2002), which included patients of all ages, has confirmed our findings of a higher brain weight in suicide (Salib & Tadros, 2000) but only after they excluded 'outdoor' cases (where the body was found at an outdoor location away from the home) and controls. Hamilton & McMahon should be congratulated on their study; however, the negative findings in the younger age group may have been confounded by the choice of the control group, some of whom may have had a mode of death not dissimilar to suicide but had a non-suicide verdict returned by the coroner. On the other hand, Hamilton & McMahon (2002) are correct in making the assumption that our control group may have included people with pre-clinical dementia with lighter brains. This may have had the opposite effect on the findings (i.e. heavier brain weight in elderly suicide cases).

Balazic, J. & Marušič, A. (2002) Apparent higher brain weight in suicide victims: possible reasons. *Psychological Reports*, **90**, 236–238.

Hamilton, S. J. & McMahon, R. F. T. (2002) Sudden death and suicide: a comparison of brain weight. *British Journal of Psychiatry*, **181**, 72–75.

Salib, E. & Tadros, G. (2000) Brain weight in suicide. An exploratory study. *British Journal of Psychiatry*, **177**, 257–261.

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Vascular events associated with pharmacotherapy

Further to an article on the prevalence of vascular events in association with the treatment of psychotic illness (Thomassen *et al*, 2001) and the subsequent correspondence (Curtin & Blum, 2002), we would like to add our comments to this interesting topic. On our unit we have recently had occasion to observe a patient with haematological abnormalities that we feel were directly associated with treatment with antipsychotic medication. The case described below attests to the potential danger of therapy for schizophrenia and adds to concerns regarding the use of clozapine in particular.

Ms B., a 40-year-old woman, was receiving treatment with antipsychotic medication for recurrent episodes of agitation and psychosis. There had been a relatively poor response to trials of three antipsychotic agents and her side-effect profile was such that there were concerns about developing signs of tardive dyskinesia. A trial of clozapine was commenced and beneficial effects were apparent within 4 weeks.

Three months into treatment there was a deterioration in Ms B.'s physical condition and she was troubled by abdominal pain and continuing dyspepsia. She was evaluated and a series of blood tests were ordered. These were normal except for a very high erythrocyte sedimentation rate (ESR) of 90 mm/l, considerably above the normal for a woman of her age. The extent of the elevation was such that a battery of tests were used by our medical colleagues to establish a cause for this abnormality. Despite extensive medical investigations no abnormality was found. The ESR remained persistently elevated above 85 mm/l.

After 5 months on treatment Ms B. developed prominent visual hallucinatory experiences, which were new developments. As these resembled epileptiform discharges that were distressing for the patient, it was decided to discontinue the clozapine therapy completely. Within 2 weeks her ESR had fallen to 15 mm/l and it has not been found to be outside the normal range since that time.

This case suggests that clozapine can produce changes in ESR, which is a crude marker of coagulation status. The persistent change seen in the ESR in this patient could not be explained by any disease process, and it certainly points to the possibility that the clozapine was implicated in increasing her blood viscosity. As a raised ESR is associated with hypercoagulability states such as those seen in malignancies, this must be a source of concern. We are pursuing our interest in this area further.

Curtin, F. & Blum, M. (2002) Antipsychotics and risk of venous thrombosis (letter). *British Journal of Psychiatry*, **180**, 85.

Thomassen, R., Vandenbroucke, J. P. & Rosendaal, F. R. (2001) Antipsychotic medication and venous thrombosis. *British Journal of Psychiatry*, **179**, 63–66.

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Outcome measurement in mental health: the Italian experience in psychogeriatrics

We would like to comment on the interesting editorial by Holloway (2002) on outcome measurement in mental health, by reporting observations on psychogeriatric services in Italy.

Our country is going through a profound economic crisis, with consequences for health expenditure. In this framework regional governments, who have the duty to coordinate health service programmes, are induced to save money in the more 'frail' areas, such as mental health and geriatric services. One of the reasons for this attitude is the claim that evidence for the usefulness of these services is weak. Yet, at the same time, there are very few attempts to fund programmes devoted to acquiring such evidence. Only a small proportion of research grants, even from central government, are devoted to outcomes research in this area. We argue that the scarcity of health resources combined with devolution of health care from central to local governments support an urgent need for outcomes research implementation in the psychogeriatric field.

At a conservative estimate, $<20\%$ of the procedures adopted in psychogeriatrics are evidence-based and follow accepted guidelines. We agree about 'the difficulty of conducting evaluation of the complex social interventions typically deployed within mental [and, we would add, geriatric] health services' (Holloway, 2002) but, paradoxically, it is in times of scarce resources that it is of most relevance to evaluate whether the allocation of money to psychogeriatric services leads to significantly improved outcomes. Moreover, the 21 regions of Italy are undergoing a process of autonomy. One of the risks of this is that each region will adopt different means of measuring the quality of procedures and outcomes. This is particularly relevant if we consider the fact that evidence-based medicine, which might be a standard reference, covers only a small proportion of interventions.

