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.

Elder, G. H. & Clipp, E. C. (1988) Combat experience, comradeship and psychological health. In *Human Adaptation to Severe Stress From The Holocaust to Vietnam* (eds J. Wilson, Z. Harel & B. Kahana). New York: Plenum.

Hamilton, J. D. & Canteen, W. (1987) Post-traumatic stress disorder in World War II naval veterans. *Hospital and Community Psychiatry*, **38**, 197–199.

Hunt, L., Marshall, M. & Rowlings, C. (eds) (1997) *Past Trauma in Late Life: European Perspective on Therapeutic Work with Older People*. London: Jessica Kingsley.

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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.

Henry, J. A. (1997) Suicide and the cost-effectiveness of antidepressants (letter). *British Journal of Psychiatry*, **170**, 88.

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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Psychiatrists has highlighted grave difficulties and lack of resources in the psychiatric service. There is also a problem of attitude. In recent years the profession has become too complacent about the degree of public 'dangerousness' presented by some categories of patient – particularly patients with behavioural disturbances and severe psychosis who so often default after discharge and cease to receive appropriate care, control or treatment. This complacency has contributed to what yet another enquiry into psychiatric homicide (Mishcon *et al*, 1995) has dubbed "a scaling down of the perceived level of risk".

Noble, P. & Rodger, A. (1989) Violence by psychiatric inpatients. *British Journal of Psychiatry*, **155**, 384–390.

Mishcon, J., Dick, D., Welsh, N., et al (1995) *The Grey Report. Report of the Independent Inquiry Team into the Care and Treatment of Kenneth Gray.* London: East London and The City Health Authority.

Wessely, S. (1997) The epidemiology of crime, violence and schizophrenia. *British Journal of Psychiatry*, **170** (suppl. 32), 8–11.

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Anorexia and the overvalued idea

Sir: Given the media interest in compulsory treatment of patients with anorexia nervosa and the confusion expressed about the competence of such patients, I was very interested in the paper by Jones & Watson (1997). However, I was very disappointed to find that the criteria for defining anorexia nervosa were not made explicit. The criterion that was given (being "at least 10% below their ideal weight") does not fulfil the criteria of either of the two main systems of diagnostic classification (ICD–10 and DSM–IV). This suggests that the patients studied by Jones & Watson either did not have anorexia nervosa as usually defined, or had been successfully treated. The conclusions we can draw from this work must, therefore, be guarded.

Jones, E. & Watson, J. P. (1997) Delusion, the overvalued idea and religious beliefs: a comparative analysis of their characteristics. *British Journal of Psychiatry*, **170**, 381–386.

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One hundred years ago

Royal Lunatic Asylum, Montrose

In his report Dr. Howden complains that many of the patients were admitted in a dying condition, and expresses the hope that the new Form of Certificate of Emergency issued by the General Board of Lunacy (Scotland), in which a medical man is required to certify that the patient is in a sufficiently good state of health to be removed to the asylum, will prove a check to the practice of sending patients in a dying condition. With regard to the allegation sometimes put forward that asylum attendants are liable to become insane, Dr. Howden's experience leads him to believe that this is an entirely erroneous impression. He has met with cases, however, outside asylums where the association of the sane with the insane seems to have had a prejudicial effect on the former. He gives several instances where this has occurred. The death-rate amongst the male patients was higher than usual, but was due to the causes already stated. The wards are somewhat overcrowded, but the resulting evils are diminished as far as possible by careful attention to ventilation and sanitation, and by giving the patients abundant exercise in the open air. Since the publication of this report Dr. Howden has retired from the active management of the asylum. He has had a long, useful and distinguished career, and during his tenure of office the Montrose Asylum has occupied a leading position amongst the institutions for the care and treatment of the insane in Scotland.

REFERENCE

Lancet, 3 July 1897, 29.

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Corrigendum

Cheng, A. T. A., Mann, A. H. & Chan, K. A., *BJP*, 170, 441–446. The final line of 'Limitations' (p. 445) was omitted. The third limitation should read, 'Owing to the limited sample size, the relationships between suicide and categories of personality disorder other than EUPD have not been thoroughly examined'.

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