people with severe dementia to replace long-stay hospital beds. The Domus Project provides three – shortly to be four – homes for 12 people each, managed and staffed by our close collaborators, South London Family Housing Association. Consultant input is no less than when the beds were in the mental hospital – indeed it is somewhat greater and the work is infinitely more rewarding. The policy of the Domus homes of providing care for those who are most seriously disabled with severe behavioural problems is shared by members of the management committee which has a good representation of health service professionals. An early evaluation of the Domus Homes to be published shortly suggests that quality of care is significantly better than in conventional long-stay wards.

Benbow & Jolley are right to stress the importance of specialists being involved and committed to long-stay care provision but the best way to do this is by working jointly with the local authority and the independent sector. There are major benefits for patients in a collaborative approach, but consultants need to 'let go' a little and be prepared to share their resources. It is worrying to read how few have grasped the opportunities now available to improve the quality of long term care for their patients.

ELAINE MURPHY
ALASTAIR MACDONALD

UMDS
Division of Psychiatry
Guy's Hospital
London SE1 9RT

Diminished responsibility

DEAR SIRS

I read with interest the letter from Dr Green (*Psychiatric Bulletin*, August 1992, **16**, 511–512). The Homicide Ordinance of Hong Kong basically follows the Homicide Act of the United Kingdom.

Section 56(2) Mental Health Ordinance of Hong Kong stipulates that defendants of capital offence be examined and reported on the presence or absence of insanity and on fitness to plead. The report is sent to the Attorney General and Registrar of the Supreme Court. Defendants of murder cases are often seen when the trial date is drawing near, that is, months after the index offence. It is fully justified to assess fitness to plead near the court date. However, the forensic psychiatrists are then left with the formidable task of retrospectively addressing the defendant's mental condition at the time of the index offence.

The 'typical case' cited by Dr Green is not uncommonly encountered in Hong Kong. The defendant may give a history suggesting the presence of psychosocial stressors and depressed mood around the time of the index offence. During mental state examination, the defendant often just appears worried about the trial but does not exhibit any mood symptoms. In such cases, the definition of abnormality of mind in the Homicide Ordinance is relevant. The key issue is whether we consider the defendant's mental condition at the time of the index offence as arising from 'inherent causes'. This is the pre-requisite question which is subject to clinical scrutiny and which we have to answer before proceeding to the issue of responsibility. There are cases in which the defence proposes personality attributes as inherent causes and the forensic psychiatrist is certainly in the position to give his opinion within his professional expertise.

Concerning the question of diminished responsibility, I share the experience of Dr Green. After submission of a psychiatric report according to Section 56(2) Mental Health Ordinance, the Crown Counsel may have copied my report to the defence counsel who then writes to me asking for a definitive opinion on whether or not the criterion of substantial impairment of responsibility is satisfied. In fact, Section 56(3) of the same Ordinance explicitly states that a report submitted in accordance with subsection (2) shall not express any opinion as to the degree of responsibility of the defendant at the time when the index offence was committed. Obviously, the law is not putting any constraint on the psychiatrist's response to questions raised by the defence. However, when a psychiatrist is prepared to give a clear-cut answer to the question of diminished responsibility, he should bear in mind what he expresses may no longer be an independent expert opinion but a personal opinion carrying some subtle emotional element.

MICHAEL G.C. YIU

Castle Peak Hospital
Tuen Mun, Hong Kong

DEAR SIRS

Dr Green's letter (*Psychiatric Bulletin*, August 1992, **16**, 511–512) rightly casts a cold eye on the complex issues raised by a plea of diminished responsibility in homicide cases. To enter into such a debate, one is obliged to take on the thankless task of stalking the borderlands between law, psychiatry and philosophy, which like most border territories are matters of wars and disputes, of danger and confusion and most significantly of change and reversal.

