the average suicide rate during the follow-up was around 8 per 100 000 per year, but the yearly rate varied between 2 and 16 per 100 000. In 16 years 140 people committed suicide but none of these was from our series. In a four-year follow-up of all 42 patients in Nottingham with three or more admissions in the year 1990, there were two cases of suicide, one homicide, and a further patient committed suicide shortly after the follow-up period ended (Davies & Payne, 1996). For a clinician, such a population of frequently admitted patients might be a better choice for the focusing of scarce resources. The case for blanket coverage of all first-admission patients remains without any evidence base.

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Transcending barriers between religion and psychiatry

Sir: George Carey (1997) suggests there is common ground to be shared by us, and it is my belief that here is an opportunity to collate knowledge and experience, and combine our resources. The hope would be to make progress in those 'Cinderella' disorders which at present tend to receive such curt treatment in our clinics.

There are pools of suffering individuals with 'broken' personalities, in places that are accessible to both disciplines. As a Christian psychiatrist, I have met with many people who have given their lives to Jesus as a result of such agonising situations that have resulted from their self-driven wills. Personalities that have quite simply given up the fight. Some of them have done so during times of reflection in prison. Others are addicts who have reached their turning-point at the 'rock-bottom' of their lives.

Alcoholics Anonymous and other 12-step fellowships have been uniquely successful in giving back the lives to millions of sufferers worldwide whose options would otherwise have been either more oblivion or suicide. Those in recovery have made a decision, through recognition of their powerlessness and folly of their self-will, that they needed to hand over their lives to God and begin to walk a different path.

We know that many personality-disordered patients are victims of abuse in childhood, with no experience of a loving father in their tender years, and consequently no adequate sense of moral values. This is where I have seen the healing ministry in its element, taking the souls of the lost and weary and giving hope with a new set of values and a new family – the Church – with all the essentials of unconditional love, forgiveness and nurturing that these vulnerable people so badly need.

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Gender and age at onset of schizophrenia

Sir: Jablensky & Cole (1997) have confused cause and consequence in suggesting that the gender differences in age at onset of schizophrenia are a result of marital status. The age at which symptoms begin and gender difference in onset are important clues to the underlying biological nature of the disorder (DeLisi, 1992). Jablensky & Cole suggest that marriage somehow delays onset of the illness, supporting this concept with data showing that married males and females do not differ in age at onset of schizophrenia. However, they fail to explain why this effect is more relevant for males than females, and why unmarried males still have an earlier age at onset than unmarried females.

Females marry at an earlier age than males, due not only to their level of brain development, and also to different reasons for mate choice. Females favour males who are more established, independent and can care for them, whereas mate choice in males has more to do with physical attraction than abilities. Thus, males, unlike females, must achieve a certain level of independence with academic and social success prior to marriage, whereas females may be dependent on parental care-taking until they marry and transfer this role to a spouse. A measure of ability to live independently is an indication of premorbid functioning prior to the onset of psychotic symptoms. One would then expect, given what is known about the development of schizophrenia, that males who have a vulnerability for schizophrenia would be less likely to marry than females, and if they did marry, they would belong to a select group of 'late-onset' males, whereas females are more likely to marry regardless of premorbid level of functioning.

Thus, the 'married' group of schizophrenics will contain both early- and late-onset females and only late-onset males, skewing the data toward no difference in age at onset between males and females. In Jablensky & Cole's analysis, single males have an earlier age at onset than single females – consistent with the notion that neither may have gained a degree of independence, but other factors affect age at onset. The authors fail to take the above into consideration and thus have not convincingly dispelled the notion that marital status is a consequence of age at onset of schizophrenia and that gender differences in age at onset suggest an underlying biological process, perhaps indicating a role for the sex chromosomes (Crow, 1995).

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War pensions

Sir: Significant mental health problems as a result of the Second World War are commonplace for European clinicians

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working with older people (Hunt *et al*, 1997). Hamilton & Canteen (1987) found a 16–20% rate of post-traumatic stress disorder diagnosis in veterans of the Second World War. Other studies have reported intergenerational mental health effects in veterans and groups of civilians such as Holocaust survivors. In Britain, little appropriate professional help was available after the war, which may have contributed to the psychological impact of traumatic wartime experiences. Previously recovered symptoms may reappear if the ageing process produces a sense of vulnerability (Elder & Clipp, 1988).

