Correspondence

EDITED BY KIRIAKOS XENITIDIS and COLIN CAMPBELL

Zero tolerance of violence

Behr *et al* (2005) raise important concerns about the relationship of mental health services with the government's Zero Tolerance Campaign against violence towards National Health Service staff. They argue that the suggested blanket exclusion of those with mental illness from this policy is stigmatising and may appear to condone violence towards staff by patients with mental illness. Clearly this would be a bad thing.

However, I have concerns about further justifications for excluding difficult patients from mental health services, this time under the guise of 'capacity'. We already have a variety of time-honoured procedures for doing this, such as geography ('not my catchment area') and diagnoses ('personality disorder' or 'drug-induced psychosis'). The authors seem to imply that patients either have or do not have capacity, failing to reflect the complexity of the law and the notion of capacity as a phenomenon that varies from situation to situation (in other words, with the gravity of the issue in question) and from time to time. It is not a static property of people, nor is it categorical.

Violent behaviour is often a symptom of mental disorder and may require intervention from mental health services. These individuals already have difficulty accessing services. I would argue that what they need is more not less. Clearly it is not acceptable for mental health professionals to be fearful for their own safety at work, and there need to be appropriate resources and settings in which to safely care for such patients. There is, however, undoubtedly an element of risk in working in such settings, which must be acknowledged and safely managed without being condoned. The criminal law applies equally to psychiatric patients, who should be prosecuted if they break the law, just as any other citizen. Perhaps in the world proposed by Behr *et al* police officers will be able to refuse to arrest violent people and prison officers refuse to attend to violent prisoners?

Behr, G. M., Ruddock, J. P., Benn, P., *et al* (2005) Zero tolerance of violence by users of mental health services: the need for an ethical framework. *British Journal of Psychiatry*, **187**, 7–8.

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Authors' reply: We are unsure whether Dr Wilson is suggesting that zero tolerance guidelines should not be applied to people who have a mental disorder or whether they should be abandoned altogether.

If the former, he perpetuates the stigma of mental illness and the public perception that psychiatrists are responsible for all actions of people receiving psychiatric treatment. Public attitude may affect people's volitional capacity (Mele, 2004). The view that all violent behaviour by users of mental health services is a manifestation of illness may therefore be anti-therapeutic by leading people to minimise their own sense of agency. If Dr Wilson is suggesting that the policy should be abandoned altogether, he is perpetuating the notion that people have unfettered rights to receive services. Our view is that this is not the case and that the rights of competent adults should be upheld in association with their observance of their duties.

Although we share Dr Wilson's concerns about the complexities of capacity assessments, ultimately it is these dichotomous judgements that determine whether people can consent to treatment, be allowed to take the consequences of self-harm or drug addiction and whether they go to jail or hospital for crimes they commit. If we reject the determinist stance that all actions by people with mental illness are undertaken because of their mental illness, it is hard to imagine a better way than by the assessment of their capacity to take responsibility for those actions in question.

Mental health workers, like prison officers, inevitably have to work with people who are aggressive and violent. It is appropriate that violence by prisoners should result in their freedom being further restricted. We believe that in addition to criminal prosecution, limiting or withdrawal of services may provide a similarly appropriate response to violence by capacitous users of mental health services.

Mele, A. R. (2004) Action: volitional disorder and addiction. In *Philosophy of Psychiatry: A Companion* (ed. J. Radden), pp. 78–88. New York: Oxford University Press.

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Domestic violence and female mental health in developing countries

We read with interest the article by Kumar *et al* (2005). In developing countries, where families are closely knit and cohesive, domestic violence was thought to be uncommon. However, studies of domestic violence in developing countries show a similar prevalence to that in developed countries. In Sri Lanka a survey at the out-patient department of the North Colombo Teaching Hospital in Ragama, a semi-urban area in the suburbs of Colombo, found that 40.7% of women had been abused by their partners (further information available from the authors on request). The abuse was physical as well as verbal, emotional and sexual and most women reacted in a submissive manner: 79% of those abused have stayed in their marriages for more than 10 years. This submissive behaviour could be because Sri Lankan women usually lack the means to leave their husbands and live independently and the fact that society looks down upon such women.

In a study in eastern Sri Lanka, Subramaniam & Sivayogan (2001) reported that most women, regardless of their level of education and their employment

https://doi.org/10.1192/S0007125000168874 Published online by Cambridge University Press