The structure of section 2 of the Homicide Act 1957 has been criticised as being obscure and of dealing in unintelligible concepts. However, there is a clear and simple message underlying this piece of legislation, which is that criminal liability depends on mental responsibility and mental responsibility depends on abnormality of mind. Thus the Act includes one psychological assessment and two decisions about responsibility, viz. one attribute of

mental responsibility and one verdict which determines criminal liability. It allows that there are degrees of abnormality of mind, and degrees of mental responsibility, and that the more abnormal the less responsible. Finally, the terms found by the trial judge in R. v. Walden (1959) to express the matter before the jury, "... Well, really it may be he is not insane but he is on the borderline, poor fellow. He is not really fully responsible for what he has done ...", discourages the suggestion that either abnormality of mind or mental responsibility, or the relationship between them, can be quantified.

The states of mind which are crucial to the verdict are thought to be determinable by the common sense judgement and worldly experience of jurors. Whatever role the forensic psychiatrist plays, the only issue that is reserved to him as expert witness is the 'aetiology of the abnormality'. Whether the defendant exhibits abnormality of mind, and in particular the extent to which he exhibits abnormality of mind, is a question which the jury alone may decide. So heavy is this burden that juries do not often have to shoulder it. Susanne Dell (1982), in her analysis of how section 2 works in practice, points out:

> "... how rare jury trial is in such cases: 80 per cent are dealt with by guilt pleas. When the prosecution does challenge the defence, the defence is quite likely to fail: of 28 cases where this happened 18 (64 per cent) resulted in murder convictions."

The expert witness should always remind the court as to the limitations of his expertise, heeding Dell's cautionary note:

> "... although the presence or absence of mental responsibility is not a medical matter, doctors grapple with it; and in half the cases where they disagreed with each other on the issue of diminished responsibility, it was on the moral and not the psychiatric aspects of the case that they disagreed."

Dr Green doubts whether the process is a 'just' one. Depending on the circumstances, the killing of a human being may produce reactions ranging from applause to abhorrence and a desire for revenge. In times of peace the legal system is responsible for establishing the correct response within rules laid down by the parliaments. The essential structure of English law concerning unlawful killing is formed by the idea that personal responsibility can be diminished because of the psychological abnormality of the offender and consequently a verdict different from murder ought to be available to mark this special status. It is easy to be critical of the present formulation of the law. In cases where a plea of diminished responsibility is raised, the character of the defendant always poses difficulties yet the courts are required to come to decisions in particular cases within a short space of time. By means of a three stage process involving mental abnormality, mental responsibility and criminal liability, it is possible that the optimal balance has been arrived at.

As for forensic psychiatrists, provided that they avoid words which they do not understand, they should be able to make sense most of the time and assist the court occasionally.

RAYMOND TRAVERS

Scott Clinic
Rainhill Road, St Helens
Merseyside WA9 5DR

Reference

DELL, S. (1982) Diminished responsibility reconsidered. CLR, pp. 809–18

Psychotherapy Register

DEAR SIRS

I am writing in response to the information submitted by Michael Pokorny, Chairman of the United Kingdom Standing Conference for Psychotherapy (*Psychiatric Bulletin*, August 1992, **16**, 483–484). In discussing the UKSCP plan to have a Registration Board, he writes: "There is provision for an extra seat for the British Psycho-Analytical Society." I think this information might be misleading for the Membership.

In fact, the British Psycho-Analytical Society withdrew its membership from the UKSCP as it felt that, unless there was a governing body of senior established organisations in overall charge, then satisfactory monitoring of registration could not be achieved. As their proposal was not acceptable, the Council of the British Psycho-Analytical Society decided to withdraw the Society from the conference. Their view was further endorsed at a General Meeting of the Society. It should also be noted that the APP (Association for Psycho-Analytic Psychotherapy in the National Health Service) also withdrew from membership of the UKSCP for similar reasons.

I felt that the Membership of the Royal College of Psychiatrists should be aware of this.

RICHARD LUCAS
Chairman of External Relations
British Psycho-Analytical Society
The Institute of Psycho-Analysis
63 New Cavendish Street
London W1M 7RD

Reply

DEAR SIRS

I am grateful to Richard Lucas for adding to my article in the August *Psychiatric Bulletin*. He is quite