Results: The self-harming group were distinguished from the remainder on a number of measures. For instance, the self-harmers had more dissociative experiences (F = 4.581, p = 0.04), more physical neglect in childhood (F = 6.09, p – 0.022) and to have more suicidal ideation (F = 10.683, p = 0.003), hopelessness (F = 5.804, p = 0.022), and more inwardly directed anger (F = 4.546, p = 0.04).

Conclusion: These empirical data provide some evidence as to reasons why women who self-harm respond to adversity in a maladaptive manner and the ways in which such women process emotionally-laden material. These data also have implications for designing an intervention to reduce this maladaptive behaviour.

MAGNETIC RESONANCE TOMOGRAPHY OF THE BRAIN IN 21 SEX OFFENDERS

R. Eher, M. Aigner, E. Wagner, K. Gutierrez. *University of Vienna, Department of Social Psychiatry, General Hospital Vienna, Währinger Gürtel 18-20, A-1090 Vienna, Austria*

21 male sex offenders admitted to prison have been investigated consecutively by magnetic resonance tomography (MRI). Patients were divided into 2 groups. Patients of group I (n = 12) had committed at least one aggressive sexual offense with vaginal or anal penetration by directly injuring severely the victim. Patients of group II (n = 9) had been sentenced for either having performed forced sex without directly injuring their victims, or they had tried to commit rape but had withdrawed because of the victim's resistance, or they had committed a non-violent pedophile or exhibitionistic offense. 9 patients of group I (75%), but only 2 patients of group II (18%) showed structural brain abnormalities according to blindly rated magnetic resonance scan reports. Groups did not differ significantly in age or general intellectual functioning. Different types of abnormalities were found: right ventricular enlargement, dilated right temporal horn, cortical atrophy and deep white matter lesion.

Furthermore, MRI abnormalities were correlated with clinical diagnoses according to DSM-III-R axis I and II, and with variables of official criminal records. Results suggest an association between structural brain abnormalities as detected by magnetic resonance tomography and the extent of physical violence in sexual offenses, exhibiting rather a symptom of general violence and sadistic and antisocial personality than of paraphilia.

THE INSANITY DEFENCE IN IRELAND: A STUDY OF GUILTY BUT INSANE PATIENTS 1850–1995

P. Gibbons, N. Mulryan, A. O'Connor. *The Central Mental Hospital, Dundrum*

Background: In common-law jurisdictions, the insanity defence has been governed by the M.Naghten rules since 1843. Very little research has been published on the application of the insanity defence in the U.K. of Ireland. This is a retrospective descriptive study of a complete sample of insanity defence cases in Ireland between 1850 and 1995.

Methods: Case records and legal files were examined for 436 acquittees in all. Socio-demographic, forensic and clinical data are described.

Results: The number of insanity acquittees has fallen five-fold since the nineteenth century. Acquittees were commonly single males from rural areas, aged in the mid-thirties who had been charged with violent crime. The majority had a major psychiatric illness. Female insanity acquittees were relatively few in number and were as likely as males to have been charged with violent crime, especially directed towards their own children. The average length of stay in hospital has decreased significantly since the nineteenth century to mean of 8.7 years.

Conclusion: The insanity defence is rarely used in Ireland and is largely confined to serious offenses, especially homicide. Acquittal continues to result in prolonged detention at the Central Mental Hospital.

DEPRIVATION OF LIBERTY IN PSYCHIATRIC TREATMENT

Riittakerttu Kaltiala-Heino. *Tampere School of Public Health, University of Tampere, BOX 607, 33101 Tampere, Finland*

In a Finnish university psychiatric clinic, 101 inpatient treatment periods of 99 18–65 years old patients (one month admission sample) were followed until discharge or up to 150 days to study deprivation of liberty in psychiatric treatment. 44% of the patients were female, 21% were admitted for the first time, and 55% were diagnosed as suffering from psychotic disorders according to DSM-III-R. 32% of the patients had been involved with the civil commitment procedures, experiencing involuntary admission, observation period for assessing the mental health status, or involuntary detainment. Involvement with involuntary procedures was more common among psychotic patients (45%) than among non-psychotic patients (16%). Independently of the civil commitment procedures, 36% of the patients had been deprived of their liberty during the treatment period experiencing seclusion, physical restraint or denial of leaving the ward, for the most those whose legal status was involuntary (66%) but also patients treated voluntarily (22%). The figures are high and probably due to a paternalistic tradition in Finnish psychiatry.

CRITERION-BASED AUDIT OF EPILEPSY IN BOTH COMMUNITY AND HOSPITAL SETTINGS IN SEVEN DISTRICTS

M. Morris, R. James, D. Rowe, J. Brylewski, S. Abell. *Slade House, Oxford, OXE 7JH and Oxford and Anglia Regional Clinical Audit Team, Headington, Oxford OX3 7LF*

Background: Approximately 2% of the general population will have developed epilepsy before the age of 40 but in patients with a learning disability, the prevalence is up to 40%. There have been few previous audits on epilepsy in learning disability. A Portsmouth study examined the medical management of 75 patients with epilepsy but this was an institutionalised sample. An American survey of 100 learning disabled patients was more relevant in that it was a community-based survey. Neither of these publications set standards of care beforehand and so were surveys rather than audits.

Standard	Result
1. Each patient should have an annual review by a psychiatrist	88%
2. Each patient should have an ICD diagnosis recorded in the notes	40%
3. Seizures should be described and recorded in the medical notes	83%
4. The evidence on which the diagnosis was made should be adequate	99%
5. The patient or main carer should know which doctor is responsible for epilepsy management	100%
6. Overall, 80% of patients should be on monotherapy	50%
7. Patients should not be receiving medication if they have not had a seizure within the past 2 years unless there has been a specific decision to continue antiepileptic drugs	31% had no specific review
8. 80% should be free from drug side-effects	89%
9. Patients should have medications provided if they are at risk of status	60%
10. Written instructions for the use of drugs in status should be provided	84%

https://doi.org/10.1016/0924-9338(96)88862-6 Published online by Cambridge University Press