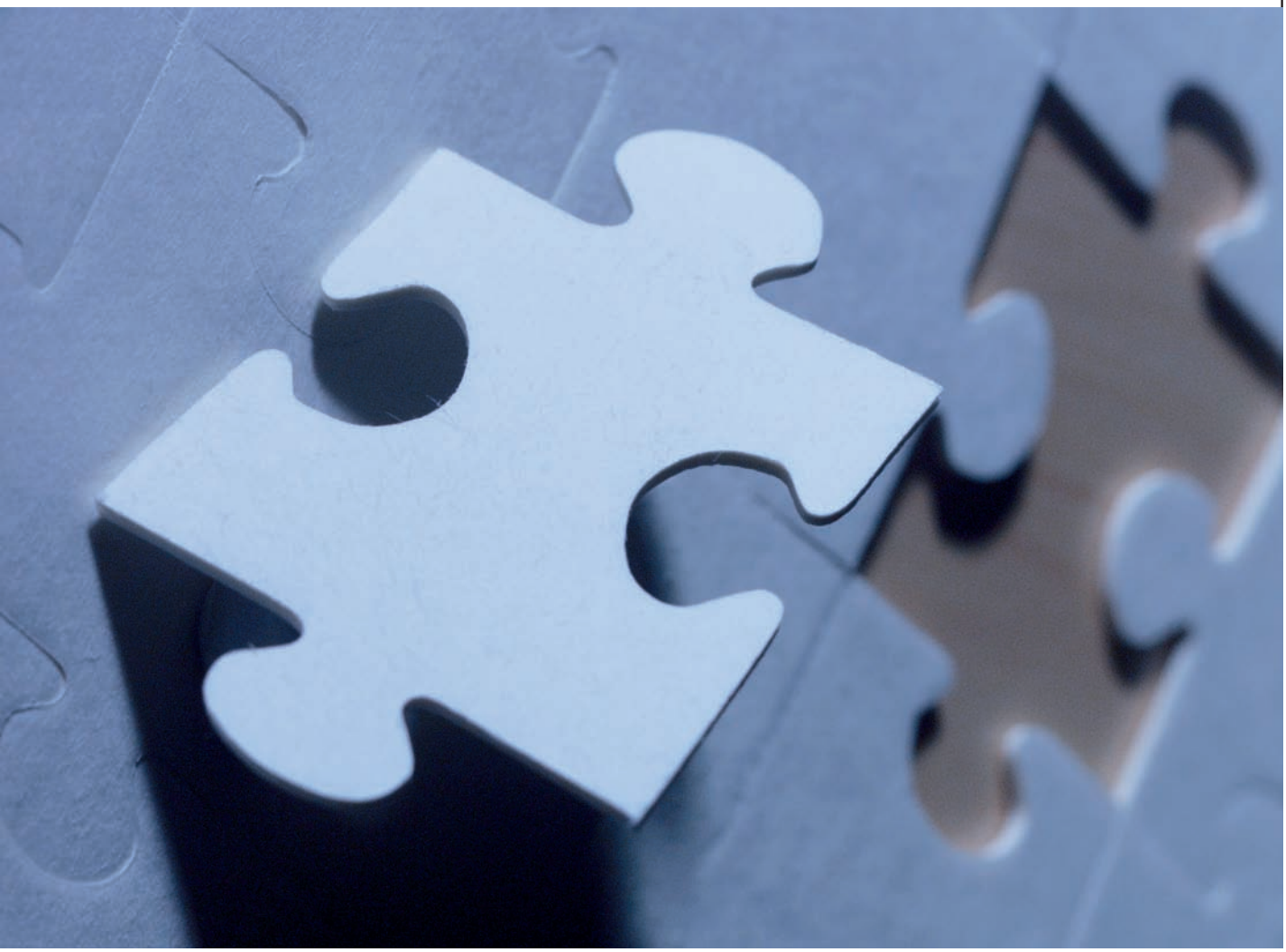
NORWEGIAN MINISTRY
OF HEALTH AND CARE SERVICES

Summary in English: NOU 2010: 3

Homicide in Norway in the period 2004–2009



NORWEGIAN MINISTRY
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Homicide in Norway in the period 2004–2009

Report from the committee appointed by Royal Decree on 24 April 2009.
Submitted to the Ministry of Health and Care Services on 3 May 2010.

Translation from the Norwegian. For information only.

To the Ministry of Health and Care Services

On 24 April 2009, the government appointed a committee by Royal Decree to investigate cases where individuals with known mental disorders have taken lives in the period 1 January 2004 to 1 May 2009. The purpose of this inquiry is learning, with a view to implementing measures designed to prevent these kinds of tragic incidents in the future.

The committee herewith submits its report.

Oslo 3 May 2010

Ann-Kristin Olsen
Chair

Bjørg Månum Andersson	Bjørn Lydersen	Geir Gudmundsen
Georg Fr. Rieber-Mohn	Hilde Guldbakke	Jon Ragnar Skotte
Marianne Kristiansson	Mette Kammen	Tom Gunnar Vik

Egil Nygaard
Anne Wie-Groenhof

English version summary

This is an English translation of selected parts of the report. The complete report is only accessible in Norwegian. The English translation includes a summary (Chapter 1), background for the committee's work (Chapter 2–4) and most of the committee's findings after their investigation of homicides in Norway in the period 2004–2009 (Chapter 5, 7 and 8).

The following chapters have been excluded from the English translation:

- Chapter 6 with results from an international literature review
- Chapters 7.1–7.6 with theory and literature about substance abuse and violence
- Chapter 9 on violence risk assessment
- Chapter 10 on communications between health services and others
- Chapter 11 on the legal issues concerning professional confidentiality and obligation to report
- Chapter 12 on the collaboration between police and health services
- Chapter 13 on individual treatment plans
- Chapter 14 on facilities in refugee and asylum centres
- Chapter 15 on the experiences of services where homicides have occurred
- Chapter 16 and 17 with the summary of the committee's recommendations and the consequences of these recommendations.

In addition 12 annexes, including detailed literature reviews, have not been translated.

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Chapter 1
Summary

This report focuses on homicide committed by people with severe mental disorders. Homicide is one of the most serious forms of physical assault that can befall a human being. In addition to the loss of life, homicide has major consequences for a number of other people – the victim's relatives, friends and acquaintances, neighbourhoods, entire local communities, etc. Homicide also has serious consequences for the perpetrator and the perpetrator's next of kin. It is not uncommon that the perpetrator and the victim are part of the same family or community. In most homicide cases, the perpetrator and the victim have some kind of relationship with one another at the time of the murder: they are related or having an intimate relationship, they are friends or acquaintances.

A large number of people are affected by murder tragedies to varying degrees as a result of media coverage and the subsequent criminal proceedings. Many people will therefore also experience a sense of insecurity and reduced quality of life, not least the people in the community where the tragedy occurred and people in a situation similar to the victim. There is much to suggest that the fear of being murdered in the population is greater than necessary, based on the facts.

We live in one of the world's safest societies, and in an international context, Norway has very few homicides. Of course, this fact offers little consolation to the people left behind, who are grieving and coping with their loss. In the interests of the general feeling of security in the community, it is nevertheless important to point out how unlikely such incidents are, and we do this to foster a realistic understanding of the risk and to ensure that fear of lethal violence does not get out of proportion.

Aggression is a part of the human emotional repertoire, and aggression can be expressed through violence. Violence and murder are usually the outcome of a complex combination of factors, and homicide can seldom be attributed to one single causal factor. However, if we had to name one important cause of serious violence or death, it would have to be substance abuse, and primarily alcohol. This applies to all homicides, regardless of whether the perpetrator has mental health problems or not. Risk factors related to substance abuse have therefore been afforded much space in this report.

In addition, the committee has examined a variety of topics including the relationship between mental illness and homicide, and we describe the follow-up the perpetrators had prior to the event. Risk assessment has been investigated in detail, and communication and the duty of confidentiality are discussed in depth. The chapter on the way the police deal with individuals with mental disorders includes an examination of the experience the various police districts have in working with health services, and the main aspects of the use of individual treatment plans for people with mental disorders who have committed murder are described at length. Similarly, the facilities in refugee and asylum centres for persons with mental disorders are described and evaluated. The committee has undertaken a comprehensive study of the experiences of services that have experienced homicides committed by people with mental disorders.

In response to the mandate, the committee has reviewed and analyzed all the homicide cases in the period, reviewed the relevant literature, described the status of knowledge in the fields that are explored, and makes a number of recommendations. Chapter 16 contains a summary of our recommendations, which are presented in more detail at the end of the relevant chapters. Information from the committee's investigation and analysis of the relevant cases is included in chapter 5 and chapter 8, and can also be found in the individual chapters.

We hope that the committee has succeeded in consistently adopting a perspective where the course of events and systems are seen in a holistic context. Our main approach has been prevention and learning. Moreover, we would like to contribute to a realistic understanding that homicide can never be prevented outright, but that our society is generally so safe that the risk of being murdered by a mentally ill stranger is minimal. A realistic perception of the risk will also help prevent unnecessary stigmatization of people with mental disorders.

Chapter 2
The committee's appointment, mandate and work

On 24 April 2009, the government appointed a committee to investigate cases where individuals with known mental disorders have taken lives. The purpose of establishing this committee is to generate learning, with a view to identifying measures that can possibly be implemented to prevent these kinds of tragic incidents in the future.

The committee was appointed as a result of the fact that there were several tragic incidents in a relatively short period of time where the perpetrator's mental illness and/or substance abuse problems were highlighted in the media coverage of the cases, including the so-called «Bodø murder» in December 2008 and the triple murder case in Tromsø in March 2009. This led to questions being raised as to whether weaknesses in the system might be a contributing factor in such tragedies.

The committee consisted of the following people:
- Ann-Kristin Olsen, County Governor, Vest-Agder County Governor's Office (chair)
- Bjørg Månum Andersson, Director General, City of Oslo
- Bjørn Lydersen, former Secretary General, Norwegian Council for Mental Health
- Georg Fredrik Rieber-Mohn, Special Adviser, Ministry of Justice and the Police
- Geir Gudmundsen, Chief of Police, Rogaland police district
- Hilde Guldbakke, Lawyer
- Jon Ragnar Skotte, psychiatric nurse, Vindern District Psychiatric Centre
- Marianne Kristiansson, Head of the Department of Forensic Psychiatry, National Board of Forensic Medicine, Sweden
- Mette Kammen, General Secretary, Mental Health Norway
- Tom Gunnar Vik, Chief Physician, Department of Psychiatry, Telemark Hospital HF

The secretariat for the committee consisted of:
- Egil Nygaard, senior adviser, and Anne Wie-Groenhof, special adviser.

The following external contributors have compiled summaries of the current knowledge, provided academic input and supplied text to various chapters of the report:
- Chapter 7 and Annexes 4 and 5 Substance abuse, mental health and violence:
  - Professor Jørgen G. Bramnes, MD, Research Director, Norwegian Centre for Addiction Research (SERAF)
  - Professor Edle Ravndal, PhD, Norwegian Centre for Addiction Research (SERAF)
  - Associate professor Thomas Clausen, physician, Norwegian Centre for Addiction Research (SERAF)
  - Professor Jørg Mørland, MD, Division Director, Norwegian Institute of Public Health and University of Oslo
  - Liliana Bachs, MD and specialist in pharmacology, Senior Medical Officer, Norwegian Institute of Public Health
  - Kristian Østby, MD, researcher, Norwegian Institute of Public Health
  - Knut Boe Kielland, MD, Regional Centre of Expertise on Substance Abuse – Eastern Norway
  - Ingeborg Rossow, PhD, Researcher, Norwegian Institute for Alcohol and Drug Research (SIRUS)
- Chapter 9 Assessment and management of violence risk:
  - Professor Stål Bjørkly, Centre for Research and Education in Forensic Psychiatry, Oslo University Hospital, Ullevaal, South-Eastern Norway Regional Health Authority
  - The Centres for Research and Education in Forensic Psychiatry for Central and Northern Norway, Western Norway and South-Eastern Norway
- Chapter 11 Duty of confidentiality, duty of disclosure and right to information:
  - Professor Tor-Geir Myhrer, Dr. juris, Norwegian Police University College
- Chapter 12 and Annex 6 Cooperation between the police and health services concerning individuals with mental disorders:
  - Arne Erik Hennum, Police Superintendent, Oslo Police District
  - Adviser John Martin Dervå

- Chapter 13 Individual plan:
  - Senior Adviser Toril Bakke, Norwegian Knowledge Centre for the Health Services
- Chapter 14 Facilities and services in refugee reception centres and follow-up of perpetrators of ethnic minority background:
  - Birgit Lie, MD, Special Adviser, Regional Resource Centre on Violence, Traumatic Stress and Suicide Prevention (RVTS) Southern Norway
- Chapter 15 The services' experiences after a person with known mental disorders has taken a life:
  - Tonje Lossius Husum, researcher and psychology specialist, SINTEF Health Services Research
  - Sissel Steihaug, MD, Senior Researcher, SINTEF
  - Rolf Gråwe, PhD, Senior Researcher and psychology specialist, SINTEF
  - Reidun Norvoll, Dr. polit., researcher, SINTEF

In addition, we would like to extend a special thanks to Maria Sigurjonsdottir, Chief Physician at Regional Safety Department for South-Eastern Norway Regional Health Authority at Oslo University Hospital, for her very useful assistance in connection with the committee's review of a number of individual cases.

The committee would like to thank all the external researchers and contributors for their valuable input. However, it must be emphasized that the committee alone is responsible for the views, assessments and recommendations in this report.

The committee has been commissioned to undertake a concrete, detailed investigation of all the cases where individuals with known mental disorders have taken lives during the last five years (from 1 January 2004 to 1 May 2009). The committee has been tasked with seeking to cast light on the circumstances surrounding the incidents in which lives were lost and investigating whether there are any similarities in the cases that may indicate system failure. It was not in the committee's mandate to assess the criminal liability or compensation issues. The committee's mandate is included in full as an annex to this report.

Access to all the relevant information was essential for the committee to be able to review the various cases in depth and have an adequate basis for its work. To this end, the government submitted a special bill, Proposition no. 90 (2008–2009) to the Odelsting relating to the Act on the duty of disclosure, duty of confidentiality, etc. of committees investigating matters related to cases where individuals with known mental disorders have taken lives.[1] The Act was passed by the Storting on 19 June 2009 and granted the committee exemption from statutory provisions concerning confidentiality to the extent necessary for the committee to be able to carry out its mandate.[2]

In addition to reviewing the cases of homicide in the period, another central task of the committee was to review and compare the existing research in this area. The literature review has been particularly important in the committee's discussion of questions concerning the causes of homicide. It was a requirement that the recommendations of the committee be based on existing research.

In line with the mandate, the committee also examined the following topics in particular:

- Substance abuse and violence/murder
- Learning from experience in the health service after a homicide
- Communication and cooperation between government agencies
- The individual plan as a tool to ensure continuity and follow-up.
- Migration health

It is stipulated in the mandate that the committee's approach and method must be based on a consistent perspective where the course of events and systems are seen in a holistic context.

This report does not include a summary of knowledge concerning treatment methods for people at risk of committing violence, although some types of existing treatment options are mentioned. Nor has the committee investigated the topic of care and confinement of criminals. It was not been possible to present a detailed summary of this extensive topic within the confines of this study.

The committee has not examined or reviewed the use of compulsion and the conditions for use of compulsion. This is an extensive topic that goes beyond the committee's mandate. However, the committee has noted that the Ministry of Health and Care Services has announced appointment of a special commission to consider the ethical, professional and legal aspects of the current policies and practices in mental health care in 2010 (see

1. Proposition no. 90 (2008–2009) to the Odelsting relating to the Act on the duty of disclosure, duty of confidentiality, etc.
2. Act of 19 June 2009 no. 73 relating to committees investigating matters related to cases where individuals with known mental disorders have taken lives.

Proposition no. 1 (2009–2010) to the Storting, chapter 734, item 72.)

The deadline for submission of the final report was set to 1 May 2010 in the mandate. The committee has had ten full-day meetings, the first of which was on 28 May 2009 and the last on 26 March 2010. Three of these meetings lasted for two days. The committee also went on a study trip to the University of Manchester in the UK in January 2010. Editing was completed on 12 April 2010.

The committee has adopted three strategies to tackle the main issues in the mandate. First, the committee undertook a detailed review of all the homicide cases ruled on during the period. To get an overview of all the perpetrators with known mental disorders in the period in question, the committee had to obtain information from a variety of sources, including the police, the Norwegian Board of Forensic Medicine (DRK), the perpetrators' doctors and the Norwegian Board of Health Supervision. Second, summaries were compiled of the knowledge on the various topics covered by this report. These summaries have been made in the form of literature searches – some carried out by the secretariat for the committee and some carried out by the expert communities collaborating with us on this study. The results of these searches constitute the main background material for the committee's proposed measures. As a third dimension of the report, the committee contacted the relevant Norwegian organizations to give the committee insight into their experiences and views, and to relevant studies, reports, guides, guidelines and other publications of relevance to the report's different topics. Interviews have also been conducted with convicted homicide perpetrators, their relatives, people who work in the affected services and the police. In addition, user organizations and relatives' organizations, assistance agencies and affected government agencies were invited to provide input at the committee's consultative meeting in November 2009. This meeting had a special focus on interdisciplinary collaboration, including communication between agencies, and on the factors that can foster good continuity in the services.

Chapter 3
Homicide studies in Norway

In the mandate, the committee is asked to undertake a general review of previous studies in this area. See section 4.2.1 of the mandate.

In the following we have organized the material into the following categories: previous research-based homicide studies, ongoing and planned research-based homicide studies, studies undertaken by public committees and working groups, reviews undertaken by permanently established bodies, and academic papers and theses submitted as part of a degree. The list is not exhaustive. In the case of reports from government committees, we have also provided an account of how the reports have since been followed up.

3.1 Previous research-based homicide studies

Below is a brief presentation and summary of some central Norwegian homicide studies. It includes completed studies and a number of ongoing studies. As far as foreign homicide studies are concerned, we refer to the literature review as presented in chapter 6 and annex 3. The overview encompasses research-based studies linked to a variety of different disciplines, including law, criminology, medicine and psychology. The summary focuses in particular on quantitative studies. The reason for this is that the variables that have been used in these studies have served as a basis for comparison in the investigation undertaken by this committee. All the Norwegian studies have been carried out retrospectively, without a control group, and therefore provide limited information about the causal factors related to the homicides.

3.1.1 «Norwegian killers 1930–1954»

In 1956 Ragnar Christensen undertook a review of the 124 homicide perpetrators in the period 1930 to 1954[1]. The material covered people convicted pursuant to section 233 of General Civil Penal Code (homicide), both actual homicide and attempted homicide. The study included only men. The author stated that the reason for this was that women convicted of homicide generally represented a different problem, from a psychological point of view. Most of the women who were convicted of homicide in the period had taken the lives of unwanted children. The people convicted of homicide were divided into groups based on the terms of the Penal Code that applied at the time: 33 were categorized as «insane», 53 had «with underdeveloped or permanently impaired mental faculties», and seven were in a «temporary state of severely reduced consciousness». 29 % had prior convictions, and 39 % were under the influence of alcohol. In 18 of the cases, the victims were strangers. Christensen categorized the material with respect to cause of death from a psychological perspective and found: 40 cases were due to jealousy, 16 cases that were psychologically incomprehensible from a normal psychology perspective, 13 cases were committed in the heat of the moment, 10 cases were to conceal another crime, 10 cases of family conflict, 8 cases were due to drunken arguments, 8 cases were due to delusions of a paranoid or hallucinatory nature, 6 cases of murder with intent to rob, 5 cases were due to conflict with sexual partner and 4 cases were due to delusions of a depressive nature. Christensen concluded that pathological mental state was a very important factor, but also stated:

> «It is however difficult to interpret the available information. It is interesting to identify correlations between personality structures, mental illness and criminality, but it is more important to find causal relationships. This survey fails in this respect primarily because the attempts to analyze causality have to be made retrospectively. We have identified a number of characteristic features in the group of killers, but we have not found a real explanation for what caused these people to take lives (...) It is probably only possible to perform a causal analysis in connection with a depth-psychological analysis of each case. Personally, I am also in doubt as to whether this would take us much farther than to linking the act of killing to a specific

1. Christensen, 1956

reference framework that builds on the special analytical theory.»[2]

In 1995 Christensen conducted a new investigation of the homicides committed in the period 1955 to 1982, but this study has not been published.

3.1.2 «Homicide and recent case law»

In 1982 Helge Røstad published a study that reviewed 55 appeal cases handled by the Supreme Court in the period 1970 to 1979 linked to murders committed by men.[3] The review covered 38 % of all the men who were convicted of murder in the period. Røstad found that 55 % of the killers had prior convictions. He also found that several of the homicide perpetrators had had troubled childhoods, that a number of the people convicted of homicide had been diagnosed as having severe personality and emotional disorders, and that a considerable proportion of them had severe alcohol problems.

3.1.3 «Murder trends in Norway 1960–1983. From the perspective of forensic autopsy material»

Torleiv Ole Rognum conducted a review of the homicides committed in Norway in two separate five-year periods, 1960–1964 and 1979–1983.[4] The study was based on the autopsy reports for the victims that were examined by the Institute of Forensic Medicine in Oslo. This material encompassed 51.1 % of all the homicides in Norway in the first period and 47.4 % of the homicides in the second period. The study showed that it was primarily men who committed murder, and median age of the homicide perpetrators was roughly 36 years. In the autopsy reports, 13 % of the perpetrators were considered criminally insane. The study also showed that drunken disputes was still the dominant cause that triggered murder. In the latter period, there were also cases where the killer was under the influence of drugs – diazepam and hashish. In most cases, the perpetrator was related to or acquainted with the victim.

3.1.4 «Fatal crimes in Western Norway 1950–1984»

J. Chr. Giertsen conducted a review where the material included 140 deaths caused by criminal activities in the period 1950 to 1984 and included all deaths where the cause of death was recorded as homicide on the death certificate.[5] The written sources included forensic expert statements and judgments. The material was grouped on the basis of the subsumption of the indictment according to the following penal provisions: section 228 (assault), section 229 (bodily harm), section 233 (homicide), section 239 (manslaughter), section 242 (rendering a person helpless) and section 267, cf. section 268 (aggravated robbery). There was a total 82 convictions for all the crimes reviewed, 78 of which were committed by men. The average age of the offenders was 35.7 years for assault, and for the other crimes the average age was between 28 and 29 years. The group included nine cases where the perpetrator was deemed criminally insane at the time of the offence, i.e. 6.4 % of the total the cases in the material. Alcohol intoxication was found in three of these nine. Otherwise, the figures showed that about 75 % of perpetrators were under the influence of alcohol when the acts of violence were committed. According to the forensic psychiatric experts, quite a few of perpetrators had alcohol problems. Only five of the perpetrators were under the influence of other drugs. In connection with assault, bodily harm and homicide, roughly half of the perpetrators had previously been convicted of crimes against property and violent crimes.

3.1.5 «Homicide and mental illness»

Kjell Noreik and Arne Gravem conducted a detailed study of the 71 people who had been charged with homicide or attempted homicide under section 233 of the General Civil Penal Code in the period 1980 to 1989 and who had been deemed criminally insane at the time of the offence or when examined.[6] The main sources used in this study were Statistics Norway's crime statistics, the National Criminal Investigation Service (KRIPOS)'s homicide statistics, forensic psychiatric evaluations as assessed by the Norwegian Board of Forensic Medicine (DRK) and the National Register of Convictions. The figures for the period in question showed that a total of 493 persons had been charged with homicide or attempted homicide under section 233 of the Penal Code and subject to forensic psychiatric evaluation. Of these, 76 (15 %) found «criminally insane», either at the time of the offence or at the time of the psychiatric examination. The study looked into 71 of these cases in

2. Christensen, 1956, p. 316
3. Røstad, 1982
4. Rognum, 1985
5. Giertsen, 1988
6. Noreik & Gravem, 1993

more detail. Noreik and Gravem found that 60 % of the «insane» perpetrators were schizophrenic, and 17 % had paranoid psychosis. Other psychotic disorders were relatively rare. Alcohol and substance abuse were less common among the «insane» perpetrators than the other people charged with homicide. Among the «criminally insane», the murder victim was most frequently within the household or family (67 %). 20 % were under the influence of alcohol at the time of the offence, but few were under the influence of other drugs. In most cases, the homicide was considered to be psychotically motivated. Nearly a third of the offenders were under treatment with psychopharmaceuticals at the time of the offence. Treatment had been instituted for 9 %, but had not been completed.

3.1.6 «All about homicide – A report on 250 people convicted of murder or attempted murder in the period 1980–1989»

Kåre Bødal and Inger Marie Fridhov published their study in 1995.[7] The main aim of the report was documentation, and the report was therefore primarily descriptive. The study included 250 people sentenced to imprisonment for three years or longer for homicide or attempted homicide in Norway in the period 1980–1989. The study did not include perpetrators who were deemed to be «of unsound mind». The source material consisted primarily of documentation in the form of transcripts of sentences, court records, forensic psychiatric evaluation reports and social inquiries and enforcement journals. In the study, the people convicted of murder were divided into groups that distinguished between offenders with several prior convictions and first-time offenders, age groups, gender, and foreigner/Norwegian. The study also described what happened after release and the risk of reoffending. The report focused on two main findings in particular. First, the review showed that many of the long-term prisoners, including the people convicted of homicide, had prior convictions. Second, it was found that alcohol played a noticeable role as a contributing factor that triggered violence.

3.2 Ongoing and planned research-based homicide studies

Section 4.2.2 of the mandate reads:

> «the committee shall keep abreast of ongoing work in the Ministry of Justice and the Police in this area, including the planned survey of homicide cases in collaboration between the Ministry of Justice and the Centre for Research and Education in Forensic Psychiatry for South-Eastern Norway».

3.2.1 Filicide

A survey is currently underway to chart the risk factors and judicial outcome of filicide in Norway in the period 1980–2009. The study defines victims as children under the age of 18 and defines the perpetrator as a parent or partner of a parent who are convicted of violations of the General Civil Penal Code, section 233 first and/or second paragraph or section 229, third penalty option or section 234. The data sources in this study were sentences and, as applicable, forensic psychiatric evaluations of the sentenced persons. The study also includes cases where the perpetrator committed suicide after the murder. In these cases, the data source was the National Criminal Investigation Service (KRIPOS)'s archive of homicide–suicide, which systematically records demographic variables for the people involved, mode of killing and the possible motive for the murder. All of the cases of filicide in the period are included in the study. Data collection is expected to end during 2010, and the results are expected to be published in international journals and in the Norwegian media in 2011. The project manager is criminologist Vibeke Ottesen from the Centre for Research and Education in Forensic Psychiatry for South-Eastern Norway. The study is being funded in full by the Norwegian Foundation for Health and Rehabilitation via the applicant organization the Norwegian Women and Family Association. The study has been approved by the Office of the Attorney General and the Regional Committee for Medical Research Ethics for South-Eastern Norway (REK).

3.2.2 Intimate partner murder – quantitative study

A study is being planned to chart the risk factors and the judicial outcome of intimate partner homicide in Norway in the period 1980–2009. The study defines intimate partners as current or former married, cohabiting or de facto partners, heterosexual and homosexual. The study defines the perpetrators as men and women who are convicted of violations of the General Civil Penal Code, section 233 first and/or second paragraph or section 229, third

7. Bødal & Fridhov, 1995

penalty option. The data source in this study is sentences. Originally, forensic psychiatric evaluations were to be used as a source in the intimate partner murder study, as is the case in the filicide study, but the Regional Committee for Medical and Health Research Ethics (REK) for South-Eastern Norway and the National Committee for Medical Research Ethics (NEM) did not approve the use of these evaluations in the upcoming intimate partner murder study. Like the filicide study, this study also includes cases where the perpetrator committed suicide after the murder, and this study uses data from the National Criminal Investigation Service (KRIPOS)'s archive of homicide–suicide. All the partner murder cases in the period are going to be included in the study. Data collection is expected to begin in 2010. The project manager is criminologist Vibeke Ottesen. The Norwegian Police Directorate has commissioned a report on the results achieved in connection with implementation of measure no. 34 in «Turning point, the Norwegian government's action plan against domestic violence». The study has been approved by the Office of the Attorney General.

3.2.3 Intimate partner murder – qualitative study

A qualitative analysis is going to be carried out of a sample of homicide cases (8–12 cases) where the perpetrator was the victim's current or former intimate partner. The focus will be on identifying risk factors, possible warning signs and explanatory variables, charting and systematization of the victim's and the perpetrator's contact with the health and social services. The project manager is Solveig Karin Bø Vatnar, PhD, a psychology specialist and former member of the committee on violence against women. The project was approved in February 2010 by the Regional Committee for Medical and Health Research Ethics (REK), the Office of the Attorney General and the Privacy Ombudsman.

