the recommendation to the community of a "prudent diet" rather than one aimed specifically at one aspect of preventive medicine. Increasing the amount of dietary fibre may "prevent" diverticular disease and would certainly decrease the frequency of constipation —one of the most common causes of morbidity in our society. Furthermore, such a diet improves glucose intolerance in the mid, and perhaps even the more severe, diabetic patient.[1] The necessity of stressing the importance of achieving ideal body weight in any set of recommendations would not be disputed, and clearly any detailed dietary advice would include information concerning essential nutrients. A diet relatively high in fibre and complex carbohydrate should, on average, contain less total fat and resemble rather more closely the diet of those countries where CHD, diabetes, and gastrointestinal disease occur infrequently.

It is relatively easy for the scientist to make specific recommendations aimed at reducing the frequency of particular diseases; it is more difficult for the public to synthesise without help a series of such isolated recommendations into guidance for a healthy overall diet. The clear recommendation of such a prudent diet is, in our opinion, overdue.

However, for many—perhaps most—members of the community the overriding factors determining diet will be economic considerations. Government and EEC policy which ensured, by appropriate subsidies, that the healthiest foods are also the cheapest might achieve more than any recommendations.

J I MANN
DIANA GALE
J S S GEAR

Oxford

[1] Brunzell, J D, *et al*, *Diabetes*, 1974, **23**, 138.

Hospital-based community service for the mentally subnormal

SIR,—The staff of many hospitals for the mentally subnormal have been faced in recent years with the problem of discharging patients who could fend for themselves in the community with a small amount of supervision but of being unable to find anyone who would be prepared to accept such a task. Many social service departments are sympathetic to this idea but have neither the resources nor premises for this work. During the past two years in this area a domiciliary nursing service has been established whereby the hospital nursing and medical staff find suitable houses, flats, and lodgings and provide an after-care service for such patients.

Six years ago the Welsh Office paid the rent and furnished two new four-bedroomed houses—built by the Cwmbran New Town Development Corporation—and sanctioned their use as "half-way houses" prior to the discharge of patients. This scheme worked so well that when the Ministry of Health cut the number of places in hospital for subnormal patients from 1% to 0·67% and increased the bed area from 40 ft² to 70 ft² per patient and it became imperative to accelerate the discharge into the community of many patients the outline of a discharge programme was ready to hand.

Suitable properties—some quite old and dilapidated—were rented, redecorated, and furnished by the League of Hospital Friends in conjunction with the domiciliary nursing staff and, to date, four four-bedroomed houses, four flats, and a 14-acre farm have been rented for discharged patients. To support the patients in the houses and others living in their own homes five clinics run by the hospital nurses and medical staff have been established at strategic sites. Three other houses have been promised by other local authorities in Gwent.

By this means it has been possible to discharge 30 patients back into the community and the three domiciliary nurses have a case load of 200. Such patients claim social security benefits and if they pool their resources they are able to live adequately from a financial point or view. They are visited regularly by one of the domiciliary hospital nurses and it is the usual practice to employ a "house mother" or domestic assistant to visit the house for a couple of hours a day and be paid by the patients. Seven patients live in the farmhouse and, with the help of one of the nursing officers, farm the 14 acres, which is financially self-supporting after an initial grant of £1000 for stock from the League of Friends.

The local authorities in Gwent have been very helpful in renting both old and new properties for this purpose and the community service order arrangement whereby an offender can be given work, such as renovating old properties in lieu of a sentence, is another scheme which it is hoped to make use of in the near future.

It has been found that sympathetic neighbours play an important part in the success of such a programme and the occupants of each house are put in touch with the local clergy, a general practitioner, and the local leisure centre. Local leagues of friends and societies for the mentally handicapped are also keen to "adopt" such houses.

The advantages of this method of help for the subnormal is that they have a tenuous link with a hospital and yet have all the advantages of complete freedom by living in the community. Perhaps our experience in this field may be of help to other hospital authorities.

T S DAVIES

Llanfrechfa Grange Hospital,
nr Cwmbran, Gwent

More thought for the elderly

SIR,—I wish to invite comments from colleagues on a disquieting situation. There is a serious gap in the medical and social services for the elderly.

I find that increasingly hospitals are discharging very infirm people back to their homes too early, knowing full well that they live completely alone. It is prompted by the assumption that the patient will be looked after by his general practitioner and the community nurse and will be provided with meals on wheels (not really geared to the requirements of the elderly in the long run and not readily available at weekends and during holidays). Adjustments are made, like rails, seat-lifting devices, raised toilet seats, etc. I sense a false security here; it works in some cases but leaves others isolated and helpless, the only alternative being a neighbour's charity.

I will mention two instances which happened in my practice in the same week recently, but there are many more. An 84-year-old man incapacitated by Parkinson's disease was found dead during a chance visit by a neighbour only a few weeks after having been discharged from hospital to his home, where he lived alone. Before his hospital admission inquiries were made for part III accommodation (residential, with full board and nursing facilities) and the waiting list proved to be formidably long. And an 87-year-old lady, very deaf, helped little by her hearing aid, was found one morning on the kitchen floor by her neighbour, having lain there all night after tripping over and not being able to raise herself. She was recently sent home from hospital, where she had been recovering from a stroke. She lives alone and has no relatives and therefore the community services were alerted. But it did not work.

The most hard hit are those who own some kind of property. The fact that a person possesses a house, no matter how dilapidated, brings obstacles in getting him or her to a welfare home for the elderly, even in the most deserving cases. Yet such a person often has no ready money for a private nursing home and no one to turn to who would undertake the selling of the property. The unfortunate elderly person, a prisoner in his own house, worries about shopping, bills, or the electric bulb which went out leaving him in darkness and is awaiting eagerly a fleeting visit from the "services" to break the fearful isolation and monotony.

Part III accommodation should be immediately available for all urgent cases; such service is at present, in my experience, a nominal one. I see good intentions being misapplied. Costly holidays for the elderly and readjustment of his dwelling are undertaken in instances where it does not serve any useful purpose—only postponing the inevitable admission to part III accommodation.

It is common knowledge that many residents of part III accommodation should not be there in the first instance. They should be in the sheltered warden-controlled houses, as they can look after themselves, leaving a place for those who cannot. In spite of its complexity the services should strive for a quick solution when confronted with dire necessity. Building homes for the elderly, both sheltered housing and part III accommodation, should take priority over any other public-sector developments—running them is cheaper than running geriatric hospital wards. And it is up to the community to help the most needy.

CHARLES ROBERTS

Harrow, Middx

Rubella vaccination in independent schools

SIR,—The finding by Dr Catherine S Peckham and her colleagues (19 March, p 760) that relatively few girls attending independent schools had been vaccinated against rubella is a matter for serious concern, but their discussion of possible explanations calls for some comment.

In the first place they postulate a "lack of structure for administering vaccine in independent schools." In interpreting their findings it should be remembered that the girls in their survey were already 12 years old when rubella vaccination first became available in 1970. While it is possible that some independent schools were slower to implement a system for rubella vaccination than maintained schools having the advantage of a centralised school health service, the situation today is very different, with many independent girls' schools achieving vaccination rates approaching 100%. Furthermore, many are now included in the area health authorities' immunisation programmes and there is no reason why this