Brit. J. Psychiat. (1978), **133**, 187–192

Correspondence

Letters for publication in the Correspondence columns should not ordinarily be more than 500 words and should be addressed to:
The Editor, British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG

PSYCHOGERIATRIC SERVICES FOR THE ELDERLY

DEAR SIR,

As a psychogeriatrician and a participant in the Conference on the Future of the Psychiatry of Old Age reported in your May 1978 issue (**132**, 514), I appreciated the largely sympathetic tone of your report; I did not feel, however, that it really did justice to the case for specialization in this field. Although this was underlined by the catalogue of needs and activities described in the morning papers, the afternoon session comprised a debate on the question of specialization. This case was put fully and fluently by Dr Klaus Bergmann, who received only passing mention in your account. This has, I know, caused concern to a number of people working in the old age field, who recognize the huge gap that exists between the sophisticated specialized service and teaching of a centre like Newcastle (and of many other 'specialized' psychiatric services for the elderly) and what passes for a service in most districts where there is no psychogeriatrician.

As an admittedly biased observer, I did not feel that Dr Thompson or the contributors from the floor were able to undermine Dr Bergmann's arguments; it would certainly have been easier for psychiatrists at large to judge, had his paper been reported.

C. GODBER

Psychiatric Unit,
Moorgreen Hospital,
Botley Road, West End,
Southampton SO3 3JB

REVIEW OF A GERIATRIC PSYCHIATRY DAY HOSPITAL

DEAR SIR,

Further to the recent paper by Bergmann *et al* (*Journal*, May 1978, **132**, 441–9), may we present some of the findings of a five-year review of a geriatric psychiatry day hospital which we feel complement their findings and conclusions. The day hospital consists of two purpose-built units, the first of which was opened in 1972, the second in 1976. Over the five-year period 210 patients diagnosed as organic and 80 diagnosed as functional were admitted for day care. Within the five-year period the percentage of admissions diagnosed as organic steadily increased from 46 per cent in the first year to 90 per cent in the fifth year. Organic patients therefore currently comprise the great majority of attenders, 65 per cent of whom are over 75 years of age.

Of the organic patients 63 per cent were discharged within six months and only 6 per cent attended for more than two years. However, a comparison of the number of patients discharged in the second half of 1975, when only one unit was open, with the second half of 1977 when both units were open, showed that despite the doubling of available places the number of patients discharged remained substantially the same. The reason for this was that although the day hospital's capacity had doubled the main outlet, namely the number of long-stay geriatric psychiatry beds in the hospital remained the same. The table shows that the majority of organic patients were admitted from home, that the main precipitating factor was the inability of the family to cope and that they were discharged to a long-stay ward within the hospital because they had deteriorated during their short period of attendance.

Contrary to early and some current views, this day hospital's role has not been that of 'a key to discharge for many patients and avoidance of hospital admission in many more' (*Report on the Psychiatrist's Contribution to the Care of the Elderly*, issued by the Royal College of Psychiatrists—Scottish Division, 1977). Rather, with the increase in the number of demented patients in the over-75 age group and the shortage of beds and other supportive facilities, its role was to offer short-term support to maintain patients in the community and relieve stress on relatives until such time as beds became available in the long-stay wards. Latterly, with the increase in the number of day places available, this role has become extended because of the shortage of such beds. If this is a general finding, and if the maintenance of the demented patient in the community is thought to be a desirable policy, then day hospitals will not only have to be increased in number but they will also have to

develop more comprehensive programmes of management. This could include more frequent attendances each week, improved transport to allow the period of attendance each day to be extended, weekend openings, night-sitter services at home, the use of some of the more active methods of behavioural intervention and the dispersal of day hospitals within the community they serve rather than their concentration within the grounds of psychiatric or other hospitals.

J. G. GREENE
G. C. TIMBURY

Gartnavel Royal Hospital,
Glasgow G12 0XH

TABLE

Admission and discharge data for organic patients 1972-77

Admission (210)		Discharge (155)	
From		*To*	
Home—no previous contact	73	Home	12
Home—previous contact	10	Long-stay ward	75
Hospital ward	13	Other hospital	6
Residential care	4	Residential care	7
Primary reason		*Primary reason*	
Family unable to cope	52	Deterioration	77
Patient unable to cope	21	Improvement	4
Other	27	Other	19

All percentages.

EPILEPTIC HOMICIDE

DEAR SIR,

I read with interest the case report by Dr John Gunn about a man who appears to have killed his wife during an epileptic fit, although the diagnosis was not clear at the time of his trial and did not feature in his defence. However, I am a little surprised that Dr Gunn has not cited my own paper describing a similar case (Brewer, 1971). It is of interest not merely because, as Dr Gunn says, homicide during an epileptic seizure is rare, but because accurate diagnosis enabled a defence of insanity due to temporal lobe epilepsy to be mounted with reasonable confidence.

The patient in my case had one transient episode of strange behaviour a few months before the homicide but was not investigated at the time. The pre-trial EEG findings were abnormal but, as is often the case with temporal lobe epilepsy, not diagnostic. Fortunately, however, he had an air-encephalogram before the trial which demonstrated atrophy of the left temporal lobe. It was the X-ray findings which enabled a defence of temporal lobe epilepsy to be sustained in the face of determined opposition from the Crown.

The advent of computerized tomography means that a really thorough pre-trial neuropsychiatric investigation, covering psychometry, EEG, and X-ray studies as well as clinical examination, can now be considered as much more of a routine than hitherto.

I am writing this letter not merely to draw attention to the existence of another well-documented case of epileptic homicide but to point out, as I have done previously (Brewer, 1974), that adequate pre-trial investigation in any case where there is a suspicion of brain disease may produce evidence of the utmost importance for the outcome of the trial and for the subsequent management of the patient. In the context of temporal lobe epilepsy, one may note that 70 per cent of the series studied by Slater and Beard (1973) had temporal lobe atrophy. In the fairly recent past, people have been executed for murder, only for significant brain disease to be discovered at post mortem which could have been detected before the trial if the appropriate tests had been done (Bourke and Sonenberg, 1969).

COLIN BREWER

Department of Psychiatry,
Queen Elizabeth Hospital,
Birmingham B15 2TH

References

BREWER, C. (1971) Homicide during a psychomotor seizure. *Medical Journal of Australia*, **1**, 857–9.

—— (1974) Alcoholic brain damage: implications for sentencing policy. *Medicine Science and the Law*, **14**, 40–3.

GUNN, J. (1978) Epileptic homicide: a case report. *British Journal of Psychiatry* May 6, **132**, 510.

SLATER, E. & BEARD, A. W. (1963) The schizophrenia-like psychoses of epilepsy. *British Journal of Psychiatry*, **109**, 95–150.

BOURKE, J. P. & SONENBERG, D. S. (1969) *Insanity and Injustice*. First edition. Queensland: Jacaranda Press.

BUTTERFLY MAN

DEAR SIR,

I would appreciate the opportunity to reply to Dr Hugh Freeman's review of my recent book, *Butterfly Man: Madness, Degradation and Redemption* (Hutchinson, 1977) in your May 1978 issue (**132**, 523).

This book attempts to demonstrate the problems that arise from reliance on physical methods of treatment in psychiatry and to show that in many cases the interpersonal approach, whether through the therapeutic milieu or psychotherapy, may be effective and have less drawbacks.