3.3 Government committees and working groups

3.3.1 The Rasmussen committee

The introductory part of the mandate for the current committee states that the factors linked to homicides committed by people with mental disorders have been reviewed previously. In this regard, particular reference is made to the Rasmussen committee from 1998.

On 20 March 1998, the Ministry of Health and Social Affairs appointed a committee to assess instances of homicide and other serious acts of violence carried out by people with mental disorders in the period 1994–96. The committee was chaired by Dr Kirsten Rasmussen, PhD, and the report was submitted to the Ministry on 10 December 1998.[8] The reason for the establishment of the committee was that in the Report no. 25 (1996–1997) to the Storting «Openness and Cohesiveness – On psychiatric disabilities and service provision», the Ministry of Health and Social Affairs had proposed:

> «a review be undertaken of all the instances of homicide and other serious acts of violence carried out by people with severe mental disorders in recent years, to reveal any system failure.»[9]

The Storting adopted the proposal, cf. Recommendation no. 258 (1996–97) to the Storting.

According to the mandate, the committee was to base its study on a casuistic review of a limited number of individual cases. This review was based on the Norwegian Board of Health's project «Homicide committed by people of unsound mind in the years 1994, 95 and 96» by project manager Randi Rosenqvist and the subsequent project report. The report dealt with three years worth of forensic psychiatric evaluations of individuals who had been charged/prosecuted pursuant to section 233 of the of the General Civil Penal Code and who had been found to be criminally insane. The material included a total of 26 cases. 14 of the cases resulted in death. In the remaining 12 cases, a total of 19 persons had been exposed to danger and/or injury. The Rasmussen committee was charged with assessing whether there were weaknesses in the health services, social services, correctional services or other public services that had contributed to the unstable person committing serious acts of violence. The committee was also to consider possible preventive measures, collaboration between agencies and the need for further investigation or assessment work in the area.

For more information about the details concerning the Ministry of Health and Social Affairs' assessment and follow-up of the committee's report, we refer to the Ministry of Health and Care Services' statement in the letter dated 22 October 2009. This letter is included as Appendix 11.

8. Rasmussen committee, 1998
9. Report no. 25 (1996–1997) to the Storting "Openness and Cohesiveness: On psychiatric disabilities and service provision"

3.3.2 The Mæland Group

Section 4.2.2 of the committee's mandate states that:

> «the committee shall keep abreast of ongoing work in the Ministry of Justice and the Police in this area, including the follow-up of the report from the study group that has tested the rules on criminal insanity, special criminal sanctions and preventive detention (the Mæland group).

The study group was appointed by the Ministry of Justice and the Police in consultation with the Ministry of Health and Care Services in a letter of 18 May 2006. The new rules on criminal insanity and special criminal sanctions came into force on 1 January 2002. Rules were defined for the mental health services, requiring that they assume responsibility for the implementation of special criminal sanctions for the criminally insane. In the proposition to the Act, the Ministry of Justice and the Police announced that the new rules concerning criminal insanity and special criminal sanctions would be tested after they had been in operation for five years.[10] According to the mandate, the study group was to chart the status of people sentenced to compulsory admission to psychiatric treatment facilities or sentenced to compulsory psychiatric care. The material consisted of enforceable judgments in the period 1 January 2002 to 31 December 2006 (sentence of compulsory admission to psychiatric treatment facilities) and 31 December 2007 (sentence of compulsory psychiatric care). The material included a number of people convicted of homicide.

The report was circulated for comment on 15 February 2008, with deadline for comment of 1 April 2009.[11] At the time the present report was being prepared, the status was that the consultative comments were pending in the Ministry of Justice and Police.

3.4 Reviews undertaken by permanently established bodies

3.4.1 The Norwegian Board of Health Supervision's review of individual cases

The Norwegian Board of Health Supervision in the Counties and the Norwegian Board of Health Supervision supervises the health personnel and enterprises in the health service. The Norwegian Board of Health Supervision has the overall responsibility for supervision of the social services and child welfare services. In these areas, the county governors monitor the services. Supervision of the health personnel and enterprises in the health service is done by a variety of means, including inspections. Inspections are initiated on the basis of complaints or reports from patients or relatives, health personnel, employers, the police, pharmacies and others. In some cases, the supervisory authority also raises matters on its own initiative, for example, as a reaction to media coverage or information that emerges in connection with other supervision activities.

Inspection cases are investigated by the Norwegian Board of Health Supervision in the County. Relevant documentation is obtained, such as patients' medical records, statements from the involved health professionals and/or enterprises, a statement from the patient, etc. Most inspection cases are dealt with exclusively by the Norwegian Board of Health Supervision in the county without comment, and are concluded with advice and guidance or confirmation of a minor breach of the health legislation. Cases that are considered so serious that there may be grounds for imposing sanctions on the health personnel pursuant to chapter 11 of the Health Personnel Act are sent to the Norwegian Board of Health Supervision for final processing. Similarly, cases pertaining to serious breaches of duty in enterprises and orders to correct matters (see chapter 7 of the Act relating to the specialist health services and section 6–3 of the Act relating to the municipal health services) are also sent to the Norwegian Board of Health Supervision. The Norwegian Board of Health Supervision makes a final decision and rules on administrative reactions in inspection cases. Decisions about sanctions pursuant to section 11 of the Health Personnel Act may be appealed to the Norwegian Appeals Board for Health Personnel.

Section 67 of the Health Personnel Act grants the Norwegian Board of Health Supervision the authority to petition for public prosecution in the event of contravention of the provisions of the Health Personnel Act. The Norwegian Board of Health Supervision and the Office of the Attorney General have prepared guidelines for the treatment of these kinds of cases (circular no. 5/2001 from the Office of the Attorney General and circular no. IK-2/2008 from the Norwegian Board of Health Supervision). There are guidelines on collaboration and internal guidelines for processing by the police and/or prosecuting authorities and the

10. Proposition no. 87 (1993–1994) concerning an Act to amend the General Civil Penal Code etc., p. 105
11. Mæland, Sagfossen & Revis, 2008

Norwegian Board of Health Supervision. In matters relating to possible contravention of the provisions of the Health Personnel Act, the supervisory authority gives advice on whether the matter should be investigated. Once the matter has been investigated, the Norwegian Board of Health Supervision decides whether to petition for prosecution. The Board may provide advice during the investigation and also gives advice in cases where the prosecuting authorities are considering corporate penalties against enterprises in the health service.

There are no written guidelines for the contact between the police and supervisory authorities in cases where people with known mental disorders have committed serious offences. In these kinds of cases, it may be appropriate for the supervisory authority to undertake an independent assessment of whether the mentally ill individual has received the proper treatment. It may also be relevant to assess whether the social service and/or child welfare services have provided proper follow-up.

3.4.2 The Norwegian Board of Forensic Medicine's review of expert declarations in homicide cases

The Norwegian Board of Forensic Medicine (DRK) is a national commission appointed by the Ministry of Justice and the Police whose main task is to conduct an external quality assurance of all forensic expert evaluations made in criminal cases, including cases of homicide where the accused has undergone judicial observation. In practice, judicial observation is used in most murder cases, with the exception of cases of combined homicide and suicide. The Board is authorized by section 146 of the Criminal Procedure Act.

The Norwegian Board of Forensic Medicine's documentation material has been used as a source for homicide studies in Norway on several occasions; for example, Giertsen (1988), Noreik and Gravem (1993), and Rasmussen et al (1998).

3.5 Academic papers and theses submitted as part of a degree

There are a considerable number of academic papers and dissertations on homicide in Norway. They have been written from the perspective of a variety of different academic disciplines, including law, criminology, medicine, education, psychology and sociology. They strive to cast light on different aspects of homicide, from different angles and using different methodological approaches.

Chapter 4
Materials and methods

The committee has used a variety of different methodological approaches to investigate and illuminate the various issues raised in the mandate. The methods that the committee has used are presented below: review of the homicide cases in the period, review of the literature, interviews with people convicted of homicide, their relatives and relatives of victims, interviews with assistance agencies, contributions from research and academic institutions, and arrangement of a large consultative assembly.

4.1 The committee's review of homicide cases, including the definition of the mandate

Section 4.1.1 of the mandate states that the committee shall investigate cases where individuals with known mental disorders have taken lives in the period 1 January 2004 to 1 May 2009. In order to ensure that the committee would have access to the necessary information, the Storting granted the committee special authorization to the collect the necessary information from various agencies and individuals through an Act of law. In practice, obtaining the necessary information in the individual homicide cases has entailed the following two main tasks: 1) identification of perpetrators and 2) mapping how many of the perpetrators had a known mental disorder.

4.1.1 «Have taken lives»

Section 1 of the Act of 19 June 2009 no. 73 *relating to committees investigating matters related to cases where individuals with known mental disorders have taken lives*, states that the committee:

> «shall investigate possible weaknesses in systems and developments linked to people with known mental disorders who have taken lives».

Section 4.1.1 of the mandate emphasizes that the committee:

> «shall investigate possible weaknesses in systems and developments linked to people with known mental disorders who have taken lives during the last five years (from 1 January 2004 to 1 May 2009).»

The phrase «taken lives» can be interpreted differently in different contexts, and the terminology may be used differently in medical and legal contexts. It should also be pointed out that the committee's interpretation of the terms «taken lives» and «homicide»/«murder» has affected the number of individual cases that the committee has investigated and the outcome of our literature searches.

Regarding «homicide» in the medical sense, we refer to the World Health Organization's system «International Classification of Diseases 10» (ICD-10), where homicide is defined as:

> «Homicide, injuries inflicted by another person with intent to injure or kill, by any means.»

This means, for example, that the offence defined in the Norwegian General Civil Penal Code «bodily harm resulting in death» counts as homicide according to the WHO classification system. In Norway, all deaths are registered and classified in accordance with ICD-10 in the Cause of Death Register. The statistics in the Cause of Death Register are based on submitted medical reports of death and, as appropriate, autopsies. Each year, Statistics Norway (SSB) publishes statistics on cause of death. However, the Cause of Death Register does not record any details about the person who committed the murder.

In the legal context and in relation to Norwegian criminal law, «taken lives» can be related to several provisions in the General Civil Penal Code. In terms of crime statistics, both the National Criminal Investigation Service (KRIPOS) and Statistics Norway (SSB) define homicide as violation of the General Civil Penal Code, section 233 first and second, paragraph, i.e. intentional or premeditated homicide, but not manslaughter, attempted homicide or bodily harm resulting in death. Other actions that lead to the perpetrator «taking a life», are treated in other provisions, such as fire resulting in loss of life (section 148 of the General Civil

Penal Code). There will nevertheless still be differences between statistics that otherwise look fairly similar in the overview of homicides from the National Criminal Investigation Service (KRIPOS) and the more general crime statistics from Statistics Norway. KRIPOS' overview of homicides lists homicides by the year in which they were committed. Here, the historical data are updated regularly. Statistics Norway has different criteria for which cases are included in their annual crime statistics. A main reason why the statistics are different is that they use different systems for when the information from the cases are used to create statistics.

The committee has based its investigations on the medical definition of homicide. In our assessments, we have attached importance to ensuring that this definition corresponds well with the wording of the mandate («taken lives»). It was also found that the medical definition is more suitable for carrying out searches in international literature. This has entailed for example that cases that under Norwegian criminal law are classified as homicide (General Civil Penal Code, section 233, first and second paragraph), bodily harm resulting in death (General Civil Penal Code, section 229, third penalty option) and fire resulting in loss of life (General Civil Penal Code, section 148), have been included in the committee's investigations. A complete overview of the criminal provisions is included below. The committee has not included attempted homicide and manslaughter in this review. Regardless, attempted homicide is not covered by the Act or the wording of the mandate «has taken lives.»

The review includes cases where the offence took place in the period between 1 January 2004 and 1 May 2009. This follows from prehistory to the establishment of the committee and wording of the mandate.

In addition, it has also been a fundamental condition that the case has been solved, in the sense that it has been established who has caused the death. Homicide cases in which no perpetrator has been found thus fall outside the realm of committee's work. Nor is it the responsibility of the committee to consider cases where liability issues have not been resolved. Thus, cases where the suspect/accused/defendant disputes involvement in the case and there is no enforceable judicial decision regarding liability also go beyond the realm of this review. If the perpetrator has taken his/her own life and the case has thus not resulted in a conviction, we used the conclusion from the police investigation of the matter.

4.1.2 Method to find people who have taken lives

The committee selected the appropriate criminal cases and the perpetrators in the period using the police records stored in the STRASAK database. This is the only database containing a complete overview of all the criminal cases in Norway. Both the national homicide statistics from the National Criminal Investigation Service (KRIPOS) and the national crime statistics from Statistics Norway (SSB) are based on data from STRASAK. The national homicide statistics include cases of homicide pursuant to section 233 of the General Civil Penal Code, and thus do not include other crimes resulting in death.

The Norwegian Police Directorate (POD) is responsible for STRASAK and the administrative system BL. The systems are operated by the Police Data and Materiel Service (PDMT). It was thus PDMT that actually performed the task of making extracts from STRASAK.

Figure 4.1 provide a schematic overview of how extracts are made. The first extract of the 3,134 cases (alleged perpetrators) was made on 28 September 2009 on the basis of the following criteria:

- Offence committed between 1 January 2004 and 30 April 2009
- Cases registered by 28 September 2009 (first extract)
- Cases registered with a code that might indicate a crime resulting in death. The following codes indicate that there has been a fatality:
- Homicide (code 1708 – section 233 of the General Civil Penal Code)
- Infanticide (code 1710 – section 234 of the General Civil Penal Code)
- Bodily harm resulting in death (code 1714 – section 229, third sentence option of the General Civil Penal Code)
- The extract also included cases that could result in death, recorded under the following codes:
- Grievous bodily harm (code 1706 – section 231 of the General Civil Penal Code)
- Deprivation of liberty (code 1602 – section 223 of the General Civil Penal Code)
- Rendering a person helpless (code 1718 – section 242 of the General Civil Penal Code)
- Life, body, health – miscellaneous (code 1799)
- Robbery, extortion – miscellaneous (code 2599)
- Arson resulting in death (code 701 – section 148 of the General Civil Penal Code)

Box 4.1 STRASAK

The administrative database BL («basic solutions») and the criminal cases database STRASAK are registers used in the processing of criminal cases and act as a record of criminal cases in terms of registration and follow-up of reported offences and investigation cases, such as missing persons and suspicious deaths. When the police initiate an investigation, the case details are entered in BL. All the data and all the relevant documents that are registered in the system are stored here. Coding is a central aspect of the registration, consisting of allocating each individual case a statistical code that indicates the relevant penal provision. Coding is done manually and is based on information available at the time the case is first registered. A case code can be changed if new information suggests that a different penal provision should be applied. Once the case has been registered, the relevant data are transferred to STRASAK. STRASAK thus provides an overview of criminal cases in that it contains information about the progress of the case and where the case is until the case is closed/enforceable. The register should provide an overview of and allow control of the procedure and development of all criminal cases.

The register forms the basis for the crime statistics, in terms of individual case processing and the scope and composition of crime in general. STRASAK reports are used as a tool in the police's work on objectives and performance, in that they can generate overviews of everything from types of crime to the backlog in individual police districts. Statistics from STRASAK are also used as the basis for police analysis work. The data are transferred to Statistics Norway (SSB) and form the basis for Norway's official crime statistics.

STRASAK contains information about all the registered criminal cases. The register contains details of the reported crime (statistics group/offence code, date of the offence, place of the offence), names, dates of birth, etc. of the accused and the complainant (the aggrieved party or plaintiff, the person reporting the offence), property involved in a criminal case, cars/boats/other vehicles involved in a criminal case, mode, who is responsible for processing the case (police district, investigator, lawyer, external), what investigations have been made, processing of the case/procedure and court decisions (prosecution decisions, judgment). In addition, the cases are organized into groups.

The statistical code is an important element of the information recorded in STRASAK. The effectiveness of STRASAK depends on the individual cases being registered with the correct code. This is of major importance for Statistics Norway and the police.

Source: Official Norwegian Report (NOU) 2003:21

– Rape resulting in death (code 1420 – section 192, third paragraph of the General Civil Penal Code)

The extract included 1,651 cases that had been dismissed for reasons other than the death of the alleged perpetrator. These cases were excluded. Of the remaining cases, 1,225 were cases registered with codes indicating offences that could result in death. These were reviewed manually, and six cases were found to have resulted in death and meet the committee's criteria for inclusion in this study.

Based on this extract, inquiries were sent to the appropriate police districts asking for the necessary information from police case documents about the offender in the 258 cases that had codes indicating an offence resulting in death. It quickly emerged that erroneous use of codes in STRASAK meant that a large number of the cases in our extract had not resulted in the death of the victim as a result of the crime. A manual review was therefore conducted of the electronically available information at the Police Data and Materiel Service (PDMT) for all the cases to determine whether the offence had resulted in the death of the aggrieved party.

In addition, information about the victim and the perpetrator was checked against the Norwegian National Population Register to verify that the victim was dead and also check whether the perpetrator was dead. In addition, the recorded date of death was verified. In order to be able to check the data against the Norwegian National Population

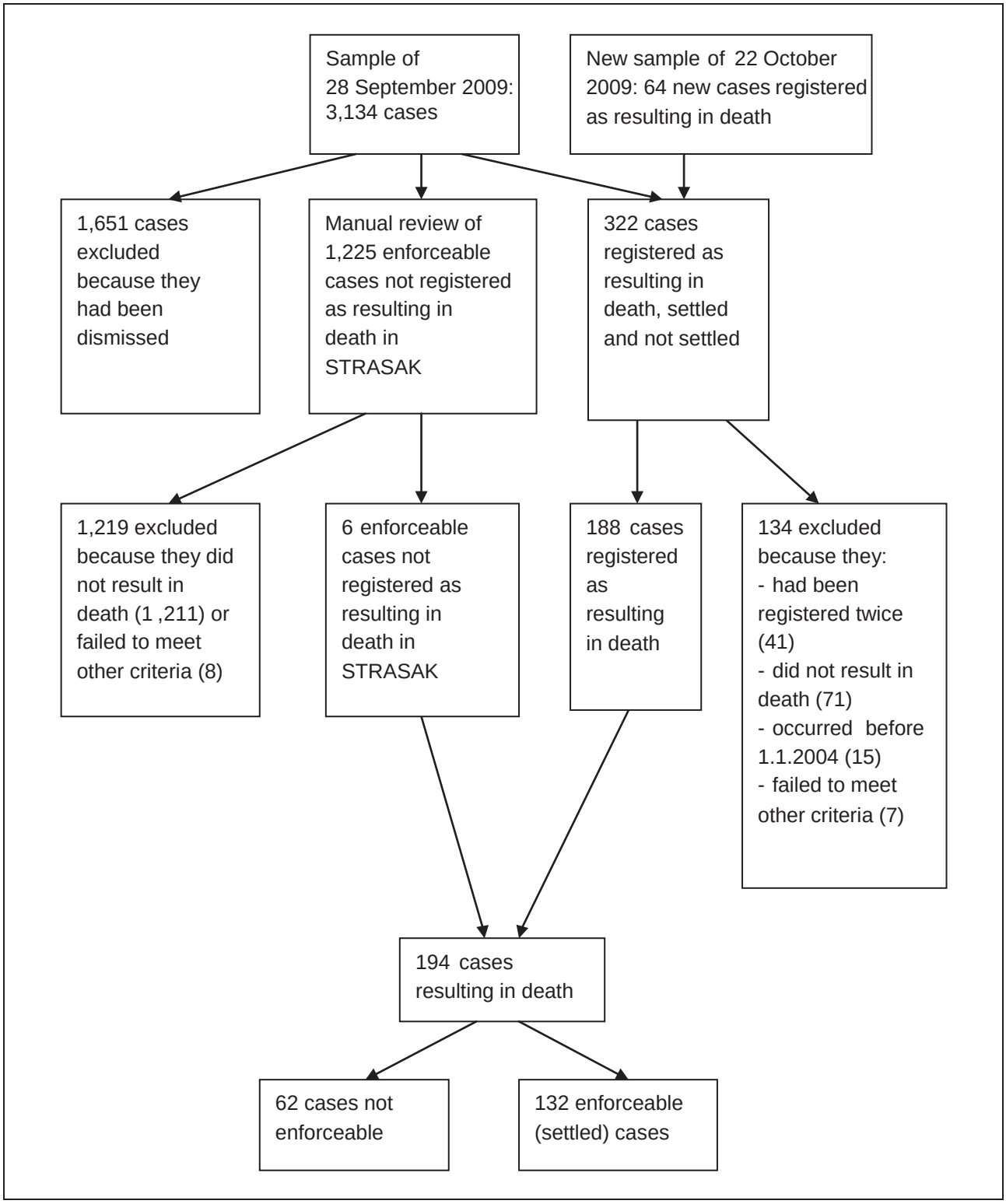

Figure 4.1 Overview of the number of cases

Register, a new extract had to be made (on 22 October 2009). The new extract included the same codes as the first extract.

This last extract contained 64 new cases recorded as resulting in death, and together the two samples gave a total of 322 registered cases resulting in death. Of these 134 cases had to be excluded: 71 cases on the basis of the fact that the manual review showed that the offence had not resulted in death.

This means that when the committee undertook its review, there were 194 perpetrators who

had taken lives in the period. Of these, 132 had enforceable judgments, and 62 had not yet been legally settled at the time of the extract.

Based on the updated list, a new request was sent to the police districts for access to police documents in the enforceable cases. The outcome was that the committee was finally granted access to the police's case documents in all 132 enforceable cases that were included in the committee's sample.

4.1.3 «Known mental disorder»

The term «mental disorder» is a broad concept that has different meanings in different settings. Whether an individual is regarded as having a mental disorder or not will depend on the perspective adopted. In this section, we will clarify how the term is used in this report. To illustrate differences in definition, however, we will first present a few examples:

- Perpetrators who were considered to be criminally insane and sentenced to compulsory admission to psychiatric treatment facilities, i.e. using a legal definition. This was the definition used by the previous committee review of homicide cases in Norway, for example.[1]
- People with a diagnosis that is regarded as a serious mental disorder, i.e., using a medical definition. There is debate concerning what counts as serious mental illness, but disorders such as schizophrenia, bipolar disorder and severe depression are usually included. In some cases, some personality disorders are also included.
- People with a mental disorder according to the World Health Organization's definition, that is, a disorder included in the chapter on mental disorders (F0-F99) in the diagnostic manual ICD-10.[2]

For the purpose of its review of the cases in the period, the committee has chosen the World Health Organization's definition of «mental disorder». The committee found it necessary to adopt an inclusive definition in the charting phase in order to gain a broad overview of the area. It provided a better basis for comparing the findings of this inquiry with previous studies. In addition, it allowed us to draw some conclusions about the ratio between the total number of people who commit homicide and the number of homicide perpetrators with different types of mental disorder.

In its recommendations, however, the committee has chosen to focus on people with severe mental disorders and severe personality disorders, especially in combination with substance use disorders. In this report, the term severe mental disorder means: schizophrenia, schizotypal disorder, paranoid psychosis, schizoaffective disorders and other psychotic orders (F20–F22, F24–F29), manic episodes and bipolar affective disorder (F30–F31) and major depressive disorders (F32.2, F32.3, F33.2, F33.3). The concept «severe personality disorders» is used in the report to mean: paranoid, schizoid, antisocial and emotionally unstable personality disorders (F60.0–F60.3). The term «substance use disorder» is used in this report to refer to disorders due to use of alcohol and other drugs (F10–F16, F18–F19).

Many perpetrators had not had any contact with assistance agencies before the homicide that might have been able to assess their disorder against diagnoses. The committee has therefore chosen to include people that have been diagnosed in a psychiatric evaluation performed after the incident as having been mentally ill before or at the time of the incident in the same way as the perpetrators who were diagnosed before the event.

4.1.4 Method for obtaining information about perpetrators with known mental disorders

The committee had to determine which of the perpetrators had a «known mental disorder». The documentation obtained from the police provided important information about mental illness in many cases, but this information was not complete. It was therefore necessary to obtain information from other sources. A natural starting point for obtaining information on mental illness was the perpetrator's GP.

Based on the findings of the review of STRASAK and the Norwegian National Population Register, the committee then requested information from the Norwegian Health Economics Administration (HELFO) about the perpetrator's GP at the time of the offence, or who had later become perpetrator's regular GP.

On the basis of the information in the HELFO register, requests were sent to all the doctors who had been a homicide perpetrator's GPs at the time of the offence or when we sent the requests. The doctors were asked whether the patient had had a mental disorder (including substance use) at the time of the offence or earlier. If the patient had had a mental disorder, the committee then asked for a

1. Rasmussen committee, 1998
2. World Health Organization; 2000.

copy of the relevant information in patient's medical records that would provide information about the mental disorder. 19 of the perpetrators did not have a regular GP, and for five of the perpetrators the committee did not receive a response to their request from the doctor. This means that the committee received information from the GPs of 108 of the perpetrators.

It became clear at an early stage that a very important source of information about the perpetrators' mental health and alcohol and/or drug use was the forensic psychiatric evaluations submitted to the courts in accordance with the section 165 of the Criminal Procedure Act. The committee had access to the psychiatric evaluations in 85 cases. There was no psychiatric evaluation in the remaining 47 cases.

In cases where an inspection of the health care was undertaken, the documents from the Norwegian Board of Health Supervision in the County and the Norwegian Board of Health Supervision were an additional source of information about perpetrators with known mental disorders. Of the 132 cases included in the committee's review, there were inspection documents from the health supervision authorities in 21 cases.

A combination of qualitative and quantitative methods was used in the review of the cases. The committee has reviewed some individual cases in detail. In addition, all the cases were reviewed with respect to 314 predefined variables, and the data was recorded using the statistics program SPSS. The variables were selected on the basis of information from literature searches, the wording of the mandate and input from the committee and the experts cooperating with us. To ensure the data were comparable, the list of variables was coordinated with the variables used in official statistics and other studies, both past and ongoing. For example, the committee had access to the coding system of a major research project in the UK.[3] The committee also had access to the codes in the completed research project carried out by Pål Grøndahl, a researcher at the Centre for Research and Education in Forensic Psychiatry for South-Eastern Norway.

4.1.5 Confidentiality

The documentation that formed the basis for the committee's review includes material on loan from the police districts, the health service, the Norwegian Board of Forensic Medicine (DRK) and the Norwegian Board of Health Supervision. The material contains sensitive, confidential information about individuals. It has therefore been essential for the committee and the experts who conducted various assessments for the committee to take great care to ensure that information does not go astray. In agreement with the bodies that were granted access to documents in certain cases pursuant to the Committees Act, the committee decided that loaned material was either to be returned to its original source or copies were to be destroyed. Similarly, used electronic storage media were disposed after the analyses had been performed.

For legal and ethical reasons, this report does not include detailed descriptions of the events and the people involved. The individual stories that are included in this report have been rewritten and partly made up to ensure it is impossible to identify the informants.

4.2 Literature review

Pursuant to section 5.2 of the mandate, one of the main objectives of the committee is to:

> «advise on what measures should be implemented in the services and the system to prevent individuals with severe mental disorders and/or substance addiction from committing homicide.»

To ensure that the committee provides sound advice based on current academic knowledge, much of the committee's work focused on the review of the existing research literature. The committee conducted a structured literature review of the link between mental illness and homicide (see appendix 3). In addition, the committee's external partners, who wrote some sections of the report, reviewed the existing research literature and describe the status of knowledge in their respective fields. Due to a shortage of time, the external partners mainly focused on literature they were already acquainted with. In some cases, they have also undertaken a literature search. See the individual chapters for more details.

The committee's review of these 132 homicide cases cannot say anything conclusive about the reasons for the killings. This type of review will always have inherent weaknesses, as the review covers a very limited number of cases and the assessments are made retrospectively (with the wisdom of hindsight). Nor has a comparable group of people been studied using the same methods,

3. Appleby, 2005

and it is therefore difficult to assess whether there are differences between the individuals who have taken a life and other people. Research carried out in the field and that does not have these kinds of weaknesses is far better suited to describing probable causal factors that lead people to kill. The committee therefore finds that it would be inappropriate to base advice that will affect many people and systems on such a limited review of cases alone.

The literature review shows that several thorough research-based studies have been undertaken on many of the topics included in the mandate. Much of this research is far better suited as a basis for proposals for advice and measures than the committee's limited review of a small number of cases, because these research-based studies have built on comprehensive data and been subject to rigid requirements concerning methods and quality assurance. In addition, the research has been done in many different ways and in different conditions, and therefore allows description of more aspects of the complex issues in the mandate than the committee's review has enabled.

