1972 cohort because the follow up of the observed mortality began that year.

NORTH KARELIA AND KUOPIO REPRESENT FINLAND

The levels of risk factors decreased more in North Karelia than in Kuopio during the first five years, but after that the trends were similar.¹⁸ The trends in mortality in the 1970s and early 1980s have been published.¹⁸⁻²⁰ The differences between the provinces have been small compared with the overall decline. To bring more stability to the analyses we pooled the data for the two provinces. In the whole of Finland the decrease in mortality from ischaemic heart disease was about 50% from 1970 to 1992. Finland is a small country with a homogeneous population, and the socioeconomic variation in the country is small; North Karelia and Kuopio probably represent the development in the whole country. The MONICA project⁵ will give better possibilities to assess the role of changing risk factors in trends in incidence of, and mortality from, coronary heart disease not only in Finland but also worldwide.

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Community survey of long term daytime use of benzodiazepines

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Media coverage suggests that many people are addicted to benzodiazepines and keen to stop taking them. Our recent efforts to recruit subjects into a programme offering withdrawal, however, had a disappointing response. As a result we initiated this survey. Our decision to study patients taking benzodiazepines long term reflects the current medical opinion that long term use is likely to cause problems.¹

Patients, methods, and results

Subjects were recruited from a general practice serving 13 000 patients. The catchment was mixed, including prosperous suburbs and council estates. Using the practice's computerised records for repeat prescriptions we identified all patients taking benzodiazepines during the day and included those in the survey who had been prescribed the drugs for more than one year. Patients were interviewed at home. Psychiatric history and detailed histories of benzodiazepine use were taken. Patients completed the benzodiazepine withdrawal symptom questionnaire.² Data were analysed using χ^2 and two sample *t* tests.

Sixty five patients had been prescribed benzodiazepines for more than one year (point prevalence 0.5%). Eight refused to be interviewed and two were not contactable. Fifty five were therefore interviewed (14 men, 41 women; mean age 57.4 years). Demographic details of those not interviewed were not significantly different from those of the study cohort.

The only variable differentiating between patients keen to stop their treatment and the rest of the cohort was age: those desiring to stop were younger (53.8 years *v* 61.4 years (95% confidence interval of the difference 1.4 to 13.8 years), $P=0.037$). Patients who had suffered withdrawal symptoms (physical dependence) as measured by the questionnaire were less likely to think that they still benefited from the benzodiazepine (11/17 *v* 32/35, $\chi^2=5.72$, $P<0.02$). They were younger than those with no history of physical dependence (50.9 years *v* 60.3 years (1.8 to

Patterns of use, attitudes towards use, and problems with dependence among patients taking benzodiazepines long term during day

	No of patients (n=55)
Pattern of use:	
Daily dose (mg equivalents of diazepam):	
> 30	5
10-30	20
< 10	30
Dose increased*	3
Benzodiazepine underused*	14
Dose varies daily*	38
Treatment continuous for > 5 years*	42
Previous episode of long term use*	24
Attitude towards use:	
Treatment beneficial*	
Currently	44
Previously	52
Want to stop taking*	28
History of withdrawal symptoms on questionnaire†	17
Psychiatric history:	
None	15
Inpatient	15
Outpatient	34
Contact with community psychiatric nurse	27
Current drug treatment:	
Antidepressant	16
Neuroleptic	3
Non-psychotropic	43

*One patient omitted owing to mental handicap.

†Three patients unable to complete questionnaire owing to dementia, stroke, or mental handicap.

See editorial by Tiller

17.1 years), $P=0.017$) but were not distinguishable by any other variable. Underusers were significantly older than the rest of the study cohort (64.2 years *v* 55.1 years (2.8 to 15.4 years), $P=0.0074$).