Recent media coverage of changes to the criteria for entitlement to a war pension with respect to loss of hearing unfortunately coincided with the authors' separate experiences of cases of conflict with the War Pensions Agency, which is responsible for awarding and administering war pensions. In one case, the war pension of a veteran of the Second World War was reduced from 80 to 60% following a psychiatric report that was interpreted as indicating an improvement in the patient's mental state. This seriously damaged the therapeutic relationship leading to a deterioration in the patient's psychiatric disorder. We wonder whether the War Pensions Agency is aware of published research in this area and whether they take this into account when reviewing war pensions.

If, as seems possible, politically driven developments in the administration of war pensions occur, the involvement of health professionals may increase. We would therefore like to raise awareness among doctors that mental health problems in later life may be closely linked to war experiences, and that these problems may be exacerbated by the psychological issues of old age and the recent commemorations of the Second World War.

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Suicide and the cost-effectiveness of antidepressants

Sir: I read the correspondence by Henry (1997) and Hotopf & Lewis (1997) with interest and wish to comment on some of the issues raised.

First, the crude cost calculations shown are not very informative since they do not include treatment costs associated with each drug class, which range from surgery attendance through to treatment for serious overdose. In the case of fatal overdose there are indirect costs associated with the suicide (e.g. support of family, loss of earnings potential). Any cost advantage of the older tricyclic antidepressants (TCAs) will soon be greatly reduced by the advent of generic selective serotonin reuptake inhibitors (SSRIs). Surely a more appropriate comparison would be of generic lofepramine with SSRIs as these compounds have broadly similar safety records in overdose.

Second, suicide is a tragic but rare event, but self-poisoning with antidepressants is more frequent and may lead to high direct treatment costs of hospital admission, cardiac monitoring and other necessary supported measures. Applying the model suggested by Henry (1997) the cost disadvantages of SSRIs and newer TCAs such as lofepramine compared with older TCAs may become less evident. For this reason, I feel a more important argument is how to make the prescribing of antidepressants more effective, in particular in terms of reduction in suicide attempt rates, regardless of the type of antidepressant used.

Third, other factors promoting fatal overdose with antidepressants may be non-specific, such as inappropriate prescribing due to misdiagnosis, or the 'wrong' decision about treatment being made, such as suggesting that talking therapies would be more appropriate than the use of antidepressants, inadequate dosage of antidepressant being prescribed, inadequate monitoring of antidepressant prescriptions, or giving antidepressants for an inappropriately short period. Targeting these factors, which may reduce the overall effectiveness (of any antidepressant), via educational and training programmes may ultimately be more productive than 'switching' from one antidepressant class to another.

Finally, it is still not clear whether some antidepressants are more associated with increased suicide risk and suicidality in certain depressed individuals. This is an important question that has not been fully resolved.

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Hotopf, N. & Lewis, G. (1997) Suicide and the cost-effectiveness of antidepressants (letter). *British Journal of Psychiatry*, **170**, 88.

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Crime, violence and schizophrenia

Sir: I read with interest Dr Wessely's clear and important account of the Camberwell Study (Wessely, 1997). I disagree with only one word: his use of "reassuring" to describe some of his findings. When compared with controls his schizophrenic patients show a twofold increase in convictions for "serious assaults and violence" by male schizophrenics and a threefold increase by female schizophrenics. The controls are catchment area psychiatric patients, from an inner-city neighbourhood with high crime levels, and thus may be expected to show higher than average conviction rates. His excellent review of the literature states: "... before hospital admission we find very high rates of disturbed behaviour, very little of which will be found in hospital records". An earlier study of Maudsley patients (Noble & Rodger, 1989) also showed high levels of violence and aggression before admission – particularly by schizophrenic patients. Dr Wessely's findings do no more than illustrate the point, well made in his review, that only a small proportion of the disturbance and violence of people with schizophrenia ever results in a criminal conviction.

The study uncovered only one killing by a schizophrenic patient, from which is calculated a homicide rate of 1 per "7800 patient-years". Is this reassuring? Nothing can be concluded from a single incident but the rate quoted is several times the national rate (600–700 per year). I worked in the Camberwell catchment service for many years and know of three other homicides by catchment patients and ex-patients during the period of the study.

I share with Dr Wessely a wish to find some reassuring news about the current treatment of schizophrenia. It is important to convey information in a way which does not add to the burden of prejudice carried by our patients and their families. In its 'Manifesto for Mental Health', circulated in April 1997, The Royal College of

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