred were admitted, if appropriate, within seven days (12 individuals) in 1990 and within four days in 1991 (33 individuals). In fact, over the last year (1992) all individuals referred (10) and admitted if appropriate, were offered a bed within one day (24 hours).

All our recommendations in 37 out of the total of 55 of our recommendations in our court reports (68 per cent) were immediately and totally followed, while eventually (cut-off period for outcome - assessment: 3 months) only in 3 cases (or 6 per cent) were our recommendations not accepted by the court. Overall (relating to all 55 individuals
referred) we are detecting a trend that an increasing percentage of recommendations are accepted if the severity (that is actual method) of both the (alleged) offence and the mental disturbance is of a substantial nature, while lesser bizarre degrees of (alleged) offence and mental disturbance show a lesser percentage of recommendations being followed by the court.

In this context, also of particular importance are Outcome Measures within the Quality Assurance procedures relating to the prevention of reoffending. We can note the following:

None of the referred individuals with a psychiatric disorder (in this context excluding individuals with a personality disorder) and under psychiatric care over the last three years (n=19, or 35 per cent) has reoffended regarding the index offence, or in a similar serious manner. One individual (in 19 or 5 per cent) was recently readmitted because of serious concern with respect to their mental state and potential dangerousness, no individual has committed suicide (during 1990-1992).

It is interesting to note that there has been a decrease in the percentage of mentally disordered, versus all individuals referred on homicide charges since 1990 (excluding personality disorder). Perhaps this reflects an improved standard of care both in the community and hospital by general and psychiatric services in Auckland?

No formal complaints were made against the Service by any individuals referred regarding any form of clinical management and with the Service supporting free access to a range of independent advocacy groups.

Matching previously suggested indicators of potential dangerousness in the mentally ill, with some of our own findings, we support a substantial number of variables indicating potential dangerous behaviour towards others (Mullen 1993, pp. 1-20). Being young, male, with a physical ability to harm others and involved in some form of escalating conflict during a time of lack of treatment or support tops the list of risk factors for potential dangerousness in all of the 55 individuals referred to our service. This is very similar in the sub-group of individuals referred suffering from a mental disorder (19), with a history of previous threats and actual violence being particularly important contributing factors (that is, more so than for the whole of the group of all 55 individuals referred).

Summary

The results so far indicate that about one third of all individuals charged with a homicide (related) offence in the Auckland region are referred to our service for a psychiatric assessment. Most individuals referred do not suffer from a formal major mental disorder, (excluding personality disorder), while at the same time schizophrenia is the most common Axis I-DSM III-R psychiatric diagnosis per se in the individuals referred. About 55 per cent of all individuals with schizophrenia in our group committed murder.

Trends in the increase in court liaison referrals over time and a coinciding decrease in prison liaison referrals could indicate that structures in place as established in Court (Court Liaison) to facilitate early assessment and treatment can contribute to a more appropriate placement and management of individuals deemed to suffer from a formal mental disorder and charged with a serious criminal offence like, for example, homicide (related) offending. In a wider sense, and cognisant of the often seen relationship between violent offending (like homicide) and suicide: the above structures could well have contributed to the recent decrease in suicide in prisons in the Auckland region from 18

By incorporating regular (and independent) review tribunals the chances of "getting lost in the system" have been reduced, possibly leading to the fact that none of the individuals charged with a serious offence, like homicide (and related offences), and suffering from a formal mental disorder, have over the last three years reoffended in a similar manner.

The establishment of meaningful measures to monitor the process and outcome of both patient management and functioning of the service, suggests an ongoing improvement in the current approach and available resources, for the better of the individual, the service and the community in general.

References


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