The committee has striven to come up with advice and measures that can lower the risk of homicide, and the advice must therefore be related to causal factors of homicide. Herein lies the main challenge, which was also identified in the conclusion of Christensen's study from 1956, where it is stated:

> «It is interesting to identify correlations between personality structures, mental illness and criminality, but it is more important to find causal relationships. This survey fails in this respect primarily because the attempts to analyze causality have to be made retrospectively. We have identified a number of characteristic features in the group of killers, but we have not found a real explanation for what made these people to take lives (...) It is probably only possible to perform a causal analysis in connection with a depth-psychological analysis of each case. Personally, I am also in doubt as to whether this would take us much farther than to linking the act of killing to a specific reference framework that builds on the special analytical theory.»[4]

Similar challenges arise in connection with section 4.1.2 of the mandate, where the committee is asked to:

> «provide an account of the factors it considers relevant to the perpetrator being in a situation where the mental disorder, and any accompanying substance abuse problems, contributed to a life being taken».

In its review, the committee has observed how often recommendations in guidelines and other standards have not been followed. However, we have not been able to draw any conclusions about causal factors in the individual case. A retrospective review of cases without studying a comparable group is not a suitable method to answer the questions raised in the mandate. This applies to this committee's review of individual cases and previous reviews alike.[5]

In its review, the committee can describe events and whether there has been deviation from or violation of applicable guidelines and standards. The committee cannot rule out that weaknesses in systems and breaches of standards have entailed that lives have been taken, but the committee cannot say whether this has happened in each individual case.

4.3 Interviews with people convicted of murder, their relatives and relatives of victims

On behalf of the Olsen committee, the Centre for Research and Education in Forensic Psychiatry, which is part of the South-Eastern Norway Regional Health Authority, carried out a limited number of interviews with people who have been convicted of serious violent crime resulting in death and interviews with their relatives. The people who conducted the interviews signed a personal oath of confidentiality with the Olsen committee in connection with this task, and the chair of committee has kept a record of all the people who received confidential information in connection with the committee's work, cf. section 8.3 of Proposition no. 90 (2008–2009) to the Odelsting relating to the Act on the duty of disclosure, duty of confidentiality, etc.[6].

The interview survey is not research-based. The survey covers a very limited number of people, and the representative selection method was not used. The interviews cannot be claimed to be representative of the group, and it would not be prudent to attempt to generalize beyond the individual case.

4. Christensen, 1956, p. 316

5. Rasmussen committee, 1998, p. 7
6. Proposition no. 90 (2008–2009) to the Odelsting relating to the Act on the duty of disclosure, duty of confidentiality, etc.

The purpose of the interviews was to cast light on and find illustrations or examples of how people convicted of murder and their relatives perceived the contact they had with the health services and hear their view of what factors might have led to the homicide. Answers were specifically sought regarding whether an individual plan or a treatment plan had been drawn up, whether various forms of treatment were offered, and whether the person convicted of murder followed up the treatment and what he or she thought about it. Quotes from the interview survey are included in the boxes in chapters 8 and 12 below.

Prior to the interviews, the committee secretariat had obtained approval from the institution where the person convicted of homicide was being held and the written consent of the person convicted. The interviews with the convicted person's relatives were also based on consent. In the cases where the interviewee agreed to it, the interviews were tape-recorded in order to have a source material that could be quoted from verbatim. In keeping with the agreement with the informants, the recordings from the interviews were subsequently destroyed. By agreement with the informants, the material will only be presented and published in an anonymous form. In order to ensure it is impossible to identify the individual cases and informants, the committee also rewritten and made up parts of the narratives.

In addition to the interviews, the committee and the individual members of the committee also received direct requests from people who were close to the perpetrator and/or the victim. These personal accounts made a very strong impression.

4.4 Interviews with assistance agencies

On assignment from the Olsen committee, SINTEF Health Services Research conducted a qualitative study in which researchers looked into six cases in more detail where a person with a known mental disorder has taken a life. SINTEF carried out a total of 43 interviews with people employed in municipal administrations, hospitals, district psychiatric centres and the police, in the form of semi-structured interviews. The purpose was to find examples of the lessons the services learned in the wake of the incidents and how they have been used in efforts to improve the quality of their work. Like the rest of the work done by the committee, the study was regulated by the Act of 19 June 2009 no. 73 relating to committees investigating matters related to cases where individuals with known mental disorders have taken lives. Transcripts of the interviews and other background materials were destroyed once the assignment was completed. For legal and ethical reasons, this report does not include detailed descriptions of the events and the people involved. The individual stories that have been included have been rewritten and partly made up to ensure it is impossible to identify the informants. The SINTEF report and the findings from the interviews have formed the basis for chapter 15.

4.5 Assistance from research and academic communities

The committee's mandate is extensive and touches upon a broad range of disciplines and areas of specialist expertise. To ensure that the committee's assessments and proposed measures are as firmly as possible rooted in knowledge, the committee has collaborated with a number of researchers and research institutions – in Norway and abroad. The report includes contributions the committee has received from researchers associated with the following Norwegian institutions: the Norwegian Institute of Public Health, the Centres for Research and Education in Forensic Psychiatry, the Norwegian Knowledge Centre for the Health Services, the Norwegian Police University College, the Regional Resource Centre on Violence, Traumatic Stress and Suicide Prevention (RVTS) for Southern Norway, the Norwegian Centre for Addiction Research (SERAF), the Norwegian Institute for Alcohol and Drug Research (SIRUS) and the Regional Centre of Expertise on Substance Abuse – Eastern Norway.

As regards overseas research institutes, the committee has primarily had contact with a research group in the UK. In January 2010, the committee had a meeting with Professor Louis Appleby and a number of employees working on the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness at the University of Manchester. Appleby is also the National Director for Mental Health at the Department of Health. In addition, the committee's Swedish member contributed with especially insightful information about current studies and research in Sweden. In terms of international research in general, the committee has focused on information found in the literature search.

4.6 Consultative assembly

On 18 November 2009, the committee held a large consultative assembly on the topic: «Prevention and cooperation. Are there collaboration problems that can affect the risk that persons with mental illness take lives?» The backdrop to the assembly was that the committee recognised that its work was entirely dependent on broad and good access to knowledge, experiences and opinions and to that end wanted to hear the opinions and advice of user and relatives' organizations and others affected parties as well as treatment institutions, government agencies, research institutions, NGOs, etc.

The meeting was divided into two parts, one where the main issue was: What factors can ensure the necessary flow of information between services that are supposed to collaborate regarding individuals with a known mental disorder? The other main question was: How do we create coherence in services for people with a known mental disorder? Each part was opened with a talk by the invited keynote speakers – Police Superintendent Arne Erik Hennum from Oslo Police District and the local medical officer in Moss Knut Michelsen – before the floor was opened for plenary discussion.

The meeting was attended by representatives of various organizations, services, agencies, institutions and experts with a special responsibility for or interest in how people with mental disorders who need multidisciplinary services are followed up. A total 117 participants attended the assembly.

Chapter 5
Homicide in the period 1 January 2004 to 1 May 2009

5.1 Delimitations

The committee's mandate is to investigate possible weaknesses in systems and developments linked to people with known mental disorders who have taken lives in the period 1 January 2004 to 1 May 2009. The committee has therefore undertaken a review of the homicide cases in the period and tried to find information about the perpetrators' mental health. Chapter 4 describes how the cases were selected and how the information was obtained. This chapter contains the results of the committee's review and analysis of all the cases. This chapter presents a description of the perpetrators and their victims; the perpetrators' mental health is described in section 5.3. The committee's findings regarding the treatment the perpetrators received from the assistance services are presented in chapter 8.

The police informed the committee that there was uncertainty linked to the information held by the police about the perpetrators' mental health in the 132 cases of homicide that the committee were granted insight into. As there was initially no reliable information about which homicide perpetrators had mental disorders, the committee had to obtain information about all the offenders and analyze it. Only in cases where the regular doctor had reported a known mental disorder did the committee request copies of the patient's medical records from the doctor, and then only the relevant case notes. Apart from the fact that we did not have the GP's medical records for the people who did not have a known mental disorder, we had access to the same information for people with and without a known mental disorder.

The committee debated whether this report should only contain statistics on individuals who had a known mental disorder, but chose in the end to present data for all the perpetrators that the committee has gathered information about. This is justified by several factors.

The definition of known mental disorder can vary (see section 4.1.3). Inclusion of all the perpetrators will provide a more balanced picture than if we excluded parts of the group. Including all perpetrators will make a larger contribution to the objective of preventing as many future deaths as possible than if we only looked at subgroups of perpetrators.

Only presenting data for people with known mental illness would not allow us to say whether perpetrators with mental illness are different from other perpetrators. It would also not be possible to say whether mental illness is rare or common among homicide perpetrators. The committee has therefore chosen to present all the available information about the entire group of perpetrators, both those with and those without a mental disorder.

The committee has reviewed all the information it has received about the 132 identified perpetrators. However, the information the committee received about their health and treatment before the event varies widely. This is due to several factors, including:

- Forensic psychiatric evaluations were an important source of information in cases where the regular doctor had limited information. However, forensic psychiatric evaluations are only performed if there is doubt about the offender's accountability or the risk of relapse into serious crime. A forensic psychiatric evaluation was not performed in 47 of the cases.
- The Norwegian Board of Health Supervision has collected detailed information about what health care the individuals concerned received. The Norwegian Board of Health Supervision in the County and/or the central Norwegian Board of Health Supervision had been involved in 21 of the cases that the committee has reviewed.
- The information that the GPs provided varied widely, partially reflecting a large variation in the intensity of treatment. The committee did not receive any information from the perpetrator's regular doctor in 24 cases, mainly because the committee has not been able to identify the perpetrator's regular doctor (19 cases).
- In cases where the perpetrator committed suicide, there was no trial and therefore no forensic psychiatric evaluation.
- In the cases where the GPs did not have information indicating that the person had a mental

disorder before the incident, the committee has not received the medical records from the patient's regular doctor.
– Within the time frame available to us, the committee was not able to obtain information from other sources, such as the specialist health service or mental health services in the municipalities. In some cases, the committee has, however, had access to detailed information about their services, for example through the forensic psychiatric evaluation, the Norwegian Board of Health Supervision's review, a summary of patient records from their regular doctor, or police documents.

Because of these limitations in the information available to the committee, the number of cases with known information (N) on the different topics varies. The percentages quoted here are calculated on the basis of the cases about which the committee had information.

In some cases, there were multiple perpetrators, and in some cases there were multiple victims. Since the focus of the study was to ascertain what follow-up the perpetrators had received in advance of the homicide, the information has been sorted according to the perpetrators and not, for example, the victims or the type of case.

The committee has based its investigation on cases where it has been legally and finally decided that someone had taken a life. The information provided applies only to cases that were finally decided before 28 September 2009, when the committee ended its review of the cases. There is therefore no information about 62 perpetrators with 38 victims where there was no enforceable court ruling by this date. In one of these cases, one of the perpetrators had been convicted; this means that for one of the victims, only one of several alleged perpetrators has been included in the committee's review. In addition, there were six murder victims with no known perpetrators in the police documents. This means that the material does not give a complete picture of all the perpetrators who have taken lives in the period. It is entirely possible that a presentation of all the cases in the period would draw a different picture. For example, it is possible that the cases that take a long time in the courts have some characteristics in common. It is also possible that the cases that occurred towards the end of the review period and that had thus not been decided legally differ from the cases earlier on in the period.

So far as it has been possible within the committee's time frame, we have tried to find the most comparable figures to see if the perpetrators in the cases are different from other groups of people. For example, we compare the offenders in our sample with the population in general, with former prisoners in Norwegian prisons, with previous samples of homicide perpetrators that have been studied in Norwegian and international studies, etc. The committee would like to stress that there are rarely directly comparable figures across studies. Usually different methods have been used, and there may be different weaknesses and skews between the studies. For example, people with serious mental illness are under-represented in quite a few population studies. It can also be problematic to compare findings across national boundaries because of differences in the health services and cultural differences.

5.2 The number of homicides in the period

The 132 perpetrators reviewed by the committee took the lives of a total of 140 persons (table 5.1). In addition there were 37 victims where none of the alleged perpetrators had received an enforceable judgment, and six victims whose murderer had not been identified. This means that in the study period, a total of 183 persons were murdered, yielding an average of 34.3 homicides per year, or 0.74 homicides per 100,000 inhabitants.

Some official statistics include only people killed pursuant to section 233 of the General Civil Penal Code, intentional or premeditated homicide.

Table 5.1 Overview of the number of perpetrators and the number of victims in the reviewed cases

	1 victim	2 victims	3 victims
1 perpetrator	110 cases	8 cases	3 cases
2 perpetrators	3 cases[1]		
3 perpetrators	2 cases		

[1] In a case involving two alleged perpetrators, only one perpetrator had received an enforceable judgment at the time the report was prepared.

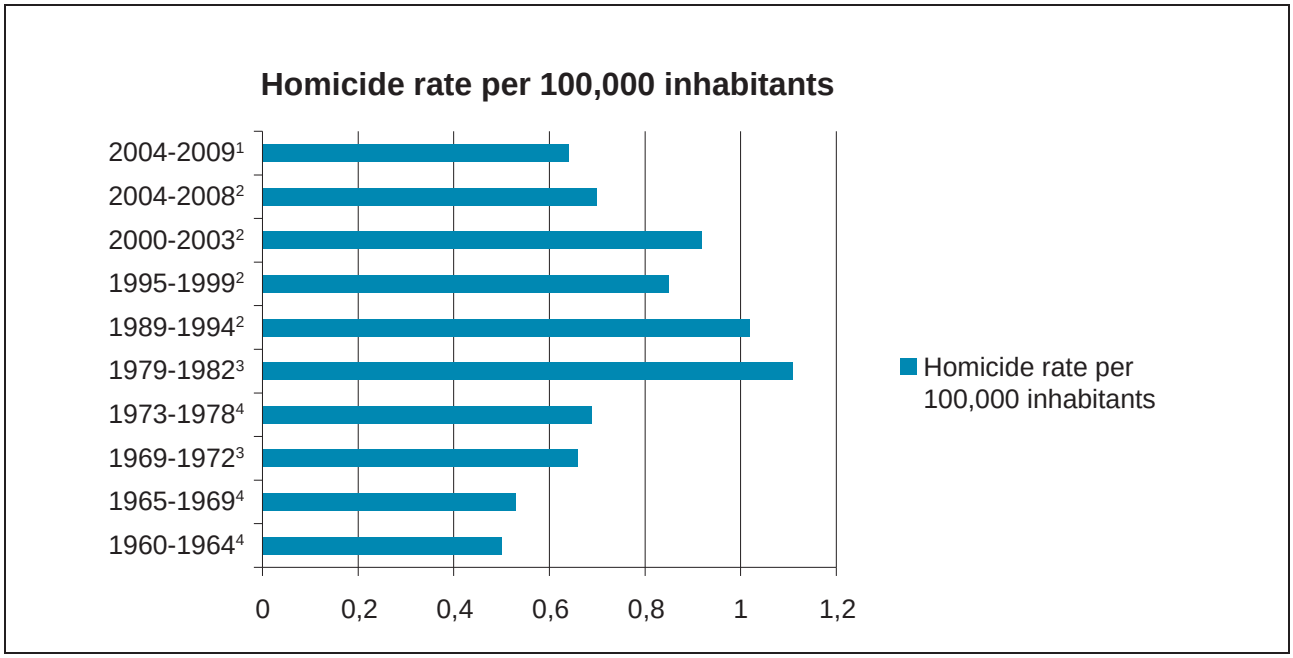

Figure 5.1 Homicide statistics over time, deaths per 100,000 inhabitants per year

1 According to the committee's review, homicide pursuant to section 233 of the General Civil Penal Code.
2 According to the National Criminal Investigation Service (KRIPOS), divided by the number of 100,000 inhabitants per year. KRIPOS, 2008.
3 According to Statistics Norway (SSB). SSB, 2004.
4 According to Statistics Norway's cause of death statistics. Rognum, 1985

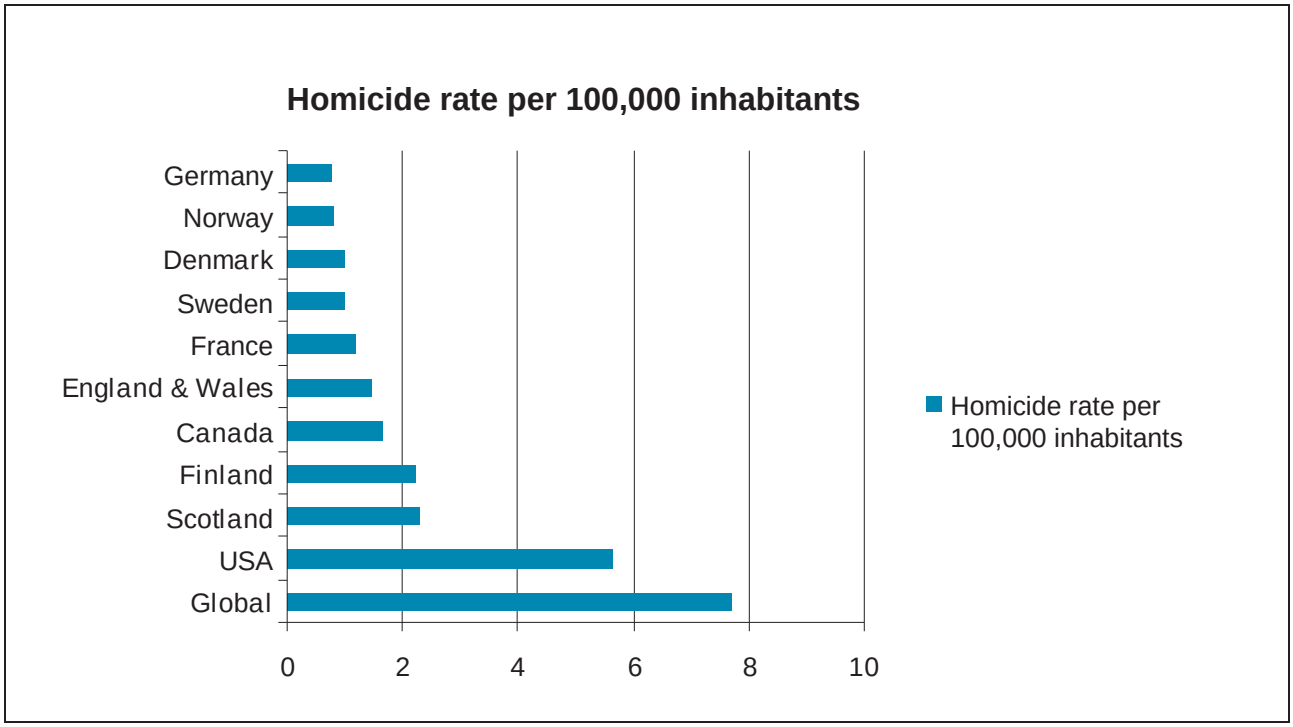

Figure 5.2 International homicide rate per 100,000 inhabitants

These homicide rates concur with the UN international statistics and are based on the average of available data in the period 2003–2008. (United Nations Office on Drugs and Crime, 2009).

According to the committee's review, this constituted a total of 157 persons, i.e. 29.5 homicides on average per year during the period studied by the committee. This corresponds to 0.64 homicides per 100,000 inhabitants per year.

In 18 cases, the alleged perpetrator committed suicide after the homicide. These perpetrators are not included in the list of victims.

The official statistics on homicide in Norway from Statistics Norway and the National Criminal Investigation Service (KRIPOS) are calculated using data from police records (STRASAK), and are based on the number of victims of homicide pursuant to section 233 of the General Civil Penal Code, i.e. intentional or premeditated murder. Although there are some differences as to when the homicides are registered with Statistics Norway and the National Criminal Investigation Service (KRIPOS), they will yield the same homicide rates over time.

As illustrated in figure 5.1, there appears to have been a decline in the number of homicides in Norway over the last 30 years. However, it should be noted that the murder rate was equally low from the late 1950s until the early 1970s, where the homicide rate rarely rose above 0.6 per 100,000 inhabitants.

It can be difficult to compare the number of homicides across different countries because the definition of homicide may vary. However, it has been known for many years that Norway has a relatively low homicide rate compared with other countries, including the other Nordic countries.[1] The UN estimated that 490,000 homicides were committed around in the world in 2004, which yields a global homicide rate of 7.7 per 100,000 inhabitants.[2] However, the Scandinavian countries have tended to have a lower homicide rate (see figure 5.2).

5.3 Scope of mental illness

In total, 92 (71 %) of the perpetrators had a diagnosable mental disorder at the time of the offence, and 97 (75 %) had had a mental disorder at some point during their life. The most common mental disorders at the time of the offence were addiction-related diagnoses (38 %), personality disorders (30 %) and schizophrenia/paranoid psychosis (18 %). The proportion of perpetrators diagnosed with schizophrenia or paranoid psychosis was significantly higher than in the population in general. There was also a high prevalence of personality disorders and addiction-related disorders. Mental disorders related to substance abuse are discussed in more depth in chapter 7.

The committee has based its review on established diagnoses, either from before the incident or from the forensic psychiatric evaluation performed after the incident. The committee has not verified the diagnoses. This means that we have not ascribed any diagnoses ourselves, even if there was information that the person should have had a particular diagnosis. However, we have accepted rough or inaccurate diagnoses. For example, we have included diagnoses made by GPs using the diagnostic system ICPC-2, which has a limited number of diagnosis options in terms of mental health.[3] We also included diagnoses that do not refer to a specific diagnosis system. This includes forensic psychiatric evaluations that state that the perpetrator has suffered from depression without specifying whether this is intended as a diagnosis or which diagnosis.

1. Olaussen, 1995
2. The UN homicide statistics do not include lives taken as part of an armed conflict (United Nations Office on Drugs and Crime, 2009)
3. Norwegian Centre for Informatics in Health and Social Care (KITH), Norwegian College of General Practitioners (NSAM), and Directorate for Health and Social Affairs, 2004

Table 5.2 The number of diagnoses

	At the time of the offence		At some point in life	
	Number	Per cent	Number	Per cent
0	37	29 %	32	25 %
1	35	27 %	31	24 %
2	32	25 %	19	15 %
3	17	13 %	14	11 %
4	3	2 %	13	10 %
5	3	2 %	8	6 %
6	2	2 %	6	5 %
7 or more			6	5 %

Table 5.3 Diagnosis of homicide perpetrators at the time of the offence and during their life (N = 129)

	At the time of the offence		At some point in life	
	Number	Per cent	Number	Per cent
Organic, including symptomatic, mental disorders (F0–F9)	3	2 %	3	2 %
Mental and behavioural disorders due to psychoactive substance use (F10–F19)	49	38 %	51	40 %
Schizophrenia, schizotypal and delusional disorders (F20–F29)	23	18 %	25	19 %
Mood [affective] disorders (F30–F39)	12	9 %	28	22 %
Neurotic, stress-related and somatoform disorders (F40–F49)	15	12 %	34	26 %
Behavioural syndromes associated with physiological disturbances and physical factors (F50–F59)	1	1 %	8	6 %
Disorders of adult personality and behaviour (F60–F69)	38	30 %	41	32 %
Mental retardation (F70–F79)	0	0 %	0	0 %
Disorders of psychological development (F80–F89)	3	2 %	4	3 %
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90–F98)	10	8 %	17	13 %
Unspecified mental disorder (F99)	0	0 %	2	2 %

Diagnoses at the time of the offence are generally established in the forensic psychiatric evaluation. In cases where the diagnosis was made by others before the incident and the data suggest that the perpetrator had this disorder at the time of the offence, this information is also included.

Both the main diagnosis and up to five secondary diagnoses have been recorded (table 5.3). In addition, the number of diagnoses has been recorded (table 5.2). The committee also registered information about the start of the main diagnosis and when it was diagnosed for the first time. Information about mental health and possible diagnoses is missing for three people in our sample.

It is impossible to find fully comparable figures for the population of Norway, as there are no complete statistics on the proportion of the population with the different diagnoses. However, there are studies that can provide indications in some areas. These studies have been summarized in a report from the Norwegian Institute of Public Health published in 2009.[4] The report also summarizes figures from studies in a number of other countries. Here we will review the most common disorders among the perpetrators in our sample (table 5.3). The findings for substance use-related disorders (F10-F19) are discussed in a separate chapter.

There were significantly more individuals with schizophrenia and related disorders than expected on the basis of the population figures. A total of 20 people (16 %) were considered to have schizophrenia at the time of the offence, and a further three people had a diagnosis of paranoid psychosis. There are no statistics on how many people have schizophrenia in Norway. A thorough Finnish study found a prevalence of schizophrenia of 1 %, whereas a meta-analysis of 188 prevalence studies found a lifetime prevalence of 0.4 %. The proportion of homicide perpetrators diagnosed with schizophrenia in the committee's sample is higher than that found in most international studies of homicide. A meta-review of 18 studies from industrialized countries indicated that on average 6 % of the homicides were committed by people diagnosed with schizophrenia.[5]

The same study also showed that there was strong correlation between the overall homicide rate in a country and the rate of homicides committed by persons diagnosed with schizophrenia. In other words, the higher the proportion of people

4. Mykletun, Knudsen, & Mathiesen, 2009

5. Large, Smith, & Nielssen, 2009

who committed murder in a country, the higher the proportion of people diagnosed with schizophrenia who had committed murder. This can also be interpreted as meaning that in countries with a high homicide rate and in countries with a low homicide rate, on average 6 % of murders were committed by persons diagnosed with schizophrenia. The higher proportion of homicide perpetrators diagnosed with schizophrenia in this study compared with the results of the meta-analysis cited above does not appear to be statistically random.[6]

No significant differences were found in the people with diagnosed schizophrenia or paranoid psychosis in terms of demographics such as gender, age, civil status, country of birth, completion of secondary education, employment status, housing situation, geographical mobility, social networks, close relationships, previous violent incidents against others or against the victim, and relationship to the victim, compared with people who did not have such a diagnosis. However, they were less likely to have custody of children (17 % vs. 40 %).[7] They were also less likely to have prior convictions (41 % vs. 67 %).[8] It is important to bear in mind that this study has few perpetrators, and it is difficult to identify statistical differences in such a small sample.

No studies were found of the proportion of people in Norway who suffer from affective disorders (F30-F39), only subgroups of affective disorders. The proportion of people with affective disorders in our sample of perpetrators (22 %) is not significantly higher than found in international population studies (14 to 21 %).[9] None of the perpetrators had been diagnosed with bipolar disorder at the time of the offence, and only one person in our sample had had such a diagnosis at some point in their life. It is possible that there were more individuals who had this diagnosis, but that this had not been registered in their medical records by their doctor, as GPs use a rather vague diagnostic system.

The proportion of the perpetrators who had had anxiety disorders (F40–F49) at some point in their life (26 %) corresponds to the lifetime prevalence of anxiety disorders in the population of Norway (27 %).[10]

There is a significantly higher proportion of people with personality disorders at the time of the offence among the perpetrators (30 %) than in the population in general (6 to 13 %).[11] The most common types of personality disorders were antisocial personality disorder (22 persons, 17 %), paranoid personality disorder (6 persons, 5 %) and emotionally unstable personality disorder (4 people, 3 %). There were four people who had symptoms corresponding to two different personality disorders at the time of the offence. Although the proportion of homicide perpetrators with personality disorders was greater in our sample than in the general population, it was lower than was found in international studies of prisoners. A meta-review, for example, found that 47 % of male prisoners have antisocial personality disorder.[12]

The most frequent diagnosis in the F90–F98 class was hyperkinetic disorder (ADHD), with six people (5 %) having this diagnosis at the time of the offence and nine people (7 %) diagnosed with it during their lifetime. This is less than has been found among men in prison (23 %), for example. However, this proportion is fairly close to the prevalence found among a representative sample of adults in the United States (4 %). [13]

In 48 of 87 known cases (55 %), the main diagnosis at the time of the offence was made after the incident. These diagnoses were: 17 cases addiction-related diagnosis, 12 cases of schizophrenia, nine cases of personality disorder, and five cases of anxiety. On average, the main diagnosis was established 2.5 years (standard deviation = 4.5 years) before the incident, while the estimated date of onset of symptoms was on average 9.9 years (standard deviation = 8.0 years) before the incident.

In 31 out of 91 known cases (34 %), the main lifetime diagnosis was made after the offence. On average, the diagnosis was established 4.4 years (standard deviation = 6.0 years) before the incident, while the estimated date of onset of symptoms was on average 11.6 years (standard deviation = 9.3 years) before the incident.

