Van Hooff, A. J. L. (2000) A historical perspective on suicide. In *Comprehensive Textbook of Suicidology* (eds R. W. Maris, A. L. Berman & M. M. Silverman), pp. 96–126. New York: Guilford.

Van Praag, H. M. (2002) Why has the antidepressant era not shown a significant drop in suicide rates? *Crisis*, **23**, 77–82.

World Health Organization (1998) *Primary Prevention of Mental, Neurological, and Psychosocial Disorders. Suicide*, pp. 75–90. Geneva: WHO.

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Concepts of social capital

McKenzie *et al* (2002) illustrate how emerging conceptions of social capital can help psychiatric researchers study links between social context and the prevalence, course and outcome of psychiatric conditions. Two further considerations deserve a place in this discussion. First, the premise that social capital is 'a property of groups rather than of individuals' (McKenzie *et al*, 2002: p. 280) does not enjoy an unqualified consensus. Work by Princeton sociologist Alejandro Portes (1998) summarises the case against insisting that social capital be treated as a group attribute. A more individualist approach draws attention to the important distinction between the social relationships that allow a person to make claims on resources held by others and the resources themselves. A family's struggle to find a job for a recently hospitalised relative may be eased somewhat when they live in a community with trusting social relationships, but this effect is more limited in a resource-poor community. (For example, Portes (2000) found that alleged effects of social capital on the academic achievement of immigrant children in the USA are drastically reduced when proper controls are used for parental socio-economic status.)

Second, McKenzie *et al* note that high social capital may be found in bad groups, such as the Mafia, and in homogeneous groups that restrict the freedom of members or exclude outsiders and minorities. This analysis of negative consequences can be expanded by an individual-oriented discussion of a dilemma familiar to clinicians working with socially marginal populations. Individuals may indulge in apparently irrational spending sprees to buy food, drugs or alcohol for companions because these allow them to make future claims for reciprocity when times are lean (Dordick, 1997). The resulting mutual obligations can make it difficult for even a highly motivated person to enter (or re-enter) the social mainstream because he or she is vulnerable to criticism for breaking ranks with compatriots (Bourgois, 1995) or to claims on cash resources saved to facilitate an exit (for tuition, a new apartment, etc.). Programmes serving these populations need to devise strategies to help patients manage this dynamic aspect of social capital, even as they focus on recovery.

Bourgois, P. (1995) *In Search of Respect: Selling Crack in El Barrio*. New York: Cambridge University Press.

Dordick, G. (1997) *Personal Relations and Survival among New York's Homeless*. Philadelphia, PA: Temple University Press.

McKenzie, K., Whitley, R. & Weich, S. (2002) Social capital and mental health. *British Journal of Psychiatry*, **181**, 280–283.

Portes, A. (1998) Social capital: its origins and applications in modern sociology. *Annual Review of Sociology*, **24**, 1–24.

—— (2000) The two meanings of social capital. *Sociological Forum*, **15**, 1–12.

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Author's reply: The problem with the emerging concept of social capital is that it is in danger of trying to be all things to all people. Dr Walkup is correct to point to the view of Portes and others that social capital can be individual. I do not think that this approach is particularly useful. Social capital is not a thing, it is a way of trying to describe a number of social processes. It is a theory that helps us understand what is happening in a society. Although there may be analogous processes occurring at group and individual levels, conceptualising them as the same thing is problematic.

Theories of causation argue that causes at different levels are often governed by different rules and need different methods of investigation. An example would be the effects of smoking on health. This can be investigated at a number of levels; there would be the cellular level (the effects of nicotine on the cell), the individual level (physical and psychological effects of smoking and addiction) and the group level (what increases smoking levels in one group compared with another).

One would not try to employ the concept of cellular biology to investigate groups of people and one would not try to use group or systems approaches to investigate the individual. Moreover, the factors that increase the level of smoking in a group may not be the same as those that increase an individual's risk of smoking-related disease.

Given that group social processes are likely to affect health in different ways from individual processes, it would not seem helpful to consider social capital as a single entity that works at both levels. A choice has to be made and the choice of the majority is to conceive of social capital as operating at an ecological or group level and to consider effects at an individual level as social networks.

