Conclusion

Primary insomnia is rare

- Patients may need long term treatment with hypnotic drugs

Secondary insomnia is more common

- Treat the underlying cause:
  - Psychiatric disturbance
  - Physical disease
  - Chronic pain
  - Misuse of substances, particularly alcohol

Complaints of not getting enough sleep are not always related to actual or easily detected changes in patterns of sleep. Satisfaction with sleep is controlled by a number of factors and often is not associated with objective findings. Insomnia is the most common disturbance of sleep, and accompanies several diseases. Psychiatric and physical disease, chronic pain, and misuse of substances (particularly alcohol) are common causes of secondary insomnia. Primary insomnia, supposedly caused by dysfunction of the sleep mechanisms in the brain, is uncommon but may develop at any age and is occasionally precipitated by changes in the system of behavioural cues or contingencies that control sleep. Subjects with primary insomnia can crudely be separated into those with high or low levels of arousal. The diagnosis of insomnia must be based on a full history, clinical examination, and an understanding both of the patient's personality and environment. For this minority of patients long term treatment with hypnotic drugs may be appropriate.

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The ABC of Sleep Disorders has been edited by Professor Colin M Shapiro.

For Debate

Long term care on the NHS: a vanishing prospect

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Because of the spectacular growth in provision the number of long stay beds in the private and voluntary sectors now dwarfs the number available for long term care in the NHS. Continued financial pressure on the NHS has led many authorities to reduce their long stay provision or to buy places within the private sector, which are often cheaper than their own beds. Nevertheless, the Department of Health's policy, as reiterated in a letter to Newcastle Health Authority in 1992 by Stephen Dorrell, states "Health authorities do, however, have—and will continue to have—a responsibility to provide or secure long term care for those people who need it by reason of the predominance of their continuing ill health."[1] At the moment the NHS is in practice abrogating that responsibility. It is time to recognise that fact and radically rethink the provision of long term care.

Current means of regulating demand

Private care is still largely confined to the elderly, which is where the conflict between the availability of beds and the needs of the relatives and the patient is most apparent. When an old person becomes so demented that she or he cannot be contained in an old people's home the choice is between a private nursing home costing about £400 a week or a free bed in the NHS. Why should anyone choose to pay? Up to now there have been four methods of regulating supply and demand, all equally iniquitous.

The first method is for the NHS to provide such a poor service that no one would choose it. This was the policy of the work house, in whose original premises most of these hospitals are sited. Such a policy runs directly counter to the current policy of using the NHS to train staff in giving long stay care and provide a model for the private sector.

The second method is to use a waiting list so that only those whose condition is mild enough to enable care to continue at home will be admitted. Those whose dementia progresses rapidly or who suddenly become unmanagable because of aggression or death of the carer have no hope of admission. In this way the NHS can show 100% bed occupancy and lots of cheerful staff and patients luxuriating in an unnecessary service. This must be the worst system of rationing.

The third method is to allocate places to those who have the muscle to demand them. In this service the middle classes—who might be able to afford private care—are admitted, and the burden of care falls on those least able to cope or argue their case.

The fourth is not so much a method as a means of disguising the reality of the other three from the public. It involves using strict criteria for admission, such as failure in a nursing home or extreme restlessness and aggression. This policy might have some justification if hospital long term care beds were separate from the private sector, but it carries no conviction when the NHS buys many of these patients places in the private sector. We have shown no significant difference in disability between people in the nursing home and those in long stay hospitals (S Turner, personal communication). The hospital staff have the skills to care for these patients such that after a month or two their behaviour improves and they become suitable for private care. Because it is inhumane to shuttle people between facilities these patients usually remain within the NHS.

Possible solutions

There are three possible solutions to this problem. Firstly, the NHS could provide good quality care for all who need nursing care—that is, those who are incontinent or immobile, those who wander, and those with additional psychotic features. Secondly, the costs of nursing could be separated from "hotel" costs, and the NHS would pay only for nursing. Thirdly, there could be a charge (under clearly defined conditions) for all long term care.

The first solution is that of Pangloss. In 1990 it was estimated that in the United Kingdom there were

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Clearly social drinking . . . but what happens when she won't drink?

