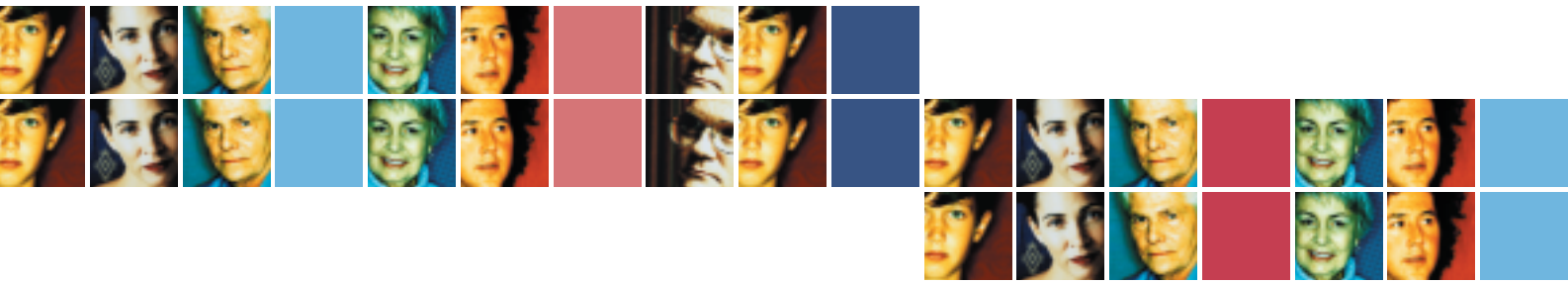

Psychiatric Day Care - An Underused Option?

The Purposes and Functions of Psychiatric Day Hospitals and Day Centres: A Study In Two Health Boards

Tara Hickey, Rosalyn Moran and Dermot Walsh

Health Research Board

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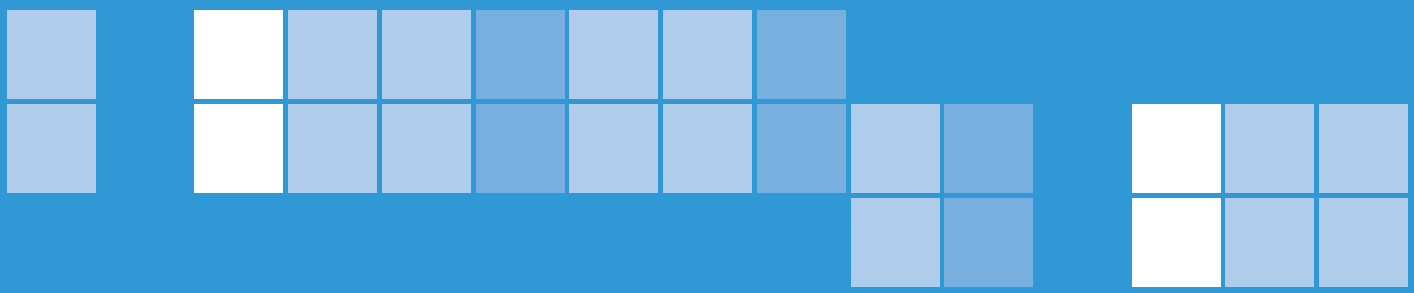

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An Board Taighde Sláinte

CONTENTS

Glossary

ANOVA	One-Way Analysis of Variance – A statistical test which investigates whether any of the population means differ from each other
BDI	Beck Depression Inventory
BPRS-E	Brief Psychiatric Rating Scale - Expanded Version
Col	Column
CPN	Community Psychiatric Nurse
DTAS	Day Therapy Appropriateness Scale
ECT	Electroconvulsive therapy
EHB	Eastern Health Board
GP	General Practitioner
HB-A	Health Board A refers to one of two health boards that participated in this study
HB-B	Health Board B refers to one of two health boards that participated in this study
Joyce	A catchment area in Health Board A
MH	Mental Health
MMPI	Mini-Multi Personality Inventory
NCHD	Non-Consultant Hospital Doctor. A doctor in one of these posts is usually in training for a consultant post or for general practice
NHS	National Health Service. The NHS refers to the British National Health Service
No.	Number
NPIRS	National Psychiatric In-Patient Reporting System. NPIRS is a computerised database, which stores data on in-patient psychiatric activities and is managed by the Health Research Board
O'Casey	A catchment area in Health Board A
OPD	Outpatients Department
OT	Occupational Therapy/Therapist
PHIS	Public Health Information System
PTS	Patients
Registrar	A Non-Consultant Hospital Doctor
SEVPD	Severe Personality Disorders
SBS	Social Behaviour Scale
Shaw	A catchment area in Health Board B
STAI	Stait-Trait Anxiety Inventory
Synge	A catchment area in Health Board A
UK	United Kingdom
US	United States
Yeats	A catchment area in Health Board B

EXECUTIVE SUMMARY

As part of the Health Research Board's programme of mental health research in the field of service delivery, the Board conducted an in-depth review of the availability and utilisation of acute psychiatric beds in the Eastern Health Board area. The results of this study by Keogh, Roche and Walsh were published in 1999, in a publication entitled, *"We Have No Beds...": An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region.* One finding to emerge from this study was that there was a shortage of day hospital places and that many day hospitals were not operating as alternatives or complements to acute inpatient care.

The purpose of the present study was to attempt to identify the extent, appropriateness and utilisation of current day care provision. Two health boards participated in the present study. The health boards were labelled as Health Board A and Health Board B for reasons of anonymity. There were *two components* to the study. First, a comprehensive examination of the participating *day hospitals* was conducted. Information regarding provision such as premises, programmes, patient capacity and staffing was collected. Utilisation data including assessment and referral procedures and patient clinical and demographic profiles were also gathered.[1] Second, an investigation into the participating *day centres* was conducted. Information regarding provision such as premises, programmes, patient capacity and staffing was only collected.

The results of the study revealed that many day hospitals and day centres were based in inappropriate premises. The most common problems with premises were the arrangement of rooms, a lack of patient activity rooms and shabby furnishing and décor. Many patients spent up to four hours travelling to and from day services in minibuses provided by the health boards.

Fifty-seven patients in Health Board A and 44 patients in Health Board B were referred to a day hospital during a four-week study period. The date of the study period was different for each day hospital and was in accordance with the fieldworker's schedule. Ninety-four per cent of patients received a psychiatric assessment prior to referral. A consultant assessed 48% of patients. In Health Board A, 39% of patients were assessed in a psychiatric hospital and 37% in an outpatient clinic. In Health Board B, 73% of patients were assessed in an outpatient clinic. Psychiatric symptoms were most frequently cited as the 'major clinical factor' influencing the decision to admit, and observation and relapse were most frequently cited as 'important clinical factors'. The main administrative reasons for admission to a day hospital in Health Board A was to facilitate re-entry back into the community following an inpatient admission (42%) followed by an alternative to inpatient care (40%). The most common reason cited in Health Board B was as an alternative to inpatient care (32%) followed by the provision of a maintenance setting for a chronic illness (16%).

Details of all day hospital patients (N = 95) registered in Health Board A and a sample of patients (n = 80) registered in Health Board B were gathered. The majority of patients were female, aged between 18 and 29 years, single, with some secondary education and were not living alone. Over half of the patients either owned their home or lived with their parents who owned their own home. Twenty-six per cent of patients were employed on a full-time basis and 18% were unskilled. The most common diagnosis was depression followed by schizophrenia and neurosis. One third of patients were suffering from a chronic illness. These patients appeared to be attending day hospitals due to a shortage of day centre places. Over half of patients were attending a day hospital for the first time. There were more first time attendees in day hospitals in Health Board B.

1 Some scales/questionnaires were completed using patients who were registered (i.e. 'on the books') when the study commenced, while others were completed using patients referred to day hospital services in the course of the study.

All day hospital patients registered in Health Board A (N = 127), plus a sample of patients who began to attend shortly after the fieldwork concluded and a sample of registered patients (n = 74) from Health Board B were assessed by a nurse for treatment appropriateness. According to the Day Therapy Appropriateness Scale the majority of patients (65% in Health Board A and 82% in Health Board B) were deemed appropriate for treatment in terms of duration of problem, behaviour, suicide or homicide risk, alcohol and drug involvement, motivation, support and transportation. However, the researchers felt that the scale was weighted towards the selection of patients with relatively mild levels of disturbance. Furthermore, very few patients were deemed appropriate for treatment in terms of severity of illness. The majority of patients (94%) who commenced day hospital treatment during the study period as well as a sample of patients, who were attending a day hospital for three months or more, were found to be suffering from a relatively mild level of illness.

Day hospitals in Health Board A provided full-day treatment and therapeutic activities for patients five days a week on a full or part-time basis. Day hospitals in Health Board B provided patients with an appointment with a nurse therapist usually for an hour, on a weekly basis. Day centres in Health Board A and Health Board B provided social activities for patients five days a week on a full or part-time basis. However, there was a lack of activity in many day care services. Some nurses found it difficult to devise new activities, were engaged in administrative work and/or felt that they had too many patients to care for. Medical staff were not present in day hospitals for the full duration of opening hours. The provision of staff in allied professions (psychologists, occupational therapists and social workers) appeared limited. There were very limited community services outside office hours.

Seventy-eight registered patients in Health Board A (representing a response rate of 92%) and 104 registered patients in Health Board B (representing a response rate of 81%) completed a patient satisfaction questionnaire. Out of this sample 155 patients plus an additional 5 patients also completed a consumer's opinion questionnaire. The majority of patients (over 80%) were satisfied with the treatment, staff, activities and food provided. A small percentage of patients reported that they did not know why they were attending the day hospital (3%), they had not been told about the treatment available (8%) and they did not know about the good and bad effects of their treatment (15%). Many patients stated that they would like to see an increase in nursing staff, activities, privacy and a redecoration of facilities.

One hundred and five staff in Health Board A and 45 day hospital staff in Health Board B were interviewed in relation to their perception of day services. This represented an overall interview rate of 92%. In Health Board A, 58% of staff knew the role of a day hospital and 85% knew what type of patient was suitable for day hospital treatment. A substantial number of staff in Health Board B did not understand the role of a day hospital (31%) and were unsure as to who was appropriate for day hospital treatment (51%). In Health Board B, 69% of staff were in favour of offering a service equivalent to inpatient care on a day basis. In terms of changes to the existing day hospital provision, the most common suggestions were an improvement in premises and an increase in the presence of multidisciplinary teams. Seventy-two per cent of staff knew the role of the day centre and what type of patient should be cared for at this facility.

We propose a series of guidelines based on the findings of the present study and information available from databases managed by the Health Research Board. Based on the experience of the study and background material a series of recommendations is also presented. These guidelines and recommendations are tentative. Thus, they should not be viewed as definitive or inflexible. The conclusions, guidelines and recommendations are outlined below. They are also presented in Chapters 7 and 8 as a stimulus to discussion regarding the future development of services.

Conclusions

- Many psychiatric day hospitals were occupying premises unsuitable for acute day hospital services
- Many patients spent up to four hours travelling to and from day hospital and day centre services each day
- Day hospitals were generally not providing a service for acutely ill patients
- A comprehensive range of treatments was not available in day hospitals
- Services provided in day hospitals in Health Board B were predominantly of a counselling type
- No day hospital provided *in situ* electroconvulsive therapy
- There was a lack of activity in some day hospitals and day centres. Some nurses found it difficult to think of new activities, were engaged in administrative work and/or felt they had too many patients to care for
- Medical consultant presence in day hospitals was limited
- There was a dearth of psychologists, occupational therapists and social workers in day hospitals
- There were very limited community-based crisis intervention services for patients outside office hours
- Almost 50% of patients were assessed prior to referral to a day hospital by a consultant psychiatrist
- The majority of patients were assessed in an outpatient clinic or in an acute psychiatric hospital prior to referral to a day hospital
- Most frequently, day hospital patients were female, aged between 18 and 29 years old, with some secondary education and were not living alone
- Most patients attending day hospitals were experiencing relatively mild mental illness
- A substantial number of patients, who were inappropriately attending a day hospital, were chronically ill. This was partially due to a lack of day centre provision
- The majority of day hospital patients were satisfied with the treatment, staff, activities and food provided
- Many mental health professionals, particularly in Health Board B, had limited perceptions of the role of a day hospital and what type of illness could be treated at such a facility.

Guidelines

Suggested proposals for planning in relation to location and design, provision/ capacity and staffing for day hospitals and day centres

DAY HOSPITALS

Location and Design

The day hospital would be best located in the largest populated area within each sector. It should be open at least five days a week. Transport should be provided for patients in rural communities and as far as possible take no longer than one hour to complete a one-way journey.

The day hospital should ideally be situated on the ground floor of a community mental health centre or a generic health centre. If the day hospital is to be a free standing building then it should preferably be a one-storey building. The structure of the premises and provision of privacy should be in accordance with the needs of patients and staff (see Appendix 11). The provision of patient areas should preferably include a large day area that could be used for a variety of specified functions, an occupational therapy room of substantial size and a dining room large enough to accommodate all patients who attend on a full-day basis at one sitting. It is essential that one of the above rooms be of sufficient size to accommodate a patient who is agitated, restless or distressed. Patient rooms should be situated adjacent to each other and be decorated in an attractive and homely style. The provision of a shower room and a laundry room is also important.

Psychiatrists and allied professions will require office accommodation. Offices should be utilised interchangeably to avoid underutilisation. Community psychiatric nurses and outreach teams will require office space and could share an open plan office and have access to a confidential interview room. The administrative function will require two rooms, one for administration work and one secure room for the storage of records. In addition, a receptionist/administrative assistant will require accommodation in the entrance foyer of the premises.

Provision/Capacity and Staffing

According to our calculations approximately 11 day hospital places are required for a sector with a population of 35,000 (see Appendix 12 for calculations). Treatments and activities such as psychotherapy or occupational therapy should be available to non-acute patients in day hospital premises. Psychiatric outpatient clinics should not be held in day hospitals but in generic health centres due to the number of patients seen at these clinics and to promote integration between mental health and primary healthcare services. Sector headquarters should be based in the same premises as the day hospital where this is possible.

The sector consultant psychiatrist should have a substantial presence and continuous availability in the day hospital premises supported by a non-consultant hospital doctor; both would of course be available for acute inpatient care, home care and outreach activity in the sector. Psychology, social work and occupational therapy personnel should form part of the day hospital and community mental health centre staffing and work out of the premises on a continuous availability/presence basis. Household staff will also be required.

DAY CENTRES

Location and Design

The day centre should be located in the largest populated area of the sector. There may be a need for two day centres in some sectors. It should be open at least five days a week. Transport should be provided for patients in rural communities and as far as possible take no longer than one hour to complete a one-way journey.

The design of a day centre will bear many similarities to the day hospital design. However, the day centre should not be located in the same building as a day hospital. The day centre should be a freestanding one-storey building. The structure of the premises and provision of privacy should be conducive to the needs of patients and staff (see Appendix 11). The provision of patient areas should, at a minimum, include a large day area and a dining room large enough to accommodate all patients at one sitting. These rooms should be situated adjacent to each other and decorated in an attractive and homely style. The provision of a shower room and a laundry room is essential. One staff office and an interview room will also be required.

Provision/Capacity and Staffing

According to our calculations 55 day centre places are required for a sector with a population of 35,000 (see Appendix 12 for calculations). This may mean having one large or two smaller day centres in each sector. The day centre should have a supervisory nurse and care assistants to cater for the needs of patients.

Suggested initiatives in relation to training, admission, assessment and discharge policies

Staff Training

All mental health professionals should be aware of how important the provision of day services is in the treatment of patients with mental health disorders. Comprehensive training should be provided at undergraduate and postgraduate levels regarding provision of services and the appropriate utilisation of each service in different circumstances. The necessity of keeping accurate records should also be cited. Ongoing training should also be provided for professionals working in mental healthcare in order to educate for change and development. Training could include workshops or visits to services that are highly regarded for their innovation and effectiveness.

Admission Policies

An admission policy should be available for each day hospital in order to determine the suitability of patients for admission. An admission policy is also required for each day centre, stating the type and severity of disability the centre is designed to cater for. The information provided should be comprehensive, clearly stated and be agreed among relevant staff. The agreed policy should be electronically recorded and be readily available to all professional staff and be accessible to the public. Admission policies are particularly useful for junior staff and registrars who move to different service components every six months. It is advisable that the implementation of admission policies is monitored through the use of an audit.

Assessment Procedures

Assessments should be carried out by the multidisciplinary team before deciding the most appropriate form of care. It is important that assessments are carried out or monitored by consultant psychiatrists. Assessments should be conducted for all patients regardless of whether they are known to the service or not. Judgements regarding referral should be made on the basis of the assessment results and clinical experience. Acute inpatients should be reviewed frequently and be discharged to home care or transferred to day hospital care once an assessment and clinical judgement deems these options appropriate. Outpatients should be assessed at outpatient clinics in the community and only the most severely ill should be considered for inpatient care. Patients who are acutely ill and do not need 24-hour care, should be considered for home treatment and/or day hospital care. Any patient whom clinicians feel may benefit from attending a day centre should also be assessed.

Discharge Policies

Discharge policies are important, as patients should be officially discharged from a day hospital or a day centre when they no longer require this form of care. Appropriate records should be kept of the discharge. Discharge plans should be particularly focused towards patients who may have difficulty functioning without formal structure and routine. Discharge plans should be designed to help patients create their own structure and routine in their daily living.

Monitoring of Policies

In order for mental health day care services to be efficient and effective, the above policies need to be actively monitored on a continuous basis. One way to ensure that clinicians are abiding by policies is to conduct a regular audit. These audits should address the standard of record keeping inter alia. Review meetings should be held on a regular basis, audit results be presented and an opportunity should be available for all professional staff to provide comment through an open forum. Policies and practice can then be revised as necessary.

Recommendations

1. Location and Design

1.1 There should be a day hospital and day centre in each sector

1.2 The day hospital and day centre should be sited in the largest centre of population in the sector

1.3 Patients should not spend more than an hour travelling to or from a day service

1.4 The day hospital should be located in the same building as an integral part of a community mental health centre or a generic health centre

1.5 Sector headquarters should be based in the same building as the day hospital, although this may not always be possible

1.6 Psychiatric outpatient clinics should not be held in the day hospital, but rather in generic health centres

1.7 Where psychiatric outpatient clinics and day hospitals are situated in generic health centres, the outpatient clinic should be a separate entity, independent of the day hospital

1.8 The day centre should not be located in the same premises as the day hospital; these two services serve different purposes and should be situated apart

1.9 Day services should be located on ground floor level, if possible

1.10 The size of day hospital and day centre buildings must relate to the necessary and appropriate use of the building in relation to activity generated by the number of patients attending and the number of staff working there

1.11 The design of such buildings should be informed by a user-orientated brief drawn up by a suitably qualified person experienced in user needs elicitation in relation to buildings.

2. Provision/Capacity & Staffing

2.1 There should be approximately two day care places per 1,000 population. A high proportion (1.57 per 1,000) of day care places should be day centre places. These figures are tentative and general and need adjustment to take account of local levels of socio-economic deprivation

2.2 The development of multidisciplinary teams is important in order to ensure comprehensive treatment programmes. Thus, it is recommended that the number and range of professionals available to day hospital patients be reviewed and augmented, where necessary.

3. Treatment and Activities

3.1 Day hospitals should be committed to treating acutely and severely ill patients

3.2 A comprehensive range of short-term time-limited treatments should be available to acutely ill patients in day hospitals

3.3 Day hospitals and day centres should provide suitable therapeutic activities to occupy patients who attend on a full or part-time basis; patients should not be left idle or bored

3.4 Non-medical treatments such as psychotherapy should be available to non-acute patients in day hospital premises

3.5 The provision of an adequate and appropriate out-of-hours assessment service is important in order to ensure a patient is placed in the most appropriate form of care

3.6 There should be no waiting lists for day hospitals.

4. Education, Research and Planning

4.1 Day care staff should be fully aware of the role of each component of the mental health service. Staff should attend workshops and conferences in order to keep up-to-date with the latest developments in mental healthcare

4.2 Each day hospital should establish and implement a mission statement and a range of policies, including admission and discharge policies, in order to clarify the role of the day hospital. A regular audit should be conducted to investigate whether the policies are being adhered to and accurate records should be available which can support an audit

4.3 Research is required to gather further information about population needs for planning purposes

4.4 Comprehensive databases need to be established regarding the usage of each component of the mental health service. The development of databases is essential for planning purposes and staff will need to be trained in their operation

4.5 The balance of day hospital and home care provision should be examined along with developing models of care

4.6 Day care services should have a uniform national goal that can be adjusted according to local needs

4.7 The future of day care needs to be discussed and evaluated from a national perspective.

PREAMBLE

From Institutional to Community Care for the Mentally Ill

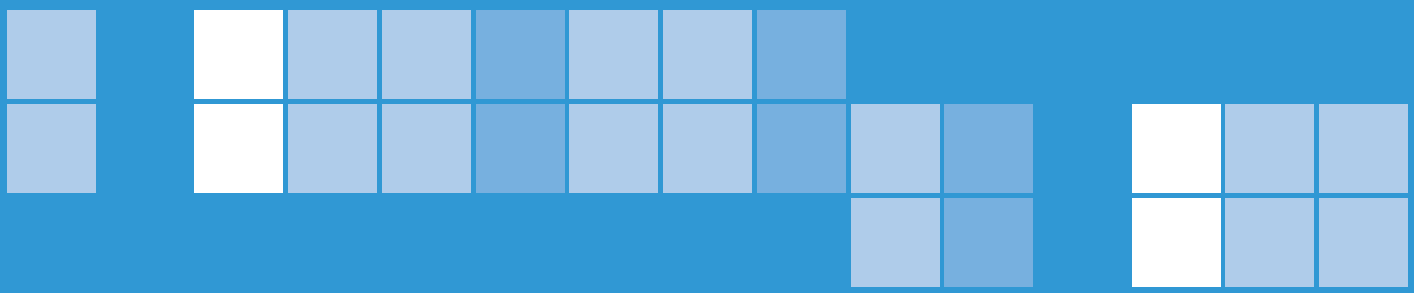
Large-scale institutional care for the mentally ill was essentially a 19th century phenomenon, ubiquitous throughout Europe and North America. The second half of the 18th century saw conspicuous demographic changes in Europe leading to extensive population increases, largely the consequence of improved nutrition with consequent decreases in mortality and extended life expectation. The dawn of the industrial age lead to increasing urbanisation of European populations from those predominantly agricultural. The consequence of these changes, in or around 1800, was increased visibility and social awareness of mental illness. One way or another the response of European countries was similar – legislation was introduced to provide asylum care for the mentally ill at varying rates and times during the century, country by country.

Policy, whether motivated by humanitarian or social order considerations, was clear; the mentally ill must be institutionalised. By 1900 this policy had largely been accomplished in Europe and North America and it was, more or less, to remain in place for the next half century, at least. As the 20th century progressed, however, increasing disquiet was felt in social, political and medical circles concerning the institutionalisation – or 'warehousing' as some of its greatest critics called it – of large numbers of persons in mental hospitals. Some of these institutions housed as many as 4,000 patients and the conditions in which patients lived and the quality of medical care offered to them was considered unacceptable.

Beginning in the 1930s and extending into the 1950s, the introduction of many successful medical remedies, such as antibiotics, had heightened public expectation of the successful treatment and cure of many illnesses. This new optimism extended to mental disorders. The arrival of antipsychotic and antidepressant drugs in the 1950s stimulated a reappraisal of therapeutic possibilities and the practice of institutionalisation. For this reason and for others perhaps not yet clearly understood, hospital populations peaked in most European countries in the mid 1950s and thereafter began steadily and continuously to decline.

Institutionalisation was replaced by a policy of community care. This was predicated on the belief that most psychiatric illness, except for those in the acute phase, could be treated by alternatives to long-term hospitalisation. It was envisaged that acute illness would be more beneficially treated in general hospital settings than in large mental hospitals. The rate at which community care substituted that of the institution varied from country to country and in some cases was preceded with before adequate community alternatives were put in place. Thus, in the United States (US) the numbers of people institutionalised in state mental hospitals declined from 600,000 to 150,000 in 5 years.

In Ireland the situation was no different. The year 1958 saw the peaking of hospitalised numbers at 21,000 and in 1966 the report of the *Commission of Enquiry on Mental Illness,* criticising the still predominantly institutional approach to illness here, urged accelerated movement towards de-institutionalisation and the spread of community care together with the provision of acute care in general hospital psychiatric units away from the large isolated mental hospital. This policy was reinforced in a report of a subsequent advisory group on mental health services, *Planning for the Future,* which reported in 1984. As a consequence the number of patients hospitalised in Irish psychiatric services had fallen to just over 4,000 in 2001 (Daly and Walsh, 2002). With this decline in hospitalised patients the provision of community alternatives, such as day hospitals and sheltered housing for the psychiatrically ill has continued to increase. Policy of providing acute care in general hospital psychiatric units has progressed to the point where the majority of Irish psychiatric services now provide acute care in such settings.



CHAPTER ONE

Adult Mental Health Services

CHAPTER ONE

Adult Mental Health Services

This chapter explains the organisation of the present Irish mental health service and describes each of its service components. It is important to note that each of the components described below are intrinsically related and should be integrated into a coherent whole. In this way the patient can gain optimum benefit from the services available (Planning for the Future, 1984).

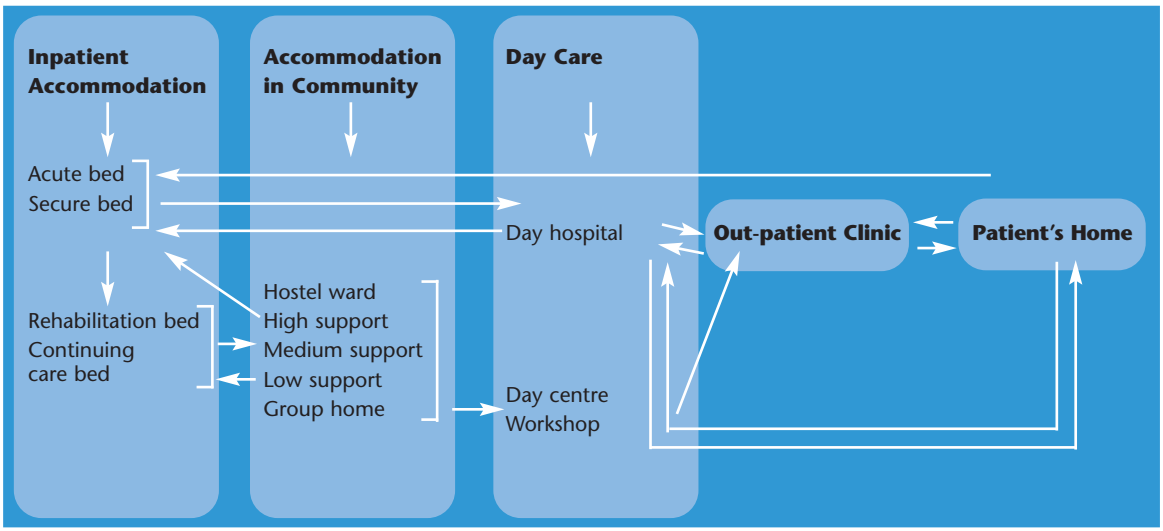
1.1 Organisation of care

In relatively recent years statutory bodies called health boards were established in Ireland and are responsible for the health and personal social services of the population in a designated geographical area. For mental health delivery purposes each health board is divided into catchment areas. A catchment area is subdivided into sectors. The term 'sectorisation' is used to describe the process of providing a comprehensive psychiatric service for each sector of the catchment area. *Planning for the Future* (1984) recommended that each sector have a multidisciplinary team and that each team should have a psychiatrist, psychiatric nurses, psychologist, social worker, occupational therapist and a health administrator. A multidisciplinary team enables patients to benefit from a variety of approaches and receive continuity of care.

1.2 Service components

In order to provide a comprehensive service a range of components must be available. It is generally agreed that each catchment area must have an acute inpatient facility and each sector should provide day care, home care, outpatient care and community-based residences. Decisions around the extent of inpatient and community care depend very much on local circumstances and ideologies. Catchment area and sector area services should be planned in accordance with the size of the population they serve and local population needs (Thornicroft and Tansella, 2001). Furthermore, the components of a comprehensive service should be co-ordinated effectively so that as patient needs change, movement is encouraged from one type of facility to another without delay (Planning for the Future, 1984). Below is an iconographic representation of the spectrum of care (Figure 1.1) and a description of each of the service components.

