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Mental Disorder & Homicide in Australia

Jenny Mouzos

A review of international literature examining the link between mental disorder and violent criminal behaviour suggests that, although a small number of mentally disordered individuals engage in violent criminal behaviour, the vast majority is unlikely to commit homicide. This study, based on available information in police reports, found that only 4.4 per cent of Australian homicide offenders were recorded as suffering from a mental disorder. This would seem to indicate that the prevalence of mental disorder amongst homicide offenders is significantly less than amongst the general population, although a more rigorous clinical assessment of the offenders might have identified more cases of this nature.

Contrary to public perceptions of mentally disordered persons, the present study has found no evidence to support the notion that mentally disordered offenders are more likely to kill strangers in public places for no apparent reason. In reality, this study has found that mentally disordered offenders who commit a homicide are more likely to victimise a family member in or at some private residence.

Adam Graycar
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The popular perception of homicide is the one often portrayed by the media, exemplified by this recent headline in the Sydney Morning Herald: *Axe Killer 'Mentally Ill'*. This depicts a crazed, senseless and highly lethal offender who preys on innocent and unsuspecting strangers in public places with no apparent motive (Gerbner et al. 1981; Link et al. 1992; Steury & Choinski 1995). A similar analysis of news media in California noted that 83 per cent of newspaper stories about former mental patients concerned acts of violence, often murderous (Shain & Phillips 1991). Such sensationalised depictions, combined with stigmatising labels such as "mad and bad" have often led to widespread community fear and a misconception of the frequency of the association between mental disorder and violent criminal behaviour.

It should be emphasised that the vast majority of people who are diagnosed as suffering from a mental disorder are as law abiding as any other citizen. In the early 1980s, this statement would have received further support from mental health professionals and researchers concurring with the notion that there was no clear relationship between mental disorder and criminal behaviour (Monahan & Steadman 1982). However, the results of recent research have made it necessary to at least consider the possibility that *some* people with a mental disorder may exhibit a modest increase in the frequency with which they become involved in violent behaviour (Mullen 1991), especially when they also have problems with substance abuse.

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Definition of Mental Disorder

The definition of mental disorder has varied over time and across professions and legal jurisdictions. For the purposes of this paper, a mental disorder implies “the existence of a clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions” (WHO 1992). The terms “mental health problems” and “mental disorders” have been used interchangeably, with both referring to the continuum of cognitive, emotional and behavioural disorders that interfere with some or all facets of the lives of people, and may also impact upon their interpersonal relationships. The continuum covers cognitive impairment and disabilities, phobias, panic attacks, substance abuse, anxiety, post-traumatic stress disorder, major depression, schizophrenia and other psychoses (NMHS 1999b).

Mental disorders can be separated into two main categories: psychotic and non-psychotic. People experiencing an acute stage of a psychotic illness (including schizophrenia and bipolar disorder—manic depression) lose touch with reality. Their ability to make sense of thoughts, feelings and external information is seriously affected. They may develop delusions or experience hallucinations. They may be depressed or elated out of all proportion to their life circumstances (NMHS 1999b).

Non-psychotic illnesses (including phobias, some forms of depression and obsessive-compulsive disorder) cause people to experience uncontrollable or exaggerated feelings of depression, sadness, tension or fear. These feelings become so disturbing and overwhelming that they have difficulty coping with day-to-day activities (NMHS 1999b).

Research has shown that many mental disorders are caused by a dysfunction of the

brain, whether organic or induced by physical trauma. It has been suggested that a person’s potential for committing acts of violence without external provocation, or with minimal provocation, may be the result of their internal control mechanisms being disturbed, as is the case in many psychiatric disorders. This disturbance would lower their tolerance to stress so that violence is more likely to occur (Wisdet et al. 1994).

A number of studies have found that co-morbidity is common, and that mental disorder may coexist with intellectual disability, drug or alcohol dependency or chronic physical illness (Abru 1997). For example, Hayes and McIlwain (1988) and Jones and Coombs (1990) profiled the intellectually disabled prisoner in Australia as follows:

... severe deficits in social and adaptive skills are present, particularly in the areas of communication and social interaction skills; there is a high prevalence of multiple problems such as psychiatric abnormality, behavioural disorder, sensory deficit, or communication deficit in addition to the intellectual disability (p.179).