5.4 Demographic information

5.4.1 Gender

During the period, there were 13 female perpetrators (10 %) and 119 men (90 %). Although there was only one woman who was mentally ill at the time of the offence, there was no significant difference in gender distribution between those with and those

6. Chi square 57.1, $p \leq 0.0001$
7. Chi square 4.2, $p = 0.04$
8. Chi square 5.4, $p = 0.02$
9. Mykletun et al, 2009
10. Mykletun et al, 2009
11. Mykletun et al, 2009
12. Fazel & Danesh, 2002
13. Friestad & Skog Hansen, 2004; Kessler et al, 2006

without a mental disorder at the time they committed homicide.

There appears to be a smaller percentage of women among people who commit homicide than among people indicted for violation of other penal provisions in Norway (15 %) or among people in prisons abroad (19 %).[14] The proportion of women is not significantly different from previous Norwegian studies (7 %) or international studies, for example, for England and Wales (10 %) of homicide.[15]

5.4.2 Age

The age of the perpetrators at the time of the offence ranged from 15 to 86 years, with an average of 36 years (standard deviation = 12 years) and a median age of 35 years. The vast majority (90 %) were under the age of 50 years old at the time of the murder. There was no difference in average age between those with and those without mental illness at the time of the offence. Figure 5.3 shows the age distribution in more detail.

Compared with Bødal and Fridhov's extensive study of accountable offenders in the period 1980–1989, this review had a higher proportion of perpetrators aged 36 to 45 years, and there is thus a slightly higher average age than in their study (31 years). There are small differences in age composition in relation to the study conducted by Rognum for the period 1979–1983 (median age 36 years) and Christensen's review of the period 1930–1954 (34 years). Internationally, the average age of homicide perpetrators is slightly lower. In England and Wales, a recent study found a median age of 27 years, while a survey in Denmark for the period 1959–1983 found a median age of roughly 30 years.[16]

5.4.3 Marital status

The marital status of the perpetrator at the time of the offence was known in 115 cases (table 5.4). The perpetrators were generally more often unmarried or divorced, and less often married, than the population in Norway in general. The percentage of married people was similar to that found among prisoners in Norwegian prisons, while the proportion of cohabitants was slightly lower than that found among prisoners (4 % vs. 19 %).[17] Among the perpetrators, significantly fewer of the people who had a mental disorder at the time of the homicide were married or cohabiting at the time of the offence (11 persons, i.e. 13 %) than among the people in the sample that did not have a mental illness (ten people, or 32 %).[18] A major study in England and Wales found no such difference in the proportion married between those with and those without

14. Fazel & Danesh, 2002; Statistics Norway, 2009a
15. Bødal & Fridhov, 1995; Rognum, 1985; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006
16. Bødal & Fridhov, 1995; R. Christensen, 1956; Gottlieb, Gabrielsen, & Kramp, 1987; Rognum, 1985; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006
17. Friestad & Skog Hansen, 2004
18. Chi square 5.3, p = 0.02

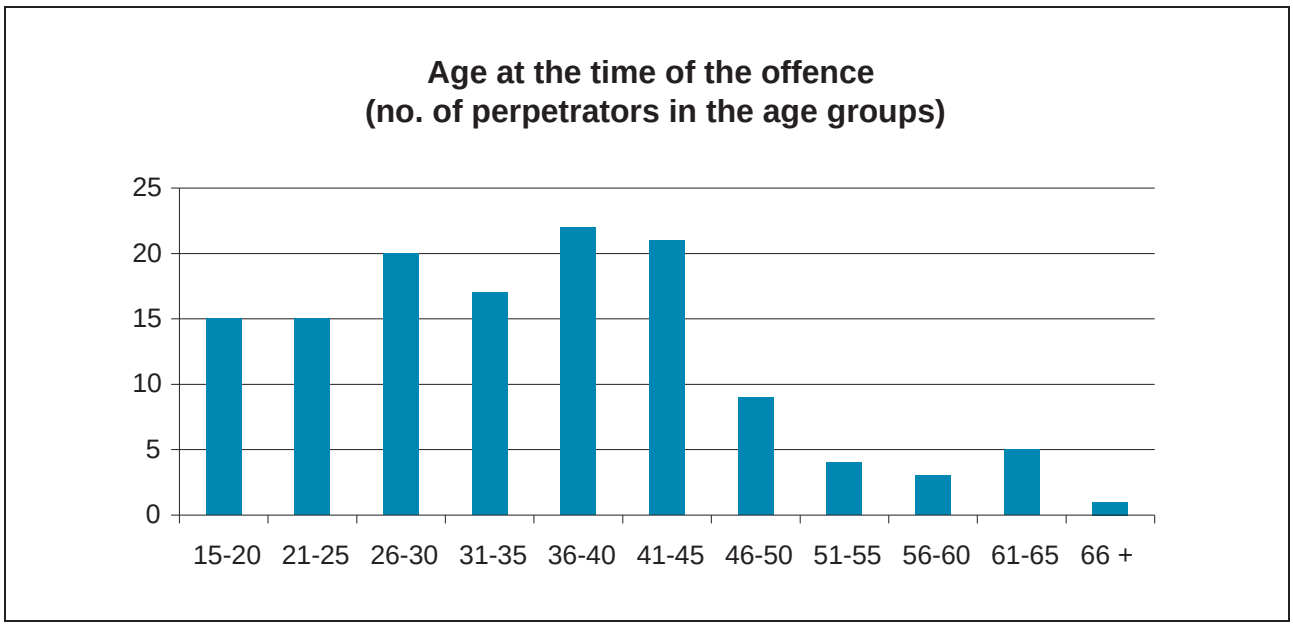

Figure 5.3 Perpetrator's age at the time of the homicide

mental illness. In England and Wales, there was also a higher proportion of married people (42 %), but it is uncertain whether this is due to methodological or social differences between Norway and the UK.[19]

5.4.4 Country of birth

Some 97 of the perpetrators (74 %) were born in Norway, while 35 (27 %) were born elsewhere. In Norway in general, 10 % of the population was born outside of Norway as per 1 January 2010.[20] The foreign-born perpetrators came from a total of 21 different countries. In our sample, the highest number of homicide perpetrators from the same country of birth (apart from Norway) was four.

106 of the perpetrators (80 %) had Norwegian citizenship. This is a smaller proportion than in the population as a whole (94 %). It is also a somewhat smaller proportion than was found among people indicted for violent crimes in 2005 (86 %).[21]

There was a significantly greater proportion of people born in Norway among the people with a mental disorder (75 persons or 82 %) than among the people in the sample that did not have a mental illness (21 persons or 57 %) at the time of the offence.[22]

5.4.5 Education, occupational status and housing situation

There was information about the educational level at the time of the offence for 111 of the perpetrators (figure 5.4).

The perpetrators generally had a significantly lower educational level than the general population. While 30 % of the general population has obligatory primary and lower secondary school as its highest completed educational level, the proportion among the perpetrators was 64 %. This included 6 % who had not completed obligatory schooling, 32 % who had only completed obligatory schooling, and 28 % who had started but not completed upper secondary education. Correspondingly, only 12 % of the perpetrators had completed two or more years of higher education, while the corresponding figure for the general population is 27 %.[23]

There was no difference in the number of people who have completed upper secondary education among the perpetrators with and without mental illness at the time of the offence.

Few of the perpetrators were employed (34 %) compared with the rest of the population (72 % in 2008; see table 5.5).[24] However, the proportion of homicide perpetrators in paid employment at the time of the offence (28 %) was roughly the same as that found among people incarcerated for other crimes (31 %).[25]

There was a significantly smaller percentage of people with mental illness at the time of the offence who were in work or studying (24 persons or 27 %) than among the people in the sample that did not have a mental illness (17 persons or 53 %).[26] No such difference in occupational status between those with and those without mental illness was found in England and Wales.[27]

In terms of housing too, the perpetrators are in a less stable situation than the population in gene-

19. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006
20. Statistics Norway (SSB), 2009c
21. Statistics Norway (SSB), 2009a, 2009b
22. Chi square 8.5, p = 0.004
23. Statistics Norway (SSB), 2009d
24. Statistics Norway (SSB), 2010
25. Friestad & Skog Hansen, 2004
26. Chi square 7.4, p = 0.006
27. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006

Table 5.4 Marital status at the time of the offence

	Number	Per cent	Population[1]
Unmarried	70	61 %	50 %
Divorced or separated	18	16 %	9 %
Married	19	17 %	36 %
Cohabiting	4	4 %	
Widow/widower	4	4 %	5 %
Total whose marital status is known	115	100 %	

1 Marital status in the population of Norway. The official statistics classify cohabiting couples as unmarried. (Statistics Norway SSB, 2009b)

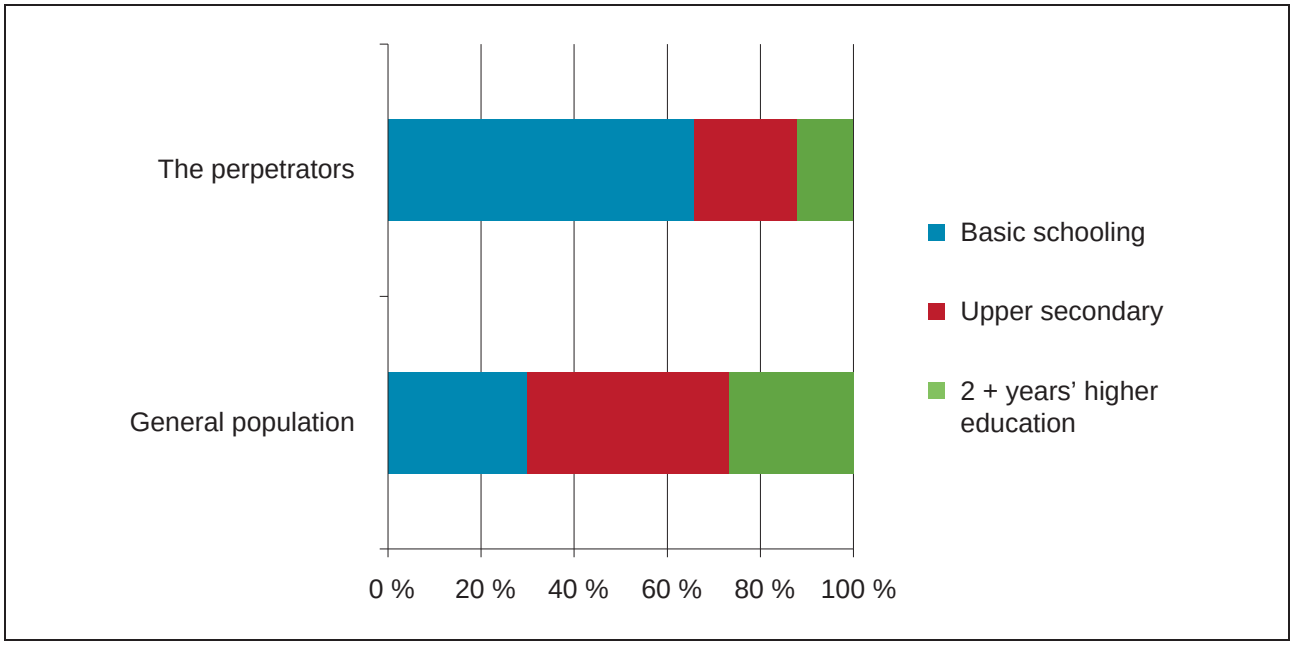

Figure 5.4 Highest level of completed education at the time of the offence for the perpetrators and the population in general

ral (table 5.6). Whereas 27 % of the perpetrators owned their own home, the corresponding figure in 2007 for the population of Norway was 81 %.[28] The proportion of homeless people (9 %) was slightly higher than was found in the homicide inquiry in England and Wales (3 %) and among prisoners in Norway (1 %), but this may be random, due to the small sample.[29]

There was no significant difference between persons with and without mental illness at the time of the offence in terms of the percentage that had a permanent home.

There was a total of 53 perpetrators (57 %) who had not moved in the last 12 months, 27 (29 %) had

Table 5.5 Occupational status at the time of the offence

	Number	Per cent
Permanent employment (full or part time)	26	21 %
Temporary work	8	7 %
Seeking employment	4	3 %
Unemployed and not seeking employment	22	18 %
Receiving disability or retirement pension	21	17 %
On sick leave or undergoing occupational or medical rehabilitation	22	18 %
Student	8	7 %
Other	13	11 %
Total	124	100 %

Table 5.6 Type of accommodation at the time of the offence

	Number	Per cent
Owned home	28	27 %
Rented dwelling	30	29 %
Own home paid for by the state (welfare housing, council housing, etc.)	9	9 %
Staying with friends, intimate partner or other family	14	14 %
Hospice, bedsit, prison, institution	11	11 %
Homeless	9	9 %
Other	2	2 %
Total	103	100 %

28. Statistics Norway (SSB), 2008a

29. Friestad & Skog Hansen, 2004; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006

moved within the municipality or urban district, and 13 perpetrators (14 %) had moved to another municipality or urban district within the last 12 months prior to the offence. This means that there is a slightly higher proportion of perpetrators who had not moved in the last 12 months before the offence than is found among prisoners in Norway (33 %).[30]

5.4.6 Personal relationships at the time of the offence

The majority of the perpetrators did not have any children at the time of the offence (n = 82, 65 %). 45 (35 %) had children, including 14 perpetrators (11 %) who had custody of children under the age five years at the time of the offence. The proportion of perpetrators who had children is lower than among prisoners in Norwegian prisons (55 %). There were no significant differences in the proportion of the perpetrators who had custody of a child between persons with and without mental illness.

An overwhelming majority of the perpetrators (n = 104, 90 %) had a close personal relationship of some kind at the time of the offence, but there were also people in our sample who had no such close relationships (n = 11, 10 %). By close personal relationship we mean an intimate partner, children, parents or other family members. There were very few cases where it emerged that the person had no friends (n = 8, 7 %), while most perpetrators had some (n = 94, 83 %) or many friends (n = 11, 11 %). There were no significant differences between persons with and without mental illness in terms of the proportion who had close personal relationships or friends at the time of the offence.

5.5 Previous history of violence and crime

Alongside age and gender, the individual's history of violence was found to be the main predictor of future violence.[31] It is therefore not surprising that the perpetrators often have a history of violence and crime.

The history of prior episodes of violence was known for 117 of the perpetrators. Approximately one-third had no history of violence, while roughly one-third had been convicted of violent incidents before the homicide (figure 5.5).

In 79 of the 110 known cases (72 %) there was no evidence of a known history of violence against the victim by the perpetrator, while in 31 cases (28 %) there were records of previous episodes of violence against the victim committed by the perpetrator. This included three cases where the perpetrator had previously been convicted of violence against the victim.

In 34 out of 87 known cases (39 %), the information did not indicate any known threats from the

30. Friestad & Skog Hansen, 2004

31. Elbogen & Johnson, 2009

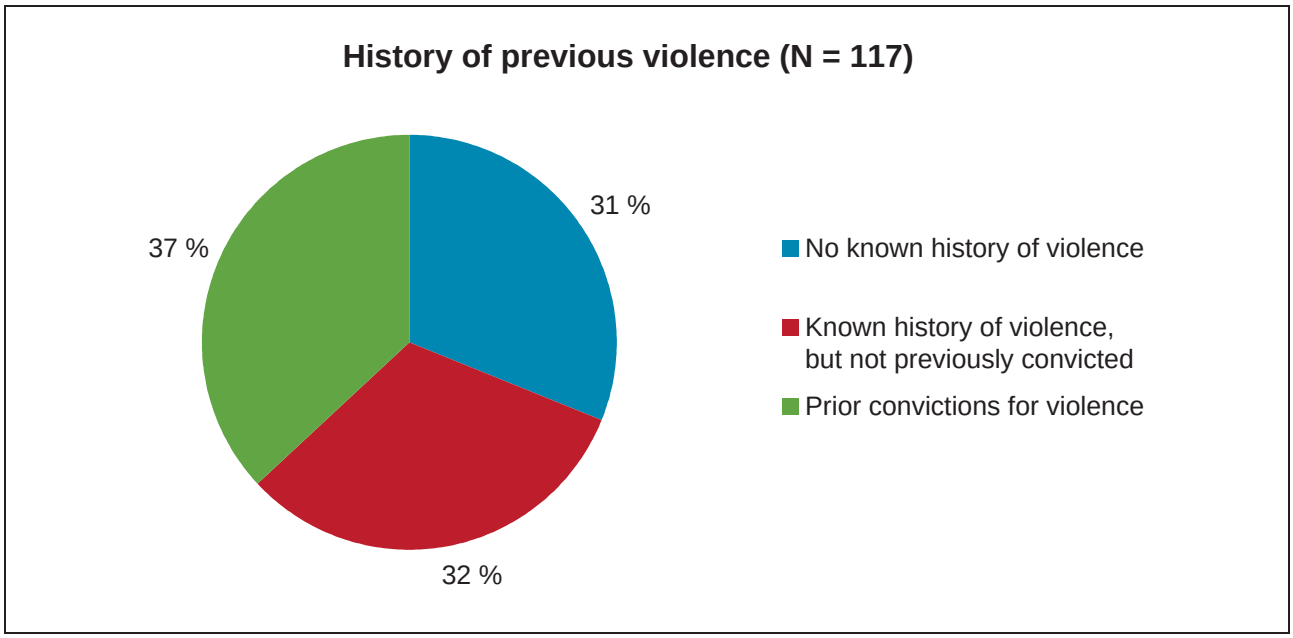

Figure 5.5 History of previous violence (N = 117)

perpetrator, while in 53 cases (61 %) it was known that the perpetrator had made threats. This included 19 perpetrators who had previously been convicted in connection with the threats. In 67 out of 96 known cases (70 %), there was no evidence that the perpetrator had threatened the victim, while in 29 cases (30 %) the information indicated that the perpetrator had threatened the victim. In two of these cases, the perpetrator had been convicted for these threats.

In 11 out of 93 known cases (8 %), the perpetrators had previously had episodes where they had been violent while they were psychotic. Five of these had had such episodes more than once prior to the offence.

There were 75 people (62 %) who had a prior conviction for something (table 5.7). This includes 15 people who had only been fined, 16 people who had been sentenced to prison for offences not linked to violence, and 44 people (36 %) who had previously been sentenced to prison for violent crime. Half of the 43 people about whom we had knowledge of when they were last in prison had come out of prison during the last two years, and 28 % had been released in the last 12 months before the offence. Four perpetrators were serving a sentence on the day they committed homicide. Most of the individuals in our sample who had previous prison sentences had one (30 %) or two (22 %) prior convictions, but there were also six people who had served ten or more prison sentences.

The committee has not found statistics indicating the proportion of the general population that has been convicted for or exercised violence. However, it is fairly obvious that people with prior convictions and a history of violence are highly overrepresented in our sample. For example, the crime statistics in Norway show that there are about 90 penalties per 1,000 inhabitants in the population per year, most of which are fines. There are fewer than six convictions per 1,000 inhabitants per year and fewer than three unconditional prison sentences per 1,000 inhabitants per year. About one person per 1,000 inhabitants has been punished for violent crimes per year.[32]

The proportion of the perpetrators who had previously been convicted for some other offence before the incident (62 %) concurs with what Bødal and Fridhov found in their review (67 %), and the distribution of the number of prior convictions is also very similar to their findings.[33] The percentage who had previously been convicted for violence or threats was very similar in both surveys too.

There was a significantly higher frequency of perpetrators who had a mental disorder at the time of the homicide who had exercised violence in the past (79 %) than among the perpetrators without a mental disorder (41 %).[34] We also identified a tendency that people with mental illness at the time of the offence were more frequently previously convicted (67 %) than perpetrators without a mental disorder (50 %), but the difference here is not statistically significant. A similar tendency was also found regarding previous acts of violence against the victim by the perpetrator, but again the difference was not statistically significant. A survey in England and Wales found the opposite tendency: that people with mental health problems at the time of the offence were less likely to have had prior convictions for violence (23 %) than people

32. Statistics Norway (SSB), 2009a
33. Bødal & Fridhov, 1995
34. Chi square 14.9, $p \leq 0.001$

Table 5.7 Criminal history of the perpetrators before the homicide

	Not previously convicted	Previously convicted	Percent previously convicted
Medicinal Products Act, sections 23 or 24 (substance abuse)	89	28	24 %
Alcohol Act, the entire Act (substance abuse)	98	9	8 %
Road Traffic Act, section 22, first paragraph or section 31 (driving under the influence of alcohol or drugs)	74	40	35 %
General Civil Penal Code, section 228 (violence)	89	31	26 %
General Civil Penal Code, section 229 (violence)	99	19	16 %
General Civil Penal Code, section 233 (homicide)	124	2	2 %
Convicted for use of weapons (regardless of clause)	98	16	14 %
Ever convicted of any crime	46	75	62 %

without mental health problems (40 %).[35] The difference between the findings in Norway and Britain may be due to differences in the definition of mental illness, as the British analyses used a narrower definition of mental illness.

5.6 The victims

The figures presented refer to the 140 victims in the cases connected to the 132 perpetrators that the committee has studied. Perpetrators who committed suicide are not included as victims in the figures.

Of the 140 victims, 73 were men (52 %) and 67 were women (48 %). There were 15 children among the victims (11 %), one of whom was an infant (one year old). This is a higher proportion of children than found in a previous Norwegian study of homicide. 46 of victims (34 %) were between the ages of 18 and 35, while 76 were 35 years or older (55 %). 23 of the victims (17 %) were young men between 18 and 35 years. This is very different from the study in England and Wales, where they found that 55 % of the victims were young men under the age of 35.[36]

A total of 69 of the victims (49 %) had or had had a family connection to the perpetrator (table 5.8). This is a higher proportion than was previously found among accountable perpetrators in Norway by Bødal and Fridhov (roughly 20 %).

Table 5.8 The victims' relationship to at least one of the perpetrators (N = 140)

	Number	Per cent
Parent of the perpetrator	13	9 %
Child of the perpetrator	14	10 %
Spouse or registered partner	15	11 %
Cohabitant	7	5 %
Former spouse or registered partner	10	7 %
Sibling	5	4 %
Other family	5	4 %
Friend, acquaintance	55	39 %
Stanger, chance interaction	12	9 %
Stranger, no interaction	4	3 %

16 people (11 %) were killed by someone they did not know before the incident, of which four people were killed without there being any interaction between the victim and the perpetrator before the homicide. The proportion of victims who did not know the perpetrator before the incident is lower than found in England and Wales (20 %) and found in an earlier Norwegian study (20 %).[37]

Of the total of 132 perpetrators, 57 (43 %) only killed a family member (including former intimate

35. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006
36. Bødal & Fridhov, 1995; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006
37. Bødal & Fridhov, 1995; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006

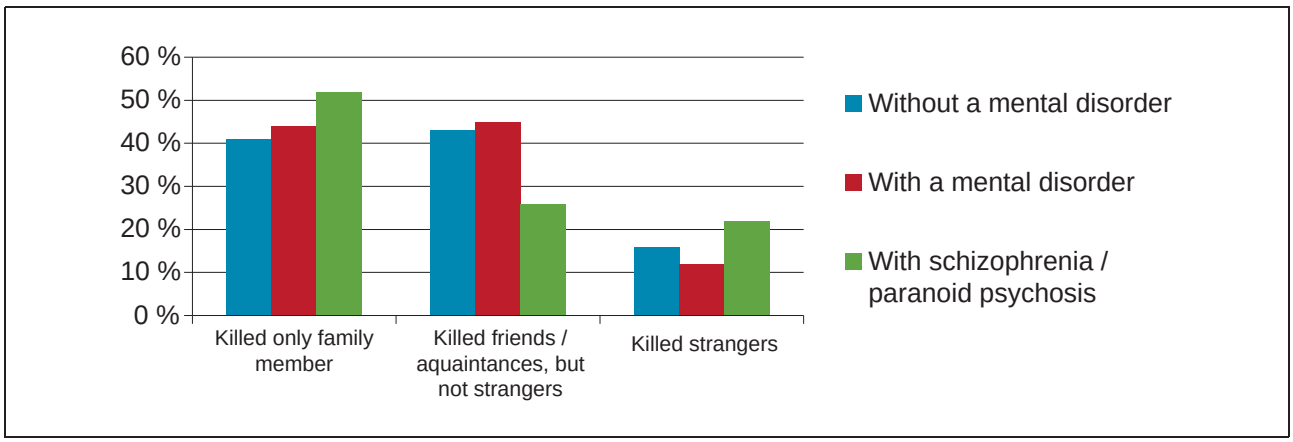

Figure 5.6 Perpetrator's relationship to the victim distributed according to perpetrators without a mental disorder, with a mental disorder and with schizophrenia or paranoid psychosis at the time of the offence

N = 129, there was no significant difference between the perpetrators with and without a mental disorder or with and without schizophrenia/paranoid psychosis at the time of the offence.

partner). A similar proportion (43 %) killed a friend/acquaintance, but not strangers, while 18 perpetrators (14 %) killed a total stranger. People with a mental disorder at the time of the offence did not kill strangers more frequently than people without a mental disorder (figure 5.6). There were five people with schizophrenia or paranoid psychosis (22 %) who killed strangers, but this figure is not significantly higher than for other perpetrators. The study in England and Wales, however, found that people with mental illness more seldom kill strangers than people without mental illness (7 % vs. 16 %, $p < 0.01$).[38]

5.7 Method and motive

The homicide method is known for 137 of the victims (table 5.9). The most common method was stabbing with a knife. There was no significant difference between the perpetrators with and without a mental disorder at the time of the offence in terms of homicide method.

The proportion of murders committed with knives is equivalent to that found in previous studies in Norway and England and Wales. Similar to the results found in England and Wales, in the majority of cases where people with schizophrenia or paranoid psychosis committed homicide, the murder weapon was a knife (14 perpetrators or 64 %). The proportion of victims who were killed with a firearm (17 %) is lower than Bødal and Fridhov found for the period 1980–1989 (35 %), but is higher than was found in England in Wales (7 %).[39]

Table 5.9 Homicide method distributed according to the number of victims (N = 137)

	Number	Per cent
Knife	46	34 %
Axe	5	4 %
Other sharp instrument	5	4 %
Blunt object	10	7 %
Hitting or kicking (physical force, unarmed fights)	20	15 %
Suffocation/hanging	20	15 %
Shooting	23	17 %
Fire	4	3 %
Other	4	3 %

38. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006

The committee assessed the perpetrators' main motive for the homicide. In this context, it is important to remember that the motive is not the same as the reason. Motive is often a legal concept, where economic or emotional reasons for the offence are considered. Other causal factors, such as age, gender, genetic factors, background, previous episodes of violence, cultural or geographical differences, etc. are rarely taken into account in discussions of motive. This means that the motive rarely includes causal factors that contribute more indirectly than is obvious from the description of the incident. Interpreting the perpetrator's motive is subjective and may be influenced by the interpre-

Table 5.10 The perpetrators' main motive

	Number	Per cent
Jealousy or reaction to intimate partner wanting to leave	24	19 %
Other family conflicts	11	9 %
Attempt to conceal another crime	1	1 %
Drunken dispute	37	29 %
Homicide committed under the influence of drugs (not drunken dispute)	6	5 %
Short-circuit reaction in the heat of the moment or other impulsive acts in the heat of the moment (not under the influence of alcohol)	8	6 %
Financial gain/murder with intent to rob	7	5 %
Murder related to gangs and drug dealing	5	4 %
Delusions of a depressive nature	5	4 %
Delusions of a paranoid or hallucinatory nature	16	12 %
Incomprehensible from a normal psychology perspective	3	2 %
Other motives	7	5 %

Note: If there were multiple main motives that seemed equally important, we have chosen the motive that is highest on the list.

39. Bødal & Fridhov, 1995; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006

ter's theories of causal relationships. This is probably the reason why the committee has found little new research on perpetrators' motives.

The most common motive was an argument while under the influence of alcohol (29 %), which is significantly higher than was found by Christensen for the period 1930–1954 (6 %).[40] By contrast, jealousy was more seldom a motive now (19 %) compared with Christensen's findings (32 %). There were also fewer people who killed to conceal another crime (1 %) than Christensen found (8 %).

5.8 Combined homicide–suicide

There were 18 perpetrators who also killed themselves (14 %). The proportion of perpetrators who committed homicide and then suicide was higher than that found in England and Wales (4 %), but the rate relative to the population (0.07 per 100,000) is similar to the rate in England and Wales (0.06 per 100,000 inhabitants).[41] Of the people who committed suicide after having committed homicide, 16 took their lives on the same day as the incident and two did it later (up to five months after the incident).