Figure 1.1 Spectrum of psychiatric care



1.2.1 Inpatient care

Inpatient care is designed to treat patients who are *severely ill* and cannot be managed in the community. A comprehensive range of treatments should be available and specific interventions such as medication, occupational therapy, or psychological therapies should be used to address patient's practical problems (Ramsay and Halloway, 1998). Activities should also be provided to create a daily structure and occupation for patients. Ideally, all admissions to the inpatient service will be provided in psychiatric units in general hospitals (Planning for the Future, 1984). It is anticipated that this arrangement will help reduce the stigma associated with mental illness and facilitate communication among professional staff.

1.2.2 Hostel ward

A hostel ward or 'ward in a house' (Bennett, 1980) should be community based. It should combine the best features of hospital care (e.g. staffing levels, professional input and individualised programmes) with a setting that is also homely in domestic scale and operation (e.g. non-institutional in appearance, good access to community facilities, 'normal' expectations of resident involvement in cooking, cleaning and housework). Hostel wards cater for patients who are severely impaired and are difficult to place in the community. A number of such units have been established in the United Kingdom (UK) and proposals have been made to establish some in Ireland.

1.2.3 Community-based residence

The provision of good quality residential accommodation is required for patients who cannot live in their own homes due to the debilitating effects of their mental illness and for those who are mentally ill and homeless. Residential accommodation is classified according to the supervision needs of the residing patients. High-support community residences provide residential care in the community as an alternative to inpatient care. These facilities are usually staffed on a 24-hour basis. In medium-support community residences, staff supervise patients, visiting usually twice a day, morning and afternoon. Low-support hostels or community residences are sometimes referred to as group homes. Low-support facilities are unstaffed. Medium- and low-support hostels house patients who are less disabled than those in high-support hostels.

1.2.4 Rehabilitation units or rehabilitation hostels

Rehabilitation units or rehabilitation hostels are staffed with the specific objective of skilling institutionalised patients or those who, although living in the community, have considerable social and vocational impairments and deficits. These units or hostels are best based in a community setting with staff especially trained in teaching social and vocational skills. Occupational therapists together with other staff have substantial roles in rehabilitating the residents and users of such units from dependency towards higher levels of function and, optimally, to independent community living and vocational employment.

1.2.5 Workshop

The primary focus of a workshop is rehabilitation and occupation in the community. It provides an opportunity to train in new skills and to gain sheltered employment for those who have difficulty in obtaining and retaining employment. There is a variety of work activities available ranging from unskilled work such as assembly and packaging on a contract basis, to more skilled work such as metalwork, woodwork and maintenance work (Planning for the Future, 1984). Few mental health professionals staff workshops; the majority of workers are crafts and skills instructors. Workshops can

be managed by a holding subsidiary attached to a health board. The aim of a holding subsidiary is to standardise services. An example of such is Eve Holdings in the Eastern Regional Health Authority area. Many patients who attend this facility also attend a day centre.

1.2.6 Day Centre

'The role of the psychiatric day centre is to provide social care for patients...the day centre may also offer treatment. Rehabilitation and activation services may be provided and these could include occupational therapy, social skills training and light industrial therapy' (Planning for the Future, 1984). 'Both day centres and day hospitals have a therapeutic role but unlike day hospitals, the orientation of day centres is social' (Planning for the Future, 1984). Many patients who attend a day centre live in supported accommodation. Day centres operate in a stress-free environment with no time limit or expectation for dramatic change (Weldon and Francis, 1977). For some patients attendance may be long term.

Sufficient space should be available to accommodate treatment, rehabilitation and activation services where these services exist. Social activity spaces such as a kitchen, dining room, and a sitting room should also be provided. The National Health Service (NHS) Estates (1998) recommended that social activity spaces be adjacent to one another. The NHS Estates' report further recommended the provision of a shower room and an optional provision of a laundry room. The day centre should operate from a community base that is independent of other psychiatric services, and in particular, should not be operated in conjunction with or in the same building as a day hospital or mental health centre.

1.2.7 Day hospital

'The function of the day hospital is to provide intensive treatment equivalent to that available in a hospital inpatient setting for acutely ill patients' (Planning for the Future, 1984). A comprehensive range of treatment should be provided and treatment should be provided on a short-term basis. The day hospital should be able to admit a patient as soon as he/she is referred for treatment. This means the day hospital can be used to prevent inpatient hospitalisation, prepare an inpatient for discharge or shorten an inpatient stay, by transferring patients to this facility before they are fully recovered from their illness (Weldon and Frances, 1977). It is sometimes used for brief partial hospitalisation for the chronically ill during a period of relapse (Kris, 1961). In addition, supportive psychotherapeutic treatment can be provided in day hospital premises on a sessional and time limited basis.

Numerous publications including *Planning for the Future* (1984) recommend that the day hospital be located in the community. The day hospital may operate in a premises independent of other services or preferably form part of a community mental health centre or a generic health centre. The sector team should be based in the day hospital, if one is located in the sector (Planning for the Future, 1884). It is important that there is a sufficient number of offices, an interview room and a case conference room for use by staff (NHS Estates, 1998) and that these are fully occupied and in daily usage. This is dependent on staff being based in and operating out of the day hospital. It is also important that there are sufficient social activity spaces such as a kitchen, dining room and a sitting room for use by patients. One of these rooms should be large enough to accommodate a patient who is agitated or distressed. NHS Estates (1998) recommended that patient activity spaces be situated adjacent to each other. NHS Estates also recommend the provision of a shower room as an essential facility and the provision of a laundry room as an optional facility. A midday meal should be provided for patients who are more seriously ill and who spend a full day at the day hospital. The emphasis of the day hospital is on structure, support and medication (Weldon and Francis, 1977) in a comfortable and non-institutional setting.

1.2.8 Mental health centre

The functioning of a mental health centre can vary between health boards. Essentially, a mental health centre is devoted to providing some or all of the following – an active day hospital treatment service, social activities for patients in the evening or general education programmes. Some mental health centres abroad manage a small number of 24-hour beds that may be available in the centre or in a house/hostel nearby. The purpose of these beds is to facilitate assessment and crisis intervention. However, this particular crisis and intervention service is not yet available in Ireland. Ideally, each service component should have its own identity and be situated in separate sections of the building. It is recommended that the mental health centre should act as the hub of the psychiatric service in a sector, and that the sector team has its headquarters there (Planning for the Future, 1984).

1.2.9 Outpatient care

Outpatient services are extensively used in mental healthcare delivery and have two primary objectives. The first objective is to provide assessment and diagnosis for new referrals from primary care and other sources. The second objective is to provide ongoing treatment of patients. It is to be expected that the majority of patients will be referred back to their general practitioner for continuing care and monitoring of progress. However, this will not be possible in all cases. Many long-term patients living in unsupervised accommodation in the community will need treatment, which can be provided only by specialist psychiatric staff (Planning for the Future, 1984). Outpatient clinics are best held in a generic health centre or other suitable community centres to facilitate and encourage contact with primary healthcare practitioners.

1.2.10 Drop-in centre

The drop-in centre was designed to provide support and socialisation for patients living in the community. As the name suggests the patient can drop-in to the centre when he/she wishes to avail of the facility. This service may operate in premises independent of other mental health services.

1.2.11 Assertive outreach

Mental health services have traditionally been delivered in office or hospital-based settings. Now emphasis is being increasingly placed on community-based crisis interventions, home care approaches for acutely ill patients and assertive outreach for more enduring illness with complex presentations.

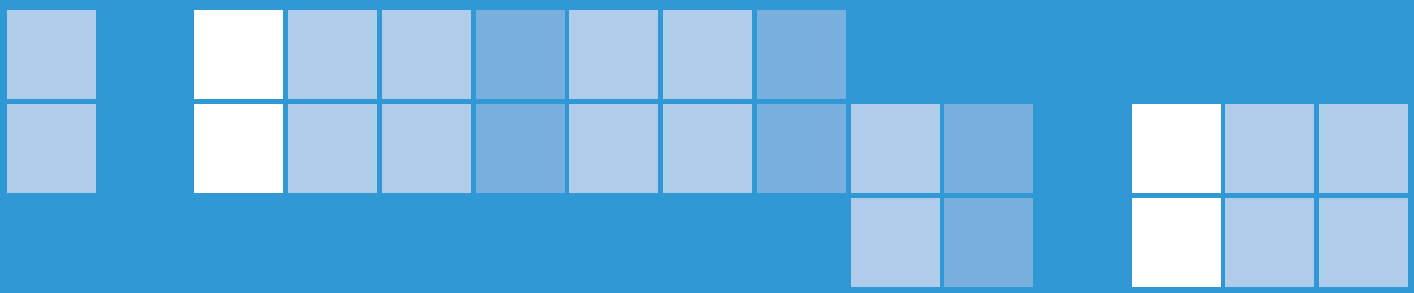
The focus of assertive outreach differs from conventional community treatment in that it concentrates on the delivery of community support through a team approach (rather than individual caseloads), high staff to patient ratio (1:10) and the use of community resources (i.e. family, neighbours, friends, employers, voluntary services and educational establishments). Its aim is to deliver anything that is required to secure community tenure and maintain social inclusion (including the safety of the patient and others) with support from professional and paraprofessional staff (including patients) (McFayden, 2001). Teams may operate from day hospital premises, a mental health centre or other appropriate community-based premises.

1.3 Voluntary organisations

Many voluntary organisations active in the field of mental health supplement and support the role of the statutory services. The primary aim of these organisations is to provide support to patients with mental health problems and their families. Many groups also attempt to heighten public awareness of mental illness and its consequences and to promote mental health research. Some voluntary groups

offer support and information in respect of a specific condition, while others offer support in relation to any mental health problem. Mental Health Ireland, Schizophrenia Ireland, AWARE, GROW and Cork Advocacy Network are examples of large voluntary organisations, active in the mental health area in Ireland.

Mental Health Ireland aims to help promote positive mental health and, through local branches, provide physical resources, such as community-based residences working through and with various agencies such as the Department of the Environment and Local Government; Schizophrenia Ireland is dedicated to advocating the rights and needs of those affected by schizophrenia and related illnesses; AWARE provides support- group meetings for sufferers of depression and their families; GROW runs a 12-step personal growth programme for people with any type of mental illness; one of the main objectives of Cork Advocacy Network is to work with service providers towards achieving better healthcare for patients.



CHAPTER TWO

Day Care in Mental Health Services – Literature Review

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Day Care in Mental Health Services – Literature Review

2.1 Day care in Ireland

The first day hospital to open in Ireland was in the Louth Hospital, Dundalk (Commission of Enquiry on Mental Illness, 1966). Day centres began to emerge in Ireland in the late 1960s and early 1970s. In 1984, the year *Planning for the Future* was published, there was a total of 40 day hospitals and day centres with approximately 2,000 places (Planning for the Future, 1984). In 2000, there were 1,192 places in 74 day hospitals representing a rate of 0.44 per 1,000 population and 2,427 places in 105 day centres representing a rate of 0.90 per 1,000 population. The rate of day care places across health boards varies greatly (Daly and Walsh, 2001). In 2001, the Inspector of Mental Hospitals suggested the planning guideline be put at 1–1.5 day hospital and day centre places per 1,000 population. The Inspector notes that most Irish services did not meet these day place requirements in 2000 (Department of Health and Children, 2001).

2.2 Evaluative research

Since the establishment of the day hospital and day centre little descriptive or evaluative research has been completed, particularly in Ireland. It is widely acknowledged that a broad variety of resources including premises, staffing, programmes and therapies exist across day hospital and day centre facilities. This diversity makes it difficult to compare studies, as the results obtained from the study of one particular facility may have limited bearing on another. This problem is further compounded by studies that are beset with methodological inadequacies. It is therefore not surprising that there are still many questions to be answered in relation to the current status and future development of the day hospital and day centre. Below is a review of the existing literature on the subject.

2.3 The day hospital

2.3.1 Patient selection

Bowman *et al.* (1983) completed a study with the Cluain Mhuire Family Centre in Dublin. The researchers examined factors determining the selection of acutely ill patients for hospital treatment. Three particularly significant factors were cited which distinguished inpatients from day patients. First, more families of inpatients requested the patient be admitted to full-time hospital care. Second, more general practitioners requested the patient be admitted to the inpatient facility. Third, more inpatients refused alternatives to inpatient care.

O'Shea *et al.* (1999) examined factors affecting the placement of patients in the Mid-Western Health Board of Ireland. Three factors emerged as being exceptionally noteworthy; (i) if a relative or friend accompanied the person on referral, the patient was more likely to be admitted to inpatient care than if the patient was alone; (ii) if the person lived nearer the inpatient hospital the more likely he/she was referred to this facility than the day hospital; and (iii) severity of psychiatric symptoms measured on the Brief Psychiatric Rating Scale (BPRS) did not determine the placement of a patient. One explanation by O'Shea *et al.* was that less experienced non-consultant hospital doctors were more likely to admit patients to inpatient care, especially if families put them under pressure.

Other studies in the international literature have noted a general resistance by staff to utilise the day hospital for acute and psychotic disorders (Platt *et al.*, 1980), a general clinician bias and discomfort with alternatives to inpatient care (Dunne *et al.*, 1982), and an inability by staff to identify a priori who

may benefit from the day hospital (Fink *et al.*, 1978). It is generally accepted that some psychiatrists are much more likely to refer patients to day hospitals than others. Washburn *et al.* (1976) suggested that clinicians sought inpatient hospitalisation due to the pressure of patients' unpredictable behaviour. Several studies have demonstrated a considerable variation in the severity and nature of disorders being treated in different day hospitals. Creed *et al.* (1991) conducted a random allocation study comparing the effectiveness of day hospital and inpatient treatment in two psychiatric services. Differences emerged between the cohorts of patients being admitted at the two day hospitals. The first day hospital managed patients with 'greater behavioural disturbance'. Only patients with 'mildly disturbed behaviour' were being treated at the second day hospital. Creed *et al.* (1991) suggested that this variation was attributable to a difference in staffing levels; hospital one had greater staffing numbers.

Mbaya *et al.* (1998) completed a one-day census at 10 day hospitals. Out of the 10 day hospitals surveyed, 5 stated that their policy was to focus on the chronically ill; 2 stated that they concentrated on both chronic and acute illness, while 3 stated that they treated acute illness. Data were collected for a total of 341 patients. Out of the 156 patients attending the 5 day hospitals catering for the chronically ill, 47% had a diagnosis of schizophrenia, 30% depression and 40% neurosis or a personality disorder. In comparison, only 32% per cent of 109 patients attending the mixed facility had a diagnosis of schizophrenia, 5% depression and 31% neurosis or personality disorder. With regard to the acute facilities the figures varied again, 27% had a diagnosis of schizophrenia, 28% depression and 20% neurosis or a personality disorder.

Weinberg *et al.* (1998) examined whether the use of the day hospital and inpatient unit is related to local community need. Previous studies had found social and economic problems to be associated with increased psychiatric admission rates (Hirsch, 1988; Jarman *et al.*, 1992). This was the first study, however, to investigate the relationship between deprivation and the day hospital. Data were collected for 2,230 inpatient admissions and 712 day patient admissions, making a total of 2,942 admissions. The Social Behaviour Scale (SBS), a measure of disturbed behaviour, was completed for 2,602 (88%) patients. The SBS summary scores for each of the day and inpatient units were then compared with the underprivileged area score for the relevant districts. Weinberg *et al.* (1998) reported 'the severity of illness of subjects admitted to inpatient units is significantly associated with a measure of social deprivation, but this is not so for day hospital admissions'. Creed (1991), Mbaya *et al.* (1998) and Weinberg *et al.* (1998) concluded that this variation probably reflected day hospital policy.

Patients' own attitudes have also been found to be important. Dick *et al.* (1985) noted 'attitude was obviously important in those patients who refused day treatment.' 'With many of these patients, it was the asylum role of the hospital which was relevant, rather than the continuous assessment and support.' Patients may feel 'the real treatment' occurs in the inpatient facility. Bowman *et al.* (1983) noted that day hospital patients were more contented with their day hospital placement than inpatients were with the inpatient facility.

It is clear that placement decision-making is affected by more than a patient's presentation of symptoms; personal, social and policy factors all have influential roles to play in the referral process.

2.3.2 Patient suitability

Some reports of day hospitals define their patient population in terms of psychotic and neurotic. McMillan and Aase (1964) reported two-thirds of day hospital cases as psychotic and one-third as neurotic; Carney *et al.* (1970) described 18% as psychotic and 53% as neurotic. More recently, Joseph *et al.* (1996) reported 52% psychotic, 28% neurotic, 14% personality disorders, 3% alcohol dependency and 3% anorexia nervosa. Shergill *et al.* (1997) report diagnosis at admission as 36%

schizophrenia, 30% depression, 16% bipolar affective disorder, 16% personality disorder and other 2%. Glasscote *et al.* (1969) noted that most day hospital studies seem to reveal a diverse patient population with schizophrenia and depressive neurosis as the most prevalent diagnostic groups.

Little is known about which patients are most likely to benefit from day hospital care (Creed *et al.*, 1988). Luborsky *et al.* (1971) warns of the hazards of employing diagnostic categories in evaluation studies. Guy and Gross (1967) have advised that symptoms, clusters of symptoms and information regarding the patients' social, economic, demographic and psychiatric past should be used to identify the sample in studies of outcome.

Dunne *et al.* (1982) collected demographic and treatment data of 84 patients attending a day hospital. Forty-two participants were followed-up for an average period of 22 months. During this time three measures were used; (i) Mini-Multi Personality Inventory - Brief Form (MMPI); (ii) a patient follow-up questionnaire; and (iii) staff rating. The results showed a decrease in psychiatric symptoms and a reduction in the use of psychotropic medications. Trends towards increased employment and independent living were also reported. This finding is in line with previous studies (Penk *et al.*, 1978; Vannicelli *et al.*, 1978; Edwards *et al.*, 1979; Moscowitz, 1980). A general outline of 'the good and the poor day hospital responder' also emerged from the study. Patients diagnosed with a psychotic disorder were poorer responders than patients diagnosed with a neurotic or a personality disorder. They noted 'the typical good responder was over 30 years of age, married, employed, living independently and neurotic, showed good attendance, had a moderate length of stay in the programme (greater than 20 weeks, less than 30 weeks), participated in the full-day programme versus the half-day programme and was not on psychotropic medication'. The typical poor responder was 'under 30 years of age, single, unemployed, living with parents, or relatives, psychotic and on high doses of medication, had a short length of stay (less than 20 weeks), demonstrated a poor attendance and showed a generally elevated pretreatment MMPI profile'. Given the rather large attrition rate, however, it is difficult to know whether the 42 participants of the original 84 were representative of the population and, therefore, of the day hospital attendees.

Vidalis and Baker (1986) surveyed 100 consecutive admissions to a psychiatric day hospital. Outcome was assessed in terms of regularity and duration of day hospital attendance, transfer to inpatient care, return to employment of unemployed patients and their relationship to other variables including diagnosis, socio-demographic factors and preference for group/individual activities was noted for 50 patients. Shergill *et al.* (1997) assessed change in terms of clinical measures administered at admission, repeated at six weeks and their relationship to diagnosis, socio-demographic details and length of stay. Out of 57 patients admitted over a one-year period, 50 patients assisted with the completion of the Beck Depression Inventory (BDI), Brief Psychiatric Rating Scale, Global Assessment Scale and Social Function Questionnaire. Both studies failed to predict which patients responded best to treatment. Shergill *et al.*'s study did, however, find that patients living by themselves improved significantly on the Global Assessment Scale at six weeks, compared to those living with others.

More recently, Kent *et al.* (2000) examined whether chronicity, social support and personality factors could predict outcome after short-term day hospitalisation. Outcome measures included the Beck Depression Inventory, the Stait-Trait Anxiety Inventory (STAI) and the Symptom Checklist-90-Revised. With regard to chronicity variables, prior psychiatric hospitalisation was associated with less symptom reduction than predicted post-treatment. This finding is not in line with Piper *et al.* (1994) who examined the ability of seven patient characteristics to predict success in a day hospital programme. Predictors that made significant independent contributions to patient success included previous psychiatric hospitalisation. Second, a shorter duration of psychiatric difficulties was not predictive of symptom reduction at discharge. Kent *et al.* note that this finding is particularly unexpected as Johnston and Busby (1997) conducted a study within the same setting but their findings are in contrast to the above. Third, having a pre-morbid personality disorder was indicative of less symptom

reduction than predicted at discharge. This finding is in line with previous studies. Vaglum *et al.* (1990) compared patients with borderline, schizotypal or paranoid personality disorders (Severe Personality Disorders – SEVPD) with patients with other personality disorders *(OPD)* and with no personality disorder *(NOPD).* At admittance the general symptom index (GSI) score of the NOPD and OPD groups were similar to each other and much lower than the SEVPD group. At discharge the NOPD group reported a lower symptom level than the other groups, which had roughly the same symptom level even when controlling for clinical syndromes. Vaglum concludes 'the personality disorder variable had a significant impact on the treatment response'. Finally, Kent *et al.* (2000) noted none of the social support variables, which included marital status, employment status, living arrangement and family problems, were predictive of outcome. With regard to personality variables, higher levels of social introversion were associated with greater distress than predicted at discharge. However, a high percentage of patients were excluded from the main analysis (34%). These omissions were due to missing data.

The lack of clarity as to which patients are most likely to benefit from day hospital treatment, in these studies, may be due to diverse patient populations. It is feasible that variables may differ in their predictive utility depending on diagnostic mix and that the same variables which may predict outcome in one study may not predict outcome in another when there are population differences (Kent *et al.*, 2000). With regard to patients who are deemed unsuitable to day hospitalisation, the picture is clearer. Clinicians usually prefer to exclude alcohol and drug dependents, personality disorders and organic brain syndrome (Hogarty *et al.*, 1968). In addition, patients who lack reasonable motivation for change, require constant supervision or nursing care, have difficulties with transportation, or are suicidal or aggressive are often excluded from day hospital care (Moscowitz, 1980).

2.3.3 Length of stay

Herz *et al.* (1971) reported the average number of days in treatment for day hospital patients was almost one-third that of the inpatient sample. More recently, Joseph *et al.* (1996) conducted a study within the Kildare Mental Health Services. They reported the average duration of stay in the inpatient unit as 14 days and the average duration of stay as 30 days in the day hospital. In the UK, Shergill *et al.* (1997) reported a much longer mean length of stay; 157.5 days for day hospital patients with 27% of patients having a stay longer than six months. No baseline socio-demographic variables were related to length of stay; however, lower scores on the Global Assessment Scale predicted a longer length of stay. Similarly, Weinberg *et al.* (1998) found the Clinical Global Impression Scale as the single best predictor of length of stay. Creed *et al.* (1997) reported that the more severe the illness the longer the length of stay and that if the patient was living with a spouse the shorter the length of stay. Increased age and referral from the inpatient ward were also significantly associated with a longer duration of stay in a study by Mbaya *et al.* (1998). A diagnosis of personality disorder has been found to be related to an increased length of stay by both Carney *et al.* (1970) and Shergill *et al.* (1997). Weinberg *et al.* (1998) noted that unlike duration of stay in an inpatient unit, individual hospital policies contribute an important proportion of the variation in the length of stay in day hospitals. Staffing levels may also explain the variation in the length of stay that clearly exists between day hospitals, severity of illness or differences in treatment programmes.

2.3.4 Day hospital care versus inpatient treatment

Two of the first controlled studies concerning the comparison of day hospital and inpatient care were conducted in the US. Wilder *et al.* (1966) randomly assigned 189 patients to a day hospital and 189 patients to the inpatient wards of the same general hospital. Two years later outcome was measured in terms of post-discharge mental health service contacts, rehospitalisation, and patients' or families' ratings of the patient's psychiatric state. No difference was found between patients admitted to

inpatient or day hospital care. Herz *et al.* (1971) reported the superiority of the day hospital as evaluated with the Psychiatric Status Schedule and the Psychiatric Evaluation Form. However, only 22% of the 424 patients seen were included in the study. The remainder of the patients were excluded; 32% were considered 'too ill', 20% were considered 'too healthy', while 27% were excluded for family reasons, physical illness or miscellaneous reasons.

Creed *et al.* (1990) completed the first study in the UK to consider all patients who were acutely ill, for random allocation. Fifty-eight per cent of 175 patients who required hospitalisation were randomly allocated to either day hospital or inpatient treatment. Forty-two per cent of patients were too ill to partake in the randomisation process and were admitted to inpatient care due to a potential danger to themselves or others, lack of housing, or the family's inability to cope with the patient at home. The Present State Examination was completed with 162 patients at admission, 82% at 3 months and 74% at 12 months. In addition, 132 of the patients at admission, 85% at 3 months and 78% at 12 months, provided informants who completed social performance and behaviour assessment schedule interviews. No differences in symptoms or social functioning were found at 3 or 12 months. Greater improvement in social functioning among inpatients did emerge at 3 months. This finding contradicts previous findings by Herz *et al.* (1971), Michaux *et al.* (1972) and Washburn *et al.* (1976) all of which report more favourable findings among day hospital patients and more recently Creed *at al.* (1991) who report no differences between the two groups.

Several studies have reported that patients discharged from a day hospital are more likely to be employed and socially adapted (Kris, 1965; Kaldau and Dirks, 1977) and less likely to be rehospitalised (Kris, 1961; Michaux *et al.*, 1973). Reports have also indicated that the beneficial effects of day hospitalisation may be of a more long-lasting nature than are those of inpatient care (Moscowitz, 1980).

Creed *et al.* (1989) and Wilkinson (1984) have criticised many of these studies on methodological grounds. Wilkinson (1984) noted that on close inspection of studies comparing treatments, methodological inadequacies invariably show up. 'For example, the number of patients tends to be small; often there is selection bias, partial or no randomisation, and little control of important variables such as diagnosis, medication, and treatment between discharge and follow-up; day care and in-patient care are often too ill defined; outcome measures are not standardised or rated blindly; and too many patients are usually lost during follow-up. All these reasons reduce the confidence that can be put in the case favouring day care for patients with severe psychiatric disorders.'

Davidson *et al.* (1996) approached the comparison of these two forms of care from a unique perspective. They compared the social environment between the two settings. They noted that the day hospital is superior to the inpatient setting in several important ways; it had 'higher expectations for patient functioning, a lower tolerance for deviance and more choice, allowing for more continuity of patients' ongoing community involvement. The programme also had a more stimulating and attractive physical environment and a social milieu that patients experienced as more cohesive, less conflictual and more comfortable. In addition, the programme promoted higher levels of patient functioning and activity, increased levels of utilisation of health services, help with daily living skills and social and recreational resources within the facility, and more integration of patients into the community outside of the facilities.'

Many psychiatrists are supportive of the day hospital on clinical grounds. It is widely recognised that prolonged inpatient care and separation from the family can have severely damaging effects on a patient's recovery. The day hospital can maintain the patient's autonomy and links with the community thereby reducing stigmatisation and institutionalisation.

2.3.5 Day hospital care versus home care

There have been no studies to date, at least none known to the authors, comparing day hospital and home care treatment. Studies evaluating home care have generally compared home treatment with inpatient care. In the 1970s Stein and Test designed a research programme evaluating home care in Madison, Wisconsin. Patients coming to hospital for admission were assigned to an experimental programme (home care) or a control programme (inpatient care). Data were collected at baseline and every four months for approximately one year.

The results of this study revealed a substantial difference between the experimental and control groups. In year 1, 57 of the 65 control patients were admitted to inpatient care for an average of 36 days. However, only 12 of the 65 experimental patients were admitted to hospital for an average of 11 days. In terms of clinical outcomes, the experimental group did better in terms of psychiatric morbidity, employment, social relationships and life satisfaction. There was no difference between groups in relation to leisure activities. Data were also collected for 14 months after the experiment ceased. However, the gains that had been made were lost in time. In terms of burden of care, there was no increase in the burden on the family or the community; on a few measures there was actually a decrease in the burden (Stein and Test, 1980). Economically, no increased cost in treating patients in their home compared with the hospital was found (Weisbrod *et al.*, 1980; Stein, 1987).