On the basis of these findings, persons with an intellectual disability were included in the present study of homicide offenders.

Mental Disorder and Violent Criminal Behaviour: Is There a Link?

Researchers have taken three distinct approaches in examining the relationship between mental disorder and violent criminal behaviour:

- examining the level of violent behaviour amongst people diagnosed with a mental disorder;
- measuring the frequency of mental disorder amongst offender/prison populations; and
- undertaking community studies in which the presence

of mental disorder and the level of engagement in violent behaviours are ascertained separately and their associations examined.

If indeed mental disorder is a contributing cause of violent criminal behaviour, then we would expect the prevalence of mental disorder to be higher among people who commit violent acts than among people who do not. However, there are potential problems that may complicate studies on the prevalence of mental disorders among offender populations: the selection process itself, which operates at every level of the criminal justice system; and also the high rates of substance abuse and severe personality disorder, which tend to obscure any mental disorder (Mullen 1997). Also, prevalence studies based on prison populations will inevitably exclude offenders who have suicided prior to, or after, being arrested. As a result, they will yield different findings according to whether or not offenders of murder-suicide incidents are included (West 1965).

International research

The results of a number of international studies of the prevalence of mental disorder amongst homicide offenders are summarised in Table 1.

In summary, the prevalence of mental disorder amongst homicide offenders ranges from as low as 2 per cent in Ceylon to as a high as 53 per cent in Northern Sweden, although the author did note that this may be because Swedish psychiatrists are more likely to pronounce offenders of homicide mentally deviant. However, no direct comparison between countries can be made because each country has studied a different year(s), sample sizes and methodologies differed, and most importantly, definitions of mental disorder were not consistent.

Haefner and Boker (1973) attempted to quantify the risks presented by people with schizo-

Table 1: International Research on the Prevalence of Mental Disorder Amongst Homicide Offenders

Researcher(s)	Country/Place	Year(s) Studied	% Mentally Disordered
Jaywardene & Ranasinghe (1963)	Ceylon		1.6
Boudouris (1974)	Detroit, US	1968	4.4
Gibson (1975)	Britain	1967–71	39.0
Gilles (1976)	Scotland		5.8
Landau (1975)	Israel	1950–64	11.8
Hart Hansen (1977)	Denmark	1946–70	*19.0
Haefner & Boker (1973)	Germany	1955–64	3.0
Grumberg, Klinger & Grumet (1977)	New York, US		19.0
Gudjonsson & Petursson (1982)	London	1900–79	34.0
Taylor & Gunn (1984)	London	1979–80	11.0
Lindqvist (1986)	Northern Sweden	1970–81	53.0
Cote & Hodgins 1992	Canada	1988	35.0
Inada, Minagawa, Iwashita & Tokuii (1995)	Tokyo	1987–91	7.3

*34 per cent were not subjected to psychiatric assessment

phrenia and estimated that the chance of a homicidal attack being perpetrated by someone with this illness is in the region of 0.05 per cent. Similarly, Eronen, Hakola and Tiihonen (1996) used the prevalence of mental disorders among homicide offenders to calculate odds ratios for the statistical increase in risk associated with specific mental disorders. Results indicated that schizophrenia increased the age-adjusted odds ratio of homicidal violence by about 8-fold in men and 6.5-fold in women.

Australian research

Very few studies in Australia have examined the prevalence of mental disorder among homicide offenders. Wallace (1986) examined the patterns of homicide in New South Wales between 1968 and 1981 and found, during the 14-year period under review, that:

- only 2.8 per cent of the offenders in the study were found to be not guilty on the grounds of insanity;
- 16 per cent were known to have some kind of mental disorder at the time of, or at some time prior to, the offence; and
- 10.8 per cent committed murder-suicides (including both attempted and successful suicides).

Wallace et al. (1998) conducted a study that involved linking a cohort of those who had been convicted on charges of murder or manslaughter in the Victorian County and Supreme Courts between 1993 and 1995 with those who had also had contact with mental health services. They found that, in the 168 findings of guilt, and including two cases found not guilty by reason of insanity, approximately 37 per cent had had contact with mental health services. They also found that, although a small number of women (9.5%) were convicted of homicide offences, there was a significant association with prior treatment for schizophrenia, and both affective psychosis and affective disorders.