There were no significant differences in terms of the gender (4 women, 14 men) or marital status of the individuals who committed suicide and the other perpetrators. As was found in England and Wales, the people who committed homicide and suicide were significantly older (average age 44 years, standard deviation 12 years) than the other perpetrators (average age 35 years, standard deviation 12 years).[42] The perpetrators who committed suicide more frequently had custody of children (60 %) than the other perpetrators (32 %).[43] The perpetrators who committed suicide only killed family members (83 %) or friends/acquaintances (17 %). This constitutes a significant difference compared with the other perpetrators.[44] The victims were one parent, ten sons or daughters, six spouses, one cohabitant, three former spouses/cohabitants and three friends/acquaintances. The study in England and Wales found a higher proportion of current or former spouses/partners (65 %) and a lower proportion of sons/daughters (19 %).[45]

The most common homicide methods were stabbing (six victims), suffocation/hanging (six victims) and shooting (five victims), which reflects the findings from the England and Wales.[46]

According to the available information, fewer of the perpetrators who committed suicide had a mental disorder at the time of the offence than other perpetrators.[47] There was no information on the medical history of two of the persons who committed combined homicide–suicide. Of the remainder, nine people had no mental disorder at the time of the offence, two people had addiction-related disorders, one person had a schizophrenia spectrum disorder, and four people had affective disorders. It is of course possible that the individuals who committed suicide had mental disorders that are not recorded in the available material. In these cases, criminal prosecution could not be initiated as the perpetrator was deceased. There was thus no forensic psychiatric evaluation.

5.9 Sentences

The extract from the Norwegian Police Directorate's register STRASAK was selected on the basis of the codes with which the cases were registered. Whereas the National Criminal Investigation Service (KRIPOS)'s homicide statistics only include people who have been registered and convicted of homicide pursuant to section 233 of the General Civil Penal Code, the committee has used a broader definition of homicide. Nevertheless, most of the perpetrators were registered in STRASAK with the code for homicide (table 5.11). The committee has not verified whether all the cases were correctly registered in STRASAK, apart from checking that the offence actually resulted in loss of life.

Naturally enough, most of the perpetrators were sentenced to imprisonment with or without preventive detention («forvaring») (table 5.12). Of a total of 22 perpetrators who were sentenced to compulsory admission to psychiatric treatment facilities, 21 had a diagnosis in the schizophrenia spectrum (F20–F29) at the time of the offence. The most common disorders among the 11 offenders sentenced to preventive detention («forvaring») were personality disorders (nine people) and addiction-related disorders (six persons), while only one person had no mental disorder at the time of the offence.

40. Christensen, 1956
41. Flynn et al, 2009; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006
42. T value 3.3, $p \leq 0.001$
43. Chi square 4.4, $p = 0.4$
44. Chi square 13.8, $p \leq 0.001$
45. Flynn et al, 2009
46. Flynn et al, 2009
47. Chi square 6.7, $p = 0.01$

Table 5.11 Perpetrators distributed according to registration in the police register STRASAK

	Number	Per cent
Homicide § 233 (code 1708)	108	82 %
Bodily harm resulting in death § 229, third penalty option (code 1714)	18	14 %
Grievous bodily harm § 231 (code 1706)	1	1 %
Rendering a person helpless § 242 (code 1718)	2	2 %
Robbery/extortion (code 2599, miscellaneous)	2	2 %
Arson that may result in loss of human life or extensive destruction § 148 (code 701)	1	1 %

Table 5.12 Sentences

	Number	Per cent	Average length[1]	From – to length
Imprisonment without preventive detention	78	59 %	9.7 years	0.2–21 years
Preventive detention	11	8 %	15 years	8–21 years
Compulsory admission to psychiatric treatment facilities	22	17 %		
Case dismissed because the suspect has taken his/her life	18	14 %		
Other sanctions or reasons for dismissal	3	2 %		

[1] Average sentence to unconditional imprisonment. In addition, four people were given suspended prison sentences of 1 to 4 years (average 2 years, with 1 year standard deviation). The standard deviation for unconditional prison sentences was 5.0 years, while the standard deviation for preventive detention was 3.9 years.

5.10 Summary

The main conclusion from the review is that there are few homicides in Norway compared with other countries. It also appears that there has been a decline in the number of homicides in recent years. As the results indicate, it is not possible to pinpoint easily who is likely to take another person's life. The perpetrators seem to be as diverse as the rest of the population. However, it is possible to highlight some general differences between the homicide perpetrators as a group and the population in general. This study thus found the same patterns as other investigations of homicide in Norway and internationally. The perpetrators are often men aged 17 to 45 years. They generally have less education and are less likely to be in work. They are more often unmarried and more often have an unstable housing situation. They often have prior convictions, especially for violent crime. The perpetrators are more often born abroad. They more often have a serious mental disorder, such as schizophrenia. They also have a higher frequency of personality disorders than the average in the population as a whole. However, it is important to emphasize that the majority of the homicides are committed by people from Norway and by people who do not have schizophrenia. Very many of the homicides are linked to substance use: that the perpetrator is under the influence of alcohol or drugs at the time of the offence or that the perpetrator has an addiction-related diagnosis. Most homicides are committed by one person and there is one victim. Half of the victims are related to the perpetrator, and it is rare that strangers are killed. The most common method of killing is stabbing with a knife.

Chapter 7
Substance use, mental health and violence

Chapter 7.1–7.6 available in Norwegian only.

7.7 The findings of the committee's review of homicide cases

7.7.1 Scope of substance use problems

The extent of substance use problems among the perpetrators varies depending on the measurement method. The committee has registered the perpetrators' drug and alcohol use problems in four different ways (box 7.3).

A total of 38 % (49 out of 129 perpetrators) had one or more diagnoses within the substance use area (F10–F19) at the time of the offence. These included nine people with psychosis triggered by substance use, of whom five had also been diagnosed with a schizophrenia spectrum disorder (F20–F29). It also included 11 % (14 out of 129 perpetrators) with alcohol dependence and 10 % (13 out of 129) with dependence on other drugs. 40 % (51 out of 129 people) had had an addiction-related diagnosis at some point in their life. The proportion diagnosed with substance addiction at some point in their life was the same as those diagnosed with substance addiction at the time of the offence. There was no diagnosis information for three people.

A total of 61 % (70 out of 115 perpetrators) were intoxicated at the time of the offence (see table 7.1). There was no information about whether the perpetrator was under the influence of intoxicants at the time of the offence for 17 individuals.

66 % (77 out of 117 perpetrators) had had harmful use of drugs and/or alcohol at some point in life. This included 56 % (65 out of 117) who had had harmful substance use during the last three months before the homicide. For 15 people it was unknown whether the person had had harmful use of drugs and/or alcohol.

The main reason that more people were registered as having a history of harmful substance use and acute intoxication at the time of the offence (table 7.1) than had diagnoses of these problems is primarily methodological. The committee was very reluctant to overrule the diagnoses made by others; in other words, a diagnosis has not been ascribed to an individual unless it was made by one of the assistance agencies or in the forensic psychiatric evaluation. However, the committee has made

Box 7.3 Four different ways of registering substance use problems in the committee's review of homicide cases

1. Addiction-related diagnoses (ICD-10 F10.0 to F19.9). Diagnoses at the time of the offence and at some in point in life have been registered. This includes diagnoses made before the incident by health personnel and diagnoses made in connection with the forensic psychiatric evaluation.
2. Intoxicated at the time of the offence. This is further broken down into alcohol and drugs. This is mainly information from the forensic toxicological analyses. In some cases there is also information from police reports, sentences and other sources.
3. Harmful use of alcohol and drugs at some point in life, broken down into alcohol and other drugs. We recorded how long before the homicide the harmful use of alcohol and/or drugs occurred. This information is based on an overall assessment of all the available information.
4. Which intoxicants the perpetrator used during the last month or year before the incident. This is determined on the basis of all the available information. This often includes information from witness interviews or provided by the perpetrator. This kind of information is often found in the forensic psychiatric evaluations.

Table 7.1 Acute intoxication at the time of the offence and harmful substance use at some point in life

	Intoxicated at the time of the offence		Harmful use at some point in life	
	N	%	N	%
No	45	39	40	34
Yes: alcohol, but not drugs	34	30	21	18
Yes: drugs, but not alcohol	13	11	21	18
Yes: both alcohol and drugs	23	20	35	30
Total	115	100	117	100

discretionary assessments of harmful substance use on the basis of the information that was available and independently of any official diagnosis. Similarly, in several cases the committee registered acute intoxication on the basis of data from forensic toxicological documents without the associated diagnoses being set.

Slightly more of the perpetrators had harmful use of drugs at some point in their life (48 %) than were under the influence of drugs when they committed the offence (31 %). The figures for the number of perpetrators with a history of harmful use of alcohol and the number who were intoxicated by alcohol when they committed the offence were roughly the same.

The fourth method for measuring substance use was looking at which intoxicants the perpetrator had used during the last month or the last year (see table 7.2). As expected, alcohol was the most commonly used intoxicant, followed by cannabis, benzodiazepines not administered by a doctor and central nervous system stimulants such as amphetamines. Most of the people who took drugs other than alcohol in the last month also consumed alcohol.

There is much higher prevalence of substance use problems among the perpetrators, regardless of measurement method, than in the Norwegian population as a whole (see section 7.4). This was expected, in light of various studies showing a very high prevalence of intoxication in connection with violence and homicide.[1] The proportion of the per-

1. Elbogen & Johnson, 2009; Fazel, Gulati et al, 2009

Table 7.2 Which drugs did the perpetrators use in the last month/year (N = 132)?

	Yes, in the last month (combined with alcohol)	Yes, in the last year (incl. the last month)	No, not used	Unknown
Alcohol	52	70	41	21
Heroin or other opiates	2 (1)	5	97	30
Methadone or subutex outside approved drug-assisted rehabilitation treatment	0	1	106	25
Amphetamines, etc.	11 (7)	26	77	29
Ecstasy	0	5	93	34
Cocaine, crack	3 (2)	8	91	33
Hallucinogenic substances, incl. LSD and magic mushrooms	0	4	98	30
Benzodiazepines not prescribed by a doctor[1]	18 (15)	26	72	34
Cannabis	21 (15)	37	71	24
Khat	1 (0)	2	104	26
Other	7 (6)	10	80	42

[1] In 45 % of the cases for which we have information (10 out of 22 perpetrators), individuals who abused benzodiazepines during the last year also received anxiolytics from a doctor.

petrators who had engaged in harmful use of alcohol at some point in their life was more than twice as high in the current study, compared with the findings of an epidemiological study of men in Oslo (45 % vs. 20 %). The proportion of the perpetrators who had engaged in harmful use of drugs was also very high compared with estimates for men in Oslo (48 % vs. 2 %). While the proportion of people diagnosed with alcohol dependence was not higher than expected in relation to the incidence among men in Oslo (11 % vs. 13 %), there was a significantly higher proportion of the perpetrators who were dependent on drugs (10 % vs. 3 %).[2] These differences may be partly due to the previous epidemiological studies not having included all the substance abusers.

The proportion of perpetrators who had drunk alcohol in the last 12 months before the incident (63 %) is lower than the national population survey has found (87 %).[3] However, this may be the result of the measurement method used in the present study, which did not inquire whether people without a history of harmful substance use had drunk alcohol in the last 12 months. There was a significantly greater proportion of people born in Norway who had consumed alcohol during the last year (73 %) compared with the individuals born outside Norway (33 %).[4]

There was a high prevalence of use of cannabis (34 %) and amphetamines (25 %) in the last 12 months compared with what would be expected on the basis of a population survey in Norway (5 % and 1 % respectively).[5] There was also a high proportion of people who used benzodiazepines not prescribed by a doctor during the last year (27 %), but we have not been able to find comparable figures for this for the population as a whole. There was a significantly greater proportion of the perpetrators born in Norway who had used cannabis (40 % vs. 16 %) or amphetamines (32 % vs. 4 %) during the last year compared with the perpetrators born outside Norway.[6] Otherwise, there were no significant differences in the use of illegal drugs in the last 12 months before the homicide among people born in Norway and people born in other countries.

There was a slight increase in the percentage of perpetrators who were under the influence of alcohol at the time of the homicide in the 1980s, but that this has since gone down again. The proportion of perpetrators under the influence of alcohol at the time of the incident found in the current study (50 %) is lower than that found by Bødal & Fridhov for the period 1980–1989 (roughly 74 %). However, Rognum reported a lower proportion in the period 1960–1964 (43 %) and in the period 1979–1983 (39 %). Christensen also recorded a lower proportion (39 %) for the period 1930–1954. However, since these studies use different methods, the figures are not directly comparable. For example, Bødal & Fridhov investigated both homicide and attempted homicide, whereas the current investigation focuses on homicide.[7]

It appears that the proportion of perpetrators who were intoxicated on drugs at the time of the offence in the current study (31 %) is higher than in previous Norwegian studies. Bødal and Fridhov found that roughly 17 % of the offenders were intoxicated on drugs other than alcohol in the period 1980–1989. Rognum reported that 7 % of perpetrators were under the influence of sedative or narcotic substances at the time of the offence in the period 1979–1983, compared with none in the period 1960 to 1964. Other drugs were not investigated in Christensen's study of the period 1930–1954.

There are few international studies of homicide that we can compare our findings with: because the studies were undertaken a long time ago, because there are major differences in how the studies have been conducted, or because the data are not comparable. However, we do have detailed information about the findings from the National Inquiry in England and Wales. The proportion of homicide perpetrators with a history of harmful use of alcohol (48 %) or other drugs (48 %) corresponds approximately to that found in England and Wales (50 % and 49 % respectively).[8] The proportions of people in our sample who have been diagnosed with alcohol dependence (11 %) and drug dependence (10 %) at the time of the offence were also similar to the figures found in England and Wales (11 % and 9 % respectively).[9] Comparing the distribution of the intoxicants the perpetrators used in the last 12 months before the incident with the findings from the UK, we observe a higher proportion of perpetrators who took amphetamines in Norway (25 % in Norway vs. 6 % in England) or benzodiazepines (26 % vs. 4 %).[10]

2. Kringlen et al, 2001
3. Horverak & Bye, 2007
4. $p \leq 0.001$
5. Hordvin, 2005
6. $p = 0.03$ for cannabis, and $p = 0.005$ for amphetamines
7. Bødal & Fridhov, 1995; R. Christensen, 1956; Rognum, 1985
8. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006
9. Shaw et al, 2006
10. Shaw et al, 2006

7.7.2 Comorbidity

Table 7.3 shows that individuals with a diagnosis within the substance use area (F10–F19) at the time of the offence more frequently also had diagnoses of behavioural and emotional disorders in childhood and adolescence. This applied to disorders at some point in life and disorders at the time of the offence. It was also revealed that people with a substance use diagnosis at some point in their life more frequently also had a lifetime diagnosis in the areas neurotic, stress-related and somatoform disorders (F40–F49) than the people without an addiction-related diagnosis. However, most of perpetrators in our sample who had a substance use diagnosis and a lifetime F40–F49 diagnosis did not have this diagnosis at the time of the offence.

The proportion of perpetrators with a combination of a substance use disorder and personality disorders is not higher in this study than has been found in other Norwegian and international studies of people with harmful substance use.[11]

The proportion of the people with a substance use diagnosis who also had affective disorders (F30–F39) and anxiety disorders (F40–F49) at some point in life (28 % and 39 %) was similar to that found internationally.[12] It is unclear why the proportion of our sample diagnosed with these kinds of disorders at the time of the offence was so low. The diagnoses at the time of the offence are primarily ascribed in connection with a forensic psychiatric evaluation, and it is possible that the forensic psychiatric evaluations underreport these kinds of diagnoses as they have no legal significance and/or because it may be difficult to distinguish between these disorders and normal reactions in the wake of having committed homicide.

11. Ravndal et al, 2005; Verheul et al, 1995
12. Kessler et al, 1996

Table 7.3 Combinations of a diagnosis of «Mental and behavioural disorders due to psychoactive substance use» (F10–F19) and other mental disorder diagnoses (N = 129)

	At the time of the offence		At some point in life	
	Without a substance use diagnosis (N = 80)	With a substance use diagnosis (N = 49)	Without a substance use diagnosis (N = 78)	With a substance use diagnosis (N = 51)
Organic, including symptomatic, mental disorders (F0–F9)	1 (1 %)	2 (4 %)	1 (1 %)	2 (4 %)
Schizophrenia, schizotypal and delusional disorders (F20–F29)	15 (19 %)	8 (16 %)	16 (21 %)	9 (18 %)
Mood [affective] disorders (F30–F39)	8 (10 %)	4 (8 %)	14 (18 %)	14 (28 %)
Neurotic, stress-related and somatoform disorders (F40–F49)	11 (14 %)	4 (8 %)	14 (18 %)	20 (39 %)[1]
Behavioural syndromes associated with physiological disturbances and physical factors (F50–F59)	1 (1 %)	0	3 (4 %)	5 (10 %)
Disorders of adult personality and behaviour (F60–F69)	14 (18 %)	24 (49 %)[2]	14 (18 %)	27 (53 %)[2]
Mental retardation (F70–F79)	0	0	0	0
Disorders of psychological development (F80–F89)	2 (3 %)	1 (2 %)	3 (4 %)	1 (2 %)
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90–F98)	3 (4 %)	7 (14 %)[1]	4 (5 %)	13 (26 %)[2]
Unspecified mental disorder (F99)	0	0	1 (1 %)	1 (2 %)

1 Significant difference between those with and those without a substance use diagnosis with $p \leq 0.05$
2 Significant difference between those with and those without a substance use diagnosis with $p \leq 0.001$

7.7.3 What monitoring and treatment had occurred?

We know whether the person had a history of harmful use of alcohol and/or drugs and whether the person's substance use problems had been identified in 107 of the cases (figure 7.1). There were 40 people who did not have harmful substance use, compared with 67 persons who did have harmful use. The majority of the people (42 out of 67) with the harmful substance use had had their substance use problems identified. However, a fairly large percentage (37 % – 25 out of 67 people) had not been assessed despite the fact that they had harmful use of alcohol and/or drugs. It is impossible to tell whether this is due to shortcomings in the assistance agencies or because the individuals did not approach the agencies for assessment. In ten cases, we do not know whether people with harmful use of their drugs had had their problems charted or not.

In 107 cases, we know whether the perpetrators have had harmful use of alcohol and/or drugs at some point during their life and whether they received treatment (figure 7.2). Of the people who have had harmful use, 30 had received treatment and 37 had not received treatment. There were ten cases where the person had been assessed with respect to problems related to substance use and the conclusion of the assessment was that they were entitled to health care, but the person had not

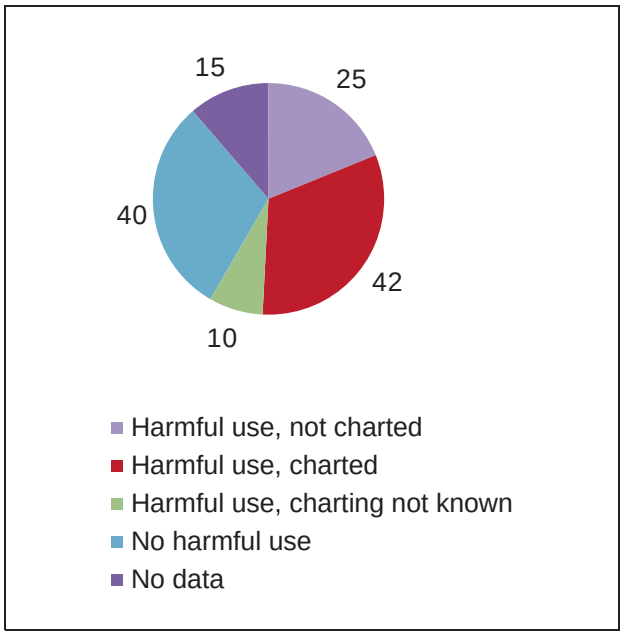

Figure 7.1 Number of perpetrators with harmful use of alcohol and/or drugs who had their substance use problems identified

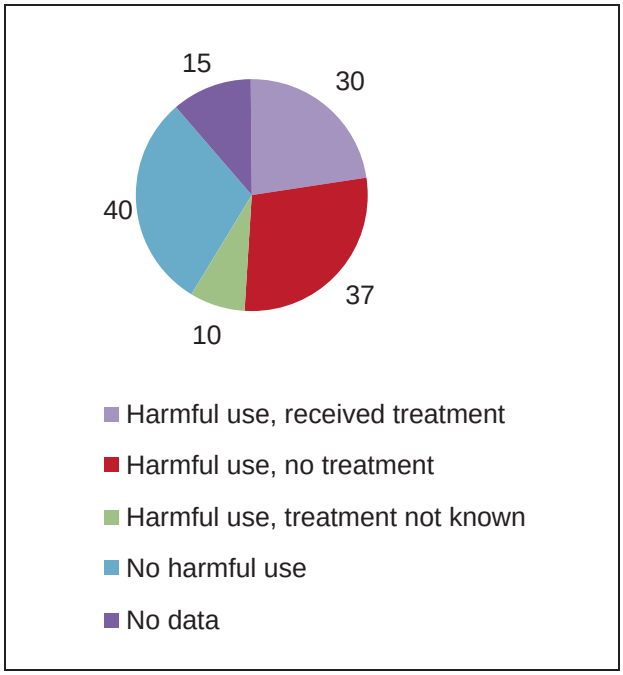

Figure 7.2 Number of perpetrators with harmful use of alcohol and/or drugs who had received treatment for substance use problems

received treatment for harmful alcohol or drug use. There were ten cases of harmful use where we do not have any information about whether they received treatment or not. In nine cases, the perpetrator received integrated treatment for both substance use problems and other mental health problems. Integrated treatment is defined here as treatment in which a substance use disorder and a co-occurring psychiatric disorder are treated by the same team in a integrated treatment programme, instead of sequentially or in parallel in different treatment systems. In seven cases, the perpetrator received interdisciplinary specialized treatment (TSB), i.e. treatment by both health and social workers. Of the perpetrators for whom the committee has information about the length of their treatment (n = 25), half (n = 13) had received treatment for harmful alcohol and/or substance use in the last 12 months before the incident.

7.7.4 Substance use and relationship to the victim

In homicides committed by perpetrators with a history of harmful use of alcohol and/or drugs, the victim was less frequently a family member and more often a friend or acquaintance than among perpetrators who did not have known harmful use of alcohol and/or drugs (table 7.4). This difference

Table 7.4 Who was the victim in cases where the perpetrator had harmful use of alcohol and/or drugs?

	History of harmful use of alcohol or drugs number (%)	
	Yes	No
Only killed family members (including former intimate partners and others)	27 (35 %)	23 (58 %)
Killed friends/acquaintances, but not strangers	40 (52 %)	13 (33 %)
Killed strangers	10 (13 %)	4 (10 %)
Total	77	40

was significant.[13] International studies have also found that people with harmful use or dependence on alcohol and/or drugs more often than people without substance use problems kill someone other than a family member.[14]

As mentioned in chapter 5, five of the homicides were related to gangs and drug dealing. Four of these cases were interpreted as such in that the judgment assumes that the homicide was partially motivated by the perpetrator owing money to the victim in connection with illegal sales of drugs.

7.8 The committee's advice

In its recommendations, the committee has focused on the people with combined harmful substance use and serious mental illness. The committee will concentrate in particular on measures aimed at this group, although general primary preventive measures are of course also important.

7.8.1 Basic recommendations concerning substance use, mental illness and violence

It is very difficult to predict who will commit homicide, and measures must be aimed at a broad group. People with ongoing problematic substance use and co-occurring severe mental illness or a severe personality disorder and who have previously exercised violence should be given special attention and follow-up. The intensity of the treatment and the attention paid to violence must be increased in line with the number of known risk factors a person has. Violent behaviour should be a priority topic in the treatment of substance-dependent patients, especially patients with alcohol dependence or addicted to benzodiazepines or central nervous system stimulants.

The committee believes that the most effective measure to prevent violence is good treatment and care. It is important that everyone who needs it is treated and that treatment is started as soon as the individual's needs have been identified without unnecessary delay. Treatment for harmful drug and alcohol use is a field in constant development, and there is constant debate as to the best way to treat it. In the light of this, the committee will recommend that resources are earmarked to ensure that substance use disorders can be always treated in line with the latest recommendations for good treatment of harmful alcohol and/or drug use.

The committee would also like to stress that the objective of all treatment and care for people with substance use disorders should be to minimize the negative consequences of intoxication, including reducing the harm to the individual and their surroundings.

7.8.2 Early intervention

The committee believes that society should strive for early identification of people who have problematic substance use and violence problems, to ensure that interventions and measures can be introduced quickly. The child welfare services play an important role in early identification and efforts to prevent future harmful substance use and violence. It is also essential that services and follow-up are continued after the individuals reach the age of 18 years. In terms of early intervention for children and young people, the committee makes special reference to goal no. 3 in the Ministry of Health and Care Services' «Escalation plan for the alcohol and drug abuse area»: «More accessible services», and to the Norwegian Directorate of Health's guide on early intervention in connection with substance abuse (August 2009).[15] Early intervention also means ensuring that primary care doctors have and make use of tools to assess problematic consumption of alcohol and/or drugs.

13. Chi square = 5.2, p = 0.02
14. Shaw et al, 2006
15. Ministry of Health and Care Services, 2007a; Norwegian Directorate of Health, 2009a

7.8.3 Integrated services and seamless transitions

People who have co-occurring substance use disorders and other mental disorders should have both the substance use disorder and the other mental disorder treated at the same time by an integrated team. Patients with this kind of combination of problems generally require flexible, individually tailored, long-term treatment with various forms of support for a long time, the intensity of which may vary depending on the patient's social situation and the amount of stress the person is experiencing. The measures should also address the individual's basic needs, such as housing, a stable financial situation, social relationships and meaningful activity. This will require collaboration and coordination among a variety of different actors. It is possible that clear organizational directives and financial incentives will be needed to ensure integrated services.

A stable living situation is an absolute prerequisite for successful treatment, both to reduce the risk of relapse and to ensure rapid intervention in times of crisis. The committee recommends that work related to welfare housing be strengthened, especially for people with combined substance use disorder and severe mental illness.

With regard to the organization of the services that the user needs, the committee believes that an integrated treatment model (cf. section 7.6.4) appears be best-suited to promote interaction, information flow and long-term planning.

To avoid breaks in the patient's progress, the committee strongly recommends establishment of binding collaboration agreements between the health trusts and the local authorities to ensure good coordination and continuity in the treatment as the patient moves between different levels of health care.

7.8.4 Commitment to active outreach and expert interdisciplinary teams

Norway does not have a tradition of ambulatory teams within interdisciplinary specialized drug and alcohol treatment. Ambulatory outpatient activity is considered particularly suitable for early intervention and to come into contact with people who for shorter or longer periods are not covered by the ordinary outpatient or inpatient services, for example, in connection with relapses into substance use. Expansion of ambulatory and outreach activities is in line with the national escalation plan for the alcohol and drug abuse area.[16] The committee recommends that these kinds of services are an integral part of the programmes offered at outpatient clinics for substance users, and that these services work closely with the municipal services and institutions within interdisciplinary specialized drug and alcohol treatment and mental health care. With the current division of responsibilities between interdisciplinary specialized drug and alcohol treatment and mental health care, this kind of treatment programme will mainly target people with a substance use disorder combined more moderate mental illness, but may also include patients with some of the more serious mental disorders not covered by programmes within the mental health care system.

The committee supports continued investment in ambulatory acute crisis teams at the district psychiatric centres.

The committee supports continued investment in ambulatory acute crisis teams at the district psychiatric centres, where the main target groups are people with severe mental illness, with or without a co-occurring substance use disorder. These kinds of teams will not normally be designed to treat the most troubled patients with dual diagnoses.