318 000 people in residential homes, including 126 000 in nursing homes.[2] This compares with a total of 341 000 beds within the NHS, of which 77 000 are devoted to mental illness.[3] If all long term care was to be given within the NHS the number of beds would have to be expanded by at least a third and probably nearly doubled if, as is often the case, those in residential homes require nursing care. Even though such a doubling of the number of beds would not produce a doubling in cost, since most long stay patients need only low technological care, it is difficult to imagine society accepting this burden.

The second solution sounds sensible and may well appeal to politicians. But it only transfers the boundaries of health and social care, which are already too ill defined, to the care of the individual patient. Two examples will suffice. Many patients with Alzheimer's disease are too apraxic to guide liquid to their mouths or too apathetic to make the effort. When a patient is clinically dehydrated pressing fluids is clearly nursing care, while presenting a client with a meal that includes fluids is social care. At what point does social care become nursing? Is it when a person needs help to lift a glass to his or her lips, or does it depend on the degree of dehydration? Would the cost of care depend on the serum sodium concentration?

Likewise, when is making a bed nursing? If a patient has a bedsore and is incontinent the frequent changing of sheets and incontinence pads might be regarded as nursing. But making a bed once a day is social. How often do patients have to wet their beds, or how inflamed must their skin be, to justify nursing care? The opportunities in this model for passing the buck between the NHS and social services would be legion.

A practical solution

The third solution is, however, a practical possibility provided that the criteria for changing from one system to the other are sufficiently clear cut to avoid too much special pleading. I propose a limit of three months' free residential treatment. After 13 weeks of inpatient care the health authority would charge a fixed fee, which could be set at the eightieth percentile of the fees charged by the private sector within a set area, or £500 per week. This would be well under the cost of the facility for the authority but would encourage those who could buy their care more cheaply to do so. Like other benefits, it would be means tested so that for some the care would remain free.

Clearly a complicated illness might merit an extension of the 13 weeks because transfer to private care would be inappropriate. Thus a patient recovering from a hip replacement might develop a bleeding peptic ulcer before discharge, which would need further investigation and treatment. Attempts to cheat the system, however, by discharging a patient briefly every three months could be thwarted by insisting that the period of discharge must last at least two weeks before the admission could be considered separate.

Any savings accrued by this system could be used to reduce the severity of the means testing, thus reducing the way small savers are currently penalised.

Drawbacks and special cases

The border between a free and charged service is always, however, a source of inequity, and I would not want to remove one anachronism to introduce others. The three month limit should cover most acute illnesses, especially if it can be extended when necessary.

Someone might question why acute illness should merit free care while chronic ones should not. The justification is that while someone is receiving acute care they have the prospect of returning to an independent life in the community, with consequent retention of personal housing. Once it has been accepted that they need continuing care their responsibility for maintaining themselves is removed.

Those most likely to object to this solution are those who have chronic illnesses and are currently receiving care within the NHS. The largest group are patients with chronic schizophrenia, a group which has already been exposed to the private sector through a move to community care. This group is in many ways similar to the elderly, except that they are less likely to be able to contribute to care from their own resources and are therefore more likely to receive a free service wherever they are placed. More difficult would be patients with a deep seated psychological problem which would require more than three months' treatment. Examples include anorexia nervosa, personality disorders, and patients with resistant depression. It might be appropriate to ask the Mental Health Act Commission to provide a second opinion on such patients at the end of their first three months with the power to extend the time for free treatment. The same would apply to patients kept in hospital under a section of the Mental Health Act, since they would be unable to find alternative care outside the hospital sector by the nature of the section.

Patients requiring terminal care are already often cared for within hospices run by the private sector, so there would be no logic in excluding this group. More contentious would be those few patients who are kept alive by such intensive care that there is no alternative outside the NHS. Examples include patients on ventilators and those being fed intravenously. One might argue that a three month deadline would be just that—a time after which teams looking after unconscious patients should make realistic decisions about their prognosis. Those for whom free care might be extended should be only those with a realistic possibility of returning to self care in the community within two years.

Children below school leaving age would also be excluded as they could not be expected to live independently in the community in any case. This would leave a difficult boundary for patients with learning difficulties so profound as to require treatment in a hospital or specialist residential home, the former being free and the latter funded by social services and means tested. Perhaps the conflict for the parent could be resolved by removing the means test until 16, while social services departments might be able to obtain central funding for this small group of children.