In 1979, Hoult *et al.* commenced a similar study in New South Wales, Australia. After 12 months the results were similar to those of Stein and Test (Hoult, 1986). Sixty per cent of the experimental group were not admitted to hospital compared with 4% of the control group and 32% of the experimental participants had one admission, compared with 45% of the controls. Furthermore, most of the experimental group who were admitted stayed less than one week. In terms of clinical outcomes, the experimental group had fewer psychiatric symptoms and there was a trend in their favour in relation to social adjustment. The majority of patients and relatives belonging to the experimental group were very pleased with home treatment. The study concluded that standard hospital care and aftercare cost 26% more than home care.

Research conducted with regard to home treatment in the Monaghan/Cavan Mental Health Service has so far been limited to an audit of service use and views of patients, carers and general practitioners (GPs). The findings of these studies are published in a monograph entitled *A Model for a New Community Mental Health Service: The Cavan/Monaghan Project* (North Eastern Health Board, 2001). These studies revealed that (a) referrals to the community mental health team have been predominantly from GPs, (b) patients receive home treatment for an average of 43 days, (c) inpatient bed usage had fallen dramatically and (d) certification rates in Monaghan have declined substantially. In 1999 certification rates in Monaghan were 31.8 per 100,000 population over 16 years (12 patients), compared to the national rate of 101.3 per 100,000. Furthermore, patients, relatives and GPs have all expressed considerable satisfaction with the new service programme. The implementation of home treatment in Cavan and Monaghan was executed by planned relocation of resources without any extra funding.

Outcome studies regarding home care have, in general, yielded very positive results. The comparative effectiveness between home treatment and day hospital care is as yet unknown. Research is required to determine the most beneficial form of care given according to circumstances.

2.3.6 Proportion of hospitalised patients manageable in the community

Tobin (1958), Kramer (1962), Pitt and Markowe (1963), Zwerling and Wilder (1964) and McDonagh and Downing (1965) reported that approximately three-quarters of all patients who are psychiatrically

hospitalised could be appropriately treated in the community. Platt *et al.* (1980) attempted a research project in which patients who were deemed appropriate by their treating psychiatrist were allocated to the day hospital. This study had to be abandoned due to the small number of patients, with only 10% referred to the facility. The majority of patients were viewed as 'mandatory inpatients' (too ill to attend the day hospital) or 'mandatory outpatients' (not ill enough to warrant admission). A second study that failed due to the small number of patients, only included patients with a diagnosis of neurosis, adjustment reaction or personality disorder (Dick *et al.*, 1985). The sample comprised only 22% of all admissions.

More recent studies based on unselected populations indicate that 30–40% of acute patients can be managed in the day hospital (Creed *et al.*, 1990; Kluiter *et al.*, 1992; Schene *et al.*, 1993). In practice, between 9 and 13% of day hospital places are used for acute illness as an alternative to inpatient admission (Mbaya *et al.*, 1998). Clearly there is a considerable range in the percentages reported. This may reflect methodological flaws, differences in policies among day hospitals or the range of resources available in the day hospital to allow the diversion of patients from the inpatient wards. There is a general agreement in the literature, however, that the day hospital is underutilised for acute and psychotic illness (Platt *et al.*, 1980).

2.3.7 Patient satisfaction and burden of care on the family

Patient satisfaction is an important factor in the development and evaluation of services. To date, all published studies examining patient satisfaction have reported that the majority of patients are either satisfied or very satisfied with day hospital services. Some aspects of care with which the patients were most satisfied include (i) supportive atmosphere and structure of the day hospital (Hsu *et al.*, 1983), (ii) the professional with whom patients had most access to and contact, plus (iii) talking and counselling (Holmes *et al.*, 1998). However, as Fischer (1983) points out patients who rate themselves as satisfied often do so knowing little about alternative forms of care. Samples of patients who have experience of both inpatient and day care may be the best source of valuable information.

A search of the literature revealed no studies examining the burden of care experienced by families whose relative attended a day hospital without prior inpatient care. Several studies, however, have examined the effects of brief hospitalisation upon the psychiatric patients' household. Platt and Hirsch (1981) randomly allocated 224 patients admitted to an inpatient facility to brief care or standard care. Brief care involved the patients being discharged within eight days with direct transfer to a day hospital if appropriate. Standard care involved no restrictions and patients were kept in hospital for as long as necessary. Comparisons between groups were made in relation to the month before admission, two weeks after admission and about 14 weeks after admission. Platt *et al.* noted 'overall, there were no significant differences between groups in the extent of objective burden or subjective distress experienced by the informants' household'. Hirsch *et al.* (1979) allocated 127 patients to brief or standard care. The results revealed no differences between the two groups in burden to the community supporting services, social security requirements or general practitioner attendance.

2.3.8 Summary and conclusions

There is considerable diversity among day hospitals and it is clear that many are not functioning as alternatives to inpatient care (Schene *et al.*, 1988, Mbaya *et al.*, 1998). Research suggests that day hospitals are underutilised for acute and psychotic illness (Platt *et al.*, 1980). This may be due to a number of factors ranging from a lack of appropriate resources to a general resistance by staff. Washburn *et al.* (1976) suggested that clinicians seek inpatient hospitalisation due to the pressure of patients' unpredictable behaviour. The problem may be compounded by a lack of specialist knowledge amongst clinicians. For example, it is not known which patients are most likely to benefit from day hospital care (Creed *et al.*, 1988). Recent studies based on unselected populations indicate

that 30–40% of acute patients can be managed in the day hospital (Creed *et al.*, 1990; Kluiter *et al.*, 1998; Schene *et al.*, 1993). In practice between 9 and 13 per cent of day hospital places are used for acute illness as an alternative to inpatient admission (Mbaya *et al.*, 1998). Further research is required in order to provide an appropriate, effective and efficient day hospital service.

2.4 The day centre

2.4.1 Patient selection

Guidry *et al.* (1979) described the profile of 65 patients out of a total of 97 attending a day centre in the US. Sixty-one per cent had a diagnosis of schizophrenia, 28% affective disorder, 3% organic brain syndrome and 8% other diagnoses. Ninety-nine per cent of patients were male and 52% per cent were single, the mean age was 41.6 years at commencement of attendance. Fallon and Talbot (1982) also found schizophrenia to be the most prevalent diagnosis at 48%. Other diagnoses included manic-depression 7%, neurotic depression 7%, personality disorders 23%, anxiety neurosis 5% and other 12%. There was a more even representation of gender, 49% were male and 51% were female. A large proportion of patients (53%) were single. Only 18% of patients were living independently. Forty-six per cent lived in the family home and 36% in residential care. The mean age was 33.5 years. In a relatively recent attendance survey conducted in Northern Ireland, Lynch *et al.* (1994) noted that out of a total of 158 day centre patients the majority were diagnosed with schizophrenia (58) or neurotic disorder (65). Of the 58 patients diagnosed with schizophrenia, two-thirds were male, 50 were single or separated, 26 lived with their parents and 15 lived alone. Forty-six patients had had two or more psychiatric admissions. With respect to the 50 patients who had a neurotic disorder, two-thirds were female and half were married or co-habiting. Thirty-two patients had two or more psychiatric admissions.

A clear trend emerges from the studies cited above; the majority of patients attending day centres has a history of psychiatric disorder, suffers from schizophrenia or an affective disorder, is single and live in the family home or in residential care.

2.4.2 Effectiveness of day centre care

Guidry *et al.* (1979) evaluated the effectiveness of a day centre programme in meeting the goals of the patient population. Pre-day centre and day centre data of equivalent time intervals for each patient were analysed. Sixty-five out of 97 patients were included in the data analysis; some records were unavailable while others did not have sufficient data recorded prior to the programme. During the pre-centre period there were 81 inpatient hospitalisations, with a total of 46 patients being hospitalised. The range of inpatient hospitalisations was 0–6, with a mean length of stay of 211 days and a range 0–3,467 days. The total number of days hospitalised for the group was 13,737. In comparison, during the day centre programme there were 40 hospitalisations, with a total of 20 patients being hospitalised. The range of hospitalisations was 0–6, with a mean length of stay 15 days, range 0–214 days. The results demonstrate the efficacy of the day treatment centre in helping to prevent hospitalisation and to decrease the average length of stay where admission is inevitable. The authors warn that the data should not be accepted without reservation. For example, the aim of mental health professionals at the time was towards early return to the community and shortening the length of stay in hospital. However, given the considerable difference between the pre-day centre and day centre data the results are noteworthy.

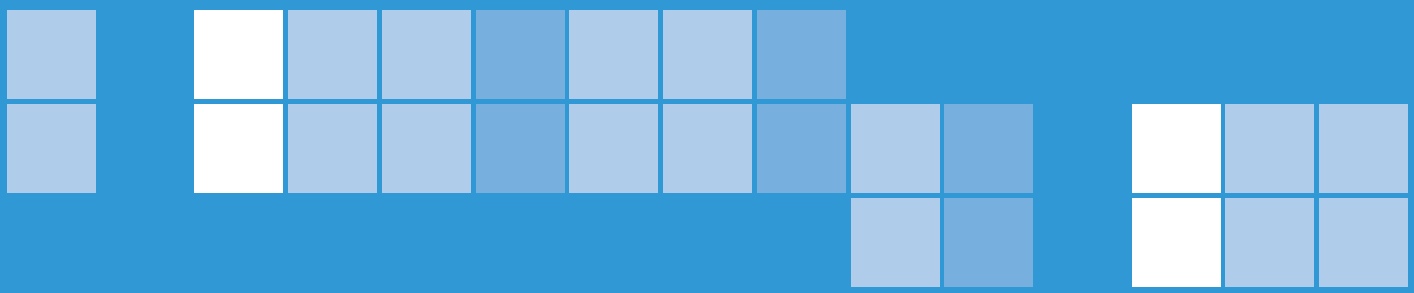
Fallon and Talbot (1982) designed and evaluated a day programme that was different to others in many ways. Behaviour treatment strategies were individually tailored to meet the needs of a wide variety of patients. Goals were devised in consultation with each patient in three broad categories; (i) socialisation (ii) vocational activity and (iii) symptoms of psychiatric illness. The programme was

intense and time limited with an aftercare programme provided. The aftercare programme was a less intense ambulatory care outpatient programme, which was available indefinitely. One afternoon a week patients could also engage in leisure pursuits and were introduced to similar activities in the community. When a crisis occurred, patients were provided with more intensive day treatment support. Twenty per cent of patients dropped out before completion of the programme, 28% achieved a poor response, while 52% achieved a good response. The authors note that a good response appeared to depend not so much on the quality of therapy rather than on the involvement of the patient in planning his or her own treatment plan.

Lynch *et al.* (1994) examined patients' views of a day centre by diagnosis. The centre located in Northern Ireland was open only one year. Seventy-eight per cent (n = 21) of patients diagnosed with schizophrenia and 78% (n = 28) of patients diagnosed with neurosis completed a day centre satisfaction questionnaire. Both groups were most satisfied with social activities including lunch, tea breaks and direct contact with staff. Therapeutic activities such as relaxation classes and educational activities including computer skills and adult education were less popular. Infrequent attendees also completed a questionnaire. Twenty-four out of 31 patients diagnosed with schizophrenia and 21 out of 27 diagnosed with neurosis completed a questionnaire. The main reason given for non-attendance was that there was not enough to do.

2.4.3 Summary and conclusions

Research would suggest that the majority of patients attending day centres suffer from schizophrenia or an affective disorder, are single and live in the family home or in residential care (Guidry *et al.*, 1979; Fallon and Talbot, 1982). Several studies have reported the beneficial effects of day care (Guidry *et al.*, 1979; Fallon and Talbot 1982; Lynch *et al.*, 1994); however, very little evaluative research has been conducted. Given the scarcity of scientific knowledge in respect of the day centre, the conduct of more scientific research is essential.



CHAPTER THREE

Background to the Present Study and Methodology

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Background to the Present Study and Methodology

3.1 Background

The Health Research Board established a programme of mental health research in the field of service delivery in 1997. The first study in the series, *"We Have No Beds...": An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region.*, was an in-depth review of the availability and utilisation of acute psychiatric beds in the Eastern Health Board (EHB) area (Keogh, Roche and Walsh, 1999). This study was conducted in response to a suggestion that the EHB psychiatric service had insufficient beds for patients who were acutely ill and who needed hospitalisation. The results revealed that while there was an adequate number of beds available for acute psychiatric usage, 45% of these 'acute' beds were occupied by non-acute patients. The high level of inappropriate occupancy was judged largely to be due to limited provision of day care places and an inadequacy of community residential accommodation. This problem was further compounded by many day hospitals which did not seem to be providing care for more seriously ill patients and therefore were not operating as alternatives to acute care.

The aim of the present study was to examine the extent of day hospital provision and function in Ireland. Drawing from experience and the literature review, it was felt that there was no representative day hospital in Ireland and a quest for such would be futile. Thus the two health boards, which were chosen for study, were limited in their representativeness of day services on a national level. Furthermore, this study confined itself to the needs of patients treated by general adult services. The day hospital and day centre requirements of those aged 65 and over and of other patient groups of a specialised nature were excluded from consideration but require a separate enquiry.

3.2 The current study

Specifically, the aims of the study were to:

1. Provide a review of existing day hospital and day centre provision
2. Examine the nature and appropriateness of day hospital and day centre function
3. Explore the demographic and clinical profiles of patients attending day hospitals
4. Investigate patient satisfaction with day hospital services
5. To elicit day hospital staff views regarding the nature and function of day care
6. Make recommendations as to the future of day hospital and day centre provision, location and function.

3.3 Participants

Five catchment areas from two health boards took part in the study. Each health board was allocated a letter and each catchment area was allocated a name (to protect the identity of the day hospitals and day centres participating in the study). As shown in Table 3.1, catchment areas in Health Board A were named Joyce, O'Casey and Synge, and catchment areas in Health Board B were named Yeats and Shaw.

There were eight day hospitals and six day centres in Health Board A. There was one day hospital in each sector with the exception of catchment area Joyce. This catchment area was not sectorised and had one day hospital only. In addition, there was no day centre in Joyce or in one sector of Synge. There were six day hospitals and 7 day centres in Health Board B. There was a day hospital in each

sector. There was one day centre in each sector with the exception of one. There were two day centres in one sector of Shaw. Thus, in total 14 day hospitals and 13 day centres participated in the present study.

In order to provide the reader with some knowledge of the mental health service in these health boards, information relating to population characteristics and inpatient care is presented below. Data relating to the characteristics of inpatient care, community care, staffing and cost are presented in Appendix 1.

Table 3.1 Health Boards A and B: Catchment areas and day care services.

	Health Board A	Health Board B
Catchment areas:	Joyce O'Casey Synge	Yeats Shaw
No. day hospitals:	8	6
No. day centres:	6	7

3.3.1 Population characteristics

The most recent general population figures for Ireland were published in the 1996 census (Central Statistics Office, 1997). At this time the population of Health Board A was 494,881 and the population of Health Board B was 205,542. Table 3.2 shows the total population and population over 15 years for each catchment area broken down by gender.

Table 3.2 Health Boards A and B: Total population and population over 15 years by gender in 1996. *Numbers*.

	Health Board A	Health Board B
Population over 15 years		
Male	183,602	75,350
Female	198,715	73,763
Total population over 15 years	382,317	149,113
Total population	494,881	205,542

Source: District Electoral Division (DED) population figures from Central Statistics Office, 1996 Census of Population (CSO, 1997)

3.3.2 Inpatient care

In Health Board A, inpatient care was provided in each of the catchment areas. In Joyce, inpatient care was provided in a general hospital unit, which contained 51 beds. Beds, mainly for continuing care purposes, were also provided by a private hospital on a contract basis. In 2000, 34 beds were contracted. In O'Casey, inpatient care was provided at two hospitals. Fifty beds were provided in an acute unit in a general hospital and 20 rehabilitation beds in a former acute psychiatric hospital. In Synge, a 30-bed integrated psychiatric unit was provided at a general hospital. Continuing care was provided in community residences.

The Health Research Board publishes information from the NPIRS on an annual basis. Table 3.3 shows acute inpatient admissions and discharges for each catchment area in Health Board A for 2000.

Table 3.3 Admissions and discharges for each catchment area in Health Board A for 2000. *Numbers and percentages.*

	Joyce	O'Casey	Synge
All admissions	243 (100%)	642 (100%)	578 (100%)
First admissions	97 (39.9%)	152 (23.7%)	177 (30.6%)
Discharges	264 (99.6%)	623 (99.7%)	568 (99.8%)

Source: NPIRS. Daly and Walsh, 2001

In Health Board B, inpatient care was also provided in each of the catchment areas. In Yeats, inpatient care was provided in a psychiatric hospital where 104 beds were provided in one male and three integrated wards. In Shaw, 184 beds were provided in four male and three female units. Details of admissions and discharges for each catchment area in Health Board B for the year 2000 are displayed in Table 3.4.

Table 3.4 Admissions and discharges for each catchment area in Health Board B for the year 2000. *Numbers and percentages.*

	Yeats	Shaw
All admissions	729 (100.0%)	804 (100.0%)
First admissions	188 (25.8%)	176 (21.8%)
Discharges	730 (99.7%)	787 (99.0%)

Source: NPIRS. Daly and Walsh, 2001

3.4 Study design

The researcher who conducted the fieldwork (T.H.) visited each of the day care services and met with staff prior to the study. Information was obtained from informal conversations with staff as to what matters were considered worthy of investigation. Based on these meetings and a review of the literature, six questionnaires were designed and three published scales were selected to elicit the information required. The three scales were chosen due to their validity, reliability, brevity and relative ease of administration. Table 3.5 lists each of the questionnaires/scales, describes the nature of the information the measure gathers, and notes the person responsible for its completion. The reader should note that the frame of reference in some questionnaires designed by the researcher was modified slightly in order to accommodate differences in services between catchment areas. For example, the wording of the Service Satisfaction Questionnaire was adjusted for patients in one day hospital. The words 'day hospital' were replaced with 'mental health centre', as this was how patients from this service referred to the day hospital. In addition, the reader should note that some questionnaires were completed using patients who were already registered (i.e. 'on the books') when the study commenced, while others were completed using patients referred in the course of the study. Lastly, it is important to note that the date of the data collection varied for each day hospital and was in accordance with the schedule of the researcher's fieldwork. (All questionnaires and instructions are presented in Appendices 2–10.)

Table 3.5 List of questionnaires/scales, nature and source of information collected.

Questionnaire/Scale	Information	Source
Day Hospital		
General Day Hospital Questionnaire	Provision and nature of service	Nursing Officer
Referral Questionnaire	Reason for referral Assessment details Diagnostic details	Psychiatrist
Patient Information Questionnaire	Demographic and clinical details	Researcher
Day Therapy Appropriateness Scale	Patient appropriateness for the day hospital	Nurse
Brief Psychiatric Rating Scale – Expanded Version	Severity of psychiatric symptoms	Nurse
Service Satisfaction Questionnaire	Patient satisfaction	Patient
Consumer Opinions Questionnaire	Patient opinions	Patient
Questionnaire Regarding Staff Views	Staff perceptions of day hospitals and day centres	Staff
Day Centre		
General Day Centre Questionnaire	Provision and nature of service	Nursing Officer

3.4.1 General Day Hospital Questionnaire

This questionnaire consists of six sections. The purpose of the first section was to describe the day hospital's geographic location in the context of the overall mental health service, its physical location in relation to the surrounding area, and the premises. Section two examined patients' usage of the service, section three the referral process while section four concerned staffing issues. Sections five and six covered two topics; treatments available and communication among staff in the services. The researcher completed this instrument with the nursing officer of each participating day hospital.

3.4.2 Referral Questionnaire

This instrument was designed to investigate the reasons for referring patients to day hospitals, assessment procedures and diagnostic details. Data were collected in each day hospital for four weeks. Psychiatrists were asked to complete the Referral Questionnaire for patients referred from the psychiatric services during the study period. When a patient was referred to a day hospital during the study period from outside the psychiatric services, for example, from a general practitioner, nurses were asked to complete this form.

3.4.3 Patient Information Questionnaire

This instrument was designed to collect clinical and demographic information regarding patients attending a day hospital. Details of all patients registered at eight day hospitals in Health Board A were collected. Details of a sample of patients registered at six day hospitals in Health Board B were gathered. It was not practical to gather details for all patients registered in Health Board B, as the

number of registered patients was quite large. The researcher completed the Patient Information Questionnaire form and when necessary a nurse was asked to assist.

3.4.4 Day Therapy Appropriateness Scale (DTAS)

The DTAS consists of seven items deemed problematic to a patient's successful completion of day treatment (Lefkovitz, 1982). Items include duration of problem, acting out or disruptive behaviour, suicide, homicide and ideation, alcohol or drug involvement, motivation, social and emotion support and transportation. A mental health professional assigns a level of functioning for each item from three possible categories of problematic functioning. The higher the total score, the more appropriate the patient is for day treatment. The DTAS is widely recognised as a good measure of adult patient appropriateness for day hospital programmes. In Health Board A, this scale was completed for all registered patients attending a day hospital at the time of the researcher's investigation. Some nurses continued to complete this scale with patients who were referred to a day hospital and commenced treatment shortly after the researcher's visit. These data were included in the study. In Health Board B, the scale was completed with a sample of registered patients attending a day hospital at the time of the researcher's investigation, as the number of registered patients was too large. A nurse completed this scale and when necessary the patient was asked to assist.

3.4.5 Brief Psychiatric Rating Scale - Expanded Version (BPRS-E)

The BPRS-E was designed to provide a relatively quick measure of the severity of psychiatric symptoms (Lukoff *et al.*, 1986). This inventory consists of 24 symptom constructs, each to be rated on a seven-point scale of severity ranging from 'not present' to 'extremely' severe. If a specific symptom is not rated, 'NA' (not assessed) is marked. Ratings are based on the patient's answers during the interview. This scale has been found to have good inter-rater reliability and good internal consistency (Hafkenscheid, 1993). It was completed with two groups of patients; (i) those at the beginning of their attendance and (ii) those attending for longer than three months. These two time periods were chosen for study in order to determine (a) whether patients were acutely ill at the time of their admission and (b) whether patients in care for a significant period of time were acutely ill. Nursing staff at each of the day hospitals administered this scale.

3.4.6 Service Satisfaction Questionnaire and Consumer Opinions Questionnaire

The Service Satisfaction Questionnaire consists of 17 items from the modified Service Satisfaction Questionnaire (Bond *et al.*, 1992), plus a further 17 items relating to specific issues of relevance and concern to day hospitals (Newnes *et al.*, 1988).

The Consumer Opinions Questionnaire addressed topics such as day hospital opening hours, awareness of the services available at the day hospital and a satisfaction rating in relation to the services provided. It also looked at whether there were any disadvantages to using the day hospital service.

The Service Satisfaction Questionnaire and the Consumer Opinions Questionnaire were distributed in the same envelope to patients. In Health Board A, all registered day hospital patients were invited to participate in the study. Sixty-six per cent of the questionnaires were distributed and collected by the researcher; 33% were distributed and collected by a nurse who assured the patient confidentiality. In Health Board B, nurses under specific instructions distributed all questionnaires to a sample of patients registered at each day hospital. In particular, nurses were asked to explain to the patient the purpose of the questionnaire, provide patients with a quiet room and assure them confidentiality. Secured collection boxes were placed in the reception area of these day hospitals. Only the researcher had access to these boxes.

The difference in the administration procedure between health boards was due to the disparity of attendance patterns at day hospital services. In Health Board A, patients attended a day hospital on a full-day basis and the researcher was able to administer the questionnaire to all patients at the same time. In Health Board B, patients received an appointment, usually for an hour each week, to attend a day hospital. It was decided that it would be more practical for a nurse to administer the questionnaires before or after an appointment.

3.4.7 Questionnaire Regarding Staff Views

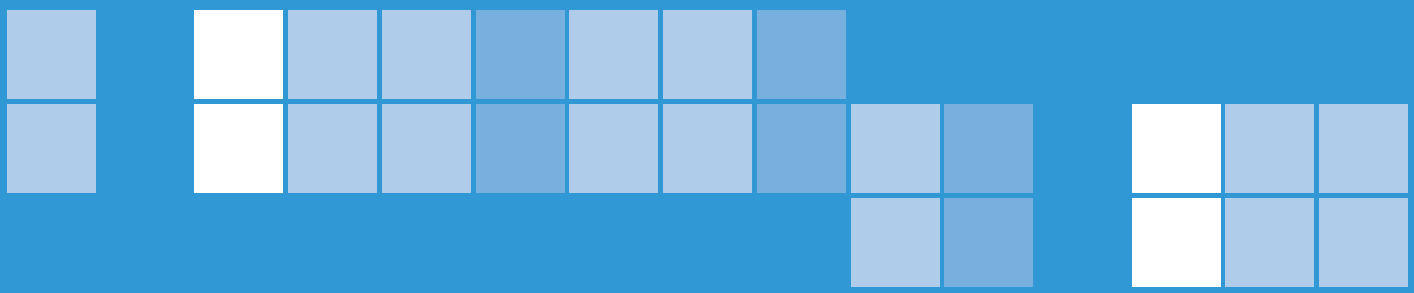
This questionnaire investigated staff perceptions of the role of the day hospital and the day centre. It also enquired more specifically about the day hospital in which the interviewee worked. All mental health professionals (with the exclusion of addiction/alcohol counsellors), who provided a service to day hospital patients, were interviewed by the researcher. A decision was made to exclude addiction/alcohol counsellors who were often based in community settings independent of mental health services.

3.4.8 General Day Centre Questionnaire

This questionnaire is very similar to the General Day Hospital Questionnaire. It consisted of four sections. Like the day hospital questionnaire the purpose of the first section was to describe the day centre's geographic location in relation to the overall mental health service, its physical location in relation to the surrounding area, and the premises. Similarly, section two examined patients' usage of the service, section three the referral process, while section four concerned staffing issues and activities available. The researcher completed this instrument with the nursing officer of each participating day centre.

3.5 Data analysis

Analysis of data was largely descriptive. Chi-square tests were performed on cross tabulations of nominal data. The chi-square results are not reported when more than 20% of the cells had an expected frequency less than 5. Missing data were excluded from tables for reasons of clarity. Mann-Whitney tests were used to analyse ordinal data. Other analyses conducted included factor analysis and one-way analysis of variance (ANOVA).



CHAPTER FOUR

Results I: Description of Day Hospital and Day Centre Services

CHAPTER FOUR

Results I: Description of Day Hospital and Day Centre Services

This chapter describes the day hospitals and day centres that participated in the study. The information was obtained using the General Day Hospital Questionnaire and the General Day Centre Questionnaire. In addition to the detailed information a short summary is provided at the beginning of each section. The findings presented below are also presented in Tables 4.1 and 4.2. The implications of the findings are discussed in Chapter 7. First, the rationale behind this section of the study is outlined below.

4.1 Rationale

A range of background information is provided which helps characterise the day hospital and day centres studied. The information reported below relates to the premises, staffing, treatment, activities and communication.

It is widely accepted that the environment in which treatment is delivered has an important bearing on the quality of life of staff and patients. In addition, premises, which match the needs of their users and are of good quality, facilitate the achievement of therapeutic goals. Questionnaires were used to capture the main characteristics of the physical environments encountered in the fieldwork and findings from these are presented below.

A research instrument was also used to capture the nature of services provided by psychiatric day care services. Although an official presentation of the services that should be offered by day hospitals and day centres was provided in *Planning for the Future* (as noted in Chapter 1), the researchers hypothesised that considerable variation would be found in practice. Thus, in the present study each day hospital and day centre service was compared with the descriptions presented in Chapter 1.

The study also investigated the assessment and referral procedures that operated in each day hospital, as these procedures, *inter alia,* dictate the type of patient placed in psychiatric day services. A comprehensive and accurate assessment conducted or supervised by an experienced psychiatrist is important in order to ensure that a patient is directed to the most appropriate form of care, thus avoiding or decreasing the inappropriate placement of patients.

Background descriptive information is provided regarding staff, treatment and activities carried out by patients. As noted in Chapter 1, a comprehensive range of treatments should be available at a day hospital as well as social therapeutic activities. Thus, a wide range of mental health professionals and personnel with occupational and other activity skills is required. The study will show the extent to which official recommendations regarding staffing, treatment and the provision of gainful activities were realised in the facilities investigated.

