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CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Brendoncare: an initiative in the care of the elderly

SIR,—It gave me great pleasure to read the article by Dr Tony Smith on Brendoncare (6 October, p 909). The Brendon nursing home shows that a good home can be provided at a reasonable cost to anyone. The combination of state, charity, and private funding provides excellent continuing care far more easily than can be apparently managed by the state alone. Of interest, however, is the waiting list for Brendon, which exceeds 100 in a home where there have been six vacancies in six months.

Inadequate development of support in the home is the ever growing root of the problem. "The maintenance and even increase of the share of resources going to hospitals and residential institutions has been something of a paradox. Despite the powerful movements in favour of community care, emergence of that sector can not be said to have properly materialised."[1] This statement by Townsend describes what is an underlying continuing failure in the care of the elderly which creates the waiting lists on which old people "often spend months or years at an inappropriate level" as described by Dr Smith.

The delicate balance of health service, social service, and local authority support required to maintain successfully the elderly in the community is impossible to maintain and develop in the ever changing political and economic climate of today. Interagency plans are the first to collapse when there is a change of policy within one of the agencies.

A single agency responsible for elderly rehabilitation and long stay services, residential and domestic support, social services, and local authority sheltered housing with a unified management structure could make an enormous impact. It could provide a single office for all referrals for statutory or voluntary support, ensure the maintenance of health, mobility, and living standards in accommodation currently outside the health service, and be far more cost effective than present arrangements. Such a body with a budget and executive powers established with appropriate funding arrangements would have a chance of succeeding where our current services are clearly failing.

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1 Townsend P. The structured dependency of the elderly; the creation of social policy in the 20th century. *Ageing and Society* 1981;**1**:5-28.

SIR,—Dr Tony Smith rightly states that the prevailing mood among health professionals working with the elderly is profound gloom, especially among those working in psychogeriatrics. One in 10 of those over 65 suffers from dementia, and in half of these the condition is severe; 20% are in an institution of some kind, and 80% are looked after or neglected in the community.[1] Those over 65 represent 12% of the population, and more than a third of those are over 75. High prevalence of psychiatric disturbance has been reported among supporting relatives, and the distress was sufficient in most cases to warrant a psychiatric diagnosis.[2]

Differences in the rates of admission to and discharge from psychogeriatric assessment units were related to the percentage over 75 (high prevalence of both mental and physical disabilities, with longer period of stay) the effect of back up facilities, the number of places in residential accommodation (these have failed to keep pace with the growth in the elderly population[3]) and last but not least pressures on reluctant relatives.

Non-specialist homes for the elderly mentally infirm on the Brendoncare model have been recommended, but this recommendation has not gone unchallenged.[4] But without enough evenly spread resources no service can fulfil its expectations.

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1 Kay DWK, Beamish P, Roth M. Old age mental disorders in Newcastle upon Tyne. *Br J Psychiatry* 1964;**110**:146-58.
2 Gilleard CJ. Emotional distress among the supporters of the elderly mentally infirm. *Br J Psychiatry* 1984; **145**:172-7.
3 Grundy E, Arie T. Falling rate of provision of residential care for the elderly. *Br Med J* 1982;**284**: 799-802.
4 Wilkin D, Evans G, Hughes B, Jolly D. The implications of managing confused and disabled people in non-specialist residential homes for the elderly. *Health Trends* 1982;**14**:98-100.

SIR,—I was a little saddened to read in Dr Tony Smith's article of the general opinion of the low standard of long stay care provision in the National Health Service. This certainly does not apply in our area, although it is not what it could be—particularly in some of the more peripheral hospitals.

In Trinity Hospital in Taunton we have active input from the occupational therapists, and sometimes the physiotherapists, on our long stay wards, and patients are taken regularly on outings. Arts competitions and various other competitions and games are organised,