

attitudes towards patients who are at risk of suicide deserve consideration. Acceptance of a patient's suicide as a solution to problems, wishes that a patient would commit suicide as a solution to his or her problem, fear of the patient and difficulties in dealing with suicidal individuals are some of the most important sources of stigma in mental health environments. Also, following an attempt many individuals feel isolated or ignored by health professionals (McGaughey *et al*, 1995). In the military environment, stigma towards mental illness is very strong and military personnel tend to deny any form of mental disorder unless they are hoping to get another job. This exposes such a population to the risk of suicide.

Yet suicide is, itself, a source of stigma as anyone with suicidal ideation is considered weak, shameful, sinful and selfish, which prevents these individuals from seeking treatment early in the suicidal process. These judgements are often shared by active churchgoers (Sawyer & Sobal, 1987), teachers and parents. Also, parents and widows of victims of suicide are stigmatised, which makes recovery from this type of loss particularly difficult (Smith *et al*, 1995). Destigmatisation should be addressed to mental illness as well as suicide. Increasing the stigma associated with having suicidal feelings will increase the suicide rate. Interventions among families, mental health professionals, military personnel and church activists aimed at decreasing the stigma associated with mental illness and suicide may contribute to the reduction of deaths by suicide.

Eagles, J. M., Carson, D. P., Begg, A., et al (2003) Suicide prevention: a study of patients' views. *British Journal of Psychiatry*, **182**, 261–265.

McGaughey, J., Long, A. & Harrison, S. (1995) Suicide and parasuicide: a selected review of the literature. *Journal of Psychiatric and Mental Health Nursing*, **2**, 199–206.

Phelan, J. C., Bromet, E. J. & Link, B. G. (1998) Psychiatric illness and family stigma. *Schizophrenia Bulletin*, **24**, 115–126.

Sawyer, D. & Sobal, J. (1987) Public attitudes toward suicide: demographic and ideological correlates. *Public Opinion Quarterly*, **51**, 92–101.

Smith, B. I., Mitchell, A. M., Bruno, A. A. et al (1995) Exploring widows' experience after suicide of their spouse. *Journal of Psychosocial Nursing and Mental Health Services*, **33**, 10–15.

M. Pompili, I. Mancinelli, R. Tatarelli

Dipartimento di Scienze Psichiatriche, Università 'La Sapienza', Via Panama 68, 00198 Roma, Italy

Social capital and mental health v. objective measures of health in The Netherlands

McKenzie *et al* (2002) reported that social capital in the neighbourhood may be beneficial for health and mental health in adults. We have reported associations between neighbourhood social capital and mental health service use in children (Van der Linden *et al*, 2003). We wished to investigate whether such effects on mental health were accompanied by similar effects on physical development, and investigated sensitive, cumulative objective measures of child health, height and weight at different ages, in relation to the neighbourhood environment.

We recorded all height and weight data registered regularly in the Municipal Youth Health Care Centre from birth up to the baseline measurement of our cohort study of 1009 children aged approximately 11 years living in the 36 neighbourhoods of a Dutch city (response rate of both child and one parent of 54%) (Drukker *et al*, 2003). This study on the effects of neighbourhood variables also included family-level and child-level measures, such as family socioeconomic status. In addition, social capital dimensions of (a) informal social control and (b) social cohesion and trust were measured in a community survey and aggregated to neighbourhood level.

Data were part of a three-level structure with height and weight measurements at different ages nested within children, and children nested within neighbourhoods. Growth curves were estimated using a multi-level random-effects regression model (including age and age²). The outcome measures were height, weight, and body mass index (weight/height²), and all variables except for age were considered fixed factors. When neighbourhood variables and individual level confounders were added to the models, results showed that none of the social capital measures was associated with any of the outcomes.

Therefore, we conclude that neighbourhood measures play a role in mental health, but that effects are more readily expressed in the psychological rather than the physical domain, in children living in The Netherlands.

Drukker, M., Kaplan, C. D., Feron, F. J. M., et al (2003) Children's health-related quality of life, neighbourhood socio-economic deprivation and social capital. A contextual analysis. *Social Science and Medicine*, **57**, 825–841.

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

Van der Linden, J., Drukker, M., Gunther, N., et al (2003) Children's mental health service use neighbourhood socio-economic deprivation and social capital. *Social Psychiatry and Psychiatric Epidemiology*, in press.