For the most troubled patients who tend to drop out of other treatment programmes, we recommend establishment and development of special interdisciplinary teams (inpatient, outpatient and ambulatory) that can work with the patient's complex problems in a long-term, holistic, integrated way. These kinds of teams could be established at hospitals, district psychiatric centres, in municipalities, or as collaboration projects between the first and second line services. The main target group for these measures will be people with co-occurring substance use disorders and serious mental disorders. It may be relevant to introduce modified versions of Assertive Community Treatment (ACT) that also include groups that fall outside the current ACT system, including people with a combination of a severe personality disorder and repeated substance-induced psychosis (see box 7.2). These kinds of teams need specialized expertise in the complicated dynamics between substance use and psychiatry, including the risk of disruptive behaviour and violence and how to deal with these situations, and must develop qualitative courses of treatment with a particular focus on the individuals who do not manage to make use of the ordinary system. The committee recommends that these expert teams be linked to research institutes in order to ensure development and regular evaluation of the guidelines for recommended practice. In this context, research on the effec-

16. Ministry of Health and Care Services, 2007a, p. 36

Box 7.4 Good practice

1. Identification of risk groups in different contexts – mental health care, social services, schemes for children and young people, the correctional services
2. Mapping previous history of violence and in which contexts violence has occurred
3. Assessment of the violence risk, substance use problems and other psychiatric disorders
4. If necessary, more detailed assessment of mental disorders, psychological mechanisms and social conditions, etc.
5. Needs analysis and individual plan, including a treatment plan, contingency plan for crisis situations, schedule for meetings of the responsible team, and plan for long-term collaboration
6. Follow-up and revision of individual plans and action plan for crises
7. Integrated treatment for substance use disorder and other co-occurring mental disorder
8. Active outreach activities to high-risk groups and individuals in need of treatment who tend to drop out of other treatment programmes
9. Therapists closer to the patient, their relatives and the patient's immediate surroundings when the risk of violence seems to be particularly high, such as during periods of intoxication
10. Well-planned discharge from the inpatient facilities
11. Establishment and maintenance of a secure housing situation

tiveness of integrated treatment in terms of minimizing aggressive and violent behaviour will be important.

7.8.5 Research

There is insufficient knowledge about the efficacy of some the measures aimed at individuals, especially in terms of treating people with combined substance use disorders, severe mental disorders and severe personality disorders. While it is not possible to wait for the results of necessary research before starting to treat these patients, it should nevertheless be considered what kind of research can be undertaken to evaluate the effectiveness of the individually tailored measures that are currently in use.

The committee recommends that the central health authorities draw up specific guidelines and recommendations, on the basis of relevant research and empirical knowledge from different disciplines, for how «grey area» patients (i.e. people who have not been diagnosed with a serious underlying mental illness, but who have repeated psychotic or psychotic-like experiences) can best be captured in both a shorter-term and a longer-term perspective.

7.8.6 Ensure assessment and stable services for people without a confirmed serious mental illness

In the event of repeated admissions with psychotic breakthrough symptoms under the influence of intoxicants, the specialist health service should not release the patient until they have been evaluated in terms of severe mental illness, severe personality disorder and the risk of exercising violence. It is especially important to assess the violence risk in connection with future substance use and to implement appropriate measures to ensure rapid intervention if the violence risk is deemed to be particularly high.

Even if the psychosis quickly recedes as the intoxication clears, in cases where the patient is not clearly coping and the risks are high, it should be considered whether compulsory mental health care can be established without admission, to ensure obligatory, lasting treatment in the mental health services, in close collaboration with the municipal services. If the treatment is to be voluntary, ambulatory outreach teams can contribute by helping the patient to seek assistance during periods of intoxication and lack of motivation.

7.8.7 Measures to prevent patients getting lost in the system and advice regarding people with personality disorders

The Drug Reform came into force on 1 January 2004. The objective of the Drug Reform was to give people with harmful use of alcohol and drugs more clearly defined rights to social services and health services and to ensure coordination and coherence in the services provided. The committee recommends that a review be undertaken to assess whether the Drug Reform and the Escalation Plan for Mental Health have in fact entailed that some groups of patients fall through the system and are particularly susceptible to ending up being shunted around the new system.

Limitations and weaknesses in the current diagnostic system and a lack of consensus in the understanding of severe mental illness appear to be posing serious challenges for the assistance agencies. The committee believes this is a potential source of system failure. Another problematic area is the use of the diagnosis substance-induced psychosis.[17] The diagnosis substance-induced psychosis must not prevent the patient being ensured proper, long-term and holistic health care. Decisions as to whether the patient's individual treatment programme should be anchored in mental health care or interdisciplinary specialized drug and alcohol treatment must be based on an overall assessment that takes the primary diagnosis, comorbidity and current functional level into account. It must also be ensured that people with antisocial personality disorder receive treatment for any co-occurring disorders, such as substance use disorders, and that the primary diagnosis does not prevent the patient from receiving the necessary health care.

In connection with personality disorders combined with substance use problems and violence problems, lasting clinical treatment and collaboration between different agencies with the goal of motivating the patient for change and treatment are essential. It is essential to invest in building up consistent, long-term treatment programmes, preferably outpatient and outreach programmes that focus on personality pathology.

7.8.8 Safety and security for patients, relatives and staff

The committee believes that at present the district psychiatric centres and the municipal assistance services are not large enough to deal with the most dangerous and most antisocial patients with combined substance use disorder and other mental illness. Adequate resources must be made available to ensure integrated, long-term solutions for the people who need them most.

Close, binding collaboration between the police, the correctional services, the health services and the social services can help ensure safety in connection with antisocial and disruptive behaviour. A detailed review must be undertaken to assess how people with combined severe personality disorder, substance use and repeated violent episodes can be assured better follow-up that attaches greater importance to external control measures and public safety. The ability of the correctional services to take special responsibility for coordinating treatment and services for persons who have been convicted and are now in their care must be strengthened.

Health and social workers also need measures to guarantee their safety at work, and in the committee's opinion, good routines and clear instructions need to be prepared to ensure their safety, especially in ambulatory activities. The committee recommends a low threshold for reporting serious threats and violence against staff, and reported incidents should lead to swift criminal prosecution and sanctions from the police and the courts. Good routines for reporting violence against health and social workers must also be ensured.

Cooperation with and support for the patient's family and friends should be integrated into the planning process, particularly in cases where the client lives near them. Not least, the assistance services should strive to have close contact with the patient's immediate surroundings in periods where the risk of violence is considered to be particularly high, such as in connection with substance use and in chaotic periods.

7.8.9 Restrictive prescription practices and secure dispensing systems

The committee recommends that clear guidelines are developed for highly restrictive prescription of benzodiazepines for people with a known substance use disorder and in connection with psychosis, and especially if the patient uses alcohol (see annex 4). Benzodiazepines should never be prescribed for people with a severe personality disorder, and alternative, less addictive drugs (or non-pharmacological treatments) should be sought. In all cases, benzodiazepines should only be prescri-

17. Lundeberg & Mjåland, 2009, p. 104

bed for short periods. Safe and controlled dispensing systems should also be established in close collaboration with qualified health personnel.

7.8.10 The public health perspective

The majority of violent incidents, including homicides, are carried out by people who had not previously been considered to be in a high-risk group for violence, and it is virtually impossible to predict who is going to kill. Measures aimed at the entire population should therefore be a priority. Primary preventive measures will generally have a greater deterrent effect on the number of violent incidents, and thus homicides, than secondary preventive measures that target individuals. A high proportion of homicides and other violence are related to harmful substance use, most commonly alcohol. A probable correlation has been found between alcohol consumption and the number of violent incidents in a society, and the committee is therefore supporting the use of primary preventive measures that serve to limit alcohol consumption in Norway.

Although alcohol consumption is more frequently linked to homicide and violence than other drugs, it is also important to maintain the current primary preventive measures to limit the use of illegal drugs in society. It has been debated whether homicide related to illegal drug dealing could be prevented by legalizing drugs; however, the committee's review found very few homicides in the study period related to drug dealing or financial problems due to drug problems. In this context, the committee refers to the review currently being undertaken by the Stoltenberg committee.

Chapter 8
The follow-up the perpetrators received before the incident

8.1 Delimitations

Section 4.1.5 of the committee's mandate states that:

> «the committee shall specifically examine and as appropriate assess ..... the follow-up that was given before individuals became seriously ill.»

In the same section, it is also stated that the committee shall investigate and as appropriate assess:

> «whether there were aspects of the discharge that ought to have been handled differently ..... and whether there was any aftercare or follow-up in the community.»

The committee interprets this to mean that we should specifically review what kind of assistance the people had received before they became seriously ill and in connection with discharge and subsequent follow-up. In other words, the committee has focused less on the quality of the services provided when the perpetrators were actually receiving treatment. This is also in line with what is feasible for the committee to achieve within its allotted time frame. The perpetrators have a wide range of mental disorders, with many different possible forms of treatment. There will also be a great deal of debate as to what type of treatment is best in the different cases. In keeping the section 4.2.5 of the mandate, which states that:

> «the committee's approach and method must be based on a consistent perspective where the course of events and systems are seen in a holistic context,»

the committee has therefore decided to give priority to looking into the transitions between the various assistance agencies, as opposed to assessing the quality of the treatment within each system.

In most treatment areas, there is no agreed standard for treatment against which we could compare our findings. However, there are some guidelines in some areas. In its review, the committee decided to assess what actually happened against the following guidelines and circulars that are directly related to the committee's mandate:

- IS-9/2007 Assessing the risk of violent behaviour – use of structured clinical tools
- IS-15/2006 The health services' and the police's responsibilities for people with mental illness – tasks and collaboration
- IS-1253 Individual Plan 2007 – Guide to the regulation on individual plans
- IS-7/2003 Patients in possession of weapons – health workers' right and/or duty to provide the police and military authorities with information about patients' health
- IS-17/2004 Regarding discharge of patients from inpatient treatment in psychiatric institutions

In this chapter the committee has chosen to focus on people who have committed homicide. This means, for example, that we have not undertaken structured literature searches or reviewed the extensive knowledge that already exists on the treatment of psychiatric disorders in Norway. The committee has drawn on general knowledge about treatment in some cases.

As mentioned above, the committee has focused on transitional situations, rather than looking at the content or quality of the treatment provided. Since there are various hypotheses on the link between use of medication and aggression, the committee has nevertheless investigated the perpetrators' use of medicines.

This chapter discusses the assistance the perpetrators received for their mental health problems. The term mental disorder as used here also includes substance use disorders. The committee has included as many of the assistance services as possible in its investigation, but has focused most on inpatient services and outpatient care by the specialist health service.

8.2 Status of knowledge

There is currently little information on the treatment and follow-up that people who have taken lives received before they took a life. It is not usually possible to draw on international literature in

Box 8.1 Alternatives to Violence (ATV)[1]

IIsdal (2000) describes the basic understanding of violence as a problem and phenomenon that forms the foundation for the ATV treatment model. Violence makes sense to the perpetrator. Violence can be seen both as a problem per se and as a symptom of underlying problems that violence is an attempt to master. In recent years, there has been an increased focus on perpetrators as parents (Råkil 2006). The treatment model has also been refined and adapted to suit people of ethnic minority background (van der Weele, Jørgensen and Ansar, 2007). Isdal and Råkil (2002) describe the four basic elements of the ATV treatment model:

Focus on violence

The main objective of treatment is to help stop violence. To this end, violence must be discussed and described, to render it visible and concrete. This serves to make the violence real – as a current, serious problem. To achieve this kind of change in perspective and promote processing, the perpetrator must be approached with respect and empathy, at the same time as they must be made to realize the seriousness of their violent actions.

Focus on responsibility

By reconstructing situations where the patient becomes violent in detail, it usually becomes clear that violence is not the result of a loss of control, but that it serves a subjective function for the perpetrator. However, violence is not always planned in advance. The threat of violence on the basis of past violence can be an effective way to get the other party to refrain from raising a sensitive or taboo topic, such as the impact and adverse effect of the violence on the children in the family.

Focus on the impact and consequences of violence

By taking their own use of violence seriously, the foundations can be laid for the perpetrator to comprehend the effect their violence has on the victims. Understanding this helps them develop a greater sense of empathy, which in turn makes it harder for the perpetrator to exercise violence again.

Focus on context

To ensure the treatment has lasting results, it is deemed important to work on the cause of violence (individual, group-related, community-related and violence-related) and its function. For example, many violence perpetrators who seek assistance for their problems via the ATV programme witnessed and were subject to violence themselves within the family in their childhood.

Previous evaluations have reported positive results (Tafjord 1997), and that the quality of the treatment work done in the ATV programme is consistently good (Høglend and Nerdrum 1996). A process and outcome study is being carried out in the period 2009–2012 of the treatment in the ATV programme under the auspices of the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS).

1. Høglend & Nerdrum, 1996; Isdal, 2000; Isdal & Råkil, 2002; Råkil, 2006; Tafjord, 1997, van der Weele, Jørgensen, & Ansar, 2007

the field, since the treatment systems, treatment methods and scope of treatment vary massively between countries. However, it is important to take into account international experiences concerning what preventive measures can be effective against homicide and violence in society.[1] It is also worth noting that some expert communities in Norway have developed forms of treatment the objective of which is reducing the risk of violence. These include Alternatives to Violence (see box 8.1) and the Brøset Anger Management Programme (see box 8.2), the latter of which has been accredited for use in Norwegian prisons. However, these programmes are not primarily aimed at people with serious mental disorders. Other programmes and research projects (see chapter 9) also encompass

1. Brookman & Maguire, 2004; Chan et al, 2004; Cherniak, Grant, Mason, Moore, & Pellizzari, 2005; Lipsey, Landenberger, & Wilson, 2007; Milton et al, 2006; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006; Tolan, Henry, Schoeny, & Bass, 2008

Box 8.2 The Anger Management Programme at Brøset Prison: «It's my choice – the way ahead»[1]

The Anger Management Programme at Brøset Prison: «It's my choice – the way ahead» is a structured cognitive programme that focuses on violence triggered by specific emotions and situations. It is the only accredited violence therapy programme in the Norwegian Correctional Services. The programme is based on the view that changes in cognitive processes, relational skills and emotional states can help reduce criminal behaviour.

Theoretical rationale

The Anger Management Programme is intended for people convicted of violent crime with a medium to high risk of relapse. The goal of the programme is to reduce the individual risk of relapse by giving the person insight into their dynamic violence factors so they can identify their own crime-inducing needs.

Main theoretical foundation

In terms of theory, the Anger Management Programme at Brøset Prison adheres to the psychoeducation school of thought. Psychoeducation programmes are time-limited and manualized. They are based on a combination of working with the cognitive aspects of the individuals' use of violence and unlearning violence as a form of action (Råkil, 2002, Milner & Myers, 2007).

The programme also contains elements from anger management programmes elsewhere. Two general review articles published in recent years strongly support the effectiveness of Motivational Interviewing in terms of motivating people to change (Hettema, Steele, Miller, 2005; Rubak, Sandboek, Lauritzen, Christensen, 2005). Motivational interviewing techniques will therefore be used throughout the programme.

The programme is based on teaching the participants about their own cognitive processes in individual and group sessions. There are individual sessions where the person is made aware of thoughts, feelings or knowledge that he can base his subsequent choices and decisions on. The goal is that through this training the participant will learn to take responsibility for their criminal and violent acts, find new ways of relating and learn to express their wishes and needs in a more socially acceptable manner.

The objective of the cognitive part of the course is to identify aggressive thoughts and feelings and dysfunctional attitudes (the basic rules that occur in specific situations). The interviews use a Socratic method of questioning, which forces the participants to develop their own thoughts and that person has to reason their way to the answer, in combination with practical exercises. This is considered important in order to be able to change your own mindset.

Summary

The prison programme attaches importance to the prisoner finding «their own way to change» through motivation, group therapy and individual adaptation of the programme. The manual stipulates that each individual must have their own needs illuminated in order to be able to change the dynamic criminogenic factors. This requires a certain degree of sensitivity and responsiveness in that the instructor has to take into account the individual prisoner's learning style. Empirical research has found that the relationship or alliance between the patient(s) and the therapist is an essential factor in processes of psychological change (Wampold, 2001). This helps motivate the individual, which is crucial for the long-term effectiveness of the treatment (Report no. 37 (2007–2008) to the Storting, page 79).

1. Hettama, Steele, & Miller, 2005; Milner & Myers, 2007; Rubak, Sandboek, Lauritzen, & Christensen, 2005; Råkil, 2002; Report no. 37 (2007–2008) to the Storting «Punishment that work – less crime – a safer society, p. 79; Wampold, 2001

patients with severe mental illness and the risk of violence.

Most previous homicide studies in Norway obtained information from the courts, forensic autopsy reports and forensic psychiatric evaluations. Additional information has rarely been collected about any mental disorders and what treatment the perpetrators have received.[2] Below is a

summary of some of the information previously gathered on the treatment homicide perpetrators had received before they committed homicide.

One of the few previous studies in Norway that touches upon treatment is Noreik and Gravem's review for the period 1980–1989. Their starting point was perpetrators who had been found to be «criminally insane». This means that they have a different perspective to the current study and that the two studies are thus not directly comparable. They found that nearly one-third of perpetrators who committed homicide had received psychopharmaceutical treatment at the time of the offence. In 9 % of the cases, treatment had been instituted but not completed. They also report that the perpetrators were frequently under outpatient psychiatric treatment.[3]

The report of the Rasmussen committee was based on 26 cases, 14 of which included fatalities. The report concerned perpetrators who had been found criminally insane. This means that there was a very limited number of cases and a substantially narrower starting point than in the current review. The findings are therefore not directly comparable with the current investigation. They found that seven of the 26 perpetrators were either patients in psychiatric institutions or receiving mental health aftercare at the time of the offence. Three people had never been hospitalized, but had received or were currently receiving outpatient treatment. Ten people had previously been hospitalized, but completed the course of treatment and had no contact with medical personnel. Six people had not previously had any contact with mental health services. They suggested that the mental health services might not have been good enough at identifying the treatment needs and assessing the dangerousness of the group who had ended treatment. They also pointed out that failure to register the concerns of friends and family could be regarded as a system failure. They suggested measures be taken to ensure better communication between the different levels in the treatment and care services in contact with the patient. They also noted that the a need for greater expertise in assessing dangerousness and risk analysis.[4]

The Norwegian Board of Health Supervision has reviewed all the cases in which the Norwegian Board of Health Supervision in the Counties had processed cases where people with mental disorders had committed homicide during the period 1 January 2004 to 3 April 2009. The review encompasses 22 incidents. One of these incidents did not have an enforceable judgment at the time of the committee's review, but the remaining 21 cases are included in the committee's review. At the time of the offence, two of the perpetrators were patients in emergency wards, 15 were undergoing outpatient treatment, two had dropped out of outpatient treatment, two had completed treatment, and one had never had contact with mental health services. Eight had a psychosis diagnosis, nine had an addiction-related diagnosis, and six had a depression diagnosis. In 19 of the cases, the victim was a close family member or a friend or acquaintance. In 13 of the cases, the safety risk was not an issue during treatment, and safety risk assessments were not conducted. In four cases where violence and threatening behaviour were recorded in the medical records, no structured risk assessments for violence, as recommended by the Norwegian Directorate of Health, had been carried out. None of the patients had been asked by the medical personnel treating them if they had access to weapons or other dangerous objects. In most of the cases, there was good collaboration between the GP, the municipal services and other service providers.[5]

The Norwegian Board of Health Supervision found four cases where there had been a breach of duty on the corporate level, and in one of these cases the health personnel in question had been given a warning. No instances of breach of duty by the perpetrator's regular doctor or in the municipal services were found. The following corporate breaches of duty/need for supervision were found:

- Violation of section 2–2 of the Act relating to the specialist health services:
  - Lack of governing documents that ensured continuity in treatment, including binding interaction routines with GPs, district psychiatric centres or social services in connection with discharge.
  - Lack of implemented routines and procedures for proper diagnosis and treatment, record keeping and transfer of a summary of the case records.
  - A therapist, who was not a doctor or psychologist, had unreasonably large responsibility to determine the limits of their own competence.
  - Lack of systems for following up patients who were in danger of taking their own lives.

2. Bødal & Fridhov, 1995; Christensen, 1956; Giertsen, 1988; Rognum, 1985; Røstad, 1982
3. Noreik & Gravem, 1993
4. Rasmussen committee, 1998
5. Norwegian Board of Health Supervision, 2010

  - Technical staff had not received training in how to respond to patients who were admitted to closed inpatient wards.
- Violation of section 3–7 of the Act relating to the specialist health services:
  - No doctor responsible for the patient's care had been appointed. A nurse, rather than a doctor or psychologist, was responsible for coordinating care. There were insufficient routines to ensure individual medical assessment and discussion of treatment with the doctor/psychologist.

One chief physician was given a warning:
- Violation of section 4 of the Health Personnel Act, which deals with proper treatment:
  - The following weaknesses were found: inadequate assessment, diagnosis, treatment and medication, and inadequate planning and measures in connection with discharge. The medical records lacked information about the assessments made in connection with the transfer from compulsory to voluntary psychiatric care, and failure to send a summary of the case records to the patient's GP.

The Norwegian Board of Health Supervision also carried out planned inspections in 2008. There were no procedures or inadequate practices for when the dangerousness assessments should be done, by whom, and how they should be followed up in six out of the 28 inspected district psychiatric centres (DPS). At some of the district psychiatric centres, it was also found that the ward had neither assessed nor ensured their development of their expertise in the area, and/or it was found that the personnel reported that they were unsure what they were supposed to do in these kinds of situations.[6]

In 2003, the Norwegian Board of Health conducted a review that is relevant for our purposes, even though it did not directly investigate people who subsequently took lives. They undertook an inspection of 39 district psychiatric centres and emergency psychiatric wards, with particular emphasis on psychotic patients and patients with suicidal tendencies. The inspection concluded that roughly half of the enterprises had inadequate routines for coordination between emergency wards and the district psychiatric centres. Individual plans were seldom used to improve coherence in services. Patients were discharged and sent home without adequate assessment and planning and without suitable arrangements for follow-up. It was found that the specialist health services lack expertise in various areas, both relative to their own quality requirements and in terms of advising the municipal health services. Weaknesses were also revealed in internal control work in that the enterprises did not have systems to evaluate and implements improvement work on the basis of their experiences, feedback and user satisfaction surveys.[7]

The quality and scope of the health services' treatment and care of adults with mental health problems has been evaluated on a variety of occasions, not least in connection with the Escalation Plan for Mental Health (1999–2008). It goes beyond the scope of this committee to consider all the aspects of the services within mental health care that may affect the risk of violence. Nevertheless, the committee would like to make reference to some of the conclusions from the comprehensive evaluation undertaken in connection with the Escalation Plan:[8]

> «A clear challenge is to ensure a qualitatively satisfactory, professional service to the group of patients who have more severe psychiatric problems. There are particular grounds for concern over the unsatisfactory outcome of treatment for young male patients with severe psychiatric problems, and especially for those who also have heavy substance use.» (page 70)
>
> «There is thus some way to go before the objectives defined in the Escalation Plan are met with regard to collaboration between the mental health care services in the municipalities and the specialist health services.» (page 72)
>
> «The evaluation report describes the collaboration between GPs and other agencies within mental health care in the municipalities as still not good enough, especially in the larger municipalities.» (page 72)
>
> «The system of 'responsibility groups' is regarded as an appropriate way of organizing the work linked to patients with serious mental disorders. The use of individual plans has increased through the escalation period, but it will be some time before they are implemented for the entire target group.» (page 73)
>
> «Some regular GPs have stated they lack expertise and have too little support to treat chronically sick individuals with serious disorders that the specialist health services regards as having completed their treatment and reaso-

6. Norwegian Board of Health Supervision, 2009
7. Norwegian Board of Health Supervision, 2004
8. Brofoss & Larsen, 2009

nably stable. This probably refers to patients with schizophrenia and severe personality disorders in particular.» (page 93)

«Individual plans, municipal responsibility groups or a coordinator in the municipality were considered appropriate tools for only 30–40 per cent of the patients. Of these patients, 75 per cent had been offered these services.» (page 93)

«Collaboration between the municipal mental health care services and NAV (formerly Aetat) ..... is poorly developed, which NAV claims is due to different organizational cultures, and that arranging meaningful activity is not one of their main tasks.» (page 94)

«A recurrent finding in the evaluation portfolio is that patients with severe psychiatric problems are given priority on all levels.» (page 94)

«The patients' regular GPs and mental health workers in municipal services reported poor collaboration on patients with personality disorders, geriatric psychiatric problems and patients with dual diagnoses.» (page 94)

«The analyses show that people with mental illness have a lower score than people without mental disorders in terms of positive living conditions such as being married or living with their partner, having close friends they confide in, having a university education, being employed and having a high income. ... ... The multivariate analyses show that, controlled for age and sex, the people with most severe mental illness have the lowest score on all living conditions indicators.» (page 119)

8.3 The findings of the committee's review of cases

8.3.1 Contact with the assistance services for mental disorders

8.3.1.1 With whom had the perpetrators had contact about their psychological problems, and when?

All in all, 97 perpetrators (78 %) had previously had contact with the assistance services because of mental health problems, 27 had not had contact with them, and there was no information on this matter for eight perpetrators. The agency that most people had used in connection with mental health problems was their regular doctor (64 persons, 56 %). This supports previous findings that indicate that the individual's regular doctor is the most commonly used assistance agency in connection with mental health problems.[9] The second most commonly used assistance agency was the outpatient specialist health services (59 people, 50 %; see figure 8.1). In this context, the outpatient specialist health services encompass both the mental health services and interdisciplinary speci-

9. Dalgard, 2008

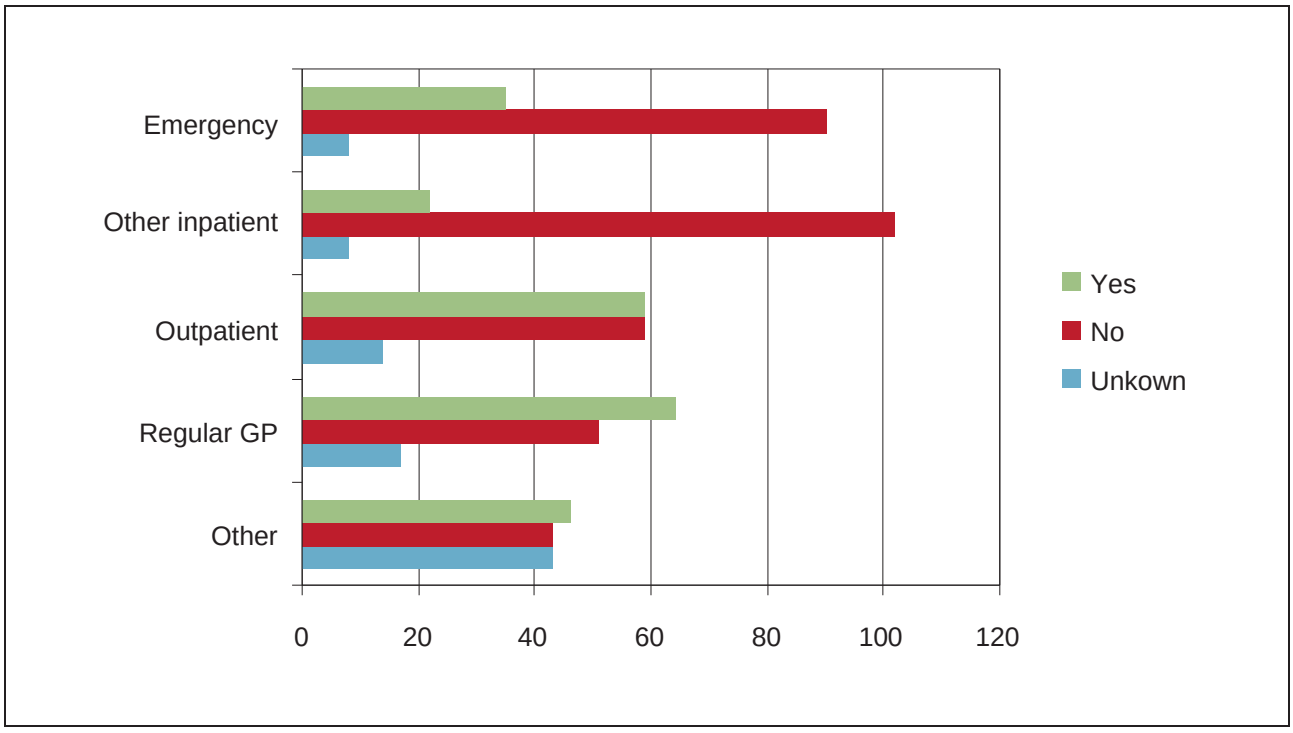

Figure 8.1 Number of perpetrators who have had contact with various assistance agencies for mental health problems at some point in life (N = 132)

Box 8.3 Statement from someone close to one of the offenders

«XX was in a queue, waiting to see psychologist. His GP can't have provided the follow-up he needed. He can't have had time, with so many patients. It's like an assembly line. If XX had seen a psychologist earlier, none of this might have happened. ..... When you are mentally ill, you need immediate help, here and now. You can't wait six months.»

alized drug and alcohol treatment. A total of 35 perpetrators (28 %) had been admitted to a emergency psychiatric ward, while 27 perpetrators (22 %) had been admitted to some other inpatient facility in the mental health service than an emergency ward.