Comment

The small number of patients identified in this survey confirms the continued decline in the prescription of benzodiazepines for anxiety.^{3,4} Twenty four patients reported having taken benzodiazepines long term on previous occasions. This should encourage optimism about the prospects of successfully stopping treatment, although it also suggests that patients may start taking benzodiazepines again. It is often forgotten that only a minority of patients taking benzodiazepines long term experience withdrawal symptoms (33% in this study).⁵ A lack of withdrawal symptoms is likely to have enabled patients to stop taking the drugs. Continued benefit and a lack of desire to stop treatment probably both work to ensure continued long term use for many patients.

Only 15 patients (27%) had not come into contact with psychiatric services before. Concern that services could be overwhelmed if all patients taking benzodiazepines long term were referred to psychiatric teams seems to be unfounded.

Our findings fail to confirm popular preconceptions about long term use of benzodiazepines. We found a small number of long term users. Some surprising attitudes were expressed, in particular the desire of

almost half of the group to continue taking their drugs. There were reassuring findings about patterns of use, continued benefit, and frequency of withdrawal symptoms. The association of a desire to stop treatment and experience of withdrawal symptoms with younger age suggests that greater caution should be exercised when considering benzodiazepines for daytime use in younger patients. If community based research is to establish the most appropriate use of benzodiazepines large catchment populations will be needed for sufficient numbers to be identified, particularly for analysis of subgroups.

Our findings do not conform to the benzodiazepine stereotype that is often presented in the media, but they do suggest reasons for the poor response to our withdrawal programme. We suggest that media coverage of this topic should be more restrained.

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NHS and Community Care Act 1990 and discharges from hospital to private residential and nursing homes

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The NHS and Community Care Act 1990 requires social services departments to assess elderly inpatients who may need help after discharge from hospital and to use a care management process to arrange their care.¹ One of the main aims of the act was to reverse the "perverse incentive" for people to be cared for in private residential and nursing homes. The act tried to achieve this aim by ensuring that money that was originally available through social security to people in private homes who received income support was transferred to social services departments; social services could use the money to maintain people in their own homes.

Concern was expressed that the new assessment and care management might delay patients' discharge from hospital,² and such delays have been reported.³ It was

also thought that a surge in the number of patients discharged to private institutions might occur before the act came into force as consultants tried to avoid becoming entangled in the new administrative procedures.

This study compared the proportions of patients discharged to private residential and nursing homes or elsewhere from a department of geriatric medicine before and after the implementation of the NHS and community care act in April 1993 and the lengths of time patients had spent in hospital before their discharge.

Patients, methods, and results

Data were extracted from the computerised records on discharge for all patients ($n=2234$) discharged from the department of geriatric medicine at St Martin's Hospital, Bath, between 1 April 1992 and 30 September 1993. The average age of the patients (85 years) was similar to that of patients discharged from other departments of geriatric medicine in the Wessex region. We made comparisons between patients discharged between 1 April and 30 September 1993—the first six months after implementation of the act—and the equivalent period in 1992, thus avoiding any systematic bias due to seasonal factors.

The table gives the numbers and percentages of patients discharged to private residential and nursing homes according to the period examined and the corresponding lengths of time spent in hospital before discharge. Between 1 April 1992 and 30 September 1993, 197 (8.8%) of the 2234 of the patients were discharged to a private residential or nursing home; in March 1993, the month before the act came into force, 17 (12.9%) of 132 patients were similarly discharged.

Comment

This is the first study of the effect of the NHS and Community Care Act 1990 on the numbers of elderly

Patients discharged from hospital to private residential or nursing homes and length of stay in hospital before discharge, according to period and year of discharge

	1 April to 30 September 1992	1 April to 30 September 1993	Difference (95% confidence interval)
No (%) of patients discharged from hospital:			
Total	737	738	
To private residential or nursing home	56 (8)	70 (9)	1.2% (3.7% to -2.0%)
Mean length of stay in hospital before discharge (days):			
To private residential or nursing home	55.3	59.8	4.5 days (20.0 days to -11 days)
To other locations	26.6	27.4	0.8 days (4.3 days to -2.7 days)