In a paper concerned with the medical care of the mentally handicapped in the community Dr H.G. Kinnell[4] has pointed out that mental and physical disease is common and hard to diagnose in the mentally handicapped. He advocates the retention of the regional handicapped hospitals as resource centres. In contrast with this, community mental handicap teams have come into being without the benefit of medical involvement. The prevailing view appears to be that the needs of the mentally handicapped are non-medical. However, Howells[5] has recently highlighted the extensive medical needs of mentally handicapped people attending a day centre. If the mentally handicapped in the community are to receive proper medical care, special provision will need to be made as this group of people are unlikely to be vociferous in demanding attention.

There is little doubt that there are mentally handicapped people currently resident in hospital who could live more independently. Whether large scale transfer of patients out of hospital and into the community is a good idea is quite a different matter. The Royal College of General Practitioners in its report to the 1985 Parliamentary Select Committee chaired by Mrs Renee Short[6] argued that transfers should take place only if accompanied by a transfer of resources to the community. The select committee also said that hospitals should not be closed down without demonstrably adequate alternative services being provided beforehand.[6] Good community care of the mentally handicapped is not going to be cheap. The number of aid staff required to run group homes is likely to exceed the numbers employed in hospitals.

At present relatives, doctors, nurses, hospital managers, social workers and the mentally handicapped themselves are uncertain about the future. No one can deny that the scale of local help for the mentally handicapped should be improved or that many hospitals are candidates for reform. However, the welfare of the majority of mentally handicapped people who are looked after in their own homes will be hindered, not helped, by hospital closures. Many hospitals have good facilities such as community halls, workshops and treatment centres. These facilities should be recognized and developed. To think of hospitals simply as a last resort will inspire dread and guilt in the minds of relatives who are no longer able to cope with the continuing care of a mentally handicapped member of the family. While no one can quarrel with attempts to dispel prejudice about mentally handicapped people living next door, it is equally important to enhance the image of the hospital.

Hospitals should be the focal point of a coordinated service embracing all forms of residential care and in which staffing and funding should be integrated. They can and should be a source of help for mentally handicapped people in the outside community, not only from the point of view of investigative help and day facilities but also as a potential haven in times of need.

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Preventive care of the elderly

THE number and proportion of old people in Britain have been growing in recent years and although they are now beginning to level out, the so-called 'elderly elderly' — a particularly vulnerable group with very special needs — are continuing to increase in number.

For many years the emphasis in general practice has been on the other end of the age spectrum with numerous pronouncements and publications on the care of children in general practice, notably the College's report *Healthier children — thinking prevention.*[1] Part of the theme of that report was multidisciplinary teamwork whereby general practitioners were recommended to work closely with health visitors and nurses in order to offer systematic surveillance to every child in the practice. Now a similar philosophy is emerging in respect of the elderly. Here again, the challenge for change is driven by evidence of unmet need and confirmation that planned intervention can be effective.[2,3] Now the question is how rather than whether such care should be provided.

The general practitioner is uniquely well placed to initiate and monitor this form of care. As many as 95% of elderly people are known to be in the care of general practitioners and as many as 33% of the over-65-year-olds see a general practitioner face-to-face within a month.[4] This remarkable statistic deserves to be more widely known not only because it shows that the elderly represent a growing and important clinical responsibility for general practitioners but because it gives a logical basis for this kind of work being undertaken by the primary care team.

Occasional paper 35 is the report of a national workshop held in Harrogate in March 1986 which was supported by the Chief Scientist of the Department of Health. Edited by Dr Rex Taylor and Dr Graham Buckley, it describes 10 schemes currently undertaking case-finding or screening programmes in primary care and offers six review papers by experts in the field. In it, a number of valuable ideas are explored, including the effectiveness of using nurses, occupational therapists and health visitors as well as volunteers in screening programmes.

Given the recent initiative from Age Concern in the form of a leaflet distributed to all members of the College with the October *Journal,* the stage is set for planned surveillance of the elderly in general practice. This occasional paper provides a useful overview of the subject and offers numerous ideas for primary care teams wishing to institute case finding or screening programmes for the elderly in their practices.

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Preventive care of the elderly — a review of current developments, Occasional paper 35, is available from the Central Sales Office, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £5.00 including postage. Cheques should be made payable to RCGP Enterprises Ltd. Access and Visa are welcome.