Reply

DEAR SIRS

Dr Bridges is perfectly entitled to question the legal barriers or safeguards (depending on your point of view) set out in Section 57 of the Mental Health Act, and placed between the consenting patient and the clinical team recommending the surgical destruction of brain tissue for the treatment of mental disorder.

The commitment of the Geoffrey Knight Unit to the welfare of seriously mentally ill patients and Dr Bridges' therapeutic enthusiasm command respect from those who are familiar with this work. It is just such enthusiasm, regrettably associated with some distortion of the evidence for dramatic effect, which is likely to be seized upon by those who have reservations about permitting the interface between the mentally ill and vulnerable patient and a committed and convincing therapist to be regulated only by established professional ethics. Dr Bridges' statistical analysis of the mortality rates of patients before and after the amendment of the Act is methodologically unsound. One cannot compare the death of two referred patients who did not proceed to surgery with one death as a direct result of the operation. The small numbers cannot be interpreted meaningfully.

The Commission has consistently attempted to interpret the provisions of Section 57 in as flexible, responsive and humane a way as possible subject, of course, to the proviso that no deviation from the legal requirements of the section is permissible, however attractive that might be in an individual case.

We are always ready to consider suggestions for improving the way that the Commission operates the provisions for consent to treatment of the Act; changing them is a matter for Parliament, not the Commission.

The Royal College of Psychiatrists and other interested bodies and individuals may wish to consider proposing alternatives to the safeguards in Section 57, including giving consideration to whether developing psychosurgical techniques should be available for patients whose capacity to consent is questionable. However, these issues are not primarily the responsibility of the Commission except insofar as it has been directed to carry out the duties of the Secretaries of State under Section 120(1) to keep under review the exercise of powers and discharge of duties under the Act.

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Diminished responsibility: is it 'substantial'?

DEAR SIRS

As a practising forensic psychiatrist, I am not infrequently, called to Court on homicide cases to give expert opinion evidence as to whether the accused, at the time of the offence, was suffering from an abnormality of the mind, such as would substantially diminish his responsibility for his actions (Homicide Act, 1959). Recently I have been involved in several cases in which the main medico-legal argument has revolved around what is considered to be 'substantial'.

A typical case is as follows. Following a marital separation, perhaps accompanied by infidelity, the husband becomes emotionally distraught. He is unable to accept that his wife has left him, and a tragic homicide in the end occurs, probably under the disinhibiting effects of alcohol. In such cases the husband, in the period leading up to the offence, generally has a history of agitation, low mood, periods of tearfulness, disturbed appetite, sleep etc. He can thus be classified as suffering from a 'depressive disorder' of reactive type and can be categorised as having an 'abnormality of mind'.

If it is accepted that he is suffering from abnormality of mind, then the argument follows that due to this 'abnormality of mind', his judgement and ability to think through the consequences of his actions has to be, to some degree, impeded. Therefore an element of diminished responsibility must be present. The key question that then arises is whether his responsibility for his actions has been 'substantially' diminished or not. The forensic psychiatric expert witness is often expected by the Court to give a definitive answer to this question. In my experience, responses such as "I am not certain" or "It depends on what you mean by the word 'substantial' ", albeit that this is what the psychiatrist may really feel about a particular case, are liable to result in increased pressure from Counsel, and possibly the judge, to give a definite opinion one way or the other.

The above question, which can take a philosophical or semantic direction, is of great importance. If it is accepted by the jury that the word 'substantial' does not apply, then a murder verdict and life sentence will ensue. If, on the other hand, the word 'substantial' is thought to apply, then there will be a verdict of manslaughter, possibly a sentence of three to five years, and of course eligibility for parole once one third of the sentence has been served.

In the process described above, the forensic psychiatrist plays a key role in a medico-legal game of high stakes, which is quite far removed from medical or psychiatric expertise. At the same time, I remain fairly convinced that although success of a diminished responsibility defence should depend

upon the application of the definition laid down by the Homicide Act 1959, in practice juries may be more influenced by various intangibles, such as their emotional reactions to the circumstances, the skill and persuasiveness of defence and prosecution counsel, the attitudes of the Judge presiding etc. The final question is whether or not this process is a 'just' one. I have my doubts. I would be interested to hear the views of other forensic psychiatrists.

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The use of old and new antidepressants

DEAR SIRS

At a recent conference on the economic evaluation of antidepressant drugs, virtually all the speakers felt that the new antidepressants, being safer in overdose, should be prescribed in preference to the older tricyclic drugs which should no longer be considered a first line treatment for depression. One speaker highlighted the number of litigation cases in the United States against psychiatrists whose patients had committed suicide using these drugs.

What is being said? Is it now negligence to prescribe amitryptiline instead of say, lofepramine or fluoxetine? The professor of psychopharmacology believed that the new antidepressants were a safer alternative. The poisons expert said that there were almost 400 deaths per year associated with tricyclic overdosage and only a very small number associated with the newer antidepressants. The senior lecturer replied that there was overwhelming evidence that the new antidepressants were as efficacious as tricyclics and also safer. Only the professor of general practice disagreed and said there were many situations in which a sedative tricyclic would be his first choice.

The professor of psychiatry stated that it was for the courts to decide negligence. But, as opinion leaders, all the above speakers carry tremendous weight as it is they who are called as expert witnesses and their views will shape the law. I am happy to prescribe the new antidepressants but there are situations in which I would prescribe a tricyclic in preference. To imply negligence because one writes such a prescription is a very serious issue.

The grounds for concern over the tricyclic related deaths per million prescriptions seem vastly oversimplified. Who are these patients? What is their diagnosis? How careful was the prescription? Was a proper assessment of suicide risk made? Do patients who fail to kill themselves by taking an overdose of a new antidepressant go onto kill themselves by another method?

I would suggest it is time for the College to produce a consensus statement on the indications for the use of old and new antidepressants. It is too important an issue to be left to the courts to decide. Depression is our bread and butter and I for one do not wish to be that meat in the sandwich.

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Community homes run by untrained staff

DEAR SIRS

Increasing numbers of people suffering from chronic mental illness live in staffed private homes, often in seaside towns, run either for profit or by voluntary organisations. These homes are registered under the Residential Homes Act (1984), some of which have received criticism.

The failure of this legislation to address the standards of care has been often stated (National Institute for Social Work, 1988). The scandals of abuse and neglect in homes for the elderly and the ineffectiveness of the statutory supervision have been reported by the media.

An extraordinary home, where adults suffering from schizophrenia wore nappies, were fed baby bottles by the staff and stood in the corner when 'naughty' was the subject of a Radio 4 documentary (Face the Facts, 10 February 1992). Professor Leff stated that this environment was likely to provoke acute relapses in those residents suffering from schizophrenia.

Dr Graham Thornicroft and I recently surveyed a sample of staffed homes registered for the under 65s, in Southend-on-Sea (submitted for publication) and found them to be of a good physical standard. It was my impression that the staff in the homes were well motivated to care for their residents. However, care homes where none of the staff had had previous psychiatric nursing experience tended to allow their residents less autonomy than homes run by carers with psychiatric nursing qualifications. Environments where residents are allowed comparatively little autonomy, may tend to worsen patients' disabilities and were present in some hospitals 30 years ago (Wing & Brown, 1970). I would contend that since appropriate training has not been offered to lay carers in privately run staffed homes by the local psychiatric services, they have not assimilated the positive changes of psychiatric in-patient care, which over the last 30 years have led to increasingly less restrictive ward environments (Curson *et al*, 1991).

It is ironic that in the rush towards deinstitutionalisation, the impoverished social environments of