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.

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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 age^2). The outcome measures were height, weight, and body mass index (weight/height^2), 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.

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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.

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