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.

DEPARTMENT OF HEALTH (1989) *Working for Patients*. London: HMSO.

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