Most people who had been admitted to an inpatient facility (emergency or other) had been hospitalized once (15 individuals, 36 %), twice (nine individuals, 21 %) or three times (six individuals, 14 %). Nine people (21 %) had been admitted four to ten times, while three people had been hospitalized more than ten times.

Most of the people who had had contact with the assistance services had their first contact long before the incident. The time of the first contact is known for 87 people, and there were only eight people (9 %) whose first contact was within the last 12 months prior to the offence. Average first contact was 10.3 years (standard deviation = 8.1 years) before the incident.

The committee had access to data on the last contact with the assistance services for 93 of the perpetrators. Average last contact with an assistance agency in connection with mental health problems was 1.6 years before the incident (standard deviation = 3.2 years). There were 33 people (36 %) who had had contact with an assistance agency in the week before the homicide, and 68 people (73 %) had had their last contact during the last 12 months before the incident. This represents 54 % of all perpetrators for whom the committee has this kind of information.

There was some variation between different patient groups in terms of their use of the psychiatric assistance services in the last year. A significantly larger proportion of the perpetrators with a diagnosis in the schizophrenia spectrum (F20–29) (83 %) and with addiction-related diagnoses (F10–F19) (67 %) had had contact with an assistance agency during the last year, compared with the people without these kinds of diagnoses. However, there was no difference between the proportion of perpetrators with personality disorders (F60–F69) (61 %) who had had contact with assistance agencies and those without this kind of diagnosis.

Of the total of 92 perpetrators for whom we have data on whom they last had contact with the assistance services, 32 people (35 %) had last had contact with their GP. In second place was outpatient mental health services (27 persons, 29 %) as the agency that most perpetrators had last been in contact with before the homicide. Twelve people

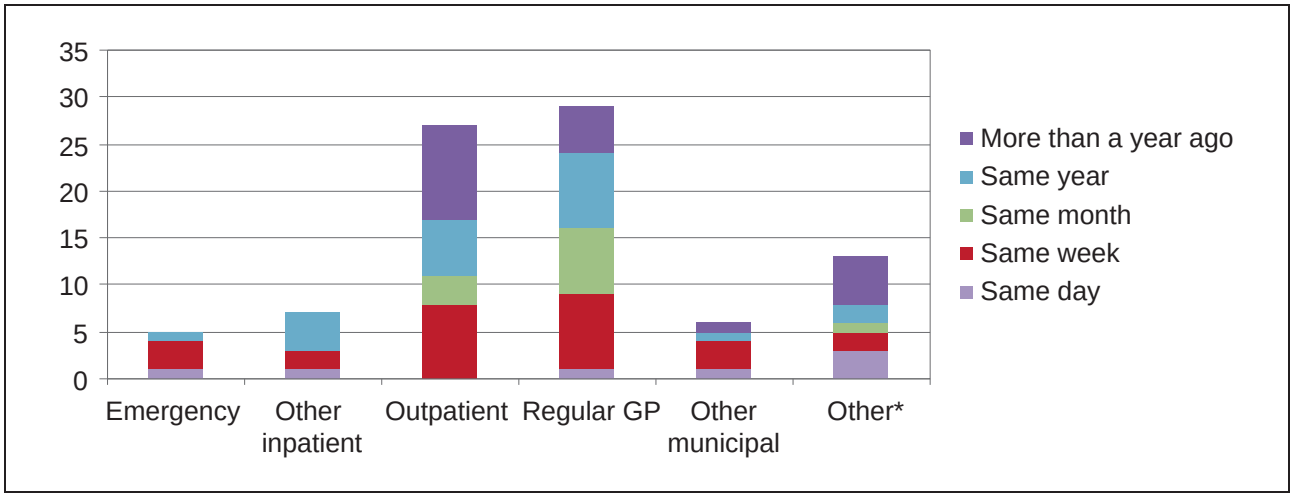

Figure 8.2 When and the unit in the assistance services with which the perpetrators last had contact for their mental health problems (N = 87)

* Other assistance agencies including Aetat, child welfare institutions, privately practising psychologists, the somatic health service, the Norwegian Emergency Medical Alarm Centre (AMK), private rehab facilities, student health services and health services overseas.

(13 %) had an inpatient facility in the mental health services as the last point of contact.

If we combine the information about when and with whom the last contact with the assistance services took place (figure 8.2), we see that it is GPs, outpatient specialist health services and emergency wards that most perpetrators had had their last contact with in the last week before the incident.

In 21 out of 80 known cases (26 %), the reason for the last contact with an assistance agency was emergency needs reported by the perpetrator or their family. In eight of these cases, the last contact was within the last week before the incident.

There is little comparative information on how common it is to have been treated for mental health problems in Norway. Official statistics covers aspects such as the number of hospital beds, the number of discharges and the number of consultations, but as far as this committee has been able to ascertain, they do not indicate the proportion of the population who have used mental health services at some point in life. The Norwegian Survey of Living Conditions for 2005 showed that 9 % of the population and 43 % of people with a lot of mental health problems had sought professional help for their mental health problems in the last 12 months.[10] This means that a higher proportion of the perpetrators (54 %) had received treatment in the last year than that found among people with a lot of mental health problems. The present study also found that 23 perpetrators (19 %) had been admitted in the last 12 months before the incident. This is a much higher proportion than among the general population (1 %) or among the people with a lot of mental health problems (5 %) according to the survey of living conditions. Although the survey of living conditions had a high non-response rate from severely ill people and thus underreports the use of the health services, the difference in the use of assistance services for mental health care nevertheless does seem to be significant. Another element that underpins the finding that a significantly high proportion of the perpetrators had sought assistance for mental health problems was that the survey of living conditions found that women and people with more education have a greater tendency to seek help for mental health problems. There is a higher proportion men with no education among homicide perpetrators than in the general population, meaning we would expect to find a lower-than-average proportion of people who sought assistance among the perpetrators. Although a higher proportion of the perpetrators had mental problems (see chapter 5) and needed mental health services than in the general population, we cannot conclude that there is a causal link between these aspects and the homicides that were committed. For example, it is important to take into account the fact that the perpetrators often have other risk factors than the general population. These include that they are men, are relatively young, have little education, are in an unstable housing situation, are out of work, etc. As described in chapters 4 and 6, this study is not capable of analyzing the causes of the homicides.

The proportion of the people in our sample who have had contact with the mental health services is higher than that found in England and Wales, where, for example, it was found that 18 % of the perpetrators had had contact with the specialist mental health services at some point in life. It is difficult to know whether this difference is due to characteristics of Norwegians who commit homicide or differences in the mental health systems in Norway and Britain.[11]

8.3.1.2 Aspects of the last appointment with an assistance agency for mental health problems

One issue that has been considered is whether the assistance agency that treated the perpetrator ought to have picked up some warning signs. In this regard, we will concentrate on the perpetrators who had contact with an assistance agency for mental health problems in the last 12 months before the incident. This constitutes 68 perpetrators (54 % of the sample), while 57 perpetrators (46 %) had not been in contact with an assistance agency for mental health problems in the last year, and there is no data on this matter for seven people. The last contact may have been with an emergency or inpatient facility, outpatient specialist health services, their own GP or some other assistance agency.

It is apparent from table 8.1 that the majority of the perpetrators for whom there is documentation of their last contact with an assistance agency exhibited signs that might indicate an increased risk of violence. However, it is difficult to know whether these figures are high or whether the figures would be equally high for patients who did not commit homicide. A study in England and Wales also found signs of emotional instability and

10. Dalgard, 2008

11. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006

Table 8.1 Aspects of the last contact with an assistance agency for mental health problems (N = 68)

	Yes	No	Unknown	Per cent negative
Did the perpetrator attend their last appointment with the assistance agency?	35	13[1]	20[2]	27 %
Was a risk assessment for violence carried out at the last contact or earlier?	14[3]	30	24	68 %
Were there clear signs of emotional instability at the last contact?	28	19	23	60 %
Were there clear signs of a depressive disorder at the last contact?	24	23	23	51 %
Were there clear signs of deterioration in physical health at the last contact?	11	32	25	26 %
Were there clear signs of delusions or hallucinations at the last contact?	10	37	23	21 %
Were there clear signs of delusions or hallucinations with violent content at the last contact?	2	45	21	4 %
Were there clear signs of hostility at the last contact?	10	36	22	22 %
Were there clear signs of increased use of alcohol at the last contact?	6	41	21	13 %
Were there clear signs of increased use of other drugs at last contact?	8	38	22	17 %
Were there clear signs of recent self-harm at the last contact?	2	50	16	4 %
Were there clear signs of suicidal thoughts at the last contact?	6	43	19	12 %
Were there clear signs of non-psychotic violent ideas at the last contact?	5	45	18	10 %
Were there clear signs of recent stress at the last contact?	30[4]	21	17	59 %

1 In four of the cases where the perpetrator had not attended their last appointment, there is no evidence that any attempt was made to contact the person. In six cases, attempts were made to phone the patient, and telephone contact was made with him/her in five of the cases. In one case, a health worker went to the perpetrator's home and made contact there. In three of the cases, other assistance agencies were contacted, and in two cases, family members of the patient were contacted. In two of the cases where the agency had telephone contact with the patient, a letter was then sent with a new appointment.

2 Twelve of the perpetrators were not receiving treatment at the time of the offence and it is not known if he/she attended their last session.

3 In eight cases, risk had previously been assessed using clinical judgement, and this kind of risk assessment had been carried out at the last contact in six cases. The conclusion of the assessment is known in nine cases: eight people were assessed at zero or low risk and one person was considered have a high risk of violence against others.

4 Examples of stress are breakdown of marriage or cohabitation, being forced to move, legal conflicts, threats or physical conflicts.

depression were common at the last contact with the perpetrators in the last 12 months before the incident.[12] They reported a slightly lower proportion with delusions or hallucinations at the last contact (8 %) than has been found in the current study (21 %). See table 8.6 for more detailed information about people diagnosed with schizophrenia.

In the majority of the cases, no risk assessment was performed, but this does not necessarily indicate negligence by the assistance agencies. For example, a study in England found that most of the homicides were committed by perpetrators whom health personnel had assessed as having no (47 %) or low (41 %) risk of exercising violence in the near future. We do not know how often violence risk assessments are made in patient populations similar to the perpetrators, and thus we do not know whether risk assessments have been undertaken less frequently among the perpetrators than is normal. In Norway, however, the scheduled inspections of district psychiatric centres performed by the Norwegian Board of Health Supervision in 2008 support the assumption that the routines linked to violence risk assessment are lacking in some places in Norway, and that this also applies

12. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006

Box 8.4 Statement from someone close to one of the offenders about the risks associated with breakdown of marriage, etc.

«When a relationship breaks down, people must be taken very seriously. For most people, it's the worst thing that ever happens to them.»

Box 8.5 Statement from someone close to one of the offenders about the period just before the incident

«The week before (the incident) he saw all these terrible things. He kept on having these hallucinations.»

Box 8.6 Statement from someone close to one of the offenders about how difficult it is to recognize the risks when the perpetrator hides their plans

«He knew the difference between right and wrong. And the fact that he hid it so well means he must surely have known how wrong it was. He tricked us all.»

to the perpetrators included in the committee's review.[13]

The committee has not examined how the health personnel have taken the risk factors listed in table 8.1 into account. Even if no risk assessment has been performed, the treatment provided may well have been the same as the treatment that would have been given if a violence risk assessment had been performed. It is not a matter of course that a violence risk assessment would have resulted in different treatment or have prevented the patient later committing homicide. See chapter 9 for a more detailed discussion of risk assessments.

8.3.2 Discharge from an emergency or inpatient psychiatric facility

A total of 42 perpetrators had been admitted to an emergency or inpatient facility in the mental health services. This does not include interdisciplinary specialized drug and alcohol treatment. For 40 of these, we know whether outpatient follow-up had been started at the time of the offence and how much time had passed from their last discharge. Two perpetrators were hospitalized at the time of the offence. Four more perpetrators had been discharged the week before the incident, and the incident occurred before outpatient follow-up had begun. For 33 perpetrators, it was more than a month since their last discharge, and for 17 of these, the last discharge was more than a year before the homicide. Outpatient follow-up had not been started for ten of the perpetrators who had been discharged more than a month earlier.

For the 42 perpetrators who had previously been admitted to and discharged from an emergency or inpatient facility, it was investigated whether the recommendations in the guide on discharge had been followed (table 8.2).[14] The committee has not obtained information directly from the specialist health services, but has relied on information already collected by the Norwegian Board of Health Supervision, case record summaries from GPs, information in the forensic psychiatric evaluations and information obtained by the police. This means that the information our analyses are based on has weaknesses in terms of both quality and scope regarding a number of factors.

Despite the lack of information, there appear to be possible deficiencies in three areas:

In many cases, we get the impression that the discharge from an emergency or inpatient facility was not gradual, but quite abrupt. In the majority of the cases, there was a direct transition from 24-hour treatment to full discharge. In some cases, this may be natural or impossible to avoid. Examples include cases where the patient wants to be discharged without further treatment or follow-up from the facility and there is no reason to use compulsion. It is also possible that discharge was more gradual than that it appears in the documentation. Nevertheless, the overall impression is that an abrupt transition from being hospitalized as an inpatient to discharge is the norm.

Similarly, in some cases there appears to be a lack of documentation regarding how the discharge was planned and what information was given about the further follow-up. There was rarely documented evidence that an individual plan had been prepared and a coordinator had been designated when the patient was discharged. There was also often a lack of information about who had

13. Norwegian Board of Health Supervision, 2009

14. Directorate for Health and Social Affairs, 2004

Table 8.2 Aspects of discharge from an emergency or inpatient facility (N = 42)

	Yes	No	Unknown	Per cent negative
Was discharge gradual?	12	21	9	64 %
Was the patient involved in planning the final discharge?	23	2	17	8 %
Was there a discharge conversation with the patient before the final discharge?	22	2	18	8 %
Was the patient (or relatives) informed about further follow-up?	16	7[1]	19	30 %
Was the patient informed about the possibility of relapse and any steps the patient could take him/herself?	9	1	32	10 %
Was the patient informed about where he/she could seek help if necessary (name and telephone number of a contact person)?	13	1	28	7 %
Were they given information on what to do if they fail to take their medications, prescriptions, medical certificates or other certificates?	1	34	7	3 %
Were the next-of-kin or guardian informed?	11	3	28	21 %
Is it clear from the medical records or summary of the case records which bodies have been notified and who is responsible for further follow-up?	12	17[2]	13	59 %
Was the patient's housing situation verified before discharge?	26	3	13	10 %
Was there an individual plan and a coordinator before the final discharge?	4	18[3]	20	82 %
Had arrangements been made to ensure transfer of necessary patient information, for example, a case record summary?	21	3	18	13 %
Was a violence risk assessment undertaken before the final discharge (cf. IS-9/2007, section 2.2)?	6	4/12[4]	20	18 %
Were clinically tested risk assessment tools used?	0	20	22	100 %
Was any identified violence risk dealt with appropriately (cf. IS-9/2007, section 2.3.3)?	10	6[5]	23/3[6]	38 %

1 In four cases, no plans had been made for follow-up after discharge, and in two cases follow-up had been planned, but there is no evidence that the patient had received information about it. In one case, the patient was given information about further follow-up, but not the contact person.

2 In three cases there was no contact with other assistance agencies, in five cases there was no documented contact before discharge (but contact after discharge). In nine cases there was documented contact with the next assistance agency, but no documentation that this agency had accepted responsibility for further follow-up and designated a contact person. There were no specific differences between diagnostic groups in terms of how frequently further follow-up had been arranged.

3 In ten cases, there was no individual plan or coordinator at the time of discharge. In six cases, a coordinator had been agreed on, but an individual plan had not been prepared. In two cases, an individual plan had been prepared, but a coordinator had not been chosen.

4 In 16 cases, no violence risk assessment had been carried out, but this kind of assessment was not required in these cases, according to the guide. In four cases, a violence risk assessment had not been carried out, although it was required, pursuant to the section 2.2 of the guide. In two of these cases, the risk of violence had nevertheless been dealt with in accordance with section 2.3.3 of the guide, and in one case there is no information about whether the violence risk was dealt with appropriately. (Directorate for Health and Social Affairs, 2007a)

5 In six cases, an identified risk of violence was not dealt with in accordance with the guide's recommendations on risk management. In five of these cases, the risk had not been assessed, but in four of these cases, this kind of assessment is not required, according to the guide. In one case, the risk of violence was assessed as medium.

6 In three cases, the risk assessment indicated that the patient was not dangerous and the guide therefore indicate that the risk did not have to be dealt with.

assumed which responsibilities for follow-up after discharge. Roughly one in three perpetrators had not started outpatient follow-up a long time after discharge from an inpatient facility. It is worth noting that the Norwegian Board of Health Supervision found similar deficiencies in the communication between emergency wards and the district psychiatric centres in its 2003 review. Weaknesses

Box 8.7 Statement from someone close to one of the offenders about the need for follow-up after discharge

«After hospitalization, we only had contact with his regular doctor, who just prescribed pills. I think people need follow-up, and preferably for a long time. For they are just sent out into the world and left to their own devices.»

Box 8.8 Statement from someone close to one of the offenders about discharge without follow-up and information

«It was terribly difficult. You are worried all the time about what might happen. Because you know that something is going to happen. And you feel so helpless because no one listens to you. It doesn't matter what you say. You call the doctor and the hospital, but you are not taken seriously.»

have also previously been found in the guidelines from the specialist health services to the municipal health services, both in the review by the Norwegian Board of Health Supervision in 2003, and also in the evaluation of the Escalation Plan.[15]

A third area where there appears to be room for improvement is risk assessment. There was seldom documentation that the patients' violence risk had been assessed. Nor was there any information about the use of structured risk assessment tools in any of the cases. In this context, however, it is important to remember that in the majority of cases a violence risk assessment was not required pursuant to section of 2.2 of the guide.[16] The majority of the perpetrators were not being transferred to a secure ward, nor admitted to, discharged, transferred or being granted leave from compulsory mental health care. They did not have violence as a problem at admission or during their inpatient stay nor did they have a medical history or behaviour that indicated a risk of violence or aggression problems. There was only one case where the information showed that a required violence risk assessment had not been performed and the violence risk had not been managed properly. The overall impression is thus that violence risk assessments are rarely documented, but that risks are dealt with as they arise.

When interpreting the information on emergency and inpatient facilities, it is important to bear in mind that it is entirely possible that there is information in hospital records that the committee has not reviewed. It is also important to be aware of the fact that even if we identify weaknesses, this does not mean that the weakness has been a contributing causal factor in the homicides. It is quite possible that the same weaknesses also exist for patients who have not taken lives. For example, the proportion of patients with an individual plan is no lower among the perpetrators who have been hospitalized than in other patient populations.[17]

8.3.3 Discharge from outpatient specialist health services

A total of 59 perpetrators (50 %) had received outpatient treatment from the specialist health service, either mental health care or interdisciplinary specialized drug and alcohol treatment. This included 25 perpetrators who were under outpatient treatment at the time of the offence. There were 59 perpetrators who had not received these kinds of services, and there was no information on this matter for 14 perpetrators. Of the 59 who had received outpatient specialist health services, 14 people had not previously been discharged from these services.

The guide on discharge from inpatient treatment is not directly applicable to outpatient services. For example, treatment and follow-up are not needed as often after outpatient treatment as they are after inpatient treatment. The committee has not considered the discharge procedures from outpatient treatment in as much detail.

The committee found that in connection with the majority of the discharges from outpatient treatment, contact was not made with other agencies prior to discharge, nor had further follow-up been arranged (table 8.3). It is difficult to judge whether this proportion is high or low without knowing how common this kind of follow-up is among other outpatients and what kind of follow-up needs the patients had.

Violence risk assessment was made even less frequently before discharge from outpatient treatment than inpatient treatment. In five cases that

15. Brofoss & Larsen, 2009; Norwegian Board of Health Supervision, 2004
16. Directorate for Health and Social Affairs, 2007a
17. SINTEF, 2009; Norwegian Board of Health Supervision, 2008

Table 8.3 Aspects of discharge from outpatient specialist health services (N = 45)

	Yes	No	Unknown	Per cent negative
Was there a plan for follow-up after the last discharge?	9	15[1]	21	63 %
Was a risk assessment for violence carried out before the final discharge?	2	5/14[2]	24	24 %
Were structured clinical risk assessment tools used?	0	18	27	100 %

[1] In ten cases, there was no contact with other assistance agencies before discharge. In five cases, there was documented contact with other assistance agencies before discharge, but not that they had assumed responsibility for further follow-up or that a contact person had been established.

[2] In 19 cases, no violence risk assessment had been performed. Of these, violence risk assessment was required pursuant to IS 9/2007, section 2.2 in five cases, while in 14 cases it was not required.

the committee is aware of, this kind of risk assessment should have be undertaken, according to the guide. This reinforces the impression from the inpatient facilities that violence risk assessment is not performed as often as intended by the Directorate's recommendations.[18]

There was sufficient information in only a few cases to allow us to assess whether the specialist outpatient health services had dealt with an identified risk of violence in accordance with the guidelines in the guide.

8.3.4 Contact with other assistance agencies

In addition to having contact with assistance agencies for mental health problems, a large proportion of our sample had also had contact with other assistance agencies (figure 8.3).

A total of 77 perpetrators (72 %) had received assistance from NAV or the social services, including 64 people who were receiving assistance from NAV or the social services at the time of the offence. 29 perpetrators (27 %) had not received any form of assistance from other agencies, and there was no information on this matter for six perpetrators. On the basis of the information in the documentation available to us, it is difficult to determine whether more assistance ought to have been provided, for example in relation to people of no fixed abode. There are signs of shortcomings in the follow-up by NAV or the social services in 12 cases, seven of which are related to housing. However, these are subjective assessments based on limited data. For example, due to the shortage of time available, the committee has not had the opportunity to gather information directly from NAV or the social services.

The second most common assistance agency with which the perpetrators had contact was the correctional services, which 55 people (46 %) had been in contact with at some point in life. Six of these were in the care of the correctional services

18. Directorate for Health and Social Affairs, 2007a

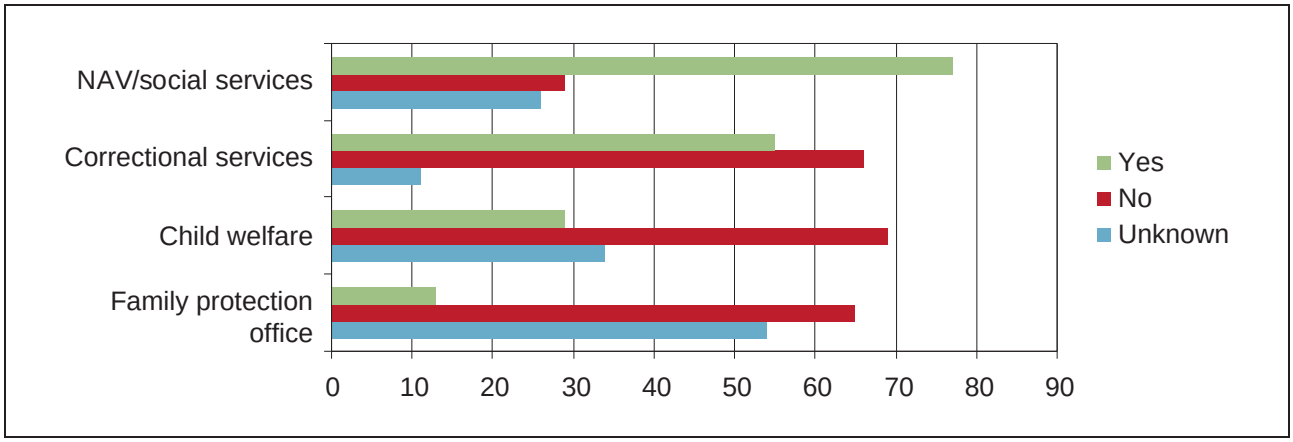

Figure 8.3 Number of perpetrators who have had contact with other assistance agencies at some point in life (N = 132)

at the time of the offence. 66 people (55 %) had never had contact with the correctional services, whereas there was no information on this matter for 11 people. There were negative comments about the last contact with the correctional services in only two cases, and these were not directly related to violence.

A total of 29 of the perpetrators (30 %) had had contact with child welfare services in their childhood and/or adolescence, of whom 27 before the age of 16. 18 of perpetrators (17 %) had been in the care of the child welfare services, 13 of whom before the age of 16. For 34 people, there was no information on whether they had had contact with the child welfare services in their childhood/adolescence or not.

Altogether 13 of the perpetrators (17 %) had received assistance from the family protection office. For 54 people, there was no information on whether they had received assistance from the family protection office or not.

8.3.5 Relatives' contact with assistance agencies and wish for admission

Relatives or close friends of 40 of the perpetrators (44 %) had been in contact with assistance agencies in connection with the perpetrators' mental health, whereas 51 (56 %) had not. The majority of the relatives had thus not had contact with the assistance services before the homicide. For six perpetrators, the last contact between their relatives/friends and an assistance agency was during the last two days before the incident.

For 11 of the perpetrators, the information revealed that four relatives/friends and seven perpetrators had asked to have the perpetrator admitted in the last month before the incident, but that this did not happen. Six of the people who wanted treatment were on a waiting list at the time of the offence, two people were assessed as not needing hospitalization, hospitalization was planned for two people, and for one person it is not known why admission had not occurred. Of these 11 people, seven had an addiction-related diagnosis, six had schizophrenia or paranoid psychosis, and two had a personality disorder at the time of the offence.

Box 8.9 Statement from an offender with schizophrenia

«It helps me to be in hospital. My thoughts are calmer.»

The four cases where relatives or friends of the perpetrator had requested admission all concerned people with a diagnosis of schizophrenia or paranoid psychosis at the time of the offence.

The data revealed that relatives or friends of eight perpetrators had requested admission more than a month before the incident, to no avail. In six of these cases, the perpetrator did not want to be admitted. For 104 perpetrators, there were no information indicating that a request for admission had not been fulfilled. For nine perpetrators, we do not know if there were any such unfulfilled requests for hospitalization.

One factor that has been discussed is whether there are sufficient treatment places within emergency and inpatient facilities. As mentioned, some patients committed homicide while they were waiting for admission. In most cases, the reason they were not admitted immediately as an emergency patient was the desire for planned admission. The committee does not have the impression that failure to admit a patient was primarily due to a shortage of places. Analyses of the correlation between changes in the number of inpatient places and changes in violence and homicide rates have yielded varying results. In Norway, serious crime rates rose in a period when there was a decline in the number of hospital beds, whereas this trend was not observed in England.[19] It is therefore difficult to comment on whether a shortage of hospital beds is a contributing factor in the homicides in Norway.

Another question is how much demand there is for these kinds of treatment places to ensure necessary health care for patients. This refers to treatment places for people in the care of the correctional services and for people who have not committed a crime. The committee has regarded it as beyond its mandate to discuss how many inpatient places there ought to be for mental health care or interdisciplinary specialized drug and alcohol treatment in Norway.

8.3.6 Use of medicines

Another interesting issue is whether the perpetrators' use of medicines, or lack thereof, may have contributed to aggression. In this context, the committee limited its investigation to medicines prescribed for mental disorders.

19. Hartvig & Kjelsberg, 2009; Mullen, Burgess, Wallace, Palmer, & Ruschena, 2000; Szmukler, Thornicroft, Holloway, & Bowden, 1999

Table 8.4 How many offenders were taking medicines at the time of the offence (N = 132)?

Medicine	Number yes	Number no	Number unknown	Per cent yes
Medicine for ADHD (Ritalin, Dexedrine, Strattera)	3	110	19	3 %
Antipsychotics	20	95	17	17 %
Antidepressants	9	102	21	8 %
Anticonvulsants, mood stabilizers	8	109	15	7 %
Anxiolytics	24[1]	84	24	22 %
Methadone/Subutex	0	119	13	0 %
One or more of these medicines	41	79[2]	12	34 %

1 Of which 12 on Diazepam, seven on Oxazepam, and five people who were taking other types or combinations
2 Among the 79 perpetrators coded as not taking their medication, there was no complete information about all types of medication for 15 people

Some 41 of the perpetrators (34 %) had a prescription for medicine at the time of the offence. The committee has not found any directly comparable figures for the general population. The 2005 Survey of Living Conditions indicated that 3 % of the population had received medication for mental health problems in the last 12 months, while 24 % of the people with a lot of mental health problems had received this kind of medication.[20] In other words, here too we find overrepresentation.