Not a comfortable option

Many will see this paper as a fundamental attack on the NHS, a means by which a free service slides down the slippery slope of privatisation. They will be ignoring the slide that has already taken place—and is accelerating. The structure that I have suggested is sufficiently robust to halt that slide and ensure that acute care remains free throughout. Long term care could develop, allowing the NHS to use the highest standards and train the staff required to run the private facilities. Patients and their carers would have a realistic choice freed from fears of favouritism and unfair influence. Transfers to and from the private sector would be eased, enabling the NHS to concentrate its long term resources on those who need its special skills. Cynical health authorities would find the closure of long stay beds a less enticing option. Private homes would be free to compete on a more even playing field, no longer subject to the whims of the local health authority.

No one can pretend that this is a comfortable option. It does indeed make those who require nursing care through no fault of their own shoulder the cost. It does, however, remove the humbug which leaves the elderly to discover that our current free health service is a sham.

1 Jolly DJ. Continuing care provision for the mentally ill. *Psychiatric Bulletin* 1992;16:567.
2 *Directory of independent hospitals and health services.* London: Longmans, 1992.
3 *The hospital and health service year book.* London: Institute of Health Service Management, 1992.

Countdown to Community Care

Mental health services—the user's view

Peter Campbell

This is one of a series of articles looking at the forthcoming changes to community care

The needs of people with serious mental illnesses have dominated much of the debate on reforming community care. In this article Peter Campbell, who has used mental health services many times in the past, explains how the reforms could affect people like him. He welcomes the thinking behind the changes, particularly the idea that people who use community care should take part in planning services, but he warns that implementing the new philosophy might prove very difficult. Mr Campbell is secretary of a voluntary organisation for users of mental health services called Survivors Speak Out. The views he expresses here are his own, and do not necessarily reflect those of Survivors Speak Out.

The past three months have proved difficult times for community mental health care policy. As the starting date for the final and most substantial series of reforms approaches there are still major doubts and fears about the practicality and desirability of the changes. The much publicised case of Ben Silcock[1] and the health secretary's response to it[2] have once again revealed important differences among mental health care providers about which care is most necessary; it has also emphasised underlying uncertainties about whether community care for people with a diagnosis of severe mental illness can ever really work. A favourable consensus may still exist, but it carries a rather battered look.

In the face of such doubts a large number of mental health service users, including me, remain resolutely in favour of community care. We believe it is not only a viable option but the only option that can lead to significant changes in our status, as recipients of services and as citizens. We know that community care is no panacea and we share current anxieties that, without proper resources, institutionalisation may be replaced by neglect. But it is hard to see how the wider transformations we seek can be established except on the foundations that community mental health services could provide. In these circumstances our concerns are not that community care changes are a step too far, but that they will not go far enough to produce radical change.

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Changing the location of care

It is certainly true that the location of care is changing. Community mental health care does imply the closure of the large, asylum style psychiatric hospitals, not least because many of the resources for new services are tied up in the old institutions. Closures have been taking place over the past 10 years. Soon the speed and scope of the closure programme will increase. A recent survey by the National Schizophrenia Fellowship has shown that 45 psychiatric hospitals will close by the year 2000.[3]

Hospital closures are major events in the lives of many users. As someone who has been admitted into psychiatric care 16 times in the past 25 years and has usually received acute care in asylum style settings, I shed few tears for the disappearance of these places. While I do not dismiss the care and treatment I have received during those admissions, I did not have to spend many weeks in the "old bins" to become aware of their shortcomings as therapeutic environments. The isolation—I have only once been in an admission ward less than a dozen miles from my home—and the physical environment—inappropriate design, upstairs dormitories that must be locked all day, uninvolving regimentation—are aspects of a system of care whose inadequacies should not be underestimated.

Moreover, while there are good reasons for concern about the availability of services for "revolving door patients" during the run down of the old psychiatric hospitals and while doubts remain over the capacity of district general hospital units to provide appropriate care to people in crisis, the relocation of the long stay population of psychiatric hospitals is achieving some successful results. There is evidence to support the anecdotal impression that long stay patients both prefer and are capable of living in community settings. Monitoring of people moved from Friern Hospital in north London and Claybury Hospital in Essex shows that they are not slipping out of the system and are enjoying a better quality of life with greater independence and a more varied social life.[4] With adequate resourcing and well designed support systems, relocation can enhance lives.

But the community care reforms imply more than a shift in the location of care. According to the govern-