M. Drukker, N. Gunther Department of Psychiatry and Neuropsychology, Maastricht University, The Netherlands

F. J. M. Feron Youth Health Care Division, Municipal Health Centre, Maastricht, The Netherlands

J. van Os Department of Psychiatry and Neuropsychology, Maastricht University, PO Box 616, 6200 MD Maastricht, The Netherlands, and Division of Psychological Medicine, Institute of Psychiatry, London, UK

One hundred years ago

Epileptic colony, Ewell, Surrey

ON Wednesday, July 1st, the first rate-supported epileptic colony in this country, founded by the London County Council for the epileptic insane of the metropolis,

was opened by H.R.H. the Duchess of Fife and the Duke of Fife, K.T., Lord Lieutenant of the County of London.

Situated on the north-eastern corner of the Horton Estate (facing the Epsom Downs), purchased in 1896 for asylum

purposes, and on which the Manor Asylum (for 700 female lunatics) and the Horton Asylum (for 2,000 lunatics) have already been erected, it has a demesne of 112 acres, to be devoted to colony purposes, separated from the rest of the estate by a public road.

The buildings, consisting of an administrative block and eight villas have been erected upon the most elevated part of the ground, some 200 feet above the sea level. A corridor leads from the administrative centre – wherein are offices for the medical superintendent, assistant medical officer, matron, clerk, etc., apartments for some of these officers, and quarters for the resident subordinate staff – to a group of buildings consisting of stores, main kitchen, and a hall for recreation and dining purposes. The boiler house, workshops, and water tower are situated between the stores and the female admission ward, the latter being a portion of the central block. On the other side of the corridor, immediately opposite the boiler house, a laundry will shortly be erected. The dining and recreation hall has seating accommodation for 326 persons, the number of colonists to be received. Here it is intended that all whose condition permits their being present shall assemble for dinner, the other meals being taken in the several wards. It is so arranged as also to serve as the chapel. At one end of the hall a platform has been provided for entertainments. The hall will be well lighted, and its heating (which is by means of steam-heated radiators) and ventilation are very completely arranged for.

Within the 20 acres of land on the east side of the administrative block are dotted

the eight villas (named after trees – Holly, Lime, Pine, Elm, Chestnut, Hawthorn, Walnut, Beech) in which all the colonists, with the exception of the 32 females to be accommodated in the admission ward at the administrative centre, will be housed. . . Each villa is similarly arranged, and has a south-eastern aspect, and the roads giving access to them enclose a space to be laid out by the colonists, and used as a cricket and recreation ground. Each villa is arranged to accommodate 38 patients, and will be under the charge of a resident married couple. The interiors are designed to enable the individual patients to have the maximum amount of freedom under supervision. The verandahs and spreading porches to the villas are important features, enabling the colonists to be in the open in all weathers. The method of warming is by double fireplace stoves arranged in the centres of the rooms.

The ventilation is by means of fresh-air inlets at floor level and outlets through the ceilings into the roof space, the necessary upcast movement being obtained by the heat from the hot-water storage tank which is placed at the base of a shaft leading into the open air. Four of the villas are built in red brick with artificial stone dressings, as are also the administrative buildings. The stores and the remaining villas are faced with rough case. All the roofs are tiled.

The lighting is by electricity throughout. Telephones connect all the buildings, and an electrical fire alarm places the villas and the centre in communication.

The estimated cost of the buildings, including fixtures, fittings, and equipment, is £98,000, which with its provision for 326 patients (60 females and 266 males) gives a total cost per bed (exclusive of the cost of land) of £300. The plans of the buildings were designed by the Asylums Committee's Engineer, Mr. William Charles Clifford Smith, M.I.C.E.

Dr. Charles Hubert Bond (D.Sc., M.D., Ch.M.Edin.), Senior Assistant Medical Officer at the Heath Asylum, Bexley, formerly Assistant Medical Officer at Banstead Asylum, and Clinical Assistant at the National Hospital for Epilepsy, and at the Wakefield and Morningside Asylums, has been appointed Medical Superintendent. For this officer a detached residence has been appointed conveniently near the administrative buildings.

REFERENCE

British Medical Journal, 4 July 1903, 43.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

Corrigendum

Early intervention service for non-abusing parents of victims of child sexual abuse. Pilot study. *BJP*, 183, 66–72. Table 1

(p. 69), published norms (col. 3) for the Child Behavior Checklist should read: total score: referred=52.1, non-referred=23.1;

internalising sub-scale: referred=14.6, non-referred=6.3; externalising sub-scale: referred=17.5, non-referred=8.2.