Lastly, a description of communication in terms of patient records, meetings held, availability of electronic mail (email), existence of planning documents, etc. for each of the study facilities is provided.

4.2 Day hospitals

4.2.1 Premises

SUMMARY

- The majority of day hospitals were based in inappropriate accommodation
- Most common problems with premises were the disposition of rooms, furnishings and décor and a lack of patient activity rooms, particularly in Health Board B
- Some patients spent up to two hours travelling in a minibus provided by the health boards, to day hospital services.

There were eight services in Health Board A and six services in Health Board B operating under the title day hospital. The majority of day hospitals were located in buildings that were not purpose built. These buildings included a domestic house, two convents, six commercial properties and a building in the grounds of a district hospital. There were many problems with these buildings and not one of them was suitable for day hospital purposes. Examples of unsuitability included a day hospital that operated from a converted office block. This day hospital was located on the second floor and was not accessible to people with mobility difficulties. Another day hospital was too small and the disposition of rooms was inappropriate for day hospital functioning. In particular, the nursing office was minute and could only be accessed through the main patient activity room. If a patient became unruly in this office, the exit could be easily blocked and there would be little room to manoeuvre. The size and design of this day hospital could exacerbate a potentially dangerous situation.

In Health Board B, the majority of day hospital premises had no room available to patients for activity purposes. Four premises also accommodated a day centre and one premises accommodated an addiction service. The latter day hospital had to close one half day per week to facilitate a methadone clinic. Some health boards had attempted to adapt basically unsuitable buildings to the needs of a day hospital. However, these attempts had been largely unsuccessful. For example, one of the commercial buildings was a warehouse and it had been internally partitioned to provide patient activity rooms, treatment rooms and a staff room. However, the internal partitioning had resulted in a lack of natural light. In addition, staff reported that this building was cold in the winter and too warm in the summer. Of the day hospitals that were purpose built, two were in health centres, one was in a mental health centre at a district hospital and one was in a psychiatric unit at a general hospital. All day hospitals were within walking distance of local amenities.

The day hospitals were established between 21 years and 1 year ago. The health boards owned all of the premises. Nine premises were classified as permanent locations and 5 as temporary locations. Four of the premises had been classified as temporary for 13 years, 11 years, 6 years and 5 years, respectively. There were no specific plans to relocate any of these day hospitals. A fifth premises was established for 13 years, but was being relocated to a former mental health community residence. The budget for this was in place and planning permission was being sought to renovate the premises to accommodate a day hospital.

In Health Board A, the day hospital located in the psychiatric unit had seven rooms for use by patients. Six of the seven rooms were located in the Occupational Therapy Department. The day hospital did not have a distinct identity of its own. Excluding this day hospital, the average number of activity rooms for use by patients was two. The largest room available to patients in any of the day hospitals measured approximately 25 ft by 20 ft. Seven out of eight premises also housed sector headquarters. One premises housed two sector headquarters, as there was no day hospital in a neighbouring sector. The number of offices available in each premises varied. There was a range of 6 to 12 offices. The nurses in charge at two day hospitals felt more offices were needed. Staff at one of these premises did not have their own office. Rooms had to be pre-booked with the receptionist. However, offices at this

location were used on a part-time basis only. It was observed that staff and patient areas were ill defined, leading to an inadequacy in the separation of function. In terms of the physical up-keep of the premises, there were cleaning and/or maintenance problems evident in three of the day hospitals.

In Health Board B, most day hospitals had a conference room, which was occasionally used for patient education programmes. However, only one day hospital had a room available to patients for therapeutic activities. All day hospital premises housed sector headquarters. Each premises had between five and seven staff offices. Two premises had a lack of office space. At one of these day hospitals patients were engaged in counselling sessions in a clinical storage room when space was at a premium. The sector team located in this facility was seeking additional office space nearby. The second day hospital was located in the grounds of a district hospital and could accommodate nursing staff only. The psychiatrists attached to this facility saw day hospital patients in the outpatient clinic in the main hospital. The psychologist and social worker had an office in an old and decrepit building nearby. Sometimes a nurse would have no alternative but to see patients in this building, as the day hospital offices were not soundproof. Prior to the use of this old building, patients had from time to time been counselled in a car or coffee shop when no office had been available. Nursing officers at an additional three day hospitals felt more offices were required, even though the existing offices were used on a part-time basis only. Three day hospitals were in need of refurbishment in order to provide a more acceptable environment.

In Health Boards A and B, nine premises were open weekdays after 5 pm and/or at weekends to facilitate meetings by voluntary organisations. Eight premises were open at the weekend to accommodate nurse therapists for patient counselling and/or community nurses for community crisis intervention purposes. All premises had psychiatric services other than a day hospital and/or non-psychiatric services operating from the same building.

4.2.2 Nature of day hospital services and patient information

SUMMARY

- In Health Board A, patients attended a treatment and therapeutic activity service for a full day on a full - or part-time basis
- In Health Board B, patients attended an individual counselling session usually for an hour on a weekly basis
- There was a lack of activity in many day hospitals.

In Health Board A, all day hospitals were open five days a week generally between the hours of 9.30 am and 4.30 pm. The majority of staff worked from 9 am to 4.45 pm. Patients could spend up to five hours per day in these facilities in treatment and engaging in activities. Two day hospitals had a counselling service for non-acute patients, every Saturday. One day hospital provided a drop-in service for day hospital patients and outpatients every Sunday.

In Health Board B, all hospitals were open five days a week generally between the hours of 9.30 am and 5.30 pm. The majority of staff worked from 9.30 am to 5.30 pm. Patients usually received an appointment for one hour per week with a nurse therapist. One day hospital provided a weekend counselling service for day hospital patients every second Sunday.

In Health Board A, the number of patients on each day hospital register ranged from 8 to 43. The average number of patients registered at each day hospital was 17. Out of a total of 139 patients registered at the day hospitals, only 7 (5%) were current inpatients. At the day hospital located in the inpatient unit, a further 20 inpatients attended the same occupational therapy programmes as the day patients. These patients were registered on the inpatient register only. There were large differences between the amounts of time patients spent at each day hospital. For example, in one day hospital

only 7% of patients were attending full time, at another day hospital every patient was attending full time. The average number of patients attending each day was 11. Twenty (14%) patients on the day hospitals' registers were considered by the nurses in charge to be more suited to a day centre. Thirty (22%) patients on the day hospitals' registers were waiting for placements with mental health programmes or 'return to work' schemes.

In Health Board B, the number of patients on each register ranged from 30 to 113 patients. Excluding the outlier on the upper range, the average number of patients registered at each day hospital was 37. No inpatient attended any of the day hospital services. The average number of patients seen per day was between 4 and 15. The nurses in charge felt that no patient attending these services was better suited to a day centre and only a handful of patients were waiting for placements with other programmes.

In Health Board A, patients attending for a full-day were provided with meals in all but one day hospital. The day hospital located in the psychiatric unit did not have the facilities to provide both inpatients and day patients with meals. Day patients were issued with vouchers to purchase food in any of the hospital food outlets. Minibus taxis were provided at three day hospitals, as some patients lived in rural areas that were quite a distance from the day hospitals. Patients could spend up to two hours on a minibus travelling to the day hospital. In more urban areas there was a local bus or taxi service. Since day hospitals in Health Board B operated on an appointment basis, no patient received a meal and transport was only provided in exceptional circumstances.

4.2.3 Referral and assessment procedures

SUMMARY

- There was a variety of referral procedures
- Only eight day hospitals used a referral form
- Two day hospitals had waiting lists.

Eight day hospitals in Health Board A and two day hospitals in Health Board B had a form to be completed on referral by the referring agent regarding patient demographic and clinical details. However, only 8 of the 10 day hospitals with a referral form, actually used the form. Day hospitals, which did not use or have a referral form, tended to refer patients by word of mouth. Three day hospitals, one from Health Board A and two from Health Board B, accepted a referral from the sector consultant psychiatrist only. Three day hospitals from Health Board B only accepted a referral from the sector consultant psychiatrist or registrar, while six day hospitals from Health Board A, only accepted a referral from a psychiatrist or a community psychiatric nurse. Only one day hospital located in Health Board A accepted a referral from any public mental health professional in the sector and only one day hospital located in Health Board B accepted a referral from any public mental health professional in the sector or from a general practitioner.

Nurses at seven day hospitals, five day hospitals in Health Board A and two in Health Board B, completed a nursing assessment once the patient was referred to the facility. Two day hospitals in Health Board A had waiting lists; one day hospital had a waiting list of one patient and the other had a list of eight patients. An additional two day hospitals located in Health Board B mentioned they had waiting lists in the recent past.

4.2.4 Staffing

SUMMARY

- No sector in Health Board A had a full multidisciplinary team. In Health Board B, the majority of sectors had access to a full multidisciplinary team
- The professional most often lacking, in Health Board A, was a psychologist
- There was limited medical presence in many day hospitals.

In Health Board A, a sector team was allocated to all but one day hospital. The day hospital located in the psychiatric unit did not have any specific team allocated to it, as its catchment area was not sectorised. Plans to sectorise this catchment area were at an advanced stage. Out of the seven sector teams, not one had a full multidisciplinary team. The professional most often lacking was a psychologist. The number of social workers and occupational therapists was also low. One sector had a home care team. Overall there were approximately 115 mental health professionals who were available to day hospital patients on a full- or part-time basis. Excluding registrars, who generally move to other service components every six months, and some nurses, who rotated their positions, 49 (56%) staff out of a total of 87 had worked with the same day hospital for over 5 years.

In Health Board B, a sector team was allocated to each day hospital. The majority of day hospitals had access to a full multidisciplinary team. Many sectors had appointed social workers and occupational therapists in recent times. Overall there were approximately 56 mental health professionals available to day hospital patients on a full- or part-time basis. Excluding registrars, approximately 38 (81%) of staff out of a total of 47 had worked with the same day hospital for over 5 years.

When asked about the level of staffing, most nurses in charge in Health Board A said they would like to see more psychologists, social workers and occupational therapists. At the time of the study the majority of these nursing officers felt nurses were trying to do the work of social workers and occupational therapists. Nursing officers (particularly in Health Board A) called for an increase in medical cover at day hospitals. Many psychiatrists spent one to two days a week at most in the same premises as the day hospital and held clinics for both outpatients and day hospital patients. Many nursing officers in Health Board A felt an extra nurse was needed in order to run a more acute service. Several nursing officers in Health Board B felt an extra nurse was needed in order to see more patients. Many nurses were engaged in administrative work and/or had difficulties in devising new activities for patients, which resulted in a low level of activity at some day hospitals. Several nursing officers from Health Board A and one nursing officer from Health Board B thought sessional staff such as an art teacher would be beneficial. There were also calls for home care teams and an increase in community psychiatric nurses from many nursing officers in Health Board A.

There were six day centres in Health Board A and seven day centres in Health Board B. Six day centres were located in the same premises as a day hospital. Nursing staff at three day hospitals occasionally carried out duties in a day centre, which was housed in the same premises.

4.2.5 Treatment

SUMMARY

- In both health boards, nurses provided supportive counselling and educational programmes for patients
- In addition to the above, nurses in Health Board A provided therapeutic activities
- Many day hospitals, particularly in Health Board A, had difficulty accessing psychology and addiction services.

In Health Board A, nurses provided supportive counselling and ran programmes for patients. These programmes included anxiety management, social skills, self-esteem and health promotion. Patients at three day hospitals could access individual cognitive therapy and patients at five day hospitals could access individual behaviour therapy. No day hospital patient had access to any type of group psychotherapy. Group occupational therapy was provided at five of the day hospitals. Three of the day hospitals provided access to an addiction counsellor and five to an alcohol counsellor. All day hospital patients had access to a psychiatrist. No day hospital provided electroconvulsive therapy (ECT) onsite. In general, community psychiatric nurses did not visit a patient while he/she was attending a day hospital. With regard to accessing the above services, four day hospitals had difficulty accessing psychology and counselling services. The waiting lists for these services ranged from two weeks to over five months. Most day patients had access to the same facilities as inpatients with the exception of ECT and in some cases occupational therapy.

In Health Board B, nurses at each day hospital provided supportive counselling. Patients could also access individual behaviour therapy and cognitive therapy in most premises. There were no psychotherapy groups available. Day hospital patients could also access courses such as personal development, assertiveness training and anxiety management. All day hospital patients had access to a psychiatrist. Community psychiatric nurses did not usually visit a patient while he/she was attending a day hospital. With regard to accessing services, four day hospitals reported problems with accessing psychology and behaviour therapy services. Most day hospital patients had access to the same treatments as inpatients with the exception of ECT.

The majority of day hospitals did not use the same case notes as the inpatient hospital. Most day hospitals used case notes that were shared between the community services. The treating psychiatrist updated the case notes each time a patient was seen. Almost all of the day hospitals had nursing notes. Nursing notes were written on a daily or weekly basis in Health Board A and each time a patient was seen in Health Board B. However, some medical and nursing notes were illegible or not easy to follow. In Health Board A, the majority of treatment plans were reviewed on a weekly basis. A small minority was reviewed on a daily basis. Treatment plans for patients who were attending a day hospital on a long-term basis were reviewed on a monthly basis. In Health Board B, the frequency with which treatment plans were reviewed ranged from weekly to every six months. All patients on medication who did not have a medical card received a prescription from a psychiatrist. Patients who were on medication and had a medical card were given the details of their medication by a psychiatrist. The patient then had to visit a general practitioner who wrote a prescription for the drugs. Ten out of 14 nurses in charge felt the day hospital in which he/she worked catered for patients in an acute phase of illness.

In Health Board A, a range of activities was provided for day hospital patients. Examples of activities included woodwork, clerical work, arts and crafts, cookery, games, and outings. Six out of eight hospitals found it difficult to run a programme that met each patient's needs. Nurses explained that this difficulty arose due to differences among patients in terms of age and illness. Patients did appear to have an input into the activity planning of each day. When necessary, four out of a possible six day

hospitals allowed patients to attend both the day hospital and day centre in order to provide a bridging gap before a move to a day centre would occur. Health Board B did not provide daily therapeutic activities for day hospital patients.

4.2.6 Communication

SUMMARY

- All day hospitals held a sector team meeting
- There was a lack of computer facilities for staff members, with the exception of secretaries, at most day hospitals
- Only two day hospitals had a five-year plan.

All day hospitals held a sector team meeting. Thirteen meetings were held on a weekly basis and one on a monthly basis. Staff at six day hospitals attended weekly meetings with staff at the inpatient facilities. There was a lack of computer facilities for staff members with the exception of secretaries/receptionists at most day hospitals. Email was available at only two day hospitals. Four out of five inpatient facilities had email. Thus, most staff members could not communicate by email with staff from another facility. Numerous members of staff pointed out that a lot of time was spent on the telephone, chasing up information regarding patients. These members of staff felt patient records should be computerised. Twelve day hospitals had yearly plans. The two hospitals that did not have yearly plans had only opened in recent times. Out of the 12 day hospitals that had yearly plans, 2 day hospitals also had a 5-year plan.

Table 4.1 Data relating to day hospitals. Numbers 1–8 refer to day hospitals in Health Board A. Numbers 9–14 refer to day hospitals in Health Board B. ***A tick represents 'yes' and a blank box represents 'no'.***

	Health Board A								Health Board B					
Day hospitals	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Premises														
Purpose built	√	√	√								√			
Suitable		√	√	√						√				
Permanent		√	√	√		√		√	√	√	√	√		
Temporary	√				√		√						√	√
Walking distance of amenities	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Patient activity rooms	√	√	√	√	√	√	√	√		√				
Office space difficulties							√		√					√
Needs refurbishment				√	√				√				√	√
Problematic layout	√				√	√		√	√		√	√	√	√
Other services in building	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Voluntary organisation use	√					√		√	√	√	√	√	√	√
Open to staff at weekends		√	√	√	√	√	√	√	√					
Patient/service information														
Open to patients 5 days	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Open to patients 6 days				√			√	√	√					
Treatment	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Activities	√	√	√	√	√	√	√	√						
Full-day service	√	√	√	√	√	√	√	√						
Appointment only									√	√	√	√	√	√
No. of registered patients	43	10	15	12	13	8	19	19	113	40	49	36	30	30

Table 4.1 (continued)

	Health Board A								Health Board B					
Day hospitals	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Average daily attendance	25	7	8	7	8	8	11	15	15	10	5	4	5	8
No. patients suited to day centre	6	1	5	2	0	1	3	2	0	0	0	0	0	0
No. patients awaiting placements	13	1	2	2	3	1	3	5	0	0	0	0	0	0
Meals supplied daily	√	√	√	√	√	√	√	√						
Minibus/taxi supplied						√	√	√						
Referral process														
Referral form	√	√	√	√	√	√	√	√			√	√		
Sector consultant only				√									√	√
Sector registrar only									√	√	√			
Sector psychiatrist/CPN only	√	√	√			√	√	√						
Sector MH professional					√									
Sector MH professional/GP												√		
Assessment procedure														
Nursing assessment			√	√		√	√	√			√	√		
Staff available onsite														
Day hospital nurse	1	2	2	3(1)	3	2	3	3	4(1)	2	1	4(2)	2(1)	2
Consultant psychiatrist	4*	1*	1*	1*	2*	1*	3*	4*	1*	1	1*	1*	1*	1*
Registrar	4*	3*	2*	2*	3*	3*	3*	2*	2*	1	1*	2*	1*	2*
Psychologist	2(1)	1					1		1ss	1	1ss	3ss(1)	1ss	1ss
Occupational therapist	4*	1*	1		1*		1*	1*	1	1	0	1	1	0
Social worker	3			2*	1	1	1	1	1	1	1	1	0	1

Inpt. = inpatient
Comm. = community
** = available on a part-time basis*
( ) = number which work part time
ss = shared with another sector

Table 4.1 (continued)

	Health Board A								Health Board B					
Day hospitals	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Community nurse	3	2	4	4	2	9	4	2	2(1ss)	2	2	2	1ss	2
Behaviour therapist					1*ss		1*ss	1*ss	1*ss	1*ss	0	0	1*ss	
Alcohol/addiction counselling		1*	1*	1*			1*							2
Receptionist/secretary	1	1	1	2	1	2	2	1	2	1	1	1	2	1
Treatment available onsite														
Psychiatric treatment	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Nurse counselling							√	√	√	√	√	√	√	√
Cognitive therapy	√	√					√		√	√	√	√	√	√
Behavioural therapy	√	√			√		√	√	√	√	√	√	√	√
Group OT	√	√			√		√	√	√	√	√	√	√	√
Addiction counselling		√	√	√					√					√
Alcohol counselling		√	√	√	√		√		√					√
ECT														
Inpt. medical folder used														
Comm. Services folder used									√	√	√	√	√	√
Nursing notes used									√	√	√	√	√	√
Communication														
Team meetings	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Meeting with inpatient staff	√	√		√		√				√		√		
Email available		√							√					
One-year plan	√			√	√	√	√	√	√	√	√	√	√	√
Five-year plan	√							√						

Inpt. = inpatient
Comm. = community
** = available on a part-time basis*
( ) = number which work part time
ss = shared with another sector

4.3 Day centres

4.3.1 Premises

SUMMARY

- The majority of day centres premises were unsuitable for their intended purpose
- Day centres were located in a variety of buildings, including a scouts' hall, a care of the elderly building, domestic houses, industrial units, converted offices, a mental health centre, a hostel and a psychiatric hospital
- Many premises were in need of repair.

There were six day centres in Health Board A and seven day centres in Health Board B. The day centres were located in a variety of buildings including a scout hall, a care of the elderly building, two domestic houses, three industrial units, three converted offices, one purpose-built mental health centre, a hostel and a psychiatric hospital. There were problems with many of these buildings. For example, the scout hall was large, difficult to heat and in need of repair. The care for the elderly building was rented for only four hours a week. Two day centres had no distinct identity of their own; one day centre was occupying a room in a psychiatric hostel; another day centre was located in a recreation centre of a psychiatric hospital.

The day centres were established between 21 years and 2 months. The health boards owned 9 of the 13 premises. Two premises were classified as temporary for less than 1 year and 4 premises were classified as temporary for 2, 5, 6 and 14 years. There were no specific plans to relocate any of these centres. The number of rooms available to patients ranged from one to eight. The average number of activity rooms in each day centre was two. The largest room measured approximately 50 ft by 22 ft. Nine day centres used each room every morning and afternoon. Each day centre, apart from two, had a nursing office. The majority of day centres had other psychiatric services including a day hospital, a recreation centre and a hostel operating from the same premises. Two day centres had non-psychiatric services operating from the same building.

4.3.2 Nature of day centre services and patient information

SUMMARY

- The majority of centres provided a social and activity programme to patients for five hours a day between the hours of 9 am and 4 pm
- Most nursing officers felt the day centre in which he/she worked was operating to its full capacity
- Patients could spend up to four hours travelling to and from a day centre in a minibus provided by the health boards.

Most nurses worked from 9 am to 5 pm. The majority of centres provided a social and activity programme to patients for five hours a day between the hours of 9 am and 4 pm. The day centre that operated from the care of the elderly building was only available to patients two days a week between the hours of 11.30 am and 1.30 pm.

In Health Board A, the average number of patients registered at each day centre was 26 with a range of 14 to 33. The average daily attendance was 12 persons. The average number of attendances per person per week was 3. No patient attended a day centre on a full-time basis. The majority of nurses in charge felt the day centre in which he/she worked was running to its full capacity.

In Health Board B, the average number of patients registered at each day centre was 44 with a range of 12 to 87. The average daily attendance for most day centres was 20. One day centre catered for an average of 40–45 patients per day. The recreation centre located in the psychiatric hospital grounds catered for both day patients, long-stay and short-stay inpatients. On average 211 inpatients attended this facility each month. Approximately 37% of patients attended a day centre five days a week. No day centre had an official limit to the number of places offered. Most nursing officers felt the day centre in which he/she worked was running to its full capacity.

Patients from both health boards were provided with a midday meal. Only one patient attended for a meal only. Patients from two day centres were provided with transport, food vouchers and were brought to a psychiatric hospital each day for lunch. Nine day centres located in rural areas provided transport in the form of a minibus for patients. Patients could spend up to four hours travelling to and from the day centre each day. Four day hospitals located in urban areas provided some patients with taxis.

4.3.3 Referral and assessment procedures

SUMMARY

- There was a variety of referral procedures
- Out of 13 day centres, 7 had a referral form and 7 completed a nursing assessment
- Four day centres had small waiting lists.

Eight day centres accepted a referral from a sector consultant psychiatrist only. One accepted a referral from the sector consultant psychiatrist and community psychiatric nurses. One day centre accepted a referral from any public mental health professional working in the relevant sector. Out of 13 day centres, 7 had a referral form and 7 completed a nursing assessment with each patient upon acceptance to the facility. Four day centres had small waiting lists.

4.3.4 Staffing

SUMMARY

- The majority of day centres had two nurses
- Day centres were staffed by community psychiatric nurses, day hospital nurses and hostel nurses
- Many nurses felt that sessional staff such as an art or music teacher would be beneficial.

In one premises, staff from a day hospital cared for patients in the day centre between day hospital appointments. Staff at the hostel cared for both residents and day patients. Two community psychiatric nurses facilitated the part-time day centre that operated from the care of the elderly building. The majority of the other day centres had two nurses. In terms of other mental health professionals, day centre patients had access to the same staff as day hospital patients.

When asked about staffing levels, nurses in charge in Health Board A repeated the concerns of the day hospital nursing officers. These nurses also wanted more psychologists, social workers and occupational therapists. Many felt sessional staff such as an art or music teacher would be beneficial. Most nursing officers felt nursing staff were compensating for the lack of social workers and occupational therapists. Several nursing officers in Health Board B said they would also like another nurse or a care assistant. In one day centre, one nurse was responsible for 87 registered patients and between 20 and 30 additional patients who dropped in. Nurses at another day centre had to cook for 10 patients each day, as there was neither household staff nor any arrangements with local catering companies.

4.3.5 Activities

SUMMARY

- Some patients attended a day centre and a workshop
- Activities available included baking, gardening, arts and crafts, games and educational classes
- There appeared to be a low level of activity in many day centres.

One day centre had a workshop on the same premises and several patients attended both facilities. Money raised in the workshop was used to fund patient outings. A second day centre had access to a workshop off-site. Other activities available included baking, gardening, arts and crafts, games and educational classes such as literacy, relaxation and computers. Programmes were flexible and patients were involved in the decision-making regarding daily activities. However, there appeared to be a low level of activity in many day centres. Other facilities available in the community included resource centres and voluntary groups such as Schizophrenia Ireland. Patients who needed prescriptions received them at a clinic on clinic days.

Table 4.2 Data relating to the description of day centres. Numbers 1–6 refer to day centres in Health Board A. Numbers 7–13 refer to day centres in Health Board B. ***A tick represents 'yes' and a blank box represents 'no'.***

	Health Board A						Health Board B						
Day centres	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
Premises													
Purpose built									√				
Suitable	√	√											
Permanent	√	√				√	√		√	√			√
Temporary			√	√	√			√			√	√	
Walking distance of amenities		√	√	√	√	√	√	√	√	√	√	√	√
Patient activity rooms	√	√	√	√	√	√	√	√	√	√	√	√	√
Needs refurbishment	√	√		√	√		√						
Problematic layout				√	√		√	√	√	√			
Other services in building			√	√	√	√	√	√	√	√	√	√	
Patient/service information													
Open to patients 5 days	√	√		√	√	√	√	√	√	√	√	√	√
Activities available	√	√	√	√	√	√	√	√	√	√	√	√	√
Full-day service	√	√		√	√	√	√	√	√	√	√	√	√
Number registered patients	30	28	14	33	21	27	87	47	55	50	12	22	34
Average daily attendance	10	11	14	15	14	9	42	10	20	30	2	12	23
Meals supplied	√	√	√	√	√	√	√	√	√	√	√	√	√
Minibus/taxi supplied	√	√	√	√	√	√	√	√	√	√	√	√	√
Referral process													
Referral form	√	√		√	√	√			√	√			

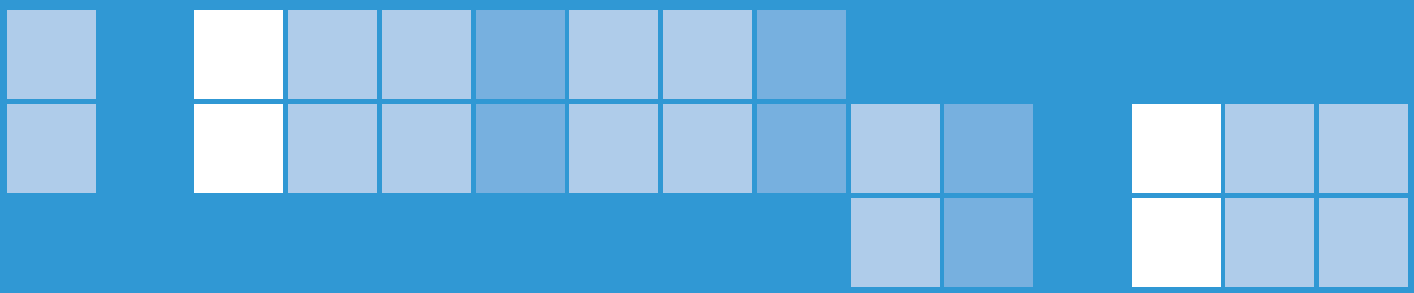
Table 4.2 (continued)

	Health Board A						Health Board B						
Day centres	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
Sector consultant only	√		√					√	√	√	√	√	√
Sector registrar only					√		√						
Sector psychiatrist/CPN only		√											
Sector MH professional				√									
Assessment procedure													
Nursing assessment	√	√		√	√	√			√	√			
Care/activity staff													
Day centre nurse	2	2	2	2	2	2	1	1	1	2	0	2	2
Visiting OT	0	1	0	1	0	1	0	0	0	0	0	1	0
Art teacher	0	0	0	0	0	1	0	0	0	0	0	0	0

4.4 Summary of results

Many of the premises being utilised for day hospitals and day centres were not purpose built and were unsuitable for day care purposes. A substantial number of these premises had been classified as temporary for several years and most had no specific plans for relocation. With regard to the services offered in the two participating health boards, the day hospital services differed dramatically. In Health Board A, day hospitals provided a treatment and activity facility five days a week for approximately five hours per day. In Health Board B, patients received an appointment with a nurse therapist usually for an hour each week. Many patients had to travel for four hours a day to and from these services. Day centres in both health boards offered a five-day week social activity service. There appeared to be a low level of activity in many day hospitals and day centres.

