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Authors' reply: Dr Buchanan notes that we allow an exception to 'pure' incapacity principles where a *serious* offence has been committed by a person with a mental disorder. We would allow the involuntary treatment of this narrowly defined subgroup of forensic patients under certain conditions, even if they regained capacity, to prevent harm to others. Buchanan believes this would discriminate unfairly between these patients and non-forensic patients. We are not convinced, however, that this would involve unjustified discrimination, because the commission of a serious offence constitutes a significant difference between their positions.

Nevertheless, Dr Buchanan's suggestion that convicted offenders might be given a choice, on disposition from the court, of accepting imprisonment or consenting to treatment in hospital deserves serious consideration. However, we think a time limit should still be placed on the period during which a patient could be treated in hospital on this basis. That time would be proportionate to the seriousness of their offence. Otherwise, the patient who accepts hospitalisation and treatment initially, but later refuses treatment when they regain capacity, would face return to court for resentencing for an indeterminate period. Or, if the patient were to make a rapid recovery with treatment, would discharge very soon after a serious offence be politically acceptable?

Professor Maden, as we understand it, fears that the legislation we propose would not reduce homicides by people with mental illness, but we have little knowledge of the effect of mental health laws on rates of serious offending. What is most likely to reduce rates of violence is early access to effective treatment. Our proposal would allow involuntary treatment for the right reasons at the right time, and it may permit intervention sooner than under the 1983 Act. Some people with personality disorders who pose a risk of harm to others may not meet our incapacity test, and the transitional position of such persons who are already detained in our mental health facilities would have to be addressed. However, on balance, we think our proposals are likely to reduce violence overall, by allowing earlier access to effective treatment for persons who are incapacitated, regardless of the cause.

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Violence and psychiatric morbidity

Coid *et al* (2006) reported an important cross-sectional survey of 8397 persons in UK households and found that psychosis was independently associated with a sixfold increase in the reporting of five or more violent incidents. Given the controversy and sensitivity over the stigma associated with psychiatric illness, particularly concerning public perceptions of links between psychosis and violence, this kind of result is prone to generate misleading impressions.

In a recent comprehensive review Hiday (2006) points out that surveys of this type are prone to exaggerate the contribution of mental illness and other diagnostic labels to violence as a result of several methodological weaknesses. The first is associated with the issue of comorbidity. It was not clear from the presentation of their data whether Coid *et al* were able to investigate the comorbidity of psychosis and other diagnostic categories and violence. It is possible that once comorbid substance misuse, personality disorder or other issues were taken into account, the unique contribution of psychosis to violence might have diminished dramatically (Hiday, 2006).

There is an even more fundamental problem that underpins violence surveys of this type: a neglect of the confounding factor that those with mental illness are more likely to reside in violent neighbourhoods and this could be the key predictive variable, not the illness itself. The term now used to describe the places where most people with severe mental illness live is 'socially disorganised communities', and these combine a multiplicity of factors that promote violence completely independently of psychiatric dysfunction (Silver *et al*, 2001). Features of these environments include chronic disabling poverty, few employment prospects or educational opportunities, decaying buildings and few amenities. In these neighbourhoods families and similar social institutions have broken down, leaving most individuals devoid of traditional social guidance and control (Swanson *et al*, 2002).

Living and growing up in such environments is possibly the key variable that predicts violence, not the mental illness of the individual (Hiday, 2006). Community household surveys such as that reported by Coid *et al* (2006) represent a unique opportunity to explicate the contribution of ecological factors when violence appears to be linked to mental illness. It would therefore be useful in terms of advancing the debate over the link between violence and mental illness if a wider theoretical background to such analyses could be encouraged in the future.

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Authors' reply: We do not want our finding of a sixfold increase in reporting five or more violent incidents in persons with psychosis to give a misleading impression regarding the association of violence with mental illness. This was the only finding suggesting increased risk and means that there is a small subgroup of people with psychosis who are repeatedly violent. The real message of our paper should have