

Zero tolerance of violence by users of mental health services: the need for an ethical framework

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Summary Concerns about violent conduct of service users towards healthcare staff have prompted a 'zero tolerance' policy within the National Health Service. This policy specifically excludes users of mental health services. We attempt to challenge artificial distinctions between users of mental health and other services, and propose an ethical underpinning to the implementation of this policy.

Declaration of interest None.

Over recent years, concern has been expressed about violence by service users directed towards healthcare staff. Nursing staff in the UK are four times more likely to experience work-related violence than other workers (Wells & Bowers, 2002). Violence towards doctors and other healthcare professionals has also been highlighted (Hobbs & Keane, 1996). In the face of these concerns the British Government launched the Zero Tolerance Zone Campaign, with the aim of reducing the number of violent incidents in the National Health Service (NHS) (Department of Health, 1999). As part of this initiative, hospital managers have been advised that it may be appropriate in some circumstances for violence against staff to lead to future treatment being withheld. The current policy states that withdrawal of treatment should not be applied to 'anyone who is mentally ill or under the influence of alcohol or drugs'. This caveat is important as psychiatrists and other mental healthcare professionals appear to be at greater risk of violence than those working in general hospitals (Health and Safety Executive, 2001). We believe that the exclusion of all people with mental illness or substance misuse

problems is unjustified and that an ethical framework needs to be established through which decisions about withdrawing and withholding healthcare can be considered. In attempting to establish such a framework, we believe that questions about the right of an individual to receive healthcare and the conditions of the implementation of such a policy need to be addressed.

IS HEALTHCARE A RIGHT?

Paying taxes for a service does not create an inalienable right to that service. For instance, children can be excluded from school if they repeatedly misbehave, and social services are not obliged to re-house someone if they are thought to have been responsible for their own homelessness. In other words, if the duties of the recipients of a public service are not fulfilled, this may compromise their right to receive those services.

The American Medical Association Code of Ethics (2002) has a chapter on 'Patients' responsibilities' which states,

'Like patients' rights, patients' responsibilities are derived from the principle of autonomy ... autonomous, competent patients assert some control over the decisions which direct their health care. With that exercise of self-governance and free choice comes a number of responsibilities.'

Eleven items are listed as patients' responsibilities, which include, among others, being cognisant of the effects of their conduct on others. Richardson (1993) has suggested that patients should be informed, as precisely as possible, what is prohibited and what the consequences of transgression will be.

Failure of patients to observe their responsibilities is not necessarily sufficient for withdrawing care (e.g. smokers are generally provided with treatments for illnesses associated with smoking). However, it may be that withdrawal of the service is rational and justifiable in circumstances where the action of the user:

- (a) negates the benefit of that person's treatment;
- (b) results in the diversion or depletion of resources to the detriment of others;
- (c) violates the autonomy and rights of health professionals and other patients who, arguably, have the right not to tolerate it.

These criteria are congruent with theories of morality such as Kantianism and utilitarianism as well as the four *prima facie* principles of medical ethics developed by Beauchamp & Childress (1989). Some, but not all, are listed in the NHS Zero Tolerance Policy as suggested thresholds for withholding of care.

We propose that access to healthcare is not an inviolable right but based on a relationship of good faith, in which there is no obligation for professionals to provide a service in the above circumstances.

WHO MERITS EXCLUSION?

It seems reasonable to exclude from this policy people who are violent as a result of health-related problems that impair their ability to make rational decisions about their actions. However the exclusion of anyone who is mentally ill or under the influence of drugs or alcohol appears to be at variance with policy and law in other areas. For instance, driving under the influence of alcohol is regarded as an offence and committing a crime under the influence of alcohol or drugs is not considered exculpatory. The assumption behind this is that adults are competent by default and able to predict that the use of such substances will increase the likelihood of rash actions or inadvertent harm. If an individual had diminished capacity to understand the impact of alcohol or drugs (or diminished ability to act in accordance with that knowledge), there may be grounds to exclude them from eligibility for withdrawing of treatment. However, apart from these instances, there seems little justification for this exclusion criterion. This is particularly pertinent in the light of a British Medical Association survey (2003) which showed that 73% of doctors in accident and emergency departments had experienced violence in the workplace, which is often associated with drug and alcohol intoxication.

Most people who experience a mental illness retain capacity, and to regard them otherwise (by default) is stigmatising

(Szmukler, 2001). The use of this term as an exclusion criterion for withholding services makes it impossible to allow appropriate action to be taken against capacious mental health service users who perpetrate violence/abuse. This apparent injustice may have important consequences for staff morale.