In terms of access to professional staff, few sectors had a full multidisciplinary team. The psychology services often had the longest waiting lists. There were calls for more psychologists, social workers, occupational therapists and nurses. Nursing staff wanted more medical coverage at the day hospital. Less than half of the day hospitals held regular meetings with staff at the inpatient facilities. There was a lack of staff computers with the exception of secretaries/receptionists at most day hospitals and day centres. Record keeping was substandard in a few day hospitals.



CHAPTER FIVE

Results II: Utilisation of the Day Hospital

CHAPTER FIVE

Results II: Utilisation of the Day Hospital

This chapter reports on the utilisation of the participating day hospitals. The information was obtained using the Referral Questionnaire, the Patient Information Questionnaire, the Day Therapy Appropriateness Scale and the Brief Psychiatric Rating Scale – Expanded Version. Figures 5.1 to 5.10 provide summaries of the results. The implications of the findings are discussed in Chapter 7. First, the rationale behind this section of the study is presented below.

5.1 Rationale

While Chapter 4 provides a comprehensive description of the participating day hospitals and day centres, little information was documented about their utilisation. It was felt that an utilisation review of day hospital services would supplement descriptive information provided in the previous chapter and further enhance our understanding of the functioning of the day hospital services. The utilisation of day centres was not examined due to time limitations.

Assessment and referral procedures were examined in detail. The importance of this process was emphasised in Chapter 4. This is the point at which patients are directed to a service. If a comprehensive assessment is not conducted and/or an inexperienced psychiatrist conducts an assessment without supervision, then patients are more likely to be referred to a service that is inappropriate to his/her needs. The Referral Questionnaire recorded information relating to clinical factors influencing the decision to admit, administrative reasons, diagnosis details and phase of illness.

A range of measures was used to capture the demographic and clinical profiles of day hospital patients. This exercise was informed by a review of the literature. The international literature clearly showed that there is a considerable diversity in the patient selection process and that many day hospitals are not functioning as an alternative to inpatient care (Schene *et al.*, 1988; Mbaya *et al.*, 1998). The Day Treatment Appropriateness Scale (Lefkovitz, 1982) was used as it is generally regarded as a good measure of adult patient appropriateness for day hospital programmes. The DTAS, however, appears to be oriented towards the selection of patients with relatively mild levels of disturbance. For example, the scale is weighted against day hospital admission of psychotic patients and those with little motivation to be in treatment. However, there was no other scale available in the literature and thus, the DTAS was used. A review of the literature further guided the selection of the BPRS-E (Lukoff *et al.*, 1986), which is well known as a reliable and valid measure of symptom-based psychiatric illness. The day hospital utilisation results are reported below.

5.2 Referral and assessment procedures

Data on referral and assessment procedures were collected during a four-week period specific to each day hospital. During these study periods, data were collected for all patients who were referred to the 14 day hospitals. In total 101 patients were referred; 57 patients were referred in Health Board A and 44 patients in Health Board B. The data were analysed using chi-square tests. Results of these analyses are reported below.

5.2.1 Assessment procedures

Table 5.1 shows the assessment data. The main findings are summarised in Figure 5.1. Prior to referral for admission, 94% of patients received a psychiatric assessment. Consultants conducted 48% of the 95 assessments, followed by a non-consultant hospital doctor (NCHD) (25%) and a consultant plus a

NCHD (22%). Of note was the fact that one-third of assessments in Health Board A were carried out by NCHDs in comparison to 14% carried out by NCHDs in Health Board B. In addition, NCHDs in Health Board B were statistically more likely to assess a patient in conjunction with a consultant ($x^2 = 9.4$, $df = 2$, $P < 0.01$).

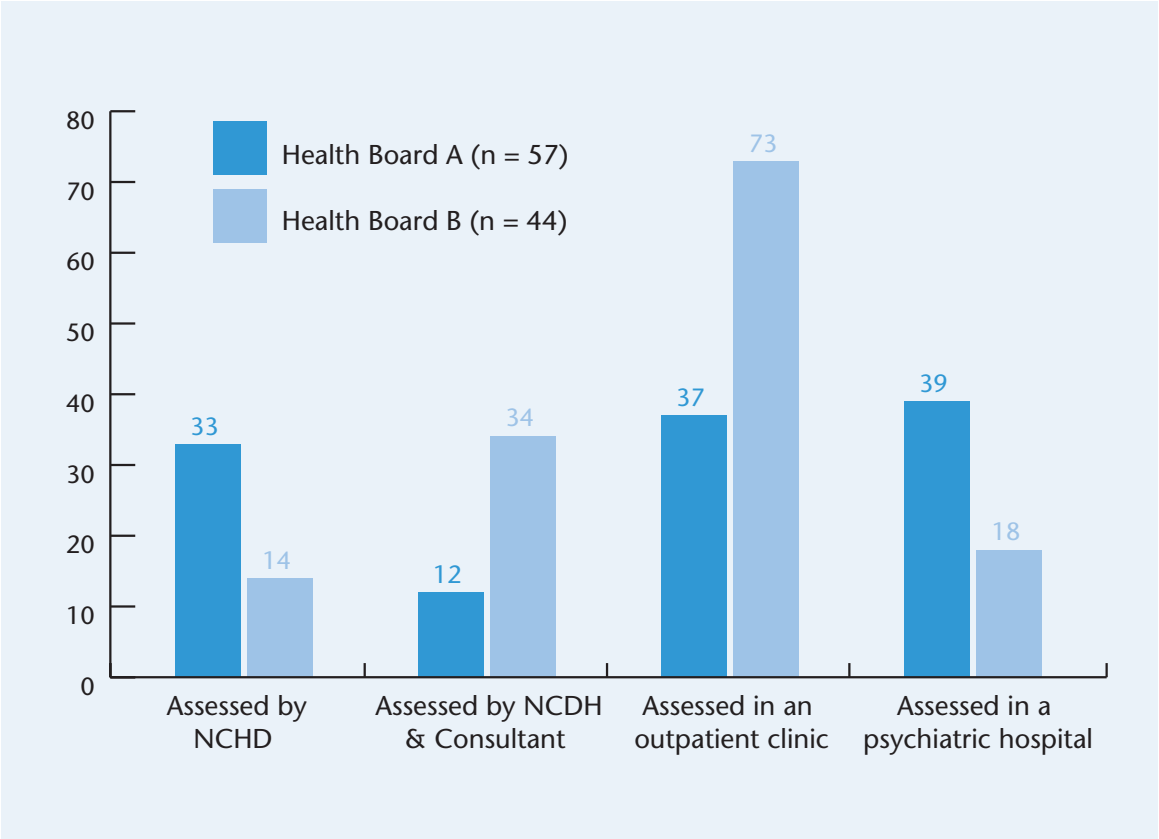
As would be expected from a day hospital service, the majority of patients were assessed in an outpatient clinic or in an inpatient setting. However, differences arose between health boards. Thirty-seven per cent of patients in Health Board A were assessed in an outpatient clinic in comparison to 73% of patients in Health Board B. This difference was supported statistically ($x^2 = 8.7$, $df = 1$, $P < 0.05$). Furthermore, 39% of patients in Health Board A were assessed in a psychiatric inpatient setting in comparison to 18% of patients in Health Board B.

The latter difference can be explained by the variation in the nature of the services reported in Chapter 4. Unlike day hospitals in Health Board A, the results showed that the services offered in day hospitals in Health Board B were actually counselling services. Generally patients do not receive counselling during the acute phases of an illness. Hence, it is not surprising that the overwhelming majority of patients in Health Board B were referred from an outpatient clinic.

Table 5.1 Patient assessment details. Data collected at referral during a four-week study period specific to each day hospital in Health Boards A and B. *Numbers and percentages*.

	Health Board A		**Health Board B**		**Total**	
	No.	Col%	No.	Col%	No.	Row%
Assessed prior to referral						
Yes	54	(95%)	41	(93%)	95	(94%)
No	3	(5%)	3	(7%)	6	(6%)
Missing data	0	(0%)	0	(0%)	0	(0%)
Who assessed patient						
Nobody	3	(5%)	0	(0%)	3	(3%)
NCHD singly	19	(33%)	6	(14%)	25	(25%)
Consultant singly	28	(49%)	20	(45%)	48	(48%)
NCHD/Consultant combined	7	(12%)	15	(34%)	22	(22%)
Other	0	(0%)	2	(5%)	2	(2%)
Missing data	0	(0%)	1	(2%)	1	(1%)
Where it took place						
General hospital	3	(5%)	0	(0%)	3	(3%)
OPD	21	(37%)	32	(73%)	53	(52%)
Accident & Emergency	2	(4%)	0	(0%)	2	(2%)
Psychiatric hospital	22	(39%)	8	(18%)	30	(30%)
Other	6	(11%)	2	(5%)	8	(8%)
Missing data	3	(5%)	2	(5%)	5	(5%)
Total: No. & Row %	57	(56%)	44	(44%)	101	(100%)

Figure 5.1. Main assessment procedures - findings by health board. *Percentages.*



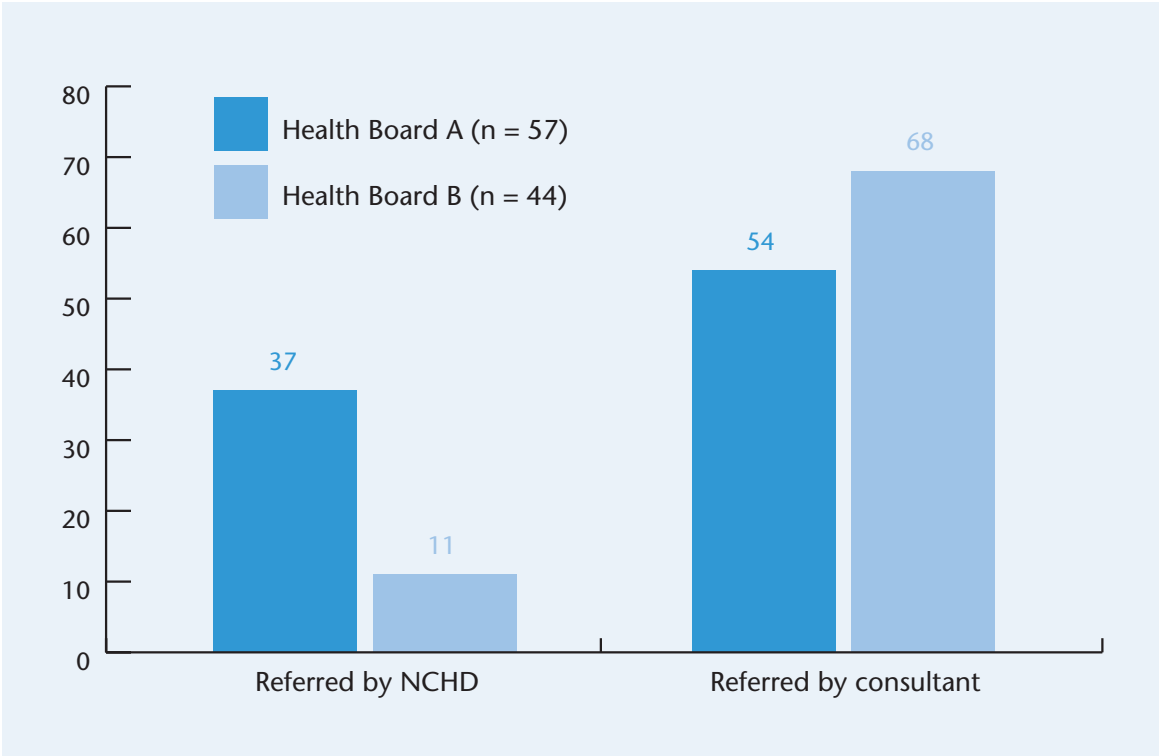
5.2.2 Referral procedures

Table 5.2 shows the referral data. The main findings are summarised in Figure 5.2. Consultants referred the largest proportion of patients; 54% in Health Board A and 68% in Health Board B. NCHDs referred 37% of patients in Health Board A in comparison to only 11% in Health Board B. The difference between health boards with regard to the percentage of patients referred by NCHDs was supported statistically ($x^2 = 6.8$, $df = 1$, $P < 0.01$). In Health Board A, other sources of referral included community psychiatric nurses (4%) and NCHD plus consultant (5%). In Health Board B, other sources of referrals included self-referrals (7%), GPs (7%) and NCHD plus consultant (5%). In Health Board A, 77% of referral decisions were made in consultation with other staff members and 73% in Health Board B. These findings provide detailed information about the proportion of patients referred by each professional group. They are consistent with the results in Chapter 4 which showed that there was no uniform referral process.

Table 5.2 Patient referral details. Data collected at referral during a four-week study period specific to each day hospital in Health Boards A and B. *Numbers and percentages.*

	Health Board A		Health Board B		Total	
	No.	Col%	No.	Col%	No.	Row%
Who was referral agent						
Consultant singly	31	(54%)	30	(68%)	61	(61%)
Self-referral	0	(0%)	3	(7%)	3	(3%)
GP	0	(0%)	3	(7%)	3	(3%)
NCHD singly	21	(37%)	5	(11%)	26	(26%)
CPN singly	2	(4%)	0	(0%)	2	(2%)
NCHD/Consultant combined	3	(5%)	2	(5%)	5	(5%)
Missing data	0	(0%)	1	(2%)	1	(1%)
Consultation with other staff						
Yes	44	(77%)	32	(73%)	76	(75%)
No	13	(23%)	10	(23%)	23	(23%)
Missing data	0	(0%)	2	(5%)	2	(2%)
Total: No. & Row %	57	(56%)	44	(44%)	101	(100%)

Figure 5.2. Main referral procedures - findings by health board. *Percentages.*



5.2.3 Clinical factors influencing a decision to admit to a day hospital

The main findings that emerged in relation to clinical factors influencing a decision to admit a patient to a day hospital are summarised in Figure 5.3. Medical staff were asked to rate a series of clinical factors which may have influenced their decision to admit each patient to day hospital care on a scale of 1 to 5, where 1 is 'not relevant' and 5 is the 'major clinical factor'. Ratings 2 to 4 were classified as 'important clinical factors' in Table 5.3. More than one factor could be rated hence the column percentages do not total 100%.

As would be expected, psychiatric symptoms were most frequently cited as the 'major clinical factor' influencing the decision to admit. Observation and prevention of relapse were most frequently cited as 'important clinical factors'. Both observation and prevention were cited more often as 'major' and 'important clinical factors' by staff in Health Board A. These findings were supported statistically ((x^2 = 19.2, *df* = 2, P < 0.001) and (x^2 = 11.2, *df* = 2, P < 0.01), respectively) and would appear to be a reflection of the differences in the nature of the services between health boards as reported in Chapter 4. In approximately 50% of cases, social and domestic factors were cited as 'major' or 'important clinical factors'. As would be expected, based on the literature review of patient suitability in Chapter 2, alcohol difficulties were cited less often as 'major' or 'important clinical factors'. These admissions would have been more appropriately dealt with in specialised community-based alcohol services.

Table 5.3 Clinical factors influencing a decision to admit to a day hospital. Data collected at referral during a four-week study period specific to each day hospital in Health Boards A and B. *Numbers and percentages*.

Admission Factors	Major Clinical Factor				Important Clinical Factor				Non-Relevant Clinical Factor				Missing Data			
	HB-A		HB-B		HB-A		HB-B		HB-A		HB-B		HB-A		HB-B	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Psychiatric symptoms	39	(68%)	32	(73%)	11	(19%)	10	(23%)	7	(12%)	2	(5%)	0	(0%)	0	(0%)
Social	7	(12%)	9	(21%)	22	(39%)	11	(25%)	28	(49%)	15	(34%)	0	(0%)	3	(7%)
Domestic	9	(16%)	7	(16%)	18	(32%)	11	(25%)	30	(53%)	17	(39%)	0	(0%)	3	(7%)
Prevent relapse	16	(28%)	9	(21%)	28	(49%)	11	(25%)	13	(23%)	17	(39%)	0	(0%)	2	(5%)
Observation	21	(37%)	3	(7%)	23	(40%)	14	(32%)	13	(23%)	19	(43%)	0	(0%)	3	(7%)
Alcohol	6	(11%)	1	(2%)	8	(14%)	3	(7%)	43	(75%)	28	(64%)	0	(0%)	0	(0%)

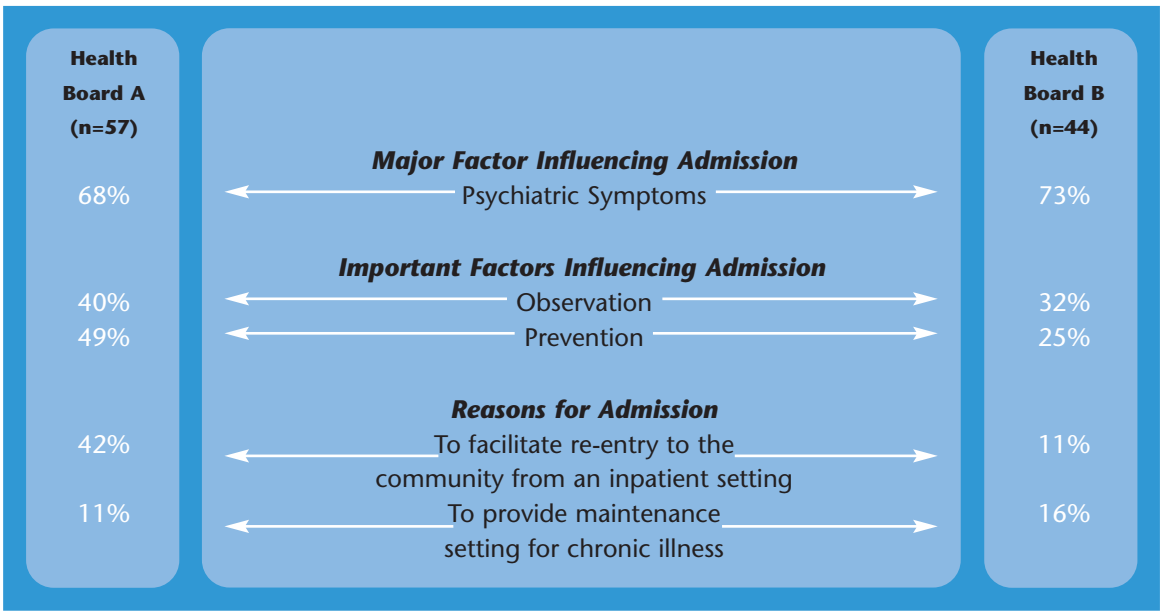
5.2.4 Reason for admission

The main administrative reasons for admission are summarised in Figure 5.3. In Health Board A, the main administrative reason for admission to a day hospital was to facilitate re-entry back into the community following an inpatient admission (Table 5.4). As would be expected based on the assessment procedures results, only a small percentage (11%) of patients in Health Board B were admitted to a day hospital for this reason. Forty per cent of patients in Health Board A and 32% in Health Board B were admitted to a day hospital as an alternative to inpatient care. Eleven per cent of patients in Health Board A and 16% of patients in Health Board B were inappropriately admitted to a day hospital to provide a maintenance setting for a chronic illness. There was no statistical difference between the two health boards in relation to the above variables.

Table 5.4 Administrative reasons for admission. Data collected at referral during a four-week study period specific to each day hospital in Health Boards A and B. *Numbers and percentages.*

	Health Board A		Health Board B		Total	
	No.	Col%	No.	Col%	No.	Row%
An alternative to inpatient care	23	(40%)	14	(32%)	37	(37%)
To facilitate re-entry to the community from an inpatient setting	24	(42%)	5	(11%)	29	(29%)
To provide a maintenance setting for a chronic illness	6	(11%)	7	(16%)	13	(13%)
An alternative to day centre care due to its full capacity	4	(7%)	4	(9%)	8	(8%)
Other	0	(0%)	7	(16%)	7	(7%)
Missing data	0	(0%)	7	(16%)	7	(7%)
Total: No. & Row %	57	(56%)	44	(44%)	101	(100%)

Figure 5.3 Main findings: Factors influencing decision to admit by health board.



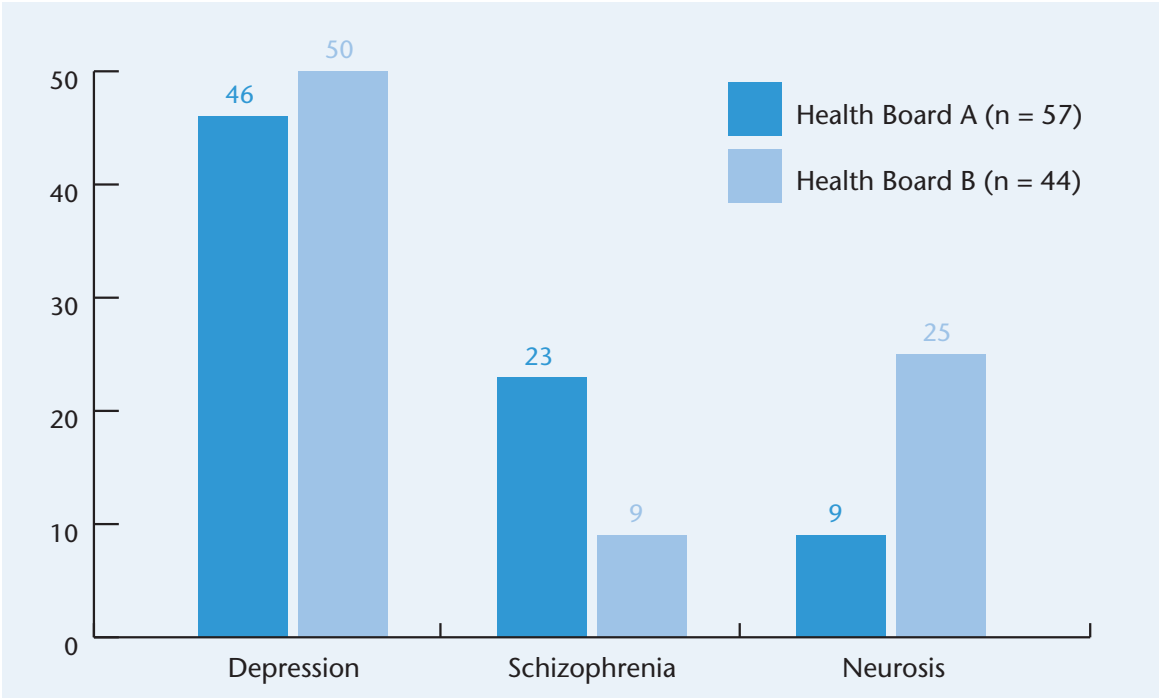
5.2.5 Diagnostic details

The diagnoses of the patients admitted during the study are shown in Table 5.5. The main findings are presented in Figure 5.4. The most common diagnosis was depression followed by schizophrenia and neurosis. This finding is consistent with Shergill *et al.* (1997) and Mbaya *et al.* (1998). Of further note was the fact that 25% of patients from Health Board B had a primary diagnosis of neurosis, in contrast to 9% in Health Board A. In addition, in Health Board A, 16% of patients had a diagnosis of other psychosis, whereas in Health Board B there were no patients with this diagnosis. However, there were no statistical differences in diagnostic information between health boards.

Table 5.5 Patient diagnostic details. Data collected at referral during a four-week study period specific to each day hospital in Health Boards A and B. *Numbers and percentages*.

	Primary		Primary Total	Secondary	
	HB-A	HB-B	HB-A & HB-B	HB-A	HB-B
	No. %	No. %	No. %	No. %	No. %
Schizophrenia	13 (23%)	4 (9%)	17 (17%)	0 (0%)	0 (0%)
Other psychosis	9 (16%)	0 (0%)	9 (9%)	2 (4%)	1 (2%)
Schizoaffective	2 (4%)	0 (0%)	2 (2%)	0 (0%)	1 (2%)
Depressive disorders	26 (46%)	22 (50%)	48 (48%)	6 (11%)	2 (5%)
Mania	6 (11%)	4 (9%)	10 (10%)	2 (4%)	0 (0%)
Neurosis	5 (9%)	11 (25%)	16 (16%)	2 (4%)	3 (7%)
Personality Disorders	6 (11%)	1 (2%)	7 (7%)	7 (12%)	1 (2%)
Alcohol	6 (11%)	1 (2%)	7 (7%)	5 (9%)	1 (2%)
Drug Dependence	3 (5%)	0 (0%)	3 (3%)	4 (7%)	1 (2%)
Mental Handicap	0 (0%)	0 (0%)	0 (0%)	3 (5%)	1 (2%)
Unspecified	0 (0%)	0 (0%)	0 (0%)	1 (2%)	0 (0%)

Figure 5.4. Major diagnostic groups by health board. *Percentages*.



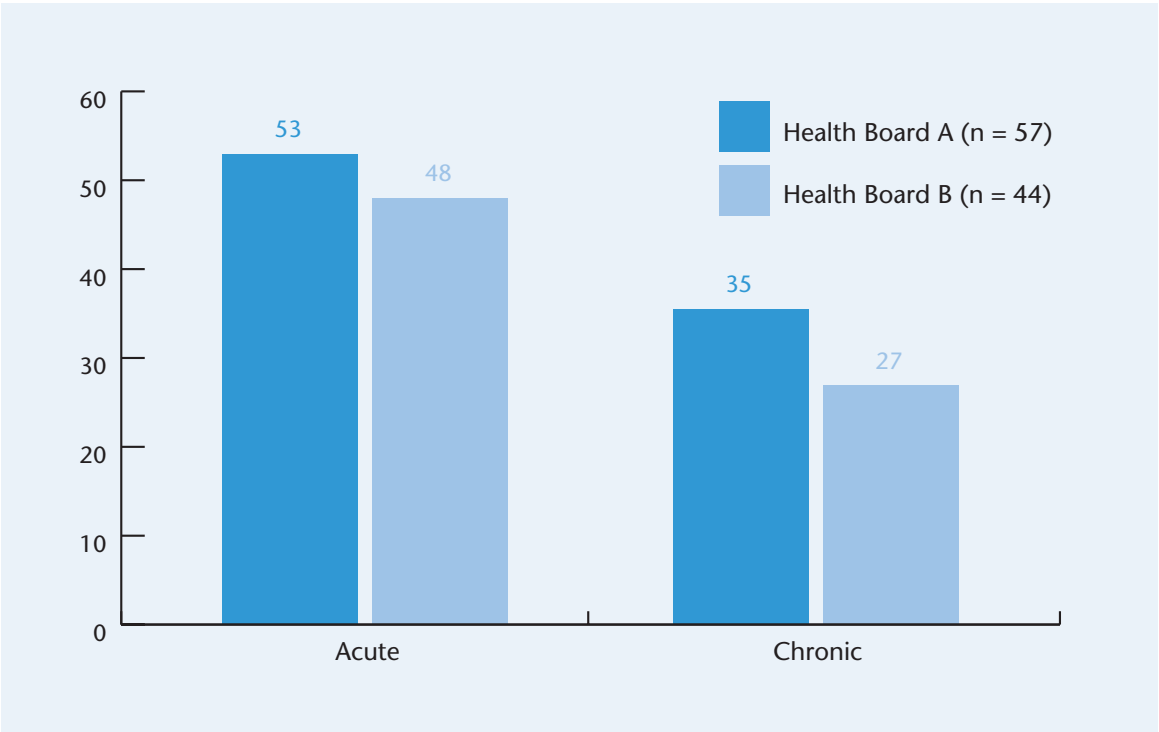
5.2.6 Phase of illness

Central to the role of the day hospital should be the admission of patients in an acute phase of illness. According to the referring agent, 53% of patients referred to day hospitals during the course of the study in Health Board A were suffering from an acute illness, 7% an acute on chronic illness, 35% a chronic illness and 5% none of the above. In Health Board B, 48% of patients referred were described as suffering from an acute phase of illness, 9% an acute on chronic phase of illness and 27% a chronic illness (Table 5.6 and Figure 5.4). Thus, according to these data a minimum of one-third of these patients was inappropriately referred to an acute day hospital. There were no statistical differences between health boards in relation to phase of illness.

