In this health district (total population 146 000) the recent cuts have meant that one residential home already built cannot be opened because of shortage of funds, and two other homes which were planned have now been cancelled.

The waiting list for a place in a part III home is already unacceptably long. The local solution, however, has been to make increasing use of the "boarding out" scheme and the growing number of private residential homes. If the person cannot meet the full cost of the fees, then in most cases the balance will be made up by the DHSS.

Many of these private homes are cheaper than part III places, and, furthermore, the capital cost of building the home has been saved. There is the added advantage that the old person has a wider choice of places and is thus more likely to find something that suits him.

Unfortunately, it is now increasingly likely that only the frailest persons will go into part III and that very soon they will become indistinguishable from nursing homes. Furthermore, it remains to be seen how well the private sector will cope with its aging residents and whether care will be continued up until the end or increasing demands made for terminal admissions to long-stay hospital beds.

Because of the high level of dependence of part III residents, the number of staff in these establishments will have to be increased, and there is no way of avoiding the necessity of allocating more funds to these homes.

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SIR,—While I agree wholeheartedly with Ms Emily Grundy and Professor Tom Arie (13 March, p 799) that the provision of residential care for the elderly in England is inadequate, I find an ethical dilemma in the comparison of old, "dementing" persons with children. In my experience the majority of demented old persons wish to return to their own home in spite of being told of the risks involved. If we equate these people with children we would be compulsorily removing vast numbers of old persons to residential care. I do not think many old people or their supporters, such as Age Concern, would agree with this attitude.

Also, I would like to know at what "level" of dementia or risk an old person should be removed from his home or refused to be allowed to return there. Risks have therefore to be taken compatible with personal freedom.

Also in my experience only a small number of the very confused at home are capable of getting on to the public roads, where they might be run over. This is often a result of concomitant physical disability. In my experience it is those with the earliest stages of dementia that are most at risk from these road accidents. If all these persons had to be institutionalised there would have to be an astronomical increase in residential care, which incidentally has its own health hazards, such as the well described "relocation effect."

Thus I feel that the emotive comparison of old people with children is hazardous and not fully justified in the light of society's choice of personal freedom.

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SIR,—The gloomy prospect for the elderly forecast by Emily Grundy and Professor Tom Arie (13 March, p 799) is true not only because of a falling rate of provision of residential care for the elderly, but also because of proposed cuts in the health service.

In inner London it is proposed that over 3200 acute beds, which are primarily used by the elderly, should be closed to make savings. Although the London Health Planning Consortium has suggested replacement of these beds by geriatric beds,[1] the figures do not correspond to the need, which is greater than the suggested and assumed norm. This is because of the special problems of inner London—that is, isolation, poor housing, poorly organised community services, less than the required amount of sheltered housing, etc.

Already we are seeing a minor crisis[2] because of the cuts since 1977 in hospital services, and if the proposals of the London Health Planning Consortium and the Resources Allocation Working Party[3] are implemented fully without further assessment or question the situation will develop into a major crisis, as has been stated by Tom Snow[4] of Age Concern.

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1 London Health Planning Consortium. *Acute health services in London.* London: HMSO, 1979.
2 Mitchell J. *Times Health Supplement* 1982 Feb 26: 3 (col 2-4).
3 Resources Allocation Working Party. *Sharing resources for health in England.* London: HMSO, 1976.
4 Snow T. *Service for old age: A growing crisis in London.* London: Age Concern, 1981.

The hyperkinetic child: two views

SIR,—I read the leading article "The hyperkinetic child: two views" by Dr Dora Black (20 February, p 533) with interest.

The hyperkinetic syndrome is more common in mentally handicapped children than in children with normal intelligence. I am surprised not to see any mention of tranquillisers in the drug treatment of hyperkinetic children in Dr Black's article. In my experience tranquillisers like haloperidol, chlorpromazine, and thioridazine are useful in hyperkinetic children with mental handicap. Barker[1] found haloperidol particularly useful for excess motor activity, restlessness, and aggressive and impulsive behaviour.

As phenobarbitone causes hyperkinesia[2] in children it is a good idea to withdraw it in hyperkinetic epileptic children, particularly in uncontrolled epilepsy, and substitute some other anticonvulsant; even a reduction in the dose of phenobarbitone helps (as was the case with one of my patients who got a reprieve from exclusion by the school). One has to bear in mind to avoid primidone as well because it is partially broken down into phenobarbitone.

As a consultant psychiatrist in mental handicap in a district with a population of about 180 000, I have come across a small hard core of pervasively hyperkinetic mentally handicapped children (referred by general practitioners, senior clinical medical officers, a consultant paediatrician, and a child psychiatrist). The total number is 12 over the last five years—nine boys and three girls. Eight of these children have autistic features over and above their severe mental handicap (all three girls have autistic features). Five children have responded to haloperidol to some extent (they are more manageable at home and at school). Three of the haloperidol responders have autistic features.

The total number of mothers suffering from depression is three—all of them have had treatment with antidepressants. Their hyperkinetic children have autistic features. I have tried stimulants—for example, methylphenidate—without any success. None of my patients is on stimulants at the moment. In my experience it is easier to control excessive activity in a hyperkinetic mentally handicapped child without autistic features than in one with autistic features.

Of course, hyperkinetic children are a heterogenous group with different aetiologies, and they need multimodality treatment. Drugs are only part of the management. Behaviour modification including good old discipline applied consistently at home and at school, educational management, and involvement of the parents and siblings are extremely useful. I find meeting the parents with the child about once a month very helpful. Parents and siblings sometimes get physically and mentally exhausted in having to live with a hyperkinetic child. They need a lot of support. Short-term care of the hyperkinetic child in hostels and hospitals (a paediatric unit and hospital for the mentally handicapped) should be part of the management. In my experience the hyperkinetic child and the family benefit immensely from short-term care.

Dr Black says: "the prognosis for hyperkinetic children is poor in adolescence." I am more optimistic when I look at my group (bearing in mind it is a hard core): two are adults and four are adolescents at the moment, and all of these six patients are less of a problem now than before.

In spite of the enormous amount of work on the subject,[3] I feel we do not try hard enough to help the hyperkinetic child and his family.

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1 Barker P. *J Child Psychol Psychiatry* 1975;16:169-72.
2 British Medical Association and Pharmaceutical Society of Great Britain. *British national formulary 1981.* London: BMA and Pharmaceutical Press, 1981:141.
3 Cantwell D. In: Rutter M, Hersov L, eds. *Child psychiatry: modern approaches.* London: Blackwell Scientific Publications, 1977.

How women view postepisiotomy pain

SIR,—Dr A E Reading and others (23 January, p 243) have commendably studied the relatively neglected subject of postepisiotomy pain and discomfort. Their study is unfortunately flawed by several sources of bias which make generalisation of some findings difficult.

Follow-up data from the postal questionnaire were available for 69 patients—a response rate of 68%. No information, however, is given about the similarities or differences between the responders and the non-responders, though one would expect differences to exist for such factors as social class, or the incidence of complex or instrumental delivery. It is conceivable also that women without problems have less incentive to answer the questionnaire.

In addition to a non-response rate of 32%, there appears to be substantial non-response to certain questions in the questionnaires returned. Though this is not alluded to in the paper, it may be reasonably inferred by calculating and comparing row totals in various tables. In table III, 41 women at follow-up rated labour pain, while women answering questions on pain (table VI) and on