Dr Walkup is correct to point to the differences between the social relationships that allow a person to call on resources, and the resources themselves. However, the theory of social capital as an ecological variable does allow for this. Bonding and bridging social capital describe factors at the community level, but the concept of vertical social capital attempts to describe the ability of a community to facilitate access to resources from those in power.

Clearly, in our individualised world our interventions tend towards helping people decrease their risk of illness and their risk of relapse, and improve their participation in the world. The exciting difference about ecological conceptualisations is that they are about how society decreases the risk of illness and relapse of its population and how society facilitates the participation of the individual. These approaches aim for the same outcome but they are not the same thing and will need different conceptualisations, investigations and interventions.

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Vulnerable individuals and the Human Rights Act

With reference to the recent editorial on the Human Rights Act and mental health legislation (Bindman *et al*, 2003), the 'steady trickle' of human rights cases rather than a flood is not surprising when considered in context of the history of UK human rights.

https://doi.org/10.1192/bjp.182.5.458-a Published online by Cambridge University Press

Since 1965 UK organisations and individuals have had the right to petition under the European Convention on Human Rights (ECHR). This was then made binding on the British Government when we joined the European Union in 1973, under Article 189. Since then, British courts have had to take into account the ECHR in their decisions and judgements. So since 1973 we have been subject to the influence of the ECHR, which is nearly identical to the Human Rights Act.

What is new in the Human Rights Act 1998? There are no new rights but, as Bindman *et al* stated, it is easier to pursue alleged injustices. However, a major difference is frequently overlooked – only a directly affected individual can pursue legal challenges. Under the ECHR anyone with sufficient interest (i.e. pressure groups or interest groups) could petition. In the Human Rights Act this has been limited to individual 'victims' only. Potentially, this leaves some vulnerable individuals, such as those with mental health problems or learning disabilities, disenfranchised under the Human Rights Act, having still to rely upon the ECHR to protect them.

Bindman, J., Maingay, S. & Szmukler, G. (2003) The Human Rights Act and mental health legislation. *British Journal of Psychiatry*, **182**, 91–94.

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One hundred years ago

London County Asylum, Claybury (Report for the year ended March 31st, 1902)

The average number of patients resident during the year was 2431, comprising 1015 males and 1416 females. The admissions during the year amounted to 426 – viz., 131 males and 295 females. Of these 364 were first admissions. Dr. Robert Jones, the medical superintendent, states in his report that the general character of the admissions was unsatisfactory as regards prospect of recovery. 38 per cent. of the admissions were over 60 years of age and over 16 per cent. of the males were suffering from general paralysis. 14 per cent. of the males and 9 per cent. of the females were admitted suffering from alcoholic insanity, "although as a predisposing cause the percentage is probably higher." It is interesting to notice, adds Dr. Jones, that the two classes which furnished the greatest number of male admissions were described as "clerks" and "persons of no occupation." The number of patients discharged as recovered during the year amounted to 148, comprising 52 males and 96 females, or 6·1 per cent. of the average number resident. The deaths during the year amounted to 201, or 8·27 per cent. as calculated on the same basis. "Asylum dysentery attacked 40 males and 81 females, and was responsible for 21 deaths, or over 10 per cent. of the total deaths." Death was due to cancer of the stomach in six cases, renal disease in seven cases, epilepsy in eight cases, pneumonia in 14 cases, senile decay in 15 cases, colitis in 21 cases, cardiac disease in 24 cases, pulmonary and other forms of tuberculosis in 25 cases, general paralysis of the insane in 50 cases, and other causes in the rest. Two patients who were pregnant upon admission were safely delivered. There has been, with the exception of colitis, no outbreak of zymotic disease during the year. The Commissioners in Lunacy state in their report that the wards were in excellent order, that the day-rooms were comfortable and cheerful, that the dormitories were clean and well aired, and that the medical case-books and records were very well kept. The sub-committee of management states in its report that owing to the drought the crops and farm produce showed a considerable falling off during the year. The sum of £9320 was spent during the year upon improvements, alterations, and repairs.

REFERENCE

Lancet, 6 December 1902, p. 1572.

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https://doi.org/10.1192/bjp.182.5.458-a Published online by Cambridge University Press