Table 5.6 Phase of illness. Data collected at referral during a four-week period specific to each day hospital in Health Boards A and B. *Numbers and percentages*.

	Health Board A		Health Board B		Total	
	No.	Col%	No.	Col%	No.	Row%
Acute	30	(53%)	21	(48%)	51	(50%)
Acute on chronic	4	(7%)	4	(9%)	8	(8%)
Chronic	20	(35%)	12	(27%)	32	(32%)
Neither	3	(5%)	7	(16%)	7	(10%)
Total: No. & Row %	57	(56%)	44	(44%)	101	(100%)

Figure 5.5. Phase of illness by health board. *Percentages*.



5.3 Socio-demographic and treatment history

Details of all day hospital patients registered in Health Board A and a sample of day hospital patients registered in Health Board B were gathered. In total the socio-demographic details of 175 patients were collected; 95 patients were from Health Board A and 80 from Health Board B. Nominal data were analysed using chi-square tests and ordinal data were analysed using Mann-Whitney U-tests.

5.3.1 Socio-demographic details

The main findings from this study are summarised in Figure 5.6. The majority of patients were female, aged between 18 and 29 years, single, with some secondary education (Table 5.7) and were not living alone (Table 5.8). Fifty-eight per cent of patients either owned their home or lived with parents who owned their home. Only 26% were employed on a full-time basis and 18% were unskilled (Table 5.9). These results are fairly consistent with the findings of Perez and Whitelaw (1987). There were statistical differences between health board day hospitals in respect of patients' age ($x^2 = 9.8$, $df = 4$, $P < 0.05$), marital status ($x^2 = 7.2$, df, $= 2$, $P < 0.05$) and employment status ($x^2 = 14.7$, $df = 4$, $P < 0.01$). However, the standard residual was less than 2 and thus it was not possible to decipher more specifically the differences between the health boards.

Table 5.7 Patient demographic characteristics. Total registered population from Health Board A and a registered sample from Health Board B. *Numbers and percentages*.

	Health Board A		Health Board B		Total	
Gender						
Male	42	(44%)	26	(33%)	68	(39%)
Female	53	(56%)	54	(67%)	107	(61%)
Age						
18–29	33	(35%)	23	(29%)	56	(32%)
30–39	17	(18%)	16	(20%)	33	(19%)
40–49	17	(18%)	25	(31%)	42	(24%)
50–59	18	(19%)	15	(19%)	33	(19%)
60+	10	(11%)	1	(1%)	11	(6%)
Marital status						
Single	54	(57%)	36	(45%)	90	(51%)
Married/Cohabiting	26	(27%)	37	(46%)	63	(36%)
Separated/Divorced	9	(10%)	6	(8%)	15	(9%)
Widowed	6	(6%)	1	(1%)	7	(4%)
Education						
Some primary school	2	(2%)	1	(1%)	3	(2%)
Completed primary school	16	(l7%)	14	(18%)	30	(17%)
Some secondary school	46	(48%)	34	(43%)	80	(46%)
Completed secondary school	16	(17%)	19	(24%)	35	(20%)
Post-secondary certificate/diploma	7	(8%)	10	(13%)	17	(10%)
One or more university degree	3	(3%)	1	(1%)	4	(2%)
Other	2	(2%)	1	(1%)	3	(2%)
Unknown	3	(3%)	0	(0%)	3	(2%)
Total: No. & Row%	95	(54%)	80	(46%)	175	(100%)

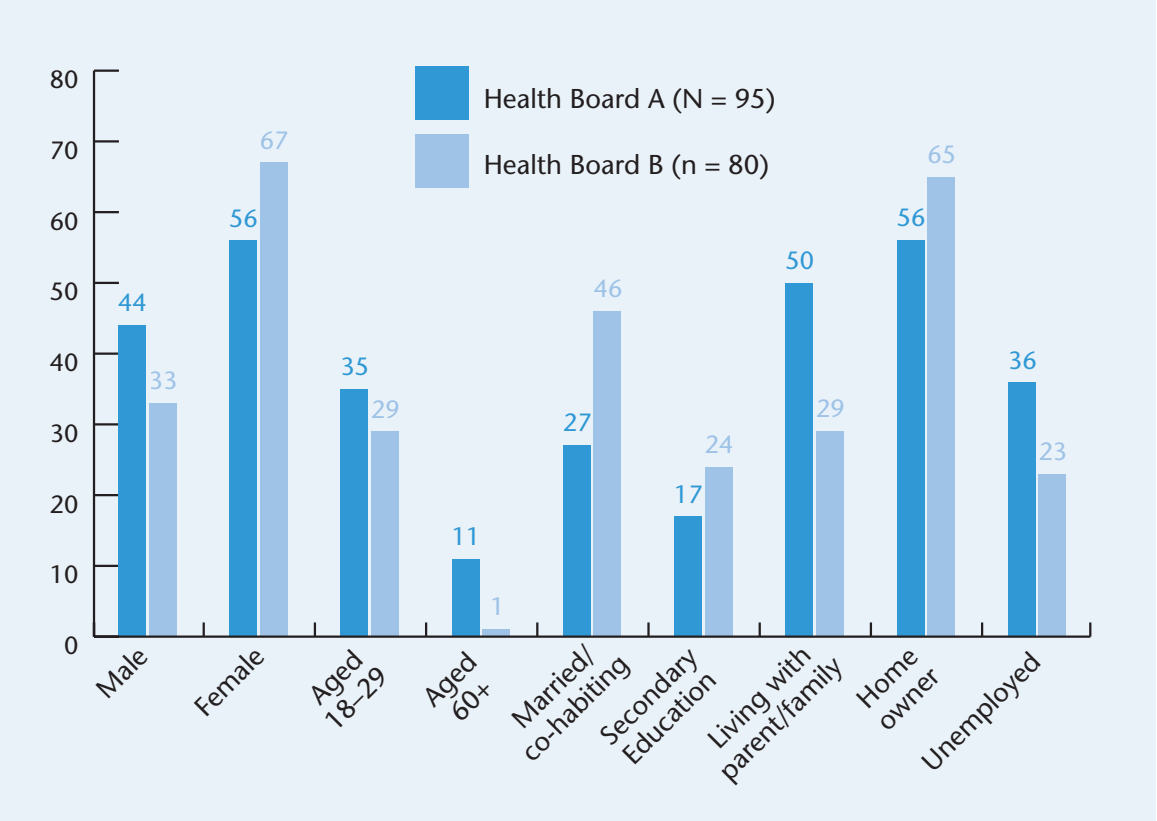
Table 5.8 Living Situation. Total registered population from Health Board A and a registered sample from Health Board B. *Numbers and percentages.*

	Health Board A		Health Board B		Total	
Living arrangements						
Alone	14	(15%)	9	(11%)	23	(13%)
With spouse	26	(27%)	36	(45%)	62	(35%)
With parents/family	47	(50%)	23	(29%)	70	(40%)
With friends	1	(1%)	3	(4%)	4	(2%)
Hostel	4	(4%)	2	(3%)	6	(3%)
Other	3	(3%)	7	(9%)	10	(6%)
Accommodation						
Private home (own)	50	(53%)	51	(64%)	101	(58%)
Private home (not own)	32	(34%)	21	(26%)	53	(30%)
Apartment (own)	3	(3%)	1	(1%)	4	(2%)
Apartment (not own)	5	(5%)	5	(6%)	10	(6%)
Hostel	3	(3%)	2	(3%)	5	(3%)
Other	2	(2%)	0	(0%)	2	(1%)
Address within catchment area						
Yes	89	(94%)	78	(98%)	167	(95%)
No	6	(6%)	2	(3%)	8	(5%)
Total: No. & Row %	95	(54%)	80	(46%)	175	(100%)

Table 5.9 Employment and social status. Total registered population from Health Board A and a registered sample from Health Board B. *Numbers and percentages.*

	Health Board A		Health Board B		Total	
Employment status immediately prior to attendance						
Employment full-time	22	(23%)	24	(30%)	46	(26%)
Employment part-time	4	(4%)	9	(11%)	13	(7%)
Unemployed	34	(36%)	18	(23%)	52	(30%)
Homemaker	17	(18%)	25	(31%)	42	(24%)
Study/Training	6	(6%)	3	(4%)	9	(5%)
Retired	6	(6%)	1	(1%)	7	(4%)
Other	4	(4%)	0	(0%)	4	(2%)
Unknown	2	(2%)	0	(0%)	2	(1%)
Social status						
Professional	3	(3%)	2	(3%)	5	(3%)
Managerial technical	1	(1%)	3	(4%)	4	(2%)
Non-skilled manual	8	(8%)	4	(5%)	12	(7%)
Skilled manual	9	(10%)	6	(8%)	15	(9%)
Partially skilled	5	(5%)	8	(10%)	13	(7%)
Unskilled	19	(20%)	12	(15%)	31	(18%)
Other (including unknown)	50	(53%)	45	(56%)	95	(54%)
Total: No. & Row %	95	(54%)	80	(46%)	175	(100%)

Figure 5.6. Main patient socio-demographic details by health board. *Percentages.*



5.3.2 History of psychiatric treatment

Over half of the patients were attending a day hospital for the first time. Sixty-eight per cent of patients had been previously hospitalised in an inpatient facility, 56% in the past five years. Thus, not all patients had been referred to a day hospital as the first port of call. Furthermore, 21% of patients had previously been admitted to an inpatient facility while attending a day hospital, 23% had attended a day hospital while they were an inpatient. The main reason cited for the last inpatient admission was a recurrence of symptoms (see Table 5.10 and Figure 5.7). These results would appear to be related to the earlier finding that a substantial number of day hospital patients were suffering from a long-term illness and needed inpatient admission from time to time.

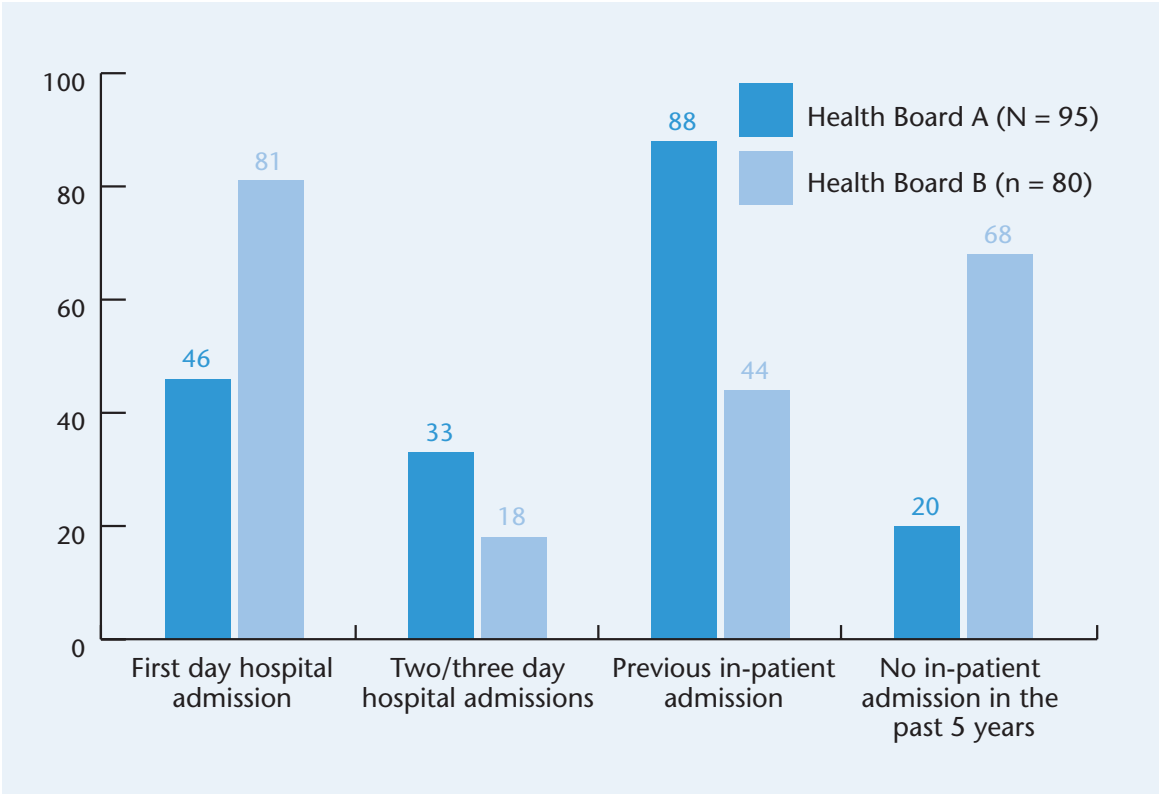
Table 5.10 History of psychiatric treatment. Total registered population from Health Board A and a registered sample from Health Board B. *Numbers and percentages.*

	Health Board A		Health Board B		Total	
No. of acceptances to day hospital						
One	44	(46%)	65	(81%)	109	(62%)
Two to three	31	(33%)	14	(18%)	45	(26%)
Four to five	9	(9%)	1	(1%)	10	(6%)
Over five	11	(12%)	0	(0%)	11	(6%)
Previous inpatient hospitalisation						
Yes	84	(88%)	35	(44%)	119	(68%)
No	9	(9%)	45	(56%)	54	(31%)
Unknown	2	(2%)	0	(0%)	2	(1%)
No. of admissions in past 5 years						
None	19	(20%)	54	(68%)	73	(42%)
One	29	(31%)	14	(18%)	43	(25%)
Two to three	26	(27%)	7	(9%)	33	(19%)
Four to five	10	(11%)	1	(1%)	11	(6%)
Over five	9	(9%)	2	(2%)	11	(6%)
Unknown	2	(2%)	2	(2%)	4	(2%)
Inpatient admissions while day patient						
Yes	28	(29%)	9	(11%)	37	(21%)
No	67	(71%)	71	(89%)	138	(79%)
Day hospital attendance while inpatient						
Yes	40	(42%)	1	(1%)	41	(23%)
No	55	(58%)	79	(99%)	134	(77%)
Reason for last inpatient admission						
Recurrence of symptoms	76	(80%)	30	(38%)	106	(61%)
Depression/suicidal ideas	8	(8%)	22	(28%)	30	(17%)
Unable to cope	0	(0%)	4	(5%)	4	(2%)
Other	11	(12%)	24	(30%)	35	(20%)
Previous treatment by OPD						
Yes	86	(91%)	56	(70%)	142	(81%)
No	9	(9%)	24	(30%)	33	(19%)
Total: No. & Row %	95	(54%)	80	(46%)	175	(100%)

Significant differences arose between patients in Health Board A and Health Board B with regard to previous psychiatric history. There was a higher proportion of patients in Health Board B new to day hospital services (Mann–Whitney U-test, $P < 0.001$) and a smaller proportion of patients who had received inpatient care, particularly in the past five years (Mann–Whitney U-test, $P < 0.001$). In Health Board A, a higher percentage of patients was admitted to inpatient care while attending a day hospital ($x^2 = 8.7$, $df = 1$, $P < 0.01$) and a higher percentage of patients had attended a day hospital while they were an inpatient ($x^2 = 40.4$, $df = 1$, $P < 0.001$).

Furthermore, Health Board B had a lower proportion of patients who had been last admitted to an inpatient facility due to a recurrence of symptoms, although a higher proportion of patients in Health Board B were last admitted to an inpatient facility due to depression or suicidal ideas ($x^2 = 32.9$, $df = 2$, $P < 0.001$). In addition, patients in Health Board B had attended an outpatient clinic on previous occasions ($x^2 = 11.9$, $df = 1$, $P < 0.001$). There were no significant differences between health boards in relation to age, gender and psychiatric history. The above results indicate that there were more patients in Health Board B who did not have a history of psychiatric treatment and that a substantial proportion of patients in this health board were referred from an outpatient clinic at their first appointment.

Figure 5.7. Main treatment history findings by health board. ***Percentages.***



5.4 Day treatment appropriateness

The Day Therapy Appropriateness Scale was completed with all day hospital patients registered in Health Board A during the fieldwork phase and also with a number of patients who began to attend shortly after the fieldwork concluded. In Health Board B the scale was completed with a sample of day hospital patients. In total the Day Therapy Appropriate Scale was completed for 201 patients; 127 patients in Health Board A and 74 patients in Health Board B. Data were analysed using Mann–Whitney U-tests.

5.4.1 Appropriateness

Lefkovitz (1982) described patients and their appropriateness for day hospitalisation as (1) those who are able to function outside of the inpatient hospital setting, (2) those who do not drop out of the day hospital programme, (3) those who are not so disruptive that they must be removed from the programme, and (4) those who are able to become reasonably involved in the treatment milieu.

The main findings of the DTAS are summarised in Figure 5.8. Sixty-five per cent of patients in Health Board A and 82% of patients in Health Board B scored within the appropriateness range (22–33) on this scale. Twenty-two per cent of patients in Health Board A and 15% of patients in Health Board B scored within the questionable range (17–21), while 13% of patients in Health Board A and 3% in Health Board B emerged as poor candidates for day treatment (range 17 and under) (Table 5.11). These differences between health boards were statistically significant (Mann–Whitney U-test, $P < 0.01$).

Table 5.11 Day Therapy Appropriateness Scale. All registered patients plus a sample of patients who registered after the fieldwork concluded in Health Board A and a sample of registered patients from Health Board B. *Numbers and percentages*.

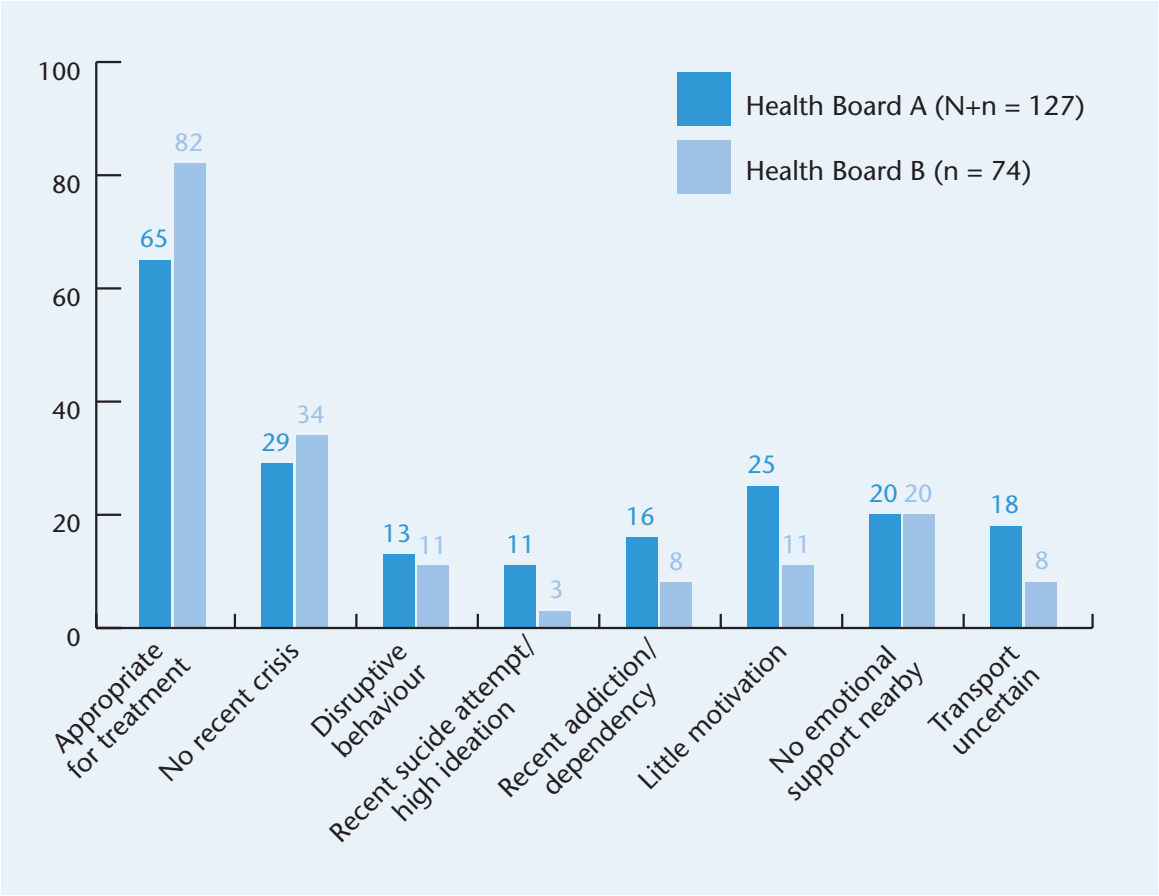
	Health Board A	Health Board B	Total
Appropriate candidate (range22–33)	82 (65%)	61 (82%)	143 (71%)
Questionable candidate (range 17–21)	28 (22%)	11 (15%)	39 (19%)
Poor candidate (17 and under)	17 (13%)	2 (3%)	19 (10%)
Total: No. & Row %	127 (63%)	74 (37%)	201 (100%)

More specifically, patients in Health Board A were more likely to be psychotic (Mann–Whitney U-test, $P < 0.01$), have a recent problem of addiction or alcohol dependency (Mann–Whitney U-test, $P < 0.000$) and have little motivation to be in treatment (Mann–Whitney U-test, $P < 0.000$). Patients in Health Board A were also less likely to live with an emotionally supportive family or friend (Mann–Whitney U-test, $P < 0.01$) and to be able to arrange transport to and from the day hospital each day (Mann–Whitney U-test, $P < 0.001$) (Table 5.12). Notably, there was no difference between patients in Health Boards A and B with respect to the duration of their illness. Approximately 30% of patients in both health boards had no recent crisis and the current episode was a reflection of a long-term problem. Similarly, there was no difference between patients with regard to suicidal or homicidal ideation. Sixty-three per cent of patients had little or no such intent.

Table 5.12 Day Therapy Appropriateness Scale data. All registered patients plus a sample of patients who registered after the fieldwork concluded in Health Board A and a sample of registered patients from Health Board B. ***Numbers and percentages.***

	Health Board A	Health Board B	Total
	(n = 127)	(n = 74)	(n = 201)
Duration of problem			
Recent crisis, no previous difficulties	18 (14%)	19 (26%)	37 (18%)
Recent crisis, previous difficulties	72 (57%)	30 (41%)	102 (51%)
No recent crisis, long-term problem	37 (29%)	25 (34%)	62 (31%)
Behaviour			
Not overt, psychotic or disruptive	79 (62%)	60 (81%)	139 (69%)
Psychotic but no disruptive behaviour	31 (24%)	6 (8%)	37 (18%)
Disruptive, acting out behaviour	17 (13%)	8 (11%)	25 (12%)
Suicide or homicide			
Little suicidal or homicidal ideation potential low	77 (61%)	50 (68%)	127 (63%)
Suicidal or homicidal ideation no recent attempt and no specific plan	36 (28%)	22 (30%)	58 (29%)
Recent attempt and continued ideation with plan – high potential	14 (11%)	2 (3%)	16 (8%)
Alcohol or drug involvement			
No history of addiction or dependency	85 (67%)	62 (84%)	147 (73%)
History but no recent problem	22 (17%)	6 (8%)	28 (14%)
Recent problem of addiction or dependency	20 (16%)	6 (8%)	26 (13%)
Motivation			
Patient highly motivated to be in treatment	27 (21%)	32 (43%)	59 (29%)
Patient has adequate motivation	68 (54%)	34 (46%)	102 (51%)
Patient has little motivation	32 (25%)	8 (11%)	40 (20%)
Support system			
Lives with emotionally supportive family, spouse or close friend	39 (31%)	41 (55%)	80 (40%)
Lives in somewhat supportive environment or lives alone and has support nearby	62 (49%)	18 (24%)	80 (40%)
Does not live with emotionally supportive family or friends and none living nearby	26 (20%)	15 (20%)	41 (20%)
Transportation			
Able to drive to the centre each day	6 (5%)	40 (54%)	46 (23%)
Can arrange a ride/is willing to take bus	98 (77%)	28 (38%)	126 (63%)
Transportation is uncertain	23 (18%)	6 (8%)	29 (14%)

Figure 5.8. Main findings of the Day Treatment Appropriateness Scale by health board. Percentages



5.5 Severity of illness

The Brief Psychiatric Rating Scale - Expanded Version (BPRS-E) was used to measure the severity of illness experienced by patients. The BPRS-E was administered to a sample of 114 patients in Health Board A and a sample of 121 patients in Health Board B. Data were analysed using factor analysis, one-way analysis of variance (ANOVAs) and descriptive statistics. In the factor analysis, the principal component extraction method was used. An eigenvalue of 0.60 was used as a cut off. The rotation method used was varimax.

5.5.1 Patients at the beginning of their attendance

In Health Board A, the BPRS-E was completed with 84 patients within their first week of attendance at a day hospital in order to determine whether patients were acutely ill upon admission. In Health Board B, the BPRS-E was completed with 66 patients during their first or second appointment at a day hospital. In total 150 inventories were completed. A summary of the results is presented in Figure 5.9.

Four components judged to be 'clinically sound' by the researchers emerged in the factor solution. All items loaded positively on all four factors. The first component consisted of items – anxiety, tension, depression and guilt. This component was interpreted to represent *anxiety and depression.* The second component, labelled *mania,* consisted of four items – motor hyperactivity, excitement, distractibility and elated mood. On the third component three items loaded: unusual thought content, hallucinations and suspiciousness. This was named *psychosis.* The fourth component comprised items associated with *negative affect* including the negative symptoms of schizophrenia. They were blunted effect, emotionally withdrawn and motor retardation (Table 5.13).

A reliability analysis was run for the total scale and the components extracted. The alpha for the total scale was 0.7245 with the components ranging from 0.7040 to 0.7935. This represents a good level of reliability.

Table 5.13 Principal component analysis, varimax rotation, restrictive loading ≥ 0.60 of BPRS-E items for a sample of patients commencing day hospital treatment.

BPRS-E Items Affect	Anxiety/ Depression	Mania	Psychosis	Negativ
Anxiety	0.849			
Tension	0.793			
Depression	0.725			
Guilt	0.636			
Motor hyperactivity		0.788		
Excitement		0.766		
Distractibility		0.686		
Elated mood		0.631		
Unusual thought content			0.817	
Hallucinations			0.751	
Suspiciousness			0.715	
Blunted effect				0.821
Emotionally withdrawn				0.816
Motor retardation				0.660

In order to explore whether differences existed between patients in each health board, a series of ANOVAs was conducted using the mean factor loading scores. Several statistical differences emerged. In terms of overall severity, patients in Health Board A scored higher on the total scale ($F(1, 149) = 4.375$, $P < 0.05$). More specifically, patients in Health Board A scored higher on components mania ($F(1, 149) = 5.753$, $P < 0.01$), psychosis ($F(1, 149) = 13.446$, $P < 0.001$) and negative affect ($F(1, 149) = 12.831$, $P < 0.001$) and patients in Health Board B scored higher on the component anxiety and depression ($F(1, 149) = 4.148$, $P < 0.05$). This finding is consistent with the patient diagnostic details reported earlier. That is, there was a higher proportion of patients in Health Board A with a diagnosis of psychosis and there was a higher proportion of patients in Health Board B with a diagnosis of neurosis. However, the diagnostic results were not statistically significant. The difference in illness type between health boards would appear to be attributable to the discrepancy in the nature of day hospital services offered in Health Board A and Health Board B.

Descriptive statistics were employed to investigate the level of illness patients were experiencing (Table 5.14). Each patient's score for each of the components, as measured by the BPRS-E, was divided by the number of items that comprised the component. The results revealed that out of the patients suffering from anxiety and depression, 61% of patients in Health Board A and 44% in Health Board B were suffering from a mild form. A further 17% in Health Board A and 39% in Health Board B were experiencing a moderate form. With regard to patients experiencing mania, 96% of patients in Health Board A and 95% in Health Board B were experiencing low levels of mania. Seventy-nine per cent of patients in Health Board A and 94% of patients in Health Board B, who were experiencing psychosis, were also suffering from a mild level of this condition. Similarly, 89% of patients in Health Board A and 95% of patients in Health Board B who were experiencing negative affect were suffering from a mild form. The total score revealed that approximately 90% of patients in Health Board A and 95% in Health Board B were suffering from mild levels of illnesses, mainly anxiety and depression.