Furthermore, in the three-year period, 0.09 per cent of men and 0.01 per cent of women with a diagnosis of schizophrenia, and who had had contact with mental health services, received a homicide conviction. In other words, the probability that someone diagnosed with schizophrenia will commit a homicide is relatively small.

This suggests that, although the vast majority of mentally disordered persons are not likely to offend, there are a small number who engage in violent criminal behaviour. Therefore, as Monahan (1992) concludes,

denying that there is a relationship between mental disorder and violence is disingenuous and counter-productive.

The Prevalence of Mental Disorder in Australia

Mental disorder in the general community

It is important to ascertain the prevalence of mental disorder in the general community as a basis for comparison, although it is a complex task as this would usually be determined through clinical diagnosis (ABS 1998). Nonetheless, the 1997 National Survey of Mental Health and Wellbeing of Adults (SMHWB) measured the prevalence of mental disorders in approximately 10,600 people aged 18 years and over during the 12 months prior to the survey.

Although many Australian adults enjoy good mental health, the survey found that almost one in five (18%) had a mental disorder during that period. Furthermore, the results indicated that young adults aged 18–24 years had the highest prevalence of mental disorder (27%) and this declined steadily to 6.1 per cent of those aged 65 years and over. Men and women had similar overall rates of mental disorder, but from the age of 35 years women were more likely to have a mental disorder than men (ABS 1998).

Overall, these findings indicate that measurable psychiatric problems occur in at least 18 per cent of the Australian adult population surveyed.

Mental disorder amongst homicide offenders

These data were collected as part of the Australian Institute of Criminology’s National Homicide Monitoring Program (NHMP), which routinely collects data on some 77 variables relating to each incident, victim and offender of homicide coming to police attention in Australia. A total of 2821

homicide incidents were recorded from 1 July 1989 until 30 June 1998, involving 3045 victims and 3314 offenders (some incidents involving more than one victim and/or offender).

NHMP data are derived exclusively from State and Territory police records and, in most cases, if there is evidence that the offender suffered from a mental disorder before or at the time of the homicide incident, such information may be recorded on police offence or apprehension reports. However, with most crime statistics there is always the so-called "dark figure", which in this case refers to the possibility that some offenders who were suffering from a mental disorder were not recorded as such. Caution should therefore be exercised in interpreting the following figures, as they may under-represent the true prevalence of mental disorder amongst homicide offenders in Australia.

During the nine-year period under review, approximately 4.4 per cent (147) of homicide offenders were recorded as suffering from a mental disorder at the time of the homicide incident. In comparison to the Australian adult population surveyed, the overall prevalence of mental disorder amongst homicide offenders appears to be significantly less than that in the general population. This finding is further supported by the Australian prison study undertaken by Herrman et al. (1991), who also found low levels (3%) of psychotic illness (although this figure excludes offenders of murder-suicide incidents). They attributed the low levels of severe mental disorder among prisoners, in part, to the adequacy of diversion schemes which redirect the mentally disordered away from correctional and into health facilities, and in part to the adequacy of mental health services in the wider community (Mullen 1997).

Characteristics of Homicides Committed by Mentally Disordered Offenders

Given that the prevalence of mental disorder amongst homicide offenders appears to be no greater than that of the general population, do the characteristics of homicides committed by mentally disordered offenders differ from those of homicides committed by other offenders?

Incident, victim, offender, and victim-offender characteristics of homicides committed by mentally disordered and other offenders are summarised in Table 2.

In brief, the main differences appear to be that a slightly greater proportion of women were killed by a mentally disordered offender and these victims were also slightly younger. Similarly, a greater proportion of mentally disordered offenders were women.

In almost nine in ten homicides committed by mentally disordered offenders, there was either no apparent motive, or the motive was unknown/not stated (Table 2). Haefner and Boeker (1982) stated that police and prosecutors are likely to subscribe to the common view that "motiveless and therefore apparently 'senseless' crimes are more frequently encountered in mentally abnormal than in mentally normal offenders" (p. 248). However, the material at hand does not indicate whether or not this is a function of police classifying homicides committed by mentally disordered offenders as apparently "motiveless".

Furthermore, contrary to popular beliefs, a mentally disordered offender was most likely to kill a family member, whereas other offenders were most likely to kill a friend or acquaintance.