We do not have programmes similar to the UK Department of Health's 'Mental Health Information Strategy' nor do we collect data to compile a minimum dataset. The majority of the work in psychogeriatrics is done without quality controls and it is not possible to benchmark different services against each other. Furthermore, clinicians are deprived of the possibility of measuring outcomes of their interventions, particularly in areas where the data do not allow a direct transfer of information in everyday clinical practice.

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Currently, the future of special care units (SCUs) in nursing homes in the Lombardia region is widely debated. In this region a network of 60 SCUs has been active for the past 8 years to treat patients with dementia with severe behavioural disturbances. The units are funded by the regional health system with 15 euros/patient/day more than regular nursing homes. Since the regional government has decided to optimise expenditures for geriatric and psychogeriatric services, it has been asked whether clinical results obtained in the SCU are worth the extra money. Unfortunately, the international literature analyses markedly different models, and Italian SCU researchers apparently have not performed adequate studies to measure outcomes. The only meaningful piece of evidence is an observational controlled study of 18 SCUs and 25 traditional nursing homes funded by the European Commission, which demonstrates that patients admitted to SCUs had behavioural disturbances of severity similar to patients cared for in traditional nursing home wards, but with significantly less physical restraints (Frisoni *et al*, 1999). Consequently, as physicians, we are unprepared to dispute the decisions of the government and cannot affect the future of SCUs.

This experience further supports the need to implement in our country a system of outcomes research. Although the promises are probably higher than the obtainable results, it is essential to start this process if we hope to improve the diffusion and the quality of psychogeriatric services in Italy.

Frisoni, G. B., Bianchetti, A., Pignatti, F., *et al* (1999) Haloperidol and Alzheimer's disease (letter). *American Journal of Psychiatry*, **156**, 2019–2020.

Holloway, F. (2002) Outcome measurement in mental health – welcome to the revolution. *British Journal of Psychiatry*, **181**, 1–2.

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Recruitment in old age psychiatry

I feel obliged to counter the assertion by O'Gara & Sauer (2002) that decrepit wards are a major contributor to poor recruitment into psychiatry. If true, it need not be so.

As an old age psychiatrist in two Black Country towns (Dudley and Wolverhampton – the latter having recently been dedicated a Black Country city) I have had several undergraduates attached to my teams. We are not a ward-based speciality, our work is done with older people in their own homes. Some of these homes may be decrepit but it is the people within that matter. They have grown old in their homes and all have interesting stories to tell. They are good people who have experienced adversity scarcely imaginable to today's cossetted youth and are the more fascinating for it.

Our students have told us (and I have no reason to doubt their sincerity) that they have felt enriched by the experience of helping these important people in their homes. The students have learned from us and we, particularly if they have been local people, have learned a lot from them. All this is done with little recourse to the great god 'resources'.

O'Gara, C. & Sauer, J. (2002) Recruitment and retention in psychiatry (letter). *British Journal of Psychiatry*, **181**, 163.

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One hundred years ago

The verdict of 'suicide while insane'

AT an inquest held recently upon the body of a medical man in London evidence was given that he had purchased prussic acid, that the bottle containing it had been found nearly empty by his bedside, and that he had died from prussic acid poisoning. There was also evidence that there was nothing in his circumstances or his life to cause him distress and there was no evidence of any motive that might be said to have induced him to take his life. The jury found a verdict of 'suicide' and a discussion took place between them and the coroner as to whether the usual addition should be made to the effect that the deceased at the time of committing the act was of unsound mind, the coroner suggesting that over-study might be considered as a possible cause of mental derangement, while the fact of suicide might be treated as evidence that mental derangement existed. The jury, however, refused to accept these suggestions and the coroner in recording their verdict made the observation that it did not now involve the consequences that used to follow a finding of *felo de se*. The penalties attaching to self-murder constituted in bygone days the effort of the law to punish one whose act had withdrawn his person from its reach. In the words of Blackstone the suicide is guilty of a double offence; one spiritual in evading the prerogative of the Almighty, the other temporal against the King who has an interest in the preservation of all his subjects. The law in Blackstone's day, being unable to punish the dead man, used to act upon what he left behind, his reputation and fortune – on the former by an ignominious burial in the highway with a stake driven through his body, on the latter by forfeiture of all his goods and chattels to the King, hoping that his care for either his own reputation or the welfare of his family would be some motive to restrain him from so desperate and wicked an act. More recently forfeiture for felony has been abolished (in 1870) and since 1882 burial with ignominy has been forbidden and the coroner has now to give directions for the interment of the remains in a churchyard or other burial ground without any right to the celebration of a burial service but not necessarily without the celebration of any such service. The returning of verdicts of "suicide while of unsound mind" without any evidence of such unsoundness is no doubt to a large extent a survival from the days of

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