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.

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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).

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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.