The above findings are fairly consistent with that of Mbaya *et al.* (1998) who noted that between 9 and 13 per cent of day hospital places are used for acute illness. They also support the assertion by Platt *et al.* (1980) that day hospitals are underutilised for the treatment of acute and psychotic illness.

Figure 5.9. Severity of illness and factor analysis components by health board. Respondent – patients at the beginning of their attendance.

Severity of Illness Health Board A (n=84)	Factor Analysis Components	Severity of Illness Health Board B (n=66)
77% mild / moderate	Anxiety / Depression	83% mild / moderate
100% mild / moderate	Mania	100% mild / moderate
99% mild / moderate	Psychosis	100% mild / moderate
96% mild / moderate	Negative affect	100% mild / moderate
100% mild / moderate	TOTAL Severity of Symptoms	100% mild / moderate

Table 5.14 Severity of illness as measured by the BPRS-E. Patients at the beginning of their attendance at day hospitals in Health Board A and Health Board B. ***Numbers and percentages.***

	Anxiety/Depression		Mania		Psychosis		Negative Affect		Total Score	
	HB-A	HB-B	HB-A	HB-B	HB-A	HB-B	HB-A	HB-B	HB-A	HB-B
Very mild / Mild	51 (61%)	29 (44%)	81 (96%)	63 (95%)	66 (79%)	62 (94%)	75 (89%)	63 (95%)	76 (90%)	63 (95%)
Moderate	14 (17%)	26 (39%)	3 (4%)	3 (5%)	17 (20%)	4 (6%)	6 (7%)	3 (5%)	8 (10%)	3 (5%)
Moderately severe	15 (18%)	7 (11%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)	2 (2%)	0 (0%)	0 (0%)	0 (0%)
Severe	3 (4%)	4 (6%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)
Extremely severe	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

5.5.2 Patients attending for over three months

The BPRS-E was completed with 85 patients who were attending a day hospital for over three months. The scale was completed with this group in order to determine whether patients who were attending a day hospital for a significant period of time were acutely ill. Thirty inventories were completed in Health Board A and 55 in Health Board B. A summary of the results is presented in Figure 5.10.

Three clinically sound components appeared in the factor solution. Similar to the previous factor analysis, the first component was named *anxiety and depression* as it consisted of the items depression, guilt, somatic concern and anxiety. The second component was interpreted to represent *psychosis.* It comprised the items hallucinations, unusual thought content and bizarre. Only two items loaded on the third component - excitement and elated mood. This component was labelled *mania* (Table 5.15).

A reliability analysis was run for the total scale and the components extracted. The alpha for the total scale was 0.7490. For anxiety and depression the alpha was 0.7297, psychosis 0.7602 and mania 0.6427. This represents a good level of reliability.

Table 5.15 Principal component analysis, varimax rotation, restrictive loading ≥ 0.60 of BPRS-E items for a sample of patients attending a day hospital for over three months.

BPRS-E Items	Anxiety/Depression	Psychosis	Mania
Depression	0.781		
Guilt	0.759		
Somatic concern	0.684		
Anxiety	0.676		
Hallucinations		0.840	
Unusual thought content		0.816	
Bizarre		0.700	
Excitement			0.814
Elated mood			0.688

One way ANOVAs were carried out to investigate any significant differences that may have existed on these components between health boards. No differences emerged between health boards. Descriptive statistics were also conducted to examine the level of illness experienced by patients in each health board (Tables 5.16). Once again, each patient's score for each of the components, as measured by the BPRS-E, was divided by the number of items that comprised the component.

Table 5.16 Severity of illness as measured by the BPRS-E. Patients attending a day hospital for over three months in Health Board A and Health Board B: ***Numbers and percentages.***

	Anxiety/Depression		Mania		Psychosis		Total Score	
	HB-A	HB-B	HB-A	HB-B	HB-A	HB-B	HB-A	HB-B
Very mild/Mild	19 (63%)	33 (60%)	30 (100%)	53 (96%)	25 (83%)	51 (93%)	29 (97%)	50 (91%)
Moderate	7 (23%)	12 (22%)	0 (0%)	2 (4%)	5 (17%)	3 (5%)	1 (3%)	4 (7%)
Moderately severe	3 (10%)	6 (11%)	0 (0%)	0 (0%)	0 (0%)	1 (2%)	0 (0%)	1 (2%)
Severe	1 (3%)	2 (4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Extremely severe	0 (0%)	2 (4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Of the patients experiencing anxiety and depression, 62% of patients from both health boards were suffering from mild levels and 23% from moderate levels. Eighty-eight per cent of patients experiencing psychosis and 98% of patients experiencing mania were suffering from a mild form. The overall score indicated that 94% of patients were suffering from mild levels of illness. In keeping with the previous results the present findings are also consistent with that of Mbaya *et al.* (1998) and Platt et al. (1980) that day hospitals are underutilised for the treatment of acute illness.

Figure 5.10. Severity of illness and factor analysis components by health board. Respondent – patients attending services for more than 3 months.

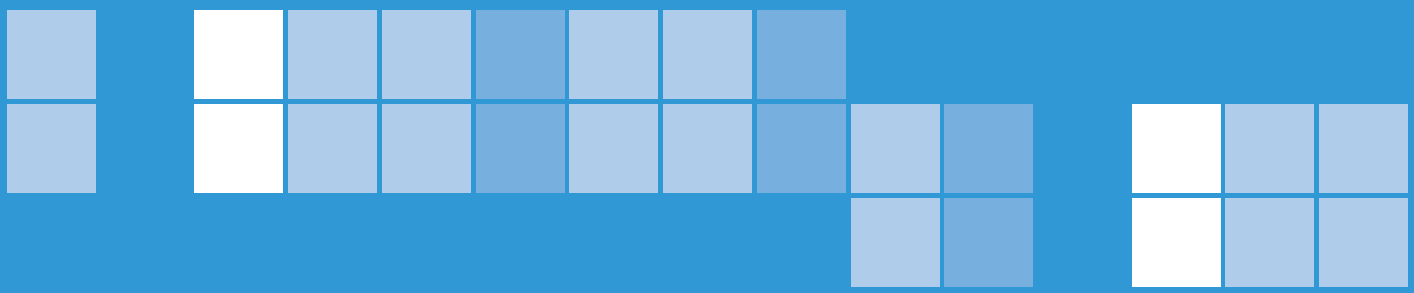
Severity of Illness Health Board A (n=30)	Factor Analysis Component	Severity of Illness Health Board B (n=55)
86% mild / moderate	Anxiety / Depression	82% mild / moderate
100% mild / moderate	Mania	100% mild / moderate
100% mild / moderate	Psychosis	98% mild / moderate
100% mild / moderate	TOTAL Severity of Symptoms	98% mild / moderate

5.6 Summary of results

The referral and assessment procedure data revealed that 94% of patients referred in the course of the study were assessed prior to referral, the majority of patients were assessed in an outpatient clinic or a psychiatric hospital and most patients were referred to a day hospital by a consultant. Patients in Health Board B were more likely to be assessed in an outpatient clinic than patients in Health Board A. Psychiatric symptoms were most frequently cited as the 'major clinical factor' influencing the decision to admit. Thirty-seven per cent of patients were admitted to a day hospital as an alternative to inpatient care, 29% to facilitate re-entry to the community from an inpatient setting and 13% were referred to provide a maintenance setting for a chronic illness. Patients in Health Board A were more likely to be admitted to a day hospital to facilitate re-entry to the community from an inpatient setting than patients in Health Board B. The main diagnoses were depressive disorders (48%), schizophrenia (17%) and neurosis (16%). Fifty per cent of patients were reported to be in an acute phase of illness and 32% in a chronic phase.

The socio-demographic data showed that the majority of registered patients were female, aged between 18 and 29 years, single, with some secondary education and were not living alone. Fifty-eight per cent of patients either owned their home or lived with parents who owned their own home. Only 26% were employed on a full-time basis and 18% were unskilled. There were differences between the two health boards in relation to psychiatric treatment history, a higher percentage of patients in Health Board B were new to day hospital services and a lower percentage of patients had received inpatient care, particularly in the past five years.

In terms of day hospital appropriateness, 65% of registered patients in Health Board A and 82% in Health Board B scored within the appropriateness range on the Day Therapy Appropriateness Scale. In terms of severity of illness, patients entering the day hospital services in Health Board A experienced more severe levels of mania, psychosis and negative affect than patients in Health Board B. Furthermore, patients from Health Board B experienced more anxiety and depression than patients in Health Board A. There was no difference in illness severity between the two health boards with regard to patients attending a day hospital for over three months. Overall, the majority of patients including both individuals at the beginning of their day hospital attendance and those attending three months or more, suffered from a relatively mild level of illness.



CHAPTER SIX

Results III: Day Hospital Patient and Staff Views

CHAPTER SIX

Results III: Day Hospital Patient and Staff Views

The first section of results presented below reports patient opinions and satisfaction in relation to the day hospital (6.2). The information was obtained using the Service Satisfaction Questionnaire and the Consumer Opinions Questionnaire. The second section of the results reports *day hospital staffs' perceptions* in relation to the day hospital and day centre (6.3). This information was collected using the Questionnaire regarding Staff Views. A discussion relating to the implications of the findings is presented in Chapter 7.

6.1 Rationale

As noted in the literature review, patient satisfaction is an important factor in the development and evaluation of services. There has been no published study in the literature to date that has investigated patient satisfaction with Irish day hospitals. The present study sought to rectify this deficit.

Day hospital staffs' perceptions in relation to the day hospital and day centre were also explored. The purpose of this aspect of the study was to investigate the level of specialist knowledge among mental health professionals. The assessment and referral procedures have been correctly emphasised as having an important role to play in the functioning of a day hospital. However, these procedures are only significant if the assessing psychiatrist has a good knowledge of the range, purpose and functioning of each component of the mental health service. There has been no published study in national or international literature in relation to this matter. Perceptions of the day services gathered from staff were compared with the descriptions of day care presented in Chapter 1.

6.2 User views of mental health day hospitals: survey questionnaires

6.2.1 Participants

In Health Board A, all registered day hospital patients were invited to participate in the study. In Health Board B, nurses distributed all questionnaires to a sample of patients registered at each day hospital. In total, 182 day hospital patients completed the Service Satisfaction Questionnaire. Seventy-eight patients were from Health Board A (representing a response rate of 92%) and 104 patients (representing a response rate of 81%) were from Health Board B. Forty per cent of the sample was male and 58% was female (2% of the gender data were missing). Seventy-four per cent of patients were between 25 and 54 years old.

Of the above sample, 155 day hospital patients as well as an additional five patients completed a Consumer Opinions Questionnaire. Eighty-three patients were from Health Board A (representing a response rate of 98%) and 77 patients (representing a response rate of 60%) from Health Board B. Forty-one per cent of the sample was male and 56% was female (3% of these gender data were missing). Seventy-two per cent of patients were between 25 and 54 years old.

The reader should note that some patients failed to complete all items on the Service Satisfaction Questionnaire and the Consumer Opinions Questionnaire. In total 4% of the data were missing. All data were analysed using Mann–Whitney U-tests and significant differences between health boards are reported. Mann–Whitney U-tests were carried out to examine the relationship between age, gender and patient satisfaction for items that had a sufficient sample size. There was no significant relationship between age, gender and items on the Service Satisfaction Questionnaire or the Consumer Opinions Questionnaire. The results of this section of the study are summarised in Figures 6.1 and 6.2.

6.2.2 Service Satisfaction Questionnaire

Premises

A substantial percentage of patients were dissatisfied with aspects of the day hospitals' premises. Twenty per cent of patients felt the rooms were dirty and untidy and 19% felt the waiting area was 'not nice' to wait in. However, 90% of patients who ate at the day hospital thought the dining area was 'nice' to eat in and 80% felt they were counselled in a comfortable room. These results are in accordance with the findings reported in Chapter 4 where it was noted that there were cleaning and/or maintenance problems evident in three of the day hospitals and a further three day hospitals were in need of refurbishment.

Staff

On the positive side, most patients displayed mild or strong positive attitudes towards staff. Ninety-three per cent of patients felt staff took their problems seriously, 89% considered they were treated with respect, 86% believed staff were competent and 84% felt staff were interested in their views regarding treatment. With regard to the availability of staff, 84% of patients agreed they were always able to speak to a member of staff in private within working hours. Eighty-two per cent agreed staff were available when they wanted to speak to them and 84% were always able to see/contact the staff member they wanted to speak to within working hours.

Treatment

On a less positive note, a substantial percentage of patients were dissatisfied with the time they had to wait to be seen when they had an appointment (44% in Health Board A and 33% in Health Board B). The difference between health boards was statistically significant (Mann-Whitney U-test, $P < 0.01$). Three per cent of patients did not know and 5% were unsure as to why they were attending a day hospital. Eight per cent believed that they had not been told about all the treatments available and a further 15% were unsure. Nineteen per cent of patients in Health Board A and 10% in Health Board B reported that they were not told about the benefits and side effects of their treatment. A further 13% in Health Board A and 21% in Health Board B were unsure. Thirteen per cent of patients felt they could not refuse a treatment while 18% were unsure. Seventy-five per cent of patients did feel, however, that they had a say and choice about their treatment. Sixty-nine per cent of patients in Health Board A and 86% of patients in Health Board B found individual counselling useful and 77% of patients found their medication useful. However, 23% were concerned about not being given a choice of a male or female therapist.

Activities and other items

Eighty per cent of patients in Health Board A liked the things they did in the day hospital and 79% found the activities offered worthwhile. Eighty-nine per cent of patients in Health Board A and 52% in Health Board B liked talking to other patients. This difference between patients was supported statistically (Mann–Whitney U-test, $P < 0.05$). Forty-four per cent of patients did not like telling people they attended a day hospital. Eighty-five per cent of patients who ate at the day hospital liked the food. Sixty-seven per cent of patients felt there was sufficient transport to get to the day hospital, 16% were unsure. Twenty-five per cent of patients in Health Board A and 17% of patients in Health Board B felt it cost too much to travel to the day hospital. This difference was statistically significant (Mann–Whitney U-test, $P < 0.05$). Nineteen per cent believed the day hospital was too far from their home.

6.2.3 Consumer Opinions Questionnaire

Opening hours

Some patients were dissatisfied with day hospital opening hours. Twenty per cent of day patients found a full day at a day hospital too long. Seventeen per cent of Health Board A patients stated they would like the day hospital services to extend into the evening and 27% into the weekend. The most common reasons for this was to keep busy and to have contact with nursing staff if needed.

Patient needs

The majority of patients (79%) felt their needs were being met. Seventy-eight per cent of Health Board A patients and 94% of Health Board B patients were satisfied with the service they received. This difference was statistically significant (Mann–Whitney U-test, $P < 0.01$). Some patients, who thought their needs were not being met, felt the day hospital could be boring with nothing to do and should be more active. Twenty-eight per cent of patients were also receiving support from a voluntary organisation.

Perception of the day hospital and treatment preference

Sixty-three per cent of Health Board A patients and 87% of Health Board B patients saw the day hospital as a separate entity to the main hospital. This difference was statistically significant (Mann–Whitney U-test, $P < 0.001$). Fifty-nine per cent of patients from Health Board A and 91% of patients from Health Board B would have preferred to have attended a day hospital for their treatment needs without ever having to have stayed at an inpatient facility. This finding was statistically significant (Mann–Whitney U-test, $P < 0.001$) and has important implications for the promotion of day hospital treatment.

Disadvantages of day hospital attendance

Twenty-eight per cent felt there were disadvantages to attending a day hospital. The main disadvantages listed included difficulty organising transportation, its interference with work or caring for a young family. Very few patients could tolerate any form of unacceptable behaviour on the part of other attendees at a day hospital. The majority of patients wanted this type of behaviour to be kept to a minimum. Many patients reported that they were frightened by disturbed behaviour.

Patient suggestions for improvement

Patients had many suggestions as to how they felt day hospitals could improve. Suggestions included an increase in the number of nursing staff, more activities and an increase in privacy. One patient expressed his unhappiness with his consultant who discussed his illness in a busy corridor. More privacy was also requested in waiting areas. A few patients pointed out that some facilities were run down and should be redecorated. Others would like the help of day hospital staff to gain employment.

Figure 6.1. Main finding from the users' views study by health board. Percentage agreed. Five point scale.

Health Board A (n=78)		Health Board B (n=104)
92%	Staff take problems seriously	94%
85%	Patients treated with respect	92%
88%	Staff available on request	78%
44%	Have to wait a long time when have appointment	33%
19%	Were not told about the good & bad effects of treatment	10%
13%	Felt could not turn down treatment	18%
69%	Individual counselling useful	86%
85%	Liked the food	N/A[1]
25%	Costs too much to travel to the day hospital	17%
24%	Rooms dirty and untidy	14%
10%	Waiting area not nice to wait in	14%

1 – Not applicable

Figure 6.2. Main findings from the consumer opinions study by health board. Percentages.

Health Board A (n=83)		Health Board B (n=77)
59%	Prefer day hospital to inpatient unit for treatment needs	91%
83%	Needs being met in the day hospital	75%
78%	Satisfied with the service	94%
29%	Disadvantages to attending day hospital (e.g. interference with work and family life)	26%

6.3 Day hospital staff views of mental health day hospitals and day centres: qualitative interviews

6.3.1 Participants

Qualitative interviews were used to explore the perceptions of day hospital staff in relation to day hospitals and day centres. Twenty-one consultants, 31 registrars, 31 day hospital nurses, 36 community nurses and 31 professionals from the allied professions were interviewed. Addiction and alcohol counsellors were excluded. In total 150 staff from a range of disciplines were interviewed. Of the 108 staff names given to the researcher in Health Board A, 105 staff were interviewed. Of the 54 staff names given to the researcher in Health Board B, 45 staff were interviewed. This represented an overall interview rate of 92%. Eight per cent of staff were not available for interview as they were on leave. Data were analysed using chi-square tests and any significant differences that occurred between health boards are reported. The main results of this study are summarised in Figures 6.3 and 6.4.

6.3.2 What is the role of a day hospital?

There needs to be consensus among mental health professionals about the role of the day hospital in order for this day service to function appropriately. However, only 76 staff (51%) provided a comprehensive description of the role of a day hospital similar to that presented in Chapter 1. Of note was the fact that 61 staff (58%) in Health Board A provided a comprehensive description in contrast to 15 staff (33%) in Health Board B. All of these accounts mentioned several roles for a day hospital including (i) an alternative to inpatient hospitalisation, (ii) decrease in inpatient stay, (iii) step down facility from an inpatient facility, (iv) adjunct to inpatient stay, and (v) short-term treatment, assessment, observation and medication. Many staff also stressed the day hospital should be located in the community.

Fifty-four staff (36% in Health Board A and 36% in Health Board B) displayed a limited knowledge of day hospital services naming one or two of the five roles mentioned above at most. Overall, 20 (13%) staff were unable to provide a comprehensive description of the role of a day hospital. There was a statistical difference between health boards with more staff in Health Board B not knowing the role of a day hospital ($x^2 = 19.0$, $df = 2$, $P < 0.001$). Fourteen staff (31%) in Health Board B did not know the role of the day hospital in contrast to 5 staff (5%) in Health Board A. Most of the 14 staff in Health Board B held a circumscribed role of the day hospital in which she/he worked, that is, they described a service that offered supportive counselling and educational classes only on an appointment basis.

6.3.3 For whom is a day hospital appropriate?

The majority (85%) of staff in Health Board A felt a day hospital should cater for patients in an acute phase of illness. Many staff members did stress, however, that some patients might be too acutely ill and warrant inpatient admission. Many staff suggested the day hospital was particularly appropriate for patients experiencing an acute illness for the first time. However, there was confusion among staff in Health Board B, only 49% of staff in Health Board B suggested that a patient in an acute phase of illness was a possible candidate for day hospital treatment. One-third considered patients who were less ill, for example 'persons under stress', suitable for a day hospital. Eighteen per cent did not know what type of illness a day hospital should cater for. Statistically, a higher percentage of staff in Health Board B did not know for whom a day hospital was appropriate ($x^2 = 22.4$, $df = 2$, $P < 0.001$).

6.3.4 For whom do you consider a day hospital inappropriate?

Unlike the answers to the previous question, there was considerable consistency in opinions among staff as to who is inappropriate for day hospital attendance. The majority of staff viewed patients who were actively suicidal, a danger to themselves or others, aggressive or disruptive, to be ill suited for treatment in a day hospital. In particular, staff were concerned about the possibility of patients with anti-social personality disorders disrupting the treatment milieu. Patients who were actively drug taking or dependent on alcohol were also deemed unsuitable. Many staff considered patients with enduring mental health problems, patients who are severely ill or those who are well enough to attend a weekly clinic to be inappropriate for attendance at a day hospital. A small number of staff, particularly in Health Board B, felt patients in an acute phase of illness should not attend a day hospital for treatment.

6.3.5 With regard to a day hospital, do you believe emphasis should be laid on dealing with acute patients or the 'worried well'?

Consultants and registrars (n = 52) were asked the above question. In Health Board A, 89% believed day hospitals should place an emphasis on dealing with acute patients. Nine per cent felt the day hospital should prioritise care for the 'worried well'. Two per cent believed the day hospital should cater equally for both groups. In Health Board B, 71% of consultants and registrars felt emphasis should be given to the treatment of the acutely ill, 14% believed stress should be laid on dealing with the 'worried well', while 7% felt the day hospital should cater equally for both groups. An additional 7% believed the day hospital should cater for patients with chronic psychiatric conditions.

6.3.6 Do you consider a day hospital as having a continuous role to play in a continuing illness?

Staff from Health Board A and Health Board B were in agreement in relation to this question. Eighty-three per cent of staff deemed the day hospital as having a continuous role to play in a continuing illness during a period of relapse. Seventeen per cent of staff either disagreed or were uncertain.

6.3.7 Do you believe the day hospital should provide specific treatment inputs?

Ninety-nine per cent of staff from both health boards believed the day hospital should devise treatment plans specific to each patient's needs.

6.3.8 How would you feel about providing a drop-in support service for day hospital patients (a) in the evenings after hours and (b) at weekends?

Staff in Health Board B were not asked the above question, as Health Board B simply offered a counselling service. All staff interviewed in Health Board A were asked the above question. The majority of staff (64%) in Health Board A were in favour of providing a drop-in support service for day hospital patients, both in the evenings after hours and at weekends. Even though many staff members were in favour of this extended service, there were many concerns surrounding its provision. Several staff were afraid that this service would encourage a dependency in some patients. Many staff members were conscious of safety issues, particularly with regard to violent patients and were aware of difficulties in recruiting staff. Two staff members questioned if this service would be worthwhile economically.

Just over 20% of staff were not in favour of this type of a drop-in service. Some staff felt that the day hospital was not set up for this purpose and other resources in the community should be utilised. Several staff suggested patients should go to an Accident and Emergency Department should they

need help after hours or at weekends. Ten per cent were uncertain about this drop-in service, while 3% felt an after hours service was needed but not a drop-in support service. Notably, numerous staff commented on the unavailability of community psychiatric nurses after 5 pm and number of staff working in the community at the weekends. Many staff felt there was a deficiency of staff in the community during weeknights and at weekends.

6.3.9 How would you feel about providing a seven-day weekday hospital?

Staff in Health Board A only were asked the above question. Staff in Health Board B were not asked, as this health board was simply offering a counselling service. Staff in Health Board A were divided about providing a seven-day weekday hospital. Fifty-five per cent were in favour of the idea, 28% were against and 10% were uncertain. Seven per cent felt that a service was needed at weekends for day hospital patients but that a seven-day weekday hospital was not the solution. Many of those who opposed the idea were afraid a seven-day service might foster dependency. Many staff also felt there was a need for more community psychiatric nurses at weekends.

6.3.10 How would you feel about providing full days in a day hospital for appropriate patients who are acutely ill offering them the same services they would find on an inpatient ward?

Staff in Health Board B only were asked the above question. The majority of staff (69%) were in favour of offering a service equivalent to an inpatient service on a 9 to 5 basis. Many staff felt this was the way forward and commented on the possible advantages of such a service. For example, patients who attend a day hospital may not feel as isolated as inpatients from their community. There were concerns, however, about a day hospital patient's safety at home during the night. Sixteen per cent of staff were opposed to the idea of caring for acute patients on a full-day basis in a day hospital. Many believed acute illness could not be treated outside an inpatient facility. A further 11% were undecided. Some staff commented that they did not have any experience of such a service and were therefore uncertain.

6.3.11 Do you believe you could use the day hospital more often than you are at present? If yes, please give details of any reason(s) that discourages you from using the day hospital.

Only consultants and registrars in Health Board A and Health Board B answered the above question, as the decision to admit a patient usually lies with the treating psychiatrist. Seventy per cent of psychiatrists in Health Board A and 100% of psychiatrists in Health Board B felt they could refer more patients to the day hospital than they were doing at that time. Most psychiatrists were discouraged from referring more patients to the day hospital due to the limited amount of places. Many psychiatrists were afraid of overcrowding and were conscious of the workload of nurses. Some psychiatrists felt the day hospital in which they worked lacked access to resources such as a behavioural therapist or a psychologist. They believed such resources would be useful and they could refer patients who would benefit from such a service. Two registrars did not feel confident enough to judge which patients were suitable for the day hospital. Several registrars felt they were not adequately introduced to the day hospital and had to find out as they went along what level of illness the day hospital in their sector or catchment area could cater for.

6.3.12 What changes would you like to see happen in relation to this day hospital?

Ninety per cent of staff interviewed said they would like to see changes to the day hospital in which they worked. Among the most common changes staff would like to see were structural changes to the fabric of the existing day hospital building or the provision of a purpose-built facility. Most of these staff felt the existing facility was not appropriate for a day hospital. Examples included premises, which were previously utilised as a warehouse, an office building and home to a religious order. In addition, most staff would like to see an increase in multidisciplinary staffing. There were calls for more nurses, psychologists, occupational therapists and social workers in particular. Several nursing staff felt the day hospital needed full-time medical coverage. Seven per cent of staff felt no changes were needed in the day hospital they worked in. Three per cent felt they did not know enough about the operation of the day hospital to be able to comment.

6.3.13 Are there any obstacles in the way of achieving these changes?

The majority of staff felt that if any significant changes were to occur more resources were needed. Resources included both skilled staff and finance. It was widely acknowledged that it was difficult to recruit staff due to skill shortages.

6.3.14 What is the role of a day centre?

Unlike the day hospital results, there was a considerable amount of consistency among day hospital staff in describing the role of a day centre. The majority of responses were similar to the description of a day centre given in Chapter 1. Most reports included words such as rehabilitation, social support, living skills and self-care. Many individuals also felt the day centre provided an opportunity for staff to observe and assess a patient's mental state and to pick up on early signs and symptoms of relapse. A significant percentage of staff, however, had little or no knowledge of the role of a day centre. Twenty-three staff (15%) provided an incomplete explanation. An example of such a response included 'to give patients a break from home'. Nineteen staff (13%) did not know the role of a day centre. Eight of these staff confused the role of the day centre with other services, particularly the day hospital and sheltered workshop.

6.3.15 For whom is a day centre appropriate?

Two-thirds of day hospital staff reported that the day centre is suitable for patients with persisting psychiatric disorders and/or long-stay patients. Staff who commented in more detail felt that a patient suitable for a day centre would also be non-acute, with a certain amount of disability preventing them from being able to hold down a job, not highly functional and often socially isolated. Thirty staff (20%) displayed a limited knowledge. Twenty-three staff (15%) clearly did not know what type of patient is suited to a day centre. Many believed patients who are acutely ill or indeed any patient in the psychiatric services are suitable for attendance at a day centre.

Figure 6.3. Main finding from the staff views study. Percentage agreed. Based on Structured interviews.

Health Board A (n=105)		Health Board B (n=45)
36%	Limited knowledge of role of day hospital	36%
5%	No knowledge of role of day hospital	31%
3%	Did not know which patients were appropriate for day hospital	18%
17%	Limited knowledge of role of day centre	11%
12%	No knowledge of role of day centre	13%
13%	Did not know which patients were appropriate for day centre treatment	20%
28%	Psychiatrist felt there was not enough day hospital places	25%

Figure 6.4. Changes wanted by staff & perceived obstacles to change.

