Correspondence

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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

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status, cited the welfare of their children as a prime reason for staying in an abusive relationship.

Parental separation is considered a risk factor for poor mental health in the offspring. Therefore parents staying together in marriage may protect their children from mental health problems. However, in our study children of 31% of the victims had witnessed the abuse. It has been demonstrated that emotional abuse in childhood has a major impact on adult mental health (Edwards *et al*, 2003). Kumar *et al* found that 56% of women who had been abused had poor mental health. Since parental mental disorder has been shown to be associated with psychological problems in the offspring (Rutter, 1966), it is doubtful whether staying in an abusive marriage is beneficial for the children.

Studies in developing countries repeatedly confirm that domestic violence is a problem that cannot be ignored and will significantly affect the mental health of future generations. We appreciate the efforts of Kumar *et al* in highlighting this issue and we consider the time has come to prevent this form of abuse in developing countries.

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Kumar, S., Jeyaseelan, L., Suresh, S., *et al* (2005) Domestic violence and its mental health correlates in Indian women. *British Journal of Psychiatry*, **187**, 62–67.

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Subramaniam, P. & Sivayogan, S. (2001) The prevalence and pattern of wife beating in the Trincomalee district in eastern Sri Lanka. *Southeast Asian Journal of Tropical Medicine and Public Health*, **32**, 186–195.

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Epidemiological approach to predicting psychiatric risk in the military

The warlike events resulting from terrorism in London on 7 July 2005 have again shown the importance of enhancing human resilience and give special relevance to June's issue of the *Journal*. In a marvellous overview, Professor Wessely (2005) gave us his thoughts concerning psychological trauma, modern psychiatric trauma concepts, and the emergence of new syndromes, especially in military settings.

Contrary to Professor Wessely, we are convinced that longitudinal selection provides considerable advantages for psychiatric risk management. Despite the unsatisfactory American experience with personality testing during the Second World War (Jones *et al*, 2003) our main field of activities is cohort-based psychometric screening and prediction models. In 2002, the Swiss Armed Forces assigned us to investigate new methods to predict psychiatric disorders in servicemen. At first we were sceptical that such a task could be fulfilled. However, we found prediction models to forecast outcome in emergency patients in the medical literature (Tuhrim *et al*, 1988). Furthermore, personality seemed to play some part in the outcome of somatic disorders (Eysenck, 1988) and suicide seemed predictable from demographic variables (Holinger *et al*, 1988). Consequently we investigated how these techniques could be transferred to psychiatry.

In a small preliminary (2002) study we screened 3000 recruits on their first day of basic training and followed their medical records for psychiatric problems. Based on clinical–epidemiological knowledge, logistic regression helped us to create a robust multivariable model. Since 2003 the model has been used by the Swiss Armed Forces for recruitment. The model compares each conscript with about 30 000 servicemen. As a result, subsequent psychiatric discharge on the grounds of receiving an ICD–10 (World Health Organization, 1992) diagnosis was significantly lowered by a factor of 3 (or 72%) compared with unscreened recruits. The personality trait of the conscripts did not have any impact.

We are convinced that our prediction model can be successfully adapted to any military service model and operational setting. Therefore, we believe it is too early to bid farewell to psychiatric screening systems in medical risk management.

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Jones, E., Hyams, K. & Wessely, S. (2003) Screening for vulnerability to psychological disorder in the military: an historical inquiry. *Journal of Medical Screening*, **10**, 40–46.

Tuhrim, S., Dambrosia, J. M., Price, T. R., *et al* (1988) Prediction of intracerebral hemorrhage survival. *Annals of Neurology*, **24**, 258–263.

Wessely, S. (2005) Risk, psychiatry and the military. *British Journal of Psychiatry*, **186**, 459–466.

World Health Organization (1992) *The ICD–10 Classification of Mental Health and Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: WHO.

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Author's reply: I thank Dr Vetter for his cordial letter. The question at issue is not whether or not it is possible to create a statistical model that can predict psychiatric breakdown in military recruits – that is certainly possible, as the experiences of the Second World War psychiatrists showed. The question is with what accuracy can one make such a prediction and what are the consequences for those both correctly identified and, even more importantly, those who have been incorrectly identified (the false positives). Dr Vetter does not provide sufficient information for us to make that judgement. What is needed is the sensitivity, specificity and most importantly the positive predictive value of whatever collection of variables he and his colleagues are using to determine the risk of future illness. It is this statistic that enables us to assess the utility of the proposed model.

Furthermore, we do not know what were the consequences of being labelled as at risk of psychiatric breakdown. Were these people denied military service? Switzerland is one of the increasingly few countries that still has compulsory military service. Serving in the Armed Forces is a fundamental part of the life of every Swiss citizen and enables a person to form social networks that operate for many years. Are people disadvantaged from being denied that opportunity? Given that the Swiss are also famed for their neutrality, the fall in psychiatric morbidity as a result of screening is not likely to be because those denied military service are not exposed to the risks of the battlefield. Instead it may be that their subsequent breakdown merely happens in another sector of Swiss life. Without data from a randomised controlled

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