

Buchanan, A. (2002) Psychiatric detention and treatment: a suggested criterion. *Journal of Mental Health Law*, **6**, 35–41.

Buchanan, A. (2005) Descriptive diagnosis, personality disorder and detention. *Journal of Forensic Psychiatry and Psychology*, **16**, 538–551.

Gunn, J. & Taylor, P. (1993) Ethics in forensic psychiatry. In *Forensic Psychiatry, Clinical, Legal and Ethical Issues* (eds J. Gunn & P. Taylor), pp. 857–884. Butterworth Heinemann.

Mullen, P., Briggs, S., Dalton, T., et al (2000) Forensic mental health services in Australia. *International Journal of Law and Psychiatry*, **23**, 433–452.

A. Buchanan Department of Psychiatry, Yale University, 34 Park Street, New Haven, CT 06519, USA. Email: alec.buchanan@yale.edu

doi: 10.1192/bjp.190.2.176a

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.

J. Dawson Faculty of Law, University of Otago, PO Box 56, Dunedin, New Zealand. Email: john.dawson@stonebow.otago.ac.nz

G. Szukler Institute of Psychiatry, King's College, London, UK
doi: 10.1192/bjp.190.2.177

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.

Coid, J., Yang, M., Roberts, A., et al (2006) Violence and psychiatric morbidity in the national household population of Britain: public health implications. *British Journal of Psychiatry*, **189**, 12–19.

Hiday, V. A. (2006) Putting community risk in perspective: a look at correlations, causes and controls. *International Journal of Law and Psychiatry*, **29**, 316–331.

Silver, E., Mulvey, E. P. & Monahan, J. (2001) Assessing violence risk among discharged psychiatric patients: toward an ecological approach. *Law and Human Behaviour*, **23**, 235–253.

Swanson, J. W., Swartz, M. S., Essock, S. M., et al (2002) The social–environmental context of violent behavior in persons with severe mental illness. *American Journal of Public Health*, **92**, 1523–1531.

R. Persaud Westways, The Maudsley Hospital, 49 St James Road, West Croydon CR0 2UR, UK. Email: R.Persaud@iop.kcl.ac.uk
doi: 10.1192/bjp.190.2.177a

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

been that the true risks of violence from people with psychosis, at the population level, are exceedingly small.

Professor Persaud's impression might be owing to the space in our paper devoted to discussing the public health impact of alcohol misuse and antisocial personality disorder on violence. In an additional paper published recently in the *American Journal of Epidemiology* we make the point about psychosis more strongly (Coid *et al*, 2006). Researchers with an interest in violence and psychosis often emphasise that relative risks of violence are greater for individuals with psychosis but they ignore the fact that illnesses such as schizophrenia are rare and that persons with psychosis account for an exceptionally small number of violent incidents at the population level. Detaining more persons with psychosis in hospital would have a very small effect in reducing violent crime (Fazel & Grann, 2006).

Misleading impressions based on relative risks are typical for homicides perpetrated by people with psychosis. These are often based on Scandinavian countries where the base rate is exceptionally low (Hodgins & Janson, 2002). In locations where the base rate is very high, for example certain areas in the USA and South American countries, people with psychosis hardly feature in criminal statistics.

Careful reading of our paper will reveal how we dealt with confounding from comorbid conditions. We agree with Professor Persaud's point about residents in violent neighbourhoods entirely, but the sampling frame was intended to exclude bias from factors such as socioeconomic deprivation. We used two-level hierarchical models throughout the analysis to take account of clustering from these areas. We would concede, however, that our study did not adequately explore the important issue of neighbourhood effects.

Coid, J., Yang, M., Roberts, A., et al (2006) Violence and psychiatric morbidity in a national household population – a report from the British Household Survey. *American Journal of Epidemiology*, **164**, 1199–1208.

Fazel, S. & Grann, M. (2006) The population impact of severe mental illness on violent crime. *American Journal of Psychiatry*, **163**, 1397–1403.

