

reported in our recent paper (Collishaw *et al.*, 2004). Controlling for childhood epilepsy/neurological problems did not reduce group differences in adult depressed affect (model adjusted only for gender: OR=2.84, 95% CI 1.7–4.9, $P<0.001$; model adjusted for gender and childhood neurological problems/epilepsy: OR=2.79, 95% CI 1.6–4.8, $P<0.001$). This is in contrast to the partial mediating effect of controlling for childhood social adversity (Maughan *et al.*, 1999; Collishaw *et al.*, 2004) and the almost complete mediating effect of additional controls for adult ill health and adult social adversity (Collishaw *et al.*, 2004).

We cannot rule out completely the possibility that some other unmeasured third factor is confounded with social adversity and could explain our findings. We also acknowledge that specific biological factors may be of particular importance for understanding affective problems in some individuals with mild learning disability. Nevertheless, when assessed in an unselected general population cohort such as the NCDS, social factors and adult health do appear to have an important contribution to depressed mood among people with mild learning disability.

Collishaw, S., Maughan, B. & Pickles, A. (2004) Affective problems in adults with mild learning disability: the roles of social disadvantage and ill health. *British Journal of Psychiatry*, **185**, 350–351.

Maughan, B., Collishaw, S. & Pickles, A. (1999) Mild mental retardation: psychosocial functioning in adulthood. *Psychological Medicine*, **29**, 351–366.

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Prevalence of dementia

We thank Dr Varghese (2005) for his letter regarding our article (Shaji *et al.*, 2005). Lack of education is a potent predictor of poor performance across many items of the Chinese version of the Mini-Mental State Examination (MMSE; Katzman *et al.*, 1988). There was no significant difference between total MMSE scores of those who were illiterate and those who were literate in the pilot study conducted with the Malayalam adaptation of the MMSE. Hence it was decided to use the same score for both groups.

We identified 55 cases of dementia among 327 people who scored at or below the cut-off on the MMSE. The one case identified from the 10% of the negatively screened population was counted as one among the ten cases in the negatively screened population of 1607 (i.e. 65 cases in 1934 people aged 65 years and above).

The assessment of risk factors based on retrospective accounts of the carers and an inadequate number of controls for calculating the odds ratios can be considered methodological limitations of the study. The prevalence of dementia increases proportionately with age ($\chi^2=40.29$, d.f.=5, $P<0.001$). This χ^2 value was not given in the text. The number of patients with Alzheimer's disease was 30. The error in the article is regretted.

Katzman, R., Zhang, M.Y., Ouang-Ya-Ou, et al (1988) A Chinese version of the Mini-Mental State Examination; impact of illiteracy in a Shanghai dementia survey. *Journal of Clinical Epidemiology*, **41**, 971–978.

Shaji, S., Bose, S. & Verghese, A. (2005) Prevalence of dementia in an urban population in Kerala, India. *British Journal of Psychiatry*, **186**, 136–140.

Varghese, S. T. (2005) Dementia prevalence (letter). *British Journal of Psychiatry*, **186**, 542.

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Measures for mental health outcomes

I was very interested to read the article by Salvi *et al.* (2005) on choosing the measure for mental health outcome assessments. Readers might be interested in a comparison of the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS; Phelan *et al.*, 1995) and Health of the Nation Outcome Scale (HoNOS; Wing *et al.*, 1998) scores. One thousand pairs of HoNOS and CANSAS scores were recorded by four trainees and myself. Figure 1 shows the means with standard errors of the HoNOS values associated with each CANSAS score.

The higher CANSAS scores (13–22) were not encountered very often and accounted for only 3.5% of scores. The large standard errors are because some of the CANSAS scores occurred infrequently.

HoNOS and CANSAS scores are related in the lower CANSAS range of 1–8, the most common range, accounting for 79% of the scores. Up to a CANSAS score of 12 ($n=955$) there is a reasonably close correlation with the HoNOS scores. The Spearman coefficient is 0.564, indicating that the correlation is significant at the 0.01 level (two-tailed).

The use of CANSAS is becoming established in Lothian mental health services. CANSAS is very useful as a needs assessment tool for individual patients. Its face

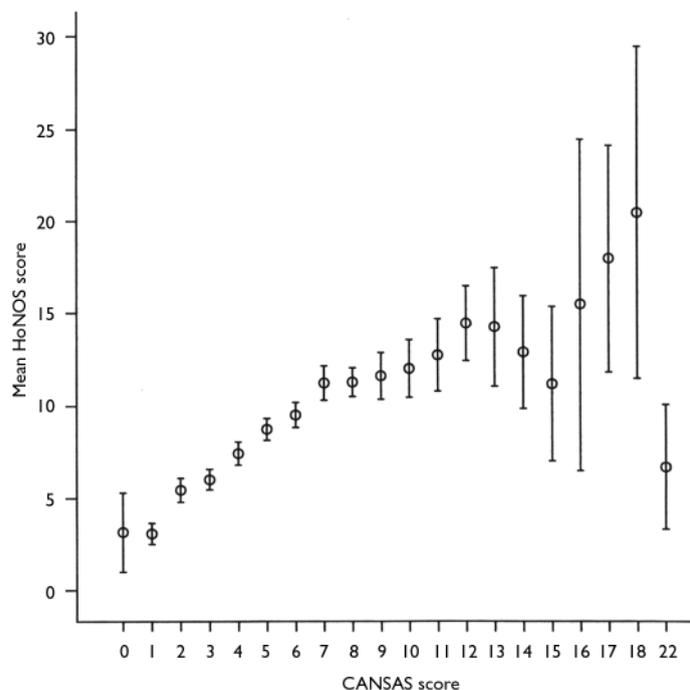


Fig. 1 Comparison of 1000 pairs of CANSAS and HoNOS scores. Bars represent two standard errors above and below the mean. CANSAS, Camberwell Assessment of Need Short Appraisal Schedule; HoNOS, Health of the Nation Outcome Scale.