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Correspondence

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USE OF 1974 A.A.M.D. CLASSIFICATION IN HOSPITALS FOR THE MENTALLY HANDICAPPED

DEAR SIR,

In July 1964, Mr. B. Benjamin, Chief Statistician to the Ministry of Health, wrote to hospitals for the mentally subnormal asking them to use the clinical section of the Classification devised by the American Association on Mental Deficiency for the completion of Box 16 of the Mental Health Enquiry Hospital Index Card A. This Classification was published in a Monograph Supplement to the *American Journal of Mental Deficiency*, September 1959, under the title *A Manual on Terminology and Classification in Mental Retardation* by Rick Heber. As applied in this country by the Ministry this classification did not involve any component to express the intellectual levels of the patients. The classification had the advantage of incorporating a number of supplementary categories to provide additional information about the patients. These were genetic component, secondary cranial anomaly, impairment of special senses, convulsive disorders, psychiatric impairment and motor dysfunction (type, location and severity) respectively.

In November 1969, Dr. A. A. Baker, then Senior Principal Medical Officer in the Department of Health and Social Security, requested hospitals for the mentally handicapped to use the section on Mental Retardation in the World Health Organization International Classification of Diseases, Eighth Edition 1965, in the completion of the Mental Health Inquiry Index Cards. This classification provides for the expression of the intellectual grade and broad aetiological categories, but does not present any other information about the patients.

The inadequacies of both the above classifications have now been largely overcome by the revised classification published by the American Association on Mental Deficiency (A.A.M.D.) under the title *Manual on Terminology and Classification in Mental Retardation* (1973), edited by Herbert J. Grossman. This new classification uses the same code numbers for the intellectual status as the I.C.D. and the same first digits as the I.C.D. for the aetiological categorization. The addition of 2nd and 3rd digits to the aetiological categorization enables much greater clarification and exactitude to be achieved in the expression of the diagnoses. The classification also includes additional medical information categories, similar to those of the 1959 A.A.M.D. Classification, but with a useful section for Disorders of Perception and Expression inserted between Impairment of Special Senses and Convulsive Disorder.

So far there has been no official recommendation to use this Classification in returns to the Department of Health, but this new revised A.A.M.D. Classification is the most comprehensive now available. In hospitals which have already classified their patients according to the 1959 A.A.M.D. Classification and the I.C.D. Classification this revised 1973 A.A.M.D. Classification can readily be applied.

This Classification meets the objections raised by Dr. J. E. Oliver in Correspondence in this *Journal*, (December 1974, 125, 612) about the I.C.D. (Mental Retardation) used alone, and avoids the need for double diagnoses on the W.H.O. Classification.

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INTRACELLULAR LITHIUM CONCENTRATION AND CLINICAL RESPONSE

DEAR SIR,

The possibility of determining the erythrocyte lithium concentration opens new perspectives in lithium salt therapy. In fact, R.B.C.—having the same enzymatic mechanisms of transferring cations across the cell membrane as the nervous cells have—seem to represent a better predictor of the brain Li concentration (Frazer *et al.*, 1973). Indeed, the clinical application of these experimental results to the screening of responders and non responders to lithium seemed to us of relevant interest. Preliminary data exist (Mendels and Frazer, 1973) suggesting that patients suffering from primary affective disorders having a high R.B.C. Li—plasma Li ratio ($>0{\cdot}50$)