Hodgins, S. & Janson, C.-G. (2002) *Criminality and Violence Among the Mentally Disordered: The Stockholm Metropolitan Project*. Cambridge University Press.

J. Coid Forensic Psychiatry Research Unit, St Bartholomew's Hospital, William Harvey House, 61 Bartholomew Close, London EC1A 7BE, UK. Email: j.w.coid@qmul.ac.uk

M. Yang, A. Roberts, S. Ullrich Forensic Psychiatry Research Unit, Queen Mary College, University of London, London, UK

P. Moran Institute of Psychiatry, London, UK

P. Bebbington Department of Psychiatry and Behavioural Science, Royal Free and University College Medical School, London, UK

T. Brugha Department of Psychiatry, University of Leicester, Leicester, UK

R. Jenkins, M. Farrell Institute of Psychiatry, London, UK

N. Singleton Office for National Statistics, London, UK

doi: 10.1192/bjp.190.2.177b

Assessment of manic symptoms in different cultures

Mackin *et al* (2006) make a laudable attempt to evaluate cultural differences in the perception of psychiatric symptoms. Unfortunately, aspects of their methodology make it difficult to draw definitive conclusions. I will leave it for the statisticians to decide whether the sample sizes for the English and Indian groups ($n=20$ and 24 respectively) are large enough to allow the findings to be generalised. Given the authors' concerns about the influence of confounding variables on the findings, however, the disparity between the size of these groups and that of the American clinicians ($n=82$) is striking. A demographic breakdown of the various groups might have been useful in allaying these concerns.

A further source of potential bias is introduced by asking the participants to complete rating scales for only two patients of a single nationality. There is a risk that cultural differences between nationalities might influence attitudes as to what can be considered 'normal' behaviour for people of other nationalities. Certainly, an English psychiatrist whose expectations of a 'typical' American have been shaped by stereotyped media images might not be expected to register certain aspects of the patients' behaviour as pathological on the Young Mania Rating Scale. The threshold for recognition of manic symptoms might well have been different had they been asked to rate their own compatriots. More revealing conclusions could perhaps have been drawn had all participants been asked to complete rating scales for patients of a variety of nationalities, including their own.

The authors make a compelling argument about the potential consequences of

cultural differences in the recognition of symptoms of mental illness, and have provided a useful starting point for future discussion and research. Unfortunately, they fall short of proving these differences exist with their preliminary data.

Mackin, P., Targum, S. D., Kalali, A., et al (2006) Culture and assessment of manic symptoms. *British Journal of Psychiatry*, **189**, 379–380.

M. Sanderson Department of General Adult Psychiatry, Bushey Fields Hospital, Bushey Fields Road, Dudley, West Midlands, UK. Email: matthewsandell@aol.com

doi: 10.1192/bjp.190.2.178

The study of Mackin *et al* was interesting but so much highly relevant information is missing that it is hard to determine whether the findings have validity. The clinicians are effectively trial participants, yet we are not told the method of selection for doctors in each country. Training and employment structures are so different in the three countries that the clinicians are likely to have had very different degrees of experience and specialisation (the American system in particular favouring greater sub-specialisation). We are required to make the assumption that the groups are similar in all respects except the culture of the country of practice, yet there is no way to tell this without a socio-demographic profile of the participants from each country. There should be an attempt to make them representative of the total population of psychiatrists in their country in terms of ethnicity, gender and other factors which have a strong subcultural influence. There is no unifying 'culture' for psychiatrists in the UK, where at least one-third are trained outside the UK, and in some areas of the country the significant majority of doctors are non-UK-trained. Sampling such a small group from the UK ($n=20$) would be most unlikely to give a representative picture of British psychiatry as a whole. Similarly, India and the USA are also among the most multicultural countries in the world, and the same issues of systematic sampling bias apply.

Furthermore, we do not actually know the ethnic and cultural background of the two videotaped individuals with mania. They are described only as 'American' – but can this be a meaningful term when describing an individual's culture in such a varied society? The authors minimise the