The most common medication was anxiolytics, usually benzodiazepines and antipsychotics (table 8.4). Comparing our figures with the survey of living conditions from 2005, we see a higher proportion of people taking anxiolytics compared with the proportion of people taking antidepressants than expected.[21]

Most of the perpetrators had only one category of medicine (24 people), but 12 people had two categories, and four people had three different categories of medicine, while one person had medicines in four of the categories listed in the table. 14 of the people on antipsychotics were also medicated with other medicines, mainly anxiolytics (nine), antidepressants (six) or mood stabilizers (six). Similarly, there were ten people taking a combination of anxiolytic and other medication, mainly antipsychotics (nine), while some people

20. Dalgard, 2008

21. Dalgard, 2008

Table 8.5 Use of medicines at the time of the offence (N = 41)

	Yes	No	Unknown	Per cent negative
Was there any information indicating problems linked to the prescription or dispensing of medicines?	24[1]	16	1	60 %
Did the perpetrator take the medicines as prescribed in the last month before the incident?	12	14[2]	15	54 %
Did the perpetrator complain of any side effects of the medicine?	11	18	12	38 %

1 These 24 perpetrators included 17 people with addiction-related diagnoses, ten people with a personality disorder, and seven people with schizophrenia or paranoid psychosis.
2 In 13 cases, the data indicates possible reasons why the perpetrator was not taking his/her medication as prescribed at the time of the offence: substance addiction (six), lack of insight into their illness (four), side effects (one), other reasons (two). 11 of the 14 perpetrators who did not take their medication as prescribed had an addiction-related diagnosis, six had a diagnosis within the schizophrenia spectrum, and four people had a personality disorder. We have information about whether the patient had been followed up with regard to his/her failure to take the medicine as prescribed in 12 of the cases. In three of the cases, the patient had not been followed. In seven cases, the patient had received information about the possible consequences or had been encouraged to take the medication through direct contact, and in one case the patient had been committed because of their failure to take prescribed medication. Ten of the 14 cases of failure to take medication as prescribed pertained to antipsychotics. In seven cases, anxiolytics had been prescribed, mainly diazepam (five cases). Some of the perpetrators who did not take their medication as prescribed had been prescribed mood-stabilizers (three), antidepressants (two), or medication for ADHD (two).

combined them with anticonvulsants (three), antidepressants (three) or medicine for ADHD (two).

Like the other perpetrators, roughly two out of three offenders who were on prescription medication were intoxicated at the time of the offence. There are no differences between the different categories of medicines, with one exception. Of the 12 perpetrators medicated with diazepam, 11 were intoxicated: on alcohol (nine) and/or drugs (eight) at the time of the offence. Most (ten) of the perpetrators medicated with diazepam had a substance use diagnosis (F10–F19). It is uncertain why such a large proportion of the perpetrators on diazepam had substance use problems. As far as the committee knows, there is nothing to suggest that this would be a preferred medicine for people with substance use problems. As discussed in the chapter on substance use, combining alcohol and benzodiazepines increases the risk of violence. We cannot conclude that this is why the homicide happened in these cases, but it may have been a contributory factor. In four of the cases, the perpetrators were also receiving antipsychotic medication.

There was information indicating problems linked to the prescription and dispensing of medicines for relatively many of the perpetrators (table 8.5). However, there was information about very many different circumstances: indications of overmedication (six cases), rapid termination of the medication by the patient without an agreement with the doctor (six cases), possible unfortunate decision to terminate the prescription of medicines by a doctor (three cases), a lot of changes of medications (three cases), practical problems linked to dispensing the medicine (three cases), financial problems preventing prescription or dispensing of medicines (two cases), and aggression from patients who wanted to have medicine prescribed (two cases). People with addiction-related diagnoses were clearly overrepresented among cases where there were indications of problems with the dispensing or prescribing of medicines. The committee has the impression that this also applies in cases where it has been difficult to create stability in other types of treatment.

Box 8.10 Statement from an offender about of his misuse of medicines

«I tried hashish for the first time at the age of 17. I was probably about 19 when I tried amphetamines. I think I was about 18 years old when I first got valium from the doctor. Later on I was put on regular tablets. In the end, I was taking 100 Vival and 100 Paralgin Forte (a month). Later I was also given Somadril as well. I have worked out that I must have had almost 25,000 tablets prescribed in the last 6–7 years. I ought to have been having my dose reduced, but I was addicted to the pills, so I was more than happy to get pills. I was also getting high on other drugs too ... I took amphetamines almost every day.»

The committee's overall impression is that many of the perpetrators had difficulties following a stable course of medicinal treatment for various reasons: such as aspects of the perpetrator's situation or factors attributable to the assistance agencies.

Another factor is that there seems to have been an unfortunate combination of medication with benzodiazepines and misuse of alcohol and/or drugs.

8.3.7 Follow-up of people with schizophrenia/paranoid psychosis

8.3.7.1 Introduction

As described in chapter 5, there were 23 perpetrators with either schizophrenia (20 individuals) or paranoid psychosis (three people) at the time of the offence. The committee's review reveals basically the same findings for this group of patients as for the sample as a whole, as described above. There appears to have been a lack of risk assessments. In some cases, discharge from an emergency or inpatient facility appears to have happened fairly abruptly, and in a few cases without the necessary planning and transfer of information. A large proportion of the perpetrators who had been prescribed anti-psychotic medication were not taking their medications as directed. A large proportion of them also had harmful use of alcohol or drugs, but had not received any treatment for this, despite the fact that a number of them had had their substance abuse assessed.

Box 8.11 Statement from an offender about a meeting with his doctor when he started to have serious health problems and could no longer work

«I told my doctor that I had problems and couldn't work. But I didn't get any help, and I didn't know that I had psychosis. My doctor said I was lying to get sick leave.»

All in all 11 of the perpetrators had been diagnosed with schizophrenia or paranoid psychosis before the incident, while 12 received this diagnosis in connection with the forensic psychiatric evaluation. This is not a large proportion of people with undiagnosed schizophrenia, compared with what we can expect to find in the population in general. For example, a meta-analysis of 188 prevalence studies found a lifetime prevalence of 0.4 %, while a study that also examined people who tend not to be captured in studies found a lifetime prevalence of 3.5 %.[22]

8.3.7.2 Aspects of discharge from an emergency/inpatient facility

A total of 15 out of the 23 individuals with schizophrenia or paranoid psychosis had previously been admitted to an emergency ward (14 persons) and/or an inpatient facility (eight people) for mental health problems. Most had been hospitalized once (six) or twice (three) or three times (three), while three people had been hospitalized ten or more times.

A question often raised in connection with such seriously ill patients is whether they were discharged too early and whether they commit homicide shortly after discharge. There was one patient who was hospitalized at the time of the offence, and one person committed homicide a few days after discharge. Otherwise, none of the people in our sample committed homicide within two months of hospitalization. It is therefore not possible to conclude that this is a general problem associated with homicide committed by people with schizophrenia.

As was the case for patients in general, outpatient follow-up after discharge had not always been initiated. This was the case for three patients who had last been discharged from an emergency ward and one patient who had last been discharged from another kind of inpatient facility.

The circumstances surrounding discharge from emergency and inpatient facilities appear to have been fairly similar for perpetrators with schizophrenia to those for the other patients. As for the other patients, a large proportion of the offenders with schizophrenia did not have gradual discharge from the emergency or inpatient ward (9 out of 13 people). However, the information shows that the patient had been involved in planning the discharge in almost all the cases and that there had been a discharge conversation. In most cases, the patient was informed about further follow-up and who their contact person was (8 out of 11 people). In six out of seven cases, close relatives were informed about the discharge. In 10 out of 13 cases, there was documentation of contact with other assistance agencies before discharge, but in five of the cases there was no evidence that these had accepted responsibility for further follow-up and that a contact person had been assigned. In nine out of 11 cases, the patient's housing situation had been resolved before discharge. There was an individual plan and treatment coordinator in three out of 12 cases. In 10 out of 12 cases, transfer of information to the next assistance agency had been ensured, for example through transfer of a summary of the case records. A violence risk assessment had been carried out in four out of 11 cases. A violence risk assessment was not required pursuant to section 2.2 of IS-9/2007 in four cases, and in three cases a required risk assessment had not been performed. Violence risk assessment ought to have been carried out in three cases of recent acts of violence or serious threats involving weapons. In two cases, there are also indications that an existing violence risk was not dealt with as stipulated in section 2.3.3 of IS-9/2007. One case pertained to reversal of a decision ordering compulsory treatment by a judge where the risk of danger was commented on, and the other pertained to a case where violence risk was not assessed and no post-discharge follow-up was planned. In addition, there was one case where no measures were implemented because the violence risk was considered low, in spite of several previous violent incidents. A year or more had passed between discharge and the homicide in all these three cases.

8.3.7.3 Aspects of the last contact with an assistance agency

A total of 20 people had had contact with an assistance agency for mental health problems. In the majority of cases (17 people), this contact had lasted for more than one year. Most of the people (19 people) had also had this kind of contact in the last 12 months before the incident. Ten people had had contact with the assistance services in the last week before the incident. This corresponds to the findings from England and Wales, where 44 % of the perpetrators with schizophrenia who had been in contact with assistance agencies had had contact with them in last week before the incident.[23] The most common agency with which the patient had

22. Mykletun et al, 2009

23. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006

Table 8.6 Aspects of the last contact with an assistance agency for mental health problems for perpetrators with schizophrenia or paranoid psychosis (N = 19)

	Yes	No	Unknown	Per cent negative
Did the perpetrator attend their last appointment with the assistance agency?	12	5[1]	2	29 %
Was a risk assessment for violence carried out at the last contact or earlier?	4	9	6	69 %
Were there clear signs of emotional instability at the last contact?	9	7	3	56 %
Were there clear signs of a depressive disorder at the last contact?	6	10	3	38 %
Were there clear signs of deterioration in physical health at the last contact?	3	11	5	21 %
Were there clear signs of delusions or hallucinations at the last contact?	8	7	4	53 %
Were there clear signs of delusions or hallucinations with violent content at the last contact?	2	11	6	15 %
Were there clear signs of hostility at the last contact?	3	12	4	20 %
Were there clear signs of increased use of alcohol at the last contact?	0	15	4	0 %
Were there clear signs of increased use of other drugs at last contact?	4	12	3	25 %
Were there clear signs of recent self-harm at the last contact?	0	17	2	0 %
Were there clear signs of suicidal thoughts at the last contact?	1	16	2	6 %
Were there clear signs of non-psychotic violent ideas at the last contact?	1	14	4	7 %
Were there clear signs of recent stress at the last contact?	7[2]	8	4	47 %

[1] In four out of the five cases where the perpetrator did not show up at their last appointment, the personnel managed to get in touch with him/her by telephone or by going to their home. In one case, no attempt was made to contact the patient.
[2] Recent stress was related to moving house (four cases), committal (two cases), increasing paranoia (two cases) and family conflict (one case).

had recent contact was the outpatient specialist services for mental health (seven people), their GP (six persons) and an inpatient facility (four people). The last contact was most frequently a routine appointment (eight people), but in four cases the reason for the last contact was an acute situation.

Since most of the perpetrators with schizophrenia were in contact with assistance agencies, it is pertinent to investigate whether there were warning signs at the last contact that the assistance agencies ought to have noticed. In this context, we are focusing on the 19 individuals who had contact with an assistance agency in the last 12 months (table 8.6). As we have seen elsewhere, here too there are many cases where violence risk was not assessed. In some of these cases, a violence risk assessment was mandatory. However, we cannot tell whether a risk assessment would have resulted in different treatment or prevented the homicide.

The majority of patients demonstrated clear signs of emotional instability, depressive disorder and/or delusions or hallucinations at the last contact. These are symptoms of the disorder, and it is difficult to say retrospectively whether these symptoms were increasing or not before the incident. However, it is likely that these were symptoms that it would be natural to treat. Nevertheless, there will always be disagreement on what type of treatment would have been most appropriate in each case and whether the treatment that was given was sufficient. Because of the lack of directly comparable data, it is also difficult to know whether these symptoms were more prevalent in these patients than among similar patients who did not commit homicide.

8.3.7.4 Medication

Ten of these 23 perpetrators had a prescription for anti-psychotic medication at the time of the offence. Seven of these were not taking the medication as prescribed at the time of the offence. Although five people complained of side effects of the medication, it appears that the main contributing cause of failure to take medicines as prescribed was lack of insight into their disorder (five per-

Box 8.12 Statement from an offender with harmful substance use and psychoses on follow-up after discharge from hospital

«Then I was on a couple of injections every two weeks. I did this for about two years. But then I started to feel that the injections weren't working any more, as I was starting to lose my temper. That might well have been the beginning of a new psychosis. So I stopped getting the injections then, but I still didn't get any follow-up from the doctor who had prescribed the injections.»

sons). Side effects (one person) or substance addiction (one person) were also contributing factors. According to the information at the committee's disposal, only one of these people was not followed up with regard to his/her failure to take the medicine as prescribed, whereas there is documentation that four individuals were followed up. Although the majority of the offenders were not taking their medicine as prescribed at the time of the offence, this does not allow us to conclude that this has been a contributing factor in the homicides. We do not know what would have happened if these individuals had taken their medication as intended. In the light of current medical knowledge, it is probable that taking their medication as prescribed would have lowered the risk of violence for some of the people.

8.3.7.5 Combined substance use and schizophrenia/paranoid psychosis

Twelve of the perpetrators with schizophrenia or paranoid psychosis were intoxicated on alcohol and/or drugs at the time of the offence, and nine were not under the influence of alcohol and/or drugs. There was no information on intoxication at the time of the offence for two people. Eight of the 23 individuals had a dual diagnosis with diagnoses in the substance use area (F10–F19) and schizophrenia (F20–F29). The most common substances that were used in the last month before the homicide were: alcohol (5 out of 12 people), cannabis (4 out of 13), amphetamines (4 out of 13) and opiates (2 out of 14). 16 of the people had a history of harmful use of alcohol and/or drugs, most of whom (13 people) had had harmful use in the last three months before the offence.

One offender was taking a larger dose of benzodiazepines than prescribed by the doctor in the month before the incident, and two people had prescriptions for Diazepam.

The majority (ten individuals) of the people with harmful use of alcohol and/or drugs had had their substance use problems identified and assessed and were deemed to be entitled to health care for them. Some people had not had their substance use assessed (six persons).

Although their substance use had been assessed, only three of the people had received treatment for harmful alcohol and/or drug use. Two of the people had undergone integrated treatment where a substance use disorder and mental disorders were treated at the same time by a single team of therapists, as opposed to sequentially in time or in parallel at different treatment institutions. Two people had undergone interdisciplinary specialized drug and alcohol treatment (TSB) consisting of services provided by health personnel and social workers.

8.3.8 Summary of the findings from the committee's review

A large proportion of the perpetrators had had contact with assistance agencies because of mental health problems, and over half had had this kind of contact in the last year. The most commonly used assistance agency was the individual's regular doctor, but a large proportion of the sample had also used the outpatient specialist health services and inpatient facilities. There was also a large proportion of people who for various reasons had had contact with other assistance agencies, such as NAV, social services, the correctional services and, in the past, child welfare services.

The majority of the perpetrators who had been in contact with an assistance agency in connection with mental health problems had displayed signs at the last contact that could indicate increased risk of exercising violence. However, it is not possible to tell if there were more such warning signs in our sample than in similar groups of patients who have not committed homicide. The data suggested that risk assessments for violence had been performed less frequently than recommended.[24] However, it is not possible to tell if these kinds of assessments were performed less frequently for the perpetrators in our sample than for patients who do not commit homicide. Previous reviews suggest that inadequate routines for violence risk assessment may be a general problem in the some parts of the mental health services.[25] It is not possible to tell

24. Directorate for Health and Social Affairs, 2007a

these kinds of shortcomings have been contributing factors in the homicides.

It appears that patients are often discharged from emergency and inpatient facilities quite abruptly. This may be one of the reasons why we did not find adequate documentation of plans for and information about further follow-up after discharge. Individual plans had seldom been prepared and a coordinator had rarely been designated when the patient was discharged. There was also often a lack of information about who had assumed which responsibilities for follow-up after discharge. In approximately one in three cases, outpatient follow-up was not started after discharge. In some cases, homicide was committed by people who were waiting for admission to an inpatient facility.

As the committee has limited information on the assistance the perpetrators received from assistance agencies such as NAV, social services, the correctional services and child welfare services, it is not possible to say anything about the quality of these services.

Most of the perpetrators who had been prescribed benzodiazepines had addiction-related problems and were intoxicated at the time of the offence. It was not uncommon for the perpetrators to be on a combination of antipsychotics and benzodiazepines.

The committee got the impression that it has been difficult to create a stable treatment situation for some of the perpetrators; for example, there have been problems ensuring stability in the medicinal treatment. This applied particularly to perpetrators with addiction-related diagnoses. A relatively large proportion of the patients did not take their medication as prescribed; this applies particularly to anti-psychotic medication.

The committee's review shows that some patients received a new diagnosis after the incident. This was the case for half of the perpetrators with schizotypal symptoms. This is common among people who do not take lives too. The committee has also found that even though people have only been officially diagnosed with, say, schizophrenia after they had committed homicide, most had received assistance for mental health problems before the incident. The committee cannot conclude that misdiagnosis or a lack of diagnosis has contributed to the perpetrators taking lives. Nevertheless, international research indicates that measures to identify people with schizotypal problems at an early stage and start treatment are cost-efficient measures that help the patients have a better life.[26]

Most people with a dual diagnosis of schizophrenia and substance use problems had had their substance use problems identified and assessed, but had not received treatment for them.

No difference was found between the perpetrators with personality disorders and the perpetrators without these kinds of disorders in terms of how many had had contact with assistance agencies in connection with their mental health problems. This may thus indicate under-consumption of mental health services by this group of patients.

8.4 The committee's advice

This section focuses on possible weaknesses in mental health care. It is important to remember that identification of weaknesses does not necessarily mean that the homicides that have occurred would have been prevented if it were not for the weakness. The committee's advice aims to counteract detected weaknesses and specify measures to prevent serious violence and homicide, regardless of whether weaknesses have been found. In other words, the advice is based both on the committee's review of the cases and on previous research concerning measures.

Previous studies consistently show that countries with low inequalities have less violence and homicide.[27] Economic progress and general social assistance will thus probably have a preventive effect.[28] This means that it is important to ensure assistance for everyone who needs treatment for mental disorders. The general objective of providing the right treatment at the right time for everyone who needs it is thus essential.

The committee's review of the follow-up the perpetrators had received before they committed homicide has mostly yielded information about the specialist health services. However, the data show that the most common contact person is the individual's regular doctor. The municipal health and social services will also play an important role for many patients. The committee's review indicates that collaboration across agencies and treatment levels is not always satisfactory. This applies to collaboration between emergency and inpatient facilities and outpatient specialist health services, and

25. Norwegian Board of Health Supervision, 2009

26. McCrone, Knapp, & Dhanasiri, 2009
27. Wilkinson & Pickett, 2006
28. Finkelhor & L. Jones, 2006

Box 8.13 Statement from someone close to one of the offenders about the regular GP scheme

«The regular GP scheme where doctors have very many patients should be thoroughly evaluated in relation to this kind of follow-up. Because the system is organized such that you have to go through your regular doctor, how quickly you get to see a psychologist depends entirely on the doctor following through. If it is a bit of a production line, with patient after patient all day long, which I think it is for many GPs, people who need psychological help do not get the follow-up they need.»

between specialist health services, GPs and municipal health and social services.

Similar deficiencies were also found in the evaluation of the escalation plan for mental health.[29] The Coordination Reform implies a continuation of the escalation plan with a continued increased degree of transfer of responsibility for treatment from the specialist health services to the municipal level. The reform should be implemented in such a way that regular GPs and health personnel in the municipal health services are ensured both the expertise and the resources to treat patients properly. The opportunity should be afforded for the assistance agencies to treat the most challenging patients.

The committee recommends that for patients with a high risk of violence, close collaboration must be ensured between the specialist health services and the first-line services. Continuity of care must be established in the health service, including in cases where the responsibility for patients is being transferred from one agency to another. It must not be possible to discharge patients with continued assistance needs from one treatment level before binding agreements on further follow-up and collaboration have been secured. Responsibility groups, individual plans and crisis plans are useful tools for ensuring collaboration between different assistance agencies. More resources ought to be allocated to the specialist health services for guidance and collaboration linked to patients for whom the front-line services have taken over the bulk of the routine treatment and follow-up.

The committee's review reveals room for improvement in the mental health service in terms of use of structured clinical tools for risk assessment. This is also supported by previous reviews by the Norwegian Board of Health Supervision. Exactly how such improvements can be effectuated must be considered. See also chapter 9 on risk assessment.

The committee's review also indicates that patients ought to be ensured follow-up after discharge from emergency and inpatient facilities. Patients who need follow-up must not be discharged until responsibility for further follow-up has been agreed. Arrangements for further follow-up must be communicated to the patient and, as appropriate, relatives before discharge. An individual plan and/or responsibility group meetings can be good tools to ensure continuity. The evidence suggests that gradual discharge ought to be used more frequently than is currently the case. It ought also to be considered whether inpatient facilities should have a stronger focus on aftercare and collaborate more closely with other assistance agencies after discharge than is currently the case. If patients are discharged from emergency or inpatient facilities without further follow-up from these institutions, the knowledge established during hospitalization will not be exploited efficiently.

Very many of the people with a severe mental disorder will need assistance from NAV or the social services. The committee found that this was the case for the majority of people who take life. The evaluation of the escalation plan pointed out that there was little collaboration between the mental health service and NAV/the social services.[30] It is difficult to provide good treatment and difficult for patients to receive the treatment if primary needs such as a stable housing and financial situation have not been secured. It is therefore important that collaboration with NAV/social services is a priority. It is possible that changes ought to be made to the rules on the duty of confidentiality (see chapters 10 and 11) to enhance the opportunities for close collaboration. This will also require changing priorities in NAV/social services. It is outside the committee's mandate to discuss these kinds of changes in more detail. However, the committee recommends that ways to improve the collaboration between NAV/social services and the mental health services be considered. This is especially important for people with a combination of severe mental illness, substance use disorders and personality disorders and who have extensive needs for help from NAV/social services.

29. Brofoss & Larsen, 2009

30. Brofoss & Larsen, 2009

Creating continuity and cohesiveness in treatment is a challenge, especially for people with problems linked to substance use. These are often people who can be difficult to treat, and it appears that the needs of this patient group are not currently being taken care of satisfactorily. See chapter 7 for the committee's recommendations concerning measures for patients with substance use disorders in combination with other mental health problems. The committee would nevertheless like to emphasize that patients with a combination of addiction-related diagnoses and, for example, schizophrenia or anti-social personality disorder, should be ensured stable, coordinated, integrated treatment.

Stable mental health services should be ensured in the form of outreach activities for patients with serious mental disorders who have not had or have lost contact with the health service.

It was not found that are more cases of problems of inadequate treatment for people with schizophrenia-related problems among the perpetrators than among those with these kinds of disorders in the general population. The committee would nevertheless strongly recommend measures to ensure early detection and treatment of psychoses. This will be cost-effective for society, give the individuals a better life and perhaps contribute to less violence in the future in this patient group.[31]

A large proportion of the perpetrators with schizophrenia/paranoid psychosis had trouble maintaining and following through on stable medicinal treatment over time. The committee did not get the impression that this group of patients was offered less stable treatment than others patients. In the event of indications that antipsychotic treatment has been discontinued abruptly, the assistance agencies should take active steps to reach these patients.[32]

The committee's review indicates that a guide should be prepared on medication specifying restrictive use of benzodiazepines for patients with addiction-related disorders, personality disorders or psychotic states (see chapter 7).

It is important that people with psychotic disorders receive adequate help to prevent relapses with active psychotic breakthrough. It is outside the committee's mandate to consider the framework within which this kind of assistance should be provided, for example, by increasing admissions or by increasing home-based services. It is also beyond the committee's mandate to discuss which methods should be used in treatment. The committee has not found research that demonstrates that the decline in the number of hospital beds has resulted in an increase in the number of homicides in Norway or in other countries. The optimal number of beds is a professional, ethical and political issue that is outside the committee's mandate. It is also outside the committee's mandate to discuss what is the ideal number of beds in the mental health services to meet the needs for necessary health care and prevent violence and homicide.

Box 8.14 Statement from someone close to one of the offenders about prescription of medication

«I called the GP and said he had to stop prescribing pills. One time I was quite shocked, because I was told that it is better that he gets them from me than going out and buying them on the street. They said this matter would be reported to the chief county medical officer, but it hasnt been. I think this GP ought to have his knuckles rapped.»

People with antisocial personality disorder can pose a major challenge for the treatment system. A substantial share of people who exercise violence have these kinds of disorders. There are currently very few treatment options for this group of patients, and in some cases they are excluded from treatment. They are less likely to seek help than many other patient groups. The committee recommends development of a treatment programme adapted to people with antisocial personality disorder who exercise violence.

Certain forms of treatment for people at risk of exercising violence have been further developed in Norway and are in use here today (see boxes 8.1 and 8.2 and chapter 9 on risk assessment). Therapeutic methods at groups at risk of violence will often be specially adapted for people with antisocial personality disorder. The committee considers it important that this kind of treatment is supported and developed. See chapter 7 for a more detailed discussion of people with a combination of a personality disorder and a substance use disorder.

The committee's investigation did not find any instances of infanticide (killing an infant under the age of one year). International studies have found that statistically people are at the greatest risk of being killed just before their first birthday.[33] The committee does not know why there were no instances of infanticide in the period. We recom-

31. McCrone et al, 2009
32. Brookman & Maguire, 2004

mended that it be assessed whether infanticide is underreported in Norway or whether we have a lower incidence than other countries.

Violence and murder perpetrated by a person's current or former intimate partner is an important research topic at present, and there is a great deal of knowledge about this internationally. However, gender roles in Norway and the Nordic countries are different to those in many other countries. There is therefore a need for more knowledge about causal mechanisms and possible measures based on research performed in Norway. The committee recommends that research in this area be given priority.

There is a lot of research-based knowledge about the correlation between alcohol and violence. Other drugs have become more common in recent years, but there is not as much knowledge about the correlations between these drugs and violence. It is recommended that research on the relationship between drugs and violence be given priority. Priority should be specifically given to research on benzodiazepines, possibly in combination with other drugs, and violence.

There are limits to what a committee can achieve within tight time limits. The committee recommends establishment of a system that ensures a continuous research-based review and analysis of all the homicide cases in Norway. In contrast to established systems, like the reviews by the Norwegian Board of Health Supervision and the police, the primary aim should not be finding fault with the health personnel, or tortious conduct or culpability in individual cases. The supervisory function is currently exercised by Norwegian Board of Health Supervision in the Counties and Norwegian Board of Health Supervision, and the committee is not recommending any changes in this area. The purpose of the new system being proposed should be to promote continuity in the development and generation of knowledge. It is recommended that the task be ascribed to established research groups. There are a number of similarities between suicide and homicide, and it is recommended that the same research institute investigates both topics. Knowledge development should be research-based, and it should be considered what methods can be used to investigate the causal factors of the homicides and suicides and consider what interventions can be made in these areas in Norway. The methods will probably have to be longitudinal and population-based, but this must be considered further by the research groups that it may be pertinent to commission to perform this ongoing research. There are few homicides per year in Norway, and the opportunities for pan-Scandinavian cooperation on a continuous knowledge development project of this nature should be explored.

The committee interprets its mandate as stating that it should also describe the few homicides in Norway committed by people with severe mental illness and to stress how rare it is that they kill strangers. This means that there is no reason to stigmatize people with mental illness by creating the impression that they often take lives. In this respect, the committee is referring to the media's extensive coverage of murders committed by persons with serious mental disorders or people who have had contact with the mental health services. Analyses have shown that the media focus more on the relationship between mental illness and dramatic violent episodes than is justified by the facts.[34] This can lead to stigmatization of individuals with mental disorders in general, create uncertainty among health and social workers, and have other adverse social consequences. It should also be stressed that the media have a more restrictive policy in terms of how they portray suicides compared with homicide. It is outside the committee's mandate to assess the role the media play, but the committee would like to be so bold as to point out the media's role in contributing to the public's fear of homicide committed by people with mental disorders and is taking this opportunity to recommend that the media consider their practice.

It is impossible to prevent all homicides. The committee would like to stress that Norway is one of the safest countries in the world to live in, with a low homicide rate (see figure 5.2). It appears that some parts of the population are more worried about homicide and violence by people with mental illness than warranted. It will therefore be important that actual knowledge about the relationship between mental illness and violence is communicated to the public when murder cases are discussed. This can be done in this report, by the decision-making authorities and educational institutions and through the media.

33. Brookman & Maguire, 2004; The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006

34. Edney, 2004; Magnusson, 2010; Morlandstø, 2006, Rasmussen & Höijer, 2005

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