Case Studies

The following case studies from the National Homicide

Monitoring Program illustrate the diversity of circumstances surrounding homicides committed by mentally disordered offenders.

CASE ONE

A mother in her early thirties, diagnosed with post-natal depression, secretly purchased two containers of petrol and hid them from her husband. On the night of the incident, after her husband had gone to sleep, she locked herself, a baby boy and her young daughter in another bedroom, jammed the door shut, poured petrol all over the room, and then set it alight, killing the children and herself.

CASE TWO

A male in his early thirties, diagnosed with paranoid schizophrenia, had stopped taking his medication and then repeatedly stabbed his elderly mother. He later telephoned police and told them what he had done. At trial he was found not guilty on the grounds of insanity.

CASE THREE

A female in her late forties, suffering from paranoid delusions, shot her young son and then herself because she thought that "the world was being taken over by aliens, and that both she and her son had become clones, along with other people, and she couldn't take it any more".

CASE FOUR

A male in his late forties, diagnosed with paranoid schizophrenia, had developed feelings of persecution regarding hospital staff after going to the consulting suites for treatment following an accident. On the day of the incident, he attended the consulting suite and shot (four times) the woman he hated and had become fixated about.

Table 2: AUSTRALIA, 1 July 1989 – 30 June 1998: Characteristics of Homicides Committed by Mentally Disordered and Other Offenders

Characteristics	Mentally Disordered Offenders	Other Offenders
<i>Incident Characteristics</i>	(n=139)	(n=2682)
Location of Incident		
Private Residence	74.8%	61.6%
Street/Open Area	10.9%	22.0%
Day & Time of Incident		
Sunday	22.1%	15.8%
Saturday	17.2%	17.9%
6 p.m. – Midnight	37.5%	40.9%
<i>Victim Characteristics</i>	(n=142)	(n=2903)
Gender		
Male	55%	63%
Female	45%	37%
Mean Age	39 years	35 years
Median Age	38 years	32 years
<i>Offender Characteristics</i>	(n=147)	(n=3167)
Gender		
Male	70.5%	88.6%
Female	29.5%	11.4%
Mean Age	35 years	30 years
Median Age	33 years	28 years
Alleged Motive of the Offender		
No Apparent Motive	21.8%	8.9%
Unknown/Not Stated	66.0%	27.0%
Known Motive	12.2%	64.1%
Weapon Used		
Knife & Other Sharp Instrument	43.2%	34.9%
Type of Mental Disorder		
Depression	10.2%	n/a
Other Mental Disorder	84.8%	n/a
Intellectual Disability	5.4%	n/a
<i>Victim-Offender Relationship</i>		
Partner/Former Partner	15.7%	20.1%
Family	49.0%	13.8%
Friends/Acquaintances	17.0%	24.9%
Strangers	10.2%	18.5%
Other	4.1%	10.3%
Unknown/Not Stated	4.1%	12.4%

Source: AIC, National Homicide Monitoring Program

Conclusion

Homicide in Australia is an infrequent occurrence; homicide committed by a mentally disordered person is even less common. The general public tends to assume that mental disorder is associated with violent criminal behaviour, and this view is reinforced by the media. This study provides some evidence dispelling the myth that “mentally disordered offenders prey on innocent and unsuspecting strangers in public places”. Although caution should be exercised in interpreting the

findings of the present study, it was found that, in most instances, the characteristics of homicides committed by mentally disordered offenders did not differ significantly from the characteristics of homicides committed by other offenders.

A review of both international and Australian literature revealed that, in some studies, mentally disordered persons were over-represented as offenders of homicide. In this study the incidence of mental disorder amongst homicide offenders did not exceed the incidence of mental disorder in the general population, although there is a possibil-

ity that this may under-represent the true extent of mental disorder amongst homicide offenders.

This highlights the importance of the media conveying accurate information regarding the low risk that mentally disordered persons pose to public safety. The media’s information base is a priority of the *Mental Health Promotion and Prevention National Action Plan* (NMHS 1999b). Two noteworthy objectives of the plan are:

- to enhance mental health and social functioning among populations and individuals; and
- to reduce the incidence, prevalence and sequelae of mental health problems and disorders (NMHS 1999b).

By addressing the mental health requirements of individuals at the community level, we may also be addressing some of the needs and requirements of the small percentage of mentally disordered persons who may engage in violent behaviour.

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