community medicine, etc., aimed at the prevention and aetiology of mental handicap, rather than the practice of mental health care.

The author rightly states that people with a mental handicap are more prone to developing psychiatric disorders, and probably appreciates that there are vulnerability factors applicable to this group of people, such as social, emotional, environmental and physical causes. Thus some people with a mental handicap have additional special mental health needs and require specialist and generic mental health care services. The outcome indicators chosen should reflect an understanding and acknowledgement of these needs. The increased adoption and use of multi-axial classification systems (DSM–III–R, and the recently proposed multi-aspect assessment (Annes *et al*, 1991)) show the appreciation of the multiplicity of factors contributing to the development of psychiatric illness, behaviour disorders, personality disorder, and offending in people with a mental handicap. Similar approaches need to be extended to outcome measurements.

In reducing the incidence of mental handicap, we should also be aiming to reduce the incidence and prevalence of additional special mental health needs as well as reducing the related effects of adverse social and environmental factors. Therefore we need to relate outcomes to input and process activities. The latter indicators should aim at ensuring good quality comprehensive service provisions, including regular individualised client reviews with forward co-ordinated planning for both providers and clients across all age groups. More specifically, indicators of specialist mental health care input must include the availability of appropriate high quality community and hospital-based specialist psychiatric services for people with a mental handicap who need them. These should consist of assessment, day-patient and in-patient treatment, rehabilitation, and follow-up components.

Measurable outcomes of input and process activities should be ideally related to reduction of disability as well as enhancement of skills. Outcomes of mental health care input should take into account relapse and readmission rates. All indicators should be applicable to people with a mental handicap living in both the community and hospitals.

Further research, together with the practices of clinical audit, quality assurance, and consumer satisfaction initiatives, should contribute to the development of specific indicators relevant to clinical practice of mental handicap and mental health. A closer dialogue and collaboration between researchers, policy makers and clinicians is undoubtedly needed.

ANNESS, V., BHAT, A., BOURAS, N., *et al* (1991) A multi-aspect assessment for people with a mental handicap. *Psychiatric Bulletin*, **15**, 146.

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Census-derived measures and planning

SIR: Thornicroft's exploration of the relationship between treated mental disorder and census-derived measures of social deprivation clearly has important implications for the planning of mental health services (*Journal*, April 1991, **158**, 475–484). The great advantage of census-derived indices is that they are based on readily accessible data that are available for all areas. However, it should be noted that there are some groups for which the census does not provide reliable information – in particular the homeless.

Until 1991, the ten-yearly census was completed in relation to households and so, by definition, omitted the homeless. While there is likely to be a relationship between homelessness and the change of address factor, it is both uncertain and indirect. However, for the first time, the 1991 census attempted to enumerate certain sub-groups of homeless individuals. Street workers who had had regular contact with the 'literal' (i.e. roofless) homeless were enrolled as enumerators to facilitate this process. It should be remembered that the roofless, while highly visible and politically embarrassing, comprise only a fraction of the total number of homeless. Further, it has been argued that this simple headcounting approach is not the best suited to estimate the size of the homeless population (Susser *et al*, 1989).

Awareness of the size of the homeless population is important for those planning mental health services, as the homeless are known both to suffer an excess of mental disorder (Tessler & Dennis, 1989) and to be heavy users of mental health services (Fisher *et al*, 1990). As a result, in accordance with 'Working for Patients' (Department of Health, 1989), it is incumbent on health authorities to make specific attempts to estimate the size and mental health needs of their local homeless population.

This information must then be utilised in a creative fashion to ensure that the health needs of the homeless are met. For example, there is no evidence that the homeless are unable to make use of existing services. Any excess unmet need is likely to reflect patterns of use of service that are so chaotic as to be

rendered useless. One innovation that may bear fruit would be the development of a case register of the homeless mentally ill. This would give such individuals a better chance of receiving some form of ongoing, co-ordinated care, wherever they might present. Further, such a register would facilitate the equitable distribution of any central funding which may be directed towards the health care of the homeless.

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FISHER, N., TURNER, S. & PUGH, R. (1990) Homeless and mentally ill. *Lancet*, 14 April, 914–915.

SUSSER, E., CONOVER, S. & STRUENING, E. L. (1989) Problems of epidemiologic method in assessing the type and extent of mental illness among homeless adults. *Hospital and Community Psychiatry*, **40**, 261–265.

TESSLER, R. & DENNIS, D. (1989) *A Synthesis of NIMH-Funded Research Concerning Persons Who are Mentally Ill*. Washington DC: National Institute of Mental Health.

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Screening of admissions to accident and emergency

SIR: Bell *et al* (*Journal*, April 1991, **158**, 554–557) confirm numerous previous reports that it is always possible in the general hospital for psychiatrists to locate some patients whose psychiatric disorders have not been diagnosed by physicians or surgeons and others who have been inappropriately referred. Does this matter?

Almost invariably in this kind of study, some identified patients, although psychiatrically disordered, will be judged unsuitable for psychiatric treatment or may decline it, or treatment may prove ineffective or even detrimental; others, after leaving hospital, may be treated by general practitioners or reach psychiatrists through various agencies. Unless a comparison is made between the outcome of similar groups of patients referred or not referred to psychiatrists it remains an open question as to how much the medical staff's failure to detect psychiatric morbidity really matters.

Every specialty has to accept some inappropriate referrals, but Drs Bell *et al* do have a point to make about the automatic referral of all overdose patients to psychiatrists in the Accident and Emergency Department at University College Hospital. This practice ceased to be mandatory in 1984 when the DHSS amended its recommendation that all self-poisoned patients should be seen by psychiatrists. Medical staff, however, are unlikely to be sufficiently motivated to carry out an initial psychiatric assessment if psychiatrists – or indeed psychiatric nurses or social workers as Drs Bell *et al* propose – are always available to do the job for them.

There is in fact ample evidence that medical and accident service staff, given suitable training, are competent to assess suicidal risk in their overdose patients and to decide the need for psychiatric or social work referral (e.g. Waterhouse & Platt, 1990). By gaining experience in making this assessment they may incidentally improve their ability to listen to the generality of their patients and to detect if they are psychiatrically unwell.

WATERHOUSE, J. & PLATT, S. (1990) General hospital admission in the management of parasuicide: a randomised controlled trial. *British Journal of Psychiatry*, **156**, 236–242.

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What's in a name?

SIR: Changing names/titles is a frequently used device to signify real or imagined change and progress (e.g. Windscale becomes Sellafield, Mental Illness Service becomes Mental Health Service, etc.). Now Consultant Psychiatrist, at least in Dr Falloon's case, becomes "Consultant Physician (Mental Health)" (Rea *et al*, *Journal*, May 1991, **158**, 642–647). This title may be less daunting and less stigmatising among patients and even other medical colleagues, although it could cause confusion as psychiatrists are not, at least in popular understanding, physicians.

I rather like the historical "Mental Hygienist"; perhaps other psychiatrists have suggestions for a new name. Should we consult widely on this issue and change not only our titles but the name of the College?

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Anorexia nervosa in the elderly

SIR: O'Shea (*Journal*, May 1991, **158**, 716–717) questions the diagnosis of anorexia nervosa in the elderly lady we previously described (*Journal*, February 1991, **158**, 286–287), and suggests that an atypical affective disorder was a more likely explanation of her symptoms. This assertion we believe to be