Mental health services are increasingly being asked to provide a service for people with personality disorders (National Institute for Mental Health in England, 2003). People with personality disorders such as antisocial and impulsive personality disorder exhibit high levels of violent and threatening behaviour. Allowing these people, most of whom are capacious, to take responsibility for their action is an important therapeutic tool; shielding them from the consequences of their choices has the potential for undermining this and perpetuating that individual's psychological problems.

Judging capacity to take responsibility for one's actions is not always straightforward, but attempting to answer that question directly is likely to yield a more ethically defensible result. The importance of this judgement is proportionate to the risks in each case, and it is worth noting that the consequences of overestimating capacity may have serious untoward consequences.

The key point is that, although mental illness may be a cause of incompetence, many people who experience mental illness retain competence and should therefore live by the same rules as the rest of society.

THE AIMS OF THE ZERO TOLERANCE POLICY AND FINDING THE BALANCE

The policy should aim to:

- (a) entrench the rights of and respect for the autonomy of health professionals (and other patients);
- (b) maximise benefit for all users of the service by:
 - (i) deterring future acts of violence/abuse;
 - (ii) enabling the just use of resources;
- (c) ensure that treatment for the perpetrator, provided within these parameters, is likely to be beneficial.

In primary care general practitioners are empowered to remove patients from their register. It then becomes the

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responsibility of the primary care trust to find care for that person elsewhere. The Zero Tolerance Policy for the NHS has the same requirement (although this is the responsibility of the trust rather than the primary care trust).

The requirement to ensure that care is provided elsewhere is not only logistically problematic (getting agreement to take on the care of a violent individual) but also ethically flawed. If treatment provided elsewhere would still conflict with the aims of the policy as above, no alternative care ought to be provided. The corollary, however, is that the minimum of care should be withheld which still allows these conditions to apply. For example, an offender at an out-patient clinic may be denied access to the specialist service but still be able to attend that pharmacy to receive medication.

The exclusion from the policy of people requiring 'urgent emergency treatment' appears to be a categorical distinction. The more serious and imminent the risk to health, the greater is the obligation to provide care. However, degrees of 'emergency' are a matter of judgement and the benefit of treatment needs to be weighed against the other objectives of the policy.

A policy will serve as a deterrent only if it becomes known widely that actions by individuals have incurred particular consequences. It is vital that staff and service users have the benefit of knowing (anonymised) outcomes.

Punishment, we would suggest, is not the role of the health service. Negative countertransference is a powerful source of punitive sentiments which may both lead to violence and to treatment being withheld subsequently. Watts & Morgan (1994) give useful pointers as to how to manage this phenomenon.

CONCLUSIONS

The introduction of the Zero Tolerance Policy in the NHS sends a clear message

to patients about their duties towards those who provide medical services. We believe that careful consideration of a patient's capacity, the benefit of treatment and the just distribution of resources provides a framework for extending this policy to people in contact with mental health services. Many NHS trusts have clinical ethics committees to help with vexing decisions such as these. Although the Zero Tolerance Policy gives broad direction and authority for action, more rigorous individualised decisions may be better made in such a forum.

REFERENCES

- American Medical Association Council on Ethical and Judicial Affairs (2002)** Opinion 10.02, patient responsibilities. In *Council on Ethical and Judicial Affairs, American Medical Association. The Code of Medical Ethics: Current Opinions*, pp. 140–142. Chicago, IL: American Medical Association.
- Beauchamp, T. L. & Childress, J. F. (1989)** *Principles of Biomedical Ethics* (3rd edn). Oxford: Oxford University Press.
- British Medical Association (2003)** *Violence at Work: The Experience of UK Doctors*. London: Health Policy and Economic Research Unit.
- Department of Health (1999)** *NHS Zero Tolerance Zone: We Don't Have To Take This*. Resource pack. London: Stationery Office.
- Health and Safety Executive (2001)** *Violence at Work: New Findings from the British Crime Survey 2000*. London: Home Office and HSE.
- Hobbs, F. D. & Keane, U. M. (1996)** Aggression against doctors: a review. *Journal of the Royal Society of Medicine*, **89**, 69–72.
- National Institute for Mental Health in England (2003)** *Personality Disorder: No Longer a Diagnosis of Exclusion*. London: NIMHE.
- Richardson, G. (1993)** *Law, Process and Custody: Prisoners and Patients*. London: Weidenfeld and Nicolson.
- Szmukler, G. (2001)** A new mental health (and public protection) act. *BMJ*, **322**, 2–3.
- Watts, D. & Morgan, G. (1994)** Malignant alienation: dangers for patients who are hard to like. *British Journal of Psychiatry*, **164**, 11–15.
- Wells, J. & Bowers, L. (2002)** How prevalent is violence towards nurses working in general hospitals in the UK? *Journal of Advanced Nursing*, **39**, 230–240.