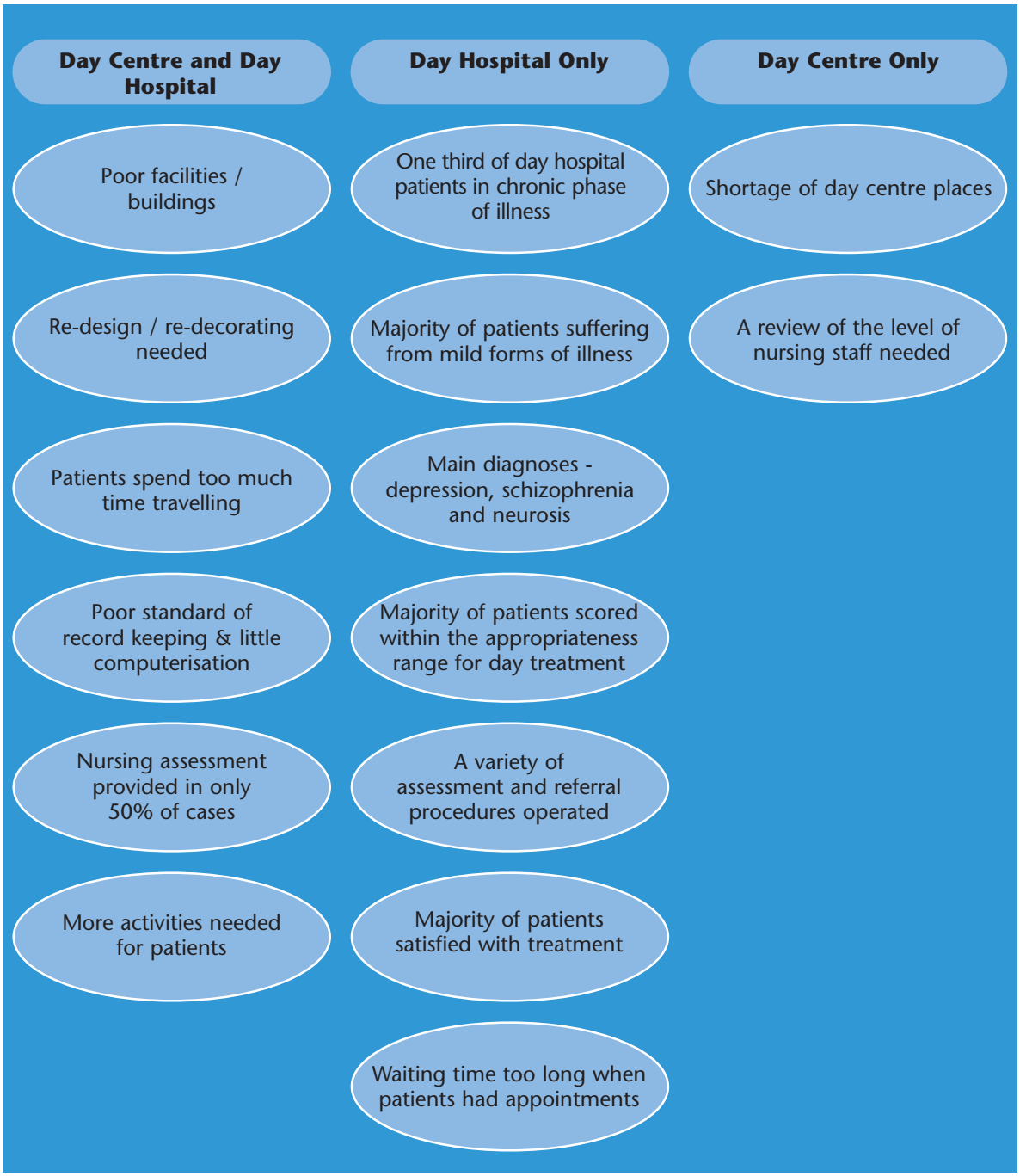
Health Board A (n=105)		Health Board B (n=45)
91%	Would like to see changes e.g. *Purpose built premises/structural changes* *More nurses, More allied professionals* *Increase in medical coverage*	89%
71%	Obstacles to Change e.g.*Lack of skilled staff, Finance*	82%

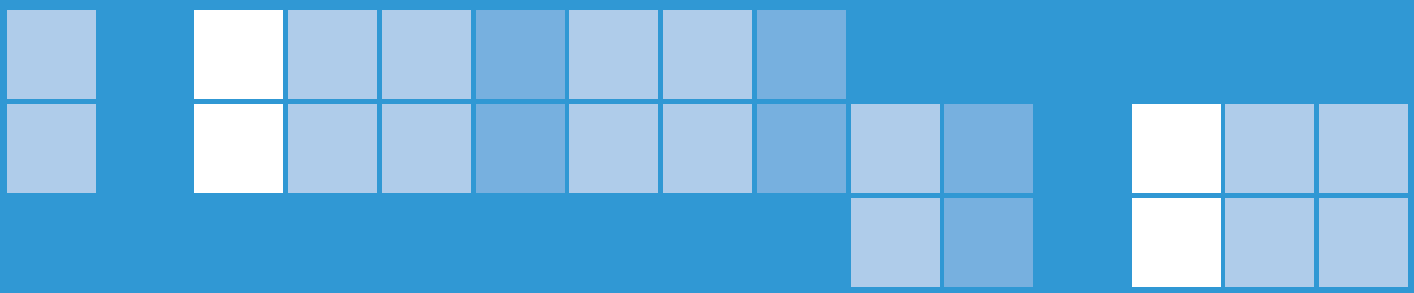
6.4 Summary of results

The majority of registered patients who completed the Service Satisfaction Questionnaire and/or the Consumer Opinions Questionnaire were satisfied with treatment, staff, activities and food provided (Figure 6.5). A small percentage of patients reported that they did not know why they were attending the day hospital (3%), they had not been told about the treatments available (8%) and they had not been told about the good and bad effects of their treatment (15%). Twenty-eight per cent felt there were disadvantages to attending the service including interference with work and family commitments. Many patients would like to see an increase in nursing staff, activities, privacy and a redecoration of facilities.

In Health Board A, 58% of staff felt they knew the role of a day hospital and 85% considered they knew what type of patient is suitable for day hospital treatment. A substantial number of staff in Health Board B did not understand the role of a day hospital (31%) and were unsure as to who was appropriate for day hospital treatment (51%). In Health Board A, 64% of staff favoured a drop-in support service for day hospital patients. Fifty-five per cent were in favour of a seven-day weekday hospital. In Health Board B, 69% of staff were in favour of offering a service equivalent to inpatient care on a day basis. The majority of psychiatrists were discouraged from referring more patients to the day hospital due to the limited number of places. In terms of changes to existing provisions, the most common suggestions were an improvement in premises and an increase in multidisciplinary teams.

Figure 6.5 Overview of findings from Day Hospital & Day Centre Study





CHAPTER SEVEN

Discussion and Conclusions

CHAPTER SEVEN

Discussion and Conclusions

7.1 Introduction

The current study was designed to obtain information on the status of day hospital and day centre services in Irish mental health services. The present chapter discusses the results of the study in relation to the nature and appropriateness of participating day care services and the utilisation of participating day hospital services. Based on the study findings and other available information a series of guidelines and recommendations are presented in Chapter 8. It is hoped that this information may provide a helpful input to discussions regarding revision and strengthening of mental health service provision.

7.2 Nature and appropriateness of current day hospital and day centre provision

7.2.1 Premises

One of the most important findings to emerge from the present study was that the majority of premises were not suited to the needs of mental health day services. The most common problems with the buildings related to the disposition of rooms and the provision of patient activity rooms. According to the NHS Estates (1998) accommodation guidelines, there should be sufficient social activity spaces such as a kitchen, dining room and sitting room for use by patients and these activity spaces should be situated adjacent to each other. Unfortunately, many day hospitals did not have sufficient social activity rooms and many of these rooms, when they were present, were inconveniently dispersed throughout the day hospital premises.

Staff and patient views support the unsuitability of many of these premises. The majority of staff said they would like to see a structural change to the existing facility or the construction of a purpose-built facility. Furthermore, many premises were in need of redecorating and refurbishing. Twenty per cent of patients felt the rooms were dirty and untidy, 19% felt the waiting area was 'not nice' to wait in and several noted that the premises were in need of redecoration.

The unsuitability of premises was largely due to the high proportion of non-purpose-built buildings and the acquisition of unsuitable buildings. It must not be construed that purpose-built buildings are necessarily superior as some purpose-built day hospitals have been designed without clear perceptions as to their functions. Accordingly, the premises are incapable of functioning as acute day hospitals. The high proportion of non-purpose-built buildings can be attributed to a number of factors. In many areas it is difficult to find and acquire land in a suitable location to build a day hospital or day centre. In addition, applying for planning permission to build a day hospital or day centre can be a lengthy process. Many health boards choose to purchase a pre-existing building, as this is a quicker and often simpler process. Unfortunately, most of the day care premises purchased by the participating health boards were unsuitable for day care purposes. Furthermore, many day hospitals and day centres had not been maintained to an acceptable standard.

The unsuitability of premises has significant implications for day hospital practice. Most notably, in many cases it is often not possible to care for acutely ill patients on a full-day basis in inappropriate day hospital premises. For example, acutely ill patients could not be treated on a full-day basis in Health Board B due primarily to a lack of patient activity spaces.

7.2.2 Nature of services

Day hospitals in Health Board A provided a five-day week treatment and therapeutic activity-based service. A counselling service was also available in two day hospitals, six days a week (see section 7.2.7 for details). According to descriptions in the literature and official publications, a day hospital should provide the same treatments that are available in an acute inpatient setting. The nature and range of services offered in Health Board A day hospitals was in accordance with this description. However, this was not the case in Health Board B. Day hospitals in Health Board B provided a five-day week nurse-led counselling service. One day hospital, in Health Board B, provided a weekend counselling service every second Sunday. No other form of treatment was available at these day hospitals. Thus, the services operating in these 'day hospitals' were actually counselling services. There was no genuine day hospital service in Health Board B.

This finding has extensive implications for patients in Health Board B. Most notably, Health Board B could not offer an alternative to full hospitalisation for patients who were acutely ill, nor could it prepare an inpatient for discharge. Both of these functions are core elements of a day hospital service.

7.2.3 Patient information

There are no official guidelines as to the number of patients who should attend a day hospital at any one time. The present study found the average number of patients on the register at each day hospital in Health Board A was 17 and the average daily attendance was 11. Five per cent of patients attending the day hospitals were inpatients. These patients travelled from an inpatient ward to a day hospital each day. The average number of patients registered at each day centre was 26 and the average daily attendance was 12.

The average number of patients registered at each day hospital in Health Board B was 37 (excluding 1 outlier of 113) and the average daily attendance was 8. There were no inpatients attending these day hospital services. The latter finding is not surprising since there were no activity spaces for day hospital patients in Health Board B and the service provided was a counselling service. The average number of patients registered at each day centre was 44 and the average daily attendance was 20. Chapter 8 provides guidelines as to the number of day care places required per sector.

All patients who attended day care services for a full day were given a midday meal. A minibus was provided for patients without transportation. Due to the transport arrangements, however, some patients were spending up to two hours travelling in minibuses to a day hospital or day centre. The commuting times for these patients were unacceptably long and needed to be considerably reduced.

7.2.4 Referral and assessment procedures

There was no uniform referral process. Out of 14 day hospitals, 6 accepted a referral from a psychiatrist only, 6 from a psychiatrist or community psychiatric nurse, 1 from any mental health professional and 1 from any mental health professional or general practitioner. Most day centres took referrals from a psychiatrist only. Unfortunately, only half of the day hospital and day centre services completed a nursing assessment upon admission.

In terms of waiting lists, two day hospitals and four day centres had lists ranging from one to eight patients. The presence of these waiting lists indicate that some day hospitals were (i) not able to admit a patient as soon as he/she was referred for treatment, and hence (ii) were not providing a service for acute patients. These waiting lists also indicated that there was a shortage of day centre places. Support for the former and latter statements is provided later in this chapter in section 7.3.4.

7.2.5 Day hospital staff

The present study noted the type and number of staff plus the time they worked in the day hospital. Based on the information gathered, there appeared to be a shortage of psychologists, social workers and occupational therapists in Health Board A and a shortage of psychologists in Health Board B.

The study also questioned nurses in charge regarding the staffing levels at the day hospital in which they worked. Nurses in charge in Health Boards A and B said they would like to see an increase in medical coverage and nursing staff at the day hospital. Psychiatrists spent one to two days per week in the same premises as the day hospital holding clinics for both day hospital patients and outpatients. Several day hospital nurses were engaged in administrative work and/or had difficulties trying to devise new activities, which resulted in a low level of patient activity in many day hospitals. These findings indicate that there is a need for an increase in administrative and support staff as well as an increase in medical presence in these day hospitals.

7.2.6 Day centre staff

There appeared to be too few carers in many day centres. Staff in numerous day centres had too many responsibilities (e.g. administration and care work) and patients were not receiving the attention they required. Care assistants and/or nursing assistants could be employed to care for day centre patients under the supervision of a nurse.

7.2.7 Day hospital treatment

No day hospital in Health Board A provided a comprehensive range of services as recommended by *Planning for the Future* (1984) (see Chapter 1 for details). Nurses in each day hospital provided supportive counselling and ran programmes such as anxiety management or social skills training. Psychiatrists assessed day hospital patients on a formal one-to-one basis. However, access to cognitive therapy, behaviour therapy, occupational therapy, addiction and alcohol counselling varied according to the day hospital. Many day hospitals did not have access to a psychologist or an occupational therapist. Several did not have access to a community-based addiction or alcohol counsellor. Half of the day hospitals had difficulty accessing psychology or counselling services. The waiting lists ranged from two weeks to over five months for these services. No day hospital provided ECT onsite. Most day hospitals had access to the same treatments as inpatients with the exception of ECT and in some cases occupational services.

In Health Board B, nurses provided counselling as well as educational programmes such as personal development, assertiveness training and anxiety management from time to time. Patients did not spend a full day at these facilities engaging in therapeutic activity programmes. Each day hospital patient had access to a psychiatrist. Most day hospitals provided individual cognitive therapy and behaviour therapy. Four out of six day hospitals reported problems accessing psychology and behaviour therapy services. Most day hospitals had access to the same services as inpatients with the exception of ECT and therapeutic activities. The interventions offered in all 'day hospitals' in Health Board B were not day hospital services as defined in Chapter 1. The interventions that were offered in these 'day hospitals' did not differ from those routinely available in outpatient clinics. These clinics do not have the ability to care for acutely ill patients or operate as an alternative to inpatient care. A radical transformation of 'day hospital' services in Health Board B is needed to provide treatment in the community for acute patients.

7.2.8 Day hospital and day centre activities

Some day hospital and day centre services clearly required an increase in activity. An increase in activity could be brought about by the use of sessional staff such as an art, music or drama teacher.

7.2.9 Day hospital communication and service planning

There were regular sector team meetings in each day hospital among staff. However, less than half of the day hospitals held meetings with nursing staff in the corresponding inpatient facility. In a few facilities the standard of record keeping was unsatisfactory with some information missing or illegible. Many staff commented that time and energy was wasted chasing up patient records. There was a lack of computerisation of patient and service information at most day hospitals. If patient records and service information was computerised this would enhance communication and improve efficiency. In relation to planning documentation, almost all day hospitals had a one-year plan. Only two day hospitals had a five-year plan even though almost two-thirds were open more than five years.

7.2.10 Patient satisfaction with the day hospital

The majority of registered patients who completed the Service Satisfaction Questionnaire and the Consumer Opinions Questionnaire were satisfied with day hospital staff, the service they received and felt their needs were being met. Sixty-nine per cent of patients who participated in the study in Health Board A and 86% of participants in Health Board B found the individual counselling useful, although nearly a quarter were concerned about not being given a choice of a male or female therapist. The majority of patients also found their medication useful.

However, a large percentage of patients felt they always had to wait a long time when they had an appointment. Nearly 10% of patients did not know or were unsure as to why they were attending a day hospital. Eight per cent of patients noted that they were not told about all the treatments available to them. One in 5 patients in Health Board A and 1 in 10 patients in Health Board B stated they were not told about the benefits and side effects of their treatment. Thirteen per cent of patients felt they could not turn down a treatment and a further 18% were unsure. The majority of patients in Health Board A liked the things they did in the day hospital. Patients, who did not like the things they did, felt the day hospital was boring due to a lack of activity.

Overall, the results revealed that the majority of patients were happy with the service they received. This finding is somewhat surprising given the limitations and deficiencies that were noted in the participating day hospitals. One possible explanation for this discrepancy is that patients are grateful for the help they receive from professionals and they are unlikely to be aware of the range and quality of care that they should be receiving. This suggestion is supported by Fischer (1983) who points out that patients who rate themselves as satisfied often do so knowing little about alternative forms of care.

7.2.11 Assessing help outside day hospital hours

In terms of accessing help out-of-hours, there were no staff working in the community at night-time and only a few at weekends. Patients were advised by day hospital staff to go to a hospital Accident and Emergency Department if a problem arose that could not wait until the day hospital reopened. The lack of out-of-hours services plays an influential role in admitting a patient to inpatient care that may be more appropriately treated in a day hospital (Keogh, Roche and Walsh, 1999). It is important that patients who are admitted to inpatient care, due to a lack of out-of-hours services, are assessed in relation to their suitability for day hospital care as soon as normal working hours resume. The

provision of an adequate and appropriate out-of-hours service is important in order to ensure a patient is placed in the most appropriate form of care. However, difficulties such as the coverage of large rural geographical areas need to be taken into account when planning such services.

7.3 Utilisation of day hospital services

7.3.1 Referral agents and assessment prior to referral

When the sources of referral were examined, it emerged that 92% of patients who were referred during the study period were referred to a day hospital by a consultant psychiatrist or registrar. There were more referrals by registrars in Health Board A than in Health Board B. A small percentage of referrals were from general practitioners, community psychiatric nurses or were self-referrals.

Psychiatrists in Health Board A assessed an almost equal percentage of patients, in terms of day hospital potential, at inpatient facilities and outpatient clinics. The overwhelming majority of potential day hospital patients in Health Board B were assessed at outpatient clinics. There were also indications that the majority of referrals received from non-medical and non-hospital practitioners were directed to psychiatric outpatient departments where it was the responsibility of a psychiatrist to decide the most appropriate form of care. These results suggest that day hospitals in Health Board B were not using day hospitals as a 'step down' facility from inpatient care. This finding supports earlier suggestions and was not surprising given the provision of inappropriate premises (see section 7.2.1) and the inadequate nature of the service offered in day hospitals in Health Board B (see section 7.2.2).

7.3.2 Administrative reasons for admission and clinical factors influencing the decision to admit

During the study period psychiatric symptoms were most frequently cited as the 'major clinical factor' influencing the decision to admit to day hospital care. Observation and prevention of relapse were most frequently cited as the 'important clinical factors', particularly in Health Board A. However, in almost 50% of cases, social and domestic factors were cited as 'major' or 'important clinical factors'. The most common diagnosis was depressive disorder, followed by schizophrenia and neurosis. This finding is in keeping with Shergill et al. (1997) and Mbaya et al. (1998), who also found depressive disorders, schizophrenia and neurosis to be the most common diagnoses treated in day hospitals. The referring agents described one-third of patients referred as chronically ill. This finding is consistent with Mbaya *et al.* (1998) who found that a high proportion of day hospitals admitted chronically ill patients.

According to the referral agents, 42% of patients who were referred during the study period in Health Board A and 11% of referred patients in Health Board B were admitted to a day hospital to facilitate re-entry to the community from an inpatient setting. The referral agents also noted that 40% of patients referred in Health Board A and 32% of patients referred in Health Board B were admitted to a day hospital as an alternative to inpatient care. The latter statistic is difficult to comprehend, as Health Board B did not have the facilities to offer patients an alternative to inpatient care. There was evidence in Health Board B that a few consultant psychiatrists asked a registrar to fill in this form on their behalf. This process could have resulted in the provision of inaccurate information.

7.3.3 Patient demographics and treatment history

Further analysis revealed the registered day hospital population in Health Board A and a registered sample of patients in Health Board B were young, with the largest percentage falling into the 18–29 years age group. There was a high number of single patients; the majority were female and were not living alone. A large percentage of the patients studied completed secondary school and was unemployed. This was particularly so in Health Board A.

Thirty-eight per cent of the patients studied had at least one previous day hospital admission. However, almost twice the number (68%) had one or more previous inpatient admissions and 56% had been admitted to an inpatient facility in the past five years. Twenty-one per cent of the patients studied had been admitted to an inpatient ward while they were attending a day hospital. The main reason for admission (particularly in Health Board A) was a reoccurrence of symptoms. These findings would appear to be related to the fact that day hospitals were dealing with a substantial proportion of patients who were chronically ill and may need periodic inpatient admission. They are consistent with the results of a study entitled *Utilisation Review of Psychiatric Hospitals in a Canadian Urban Region* (Perez and Whitelaw, 1987).

7.3.4 Day treatment appropriateness and severity of illness

The data revealed that 65% of the sample of registered patients studied in Health Board A and 82% of the sample of registered patients studied in Health Board B scored within the appropriateness range on the Day Therapy Appropriateness Scale (DTAS). According to this scale, these findings indicate that the majority of participants were appropriate for treatment in terms of duration of problem, behaviour, suicide/homicide ideation, addiction/dependency, motivation, support and transportation. However, the researchers felt that the scale was weighted towards the selection of patients with relatively mild levels of disturbance. If this reservation is justified, the data indicates that although 65% of patients in Health Board A and 82% of patients in Health Board B were likely to be amenable to treatment in terms of the variables measured, few of these patients were likely to be seriously ill. This statement is based on the premise that many patients who were seriously ill would not score within the appropriateness range of the scale. For example, the scale is oriented towards the admission of patients who are highly motivated to be in treatment. However, many patients who are seriously ill lack motivation.

The BPRS-E was administered to measure severity of illness in order to determine whether day hospital patients were acutely ill. Factor analysis of the BPRS-E, for patients *commencing* treatment, revealed four components labelled as anxiety and depression, mania, psychosis and negative affect. Patients in Health Board A scored higher on mania, psychosis and negative affect. Patients in Health Board B were more ill in relation to anxiety and depression. However, approximately 50% of participants who were found to be suffering from mild levels of anxiety and depression were experiencing a mild level of illness. The majority of participants, who were found to be suffering from mania, psychosis or negative affect, were also experiencing very mild or mild levels of illness.

Factor analysis of the BPRS-E, for patients who were *attending day hospital services for three months or more,* revealed three components labelled as anxiety and depression, psychosis and mania. Unlike the previous factor analysis, conducted with data from patients at the beginning of their attendance, negative affect did not emerge in the solution. This finding is somewhat surprising and difficult to interpret. It may have been that patients experiencing symptoms of negative affect were more likely to be admitted as inpatients than persevered with as day patients. However, the BPRS-E was completed with fewer patients who were attending day hospital services for three months or more than those who were commencing treatment. It is also possible and, likewise, that this finding resulted from a lack of statistical power. In terms of illness severity, approximately 60% of participants, who were attending for 3 months or more were found to be suffering from anxiety and depression, were experiencing a mild level of illness. The majority of participants who were found to be suffering from mania or psychosis were experiencing very mild or mild levels of illness.

Taking into consideration the findings from both scales, it is clear that the day hospitals in the present study were not being utilised efficiently or effectively. The majority of patients admitted to day hospital care could probably have been cared for at outpatient clinics complemented by home care. Very few patients were ill enough to warrant day hospital treatment. These findings are in line with Mbaya *et al.*

(1998) who noted that day hospitals are underutilised for the treatment of acute and psychotic patients. Mbaya *et al.* (1998) found that in practice between 9 and 13% of day hospital places are used for acute illness as an alternative to admission, although recent studies indicate that 30–40% of acute patients could be managed in the day hospital (Creed *et al.*, 1990; Kluiter *et al.*, 1992; Schene *et al.*, 1993).

7.4 Staff views

Staff were asked about the role of the day care services and who was appropriate for day care attendance. Responses to these questions were compared with the description of day care services provided in Chapter 1. There was confusion among day hospital staff in relation to the functioning of day hospital services. Only 51% of staff provided a comprehensive description of the role of a day hospital and 67% knew what type of illness was appropriate for day hospital treatment. Most of the staff in Health Board B, who did not know the role of a day hospital, described a service that offered supportive counselling and educational classes only. When the role of the day hospital was explained to staff in Health Board B, 69% were in favour of providing such a service. Day hospital staff were more knowledgeable about day centre services. The majority of staff provided a comprehensive description of the role of a day centre and knew what type of patient was suitable for day centre attendance.

In Health Board A, 64% of staff favoured the provision of a drop-in centre as an additional facility for day hospital patients. Fifty-five per cent were in favour of a seven-day weekday hospital. The majority of psychiatrists stated that they were discouraged from referring more patients to the day hospital due to the limited number of places. However, it was clear that many psychiatrists were not utilising the day hospital appropriately.

The lack of clear understanding as to the purpose of day hospital function has substantial implications for the delivery of community care. Unless clinicians fully comprehend the objective of day care services, any intervention or effort to improve community care will be compromised.

7.5 Possible explanations for the present findings

There are several possible explanations as to why the day hospital facilities in this study were not operating a service that catered for acutely ill patients as they were established to do. It is possible that clinicians did not view day hospitals as a legitimate alternative to inpatient admission due to the inadequacies and deficiencies of the present provision. In Health Boards A and B, most premises were not suited to the needs of a day hospital and there appeared to be a shortage of staff and skills mix required for day hospitals to function as an alternative to inpatient care. In particular, there was a dearth of medical coverage and shortage of psychologists, social workers and occupational therapists. A comprehensive range of treatments was not available. In Health Board B, 'day hospital' services were in fact counselling services; staff did not care for patients on a full-day basis and there was no space to accommodate this type of service. There was very little access to community-based crisis intervention services in either health board when day hospitals were closed.

There were too few day centres available for long-term users of the services. Several sectors had no day centre facilities for chronically ill patients. One catchment area did not have a day centre. This shortage of day centre places resulted in a substantial number of patients with persisting illness being inappropriately referred to a day hospital, as there was no other form of day care available to them. Furthermore, it is possible that patients were being inappropriately referred to a day hospital due to the substantial number of staff who had a limited understanding of the role of the day hospital. Over half of the staff in Health Board B had difficulty in identifying the type of patient most appropriate for day hospital treatment. Furthermore, day hospitals in Health Board B provided a counselling service only. A counselling service cannot cater for acutely ill patients who require partial hospitalisation.

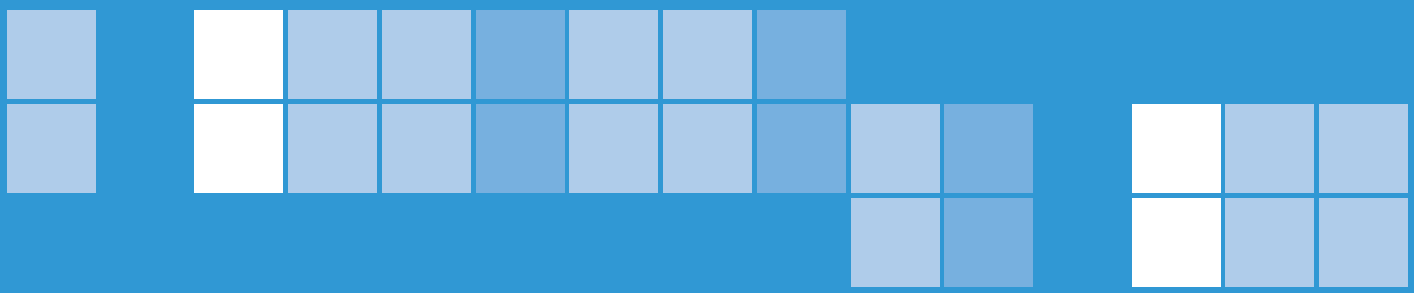
Taking the above considerations into account, it would appear very likely that acute patients who could be treated in a day hospital were being admitted to inpatient care. This suggestion is further supported by a study, *"We Have No Beds...": An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region,* conducted in the Eastern Health Board (Keogh, Roche and Walsh, 1999). The results of this study showed that no less than 45% of inpatient beds were inappropriately occupied. There were patients who were 'inappropriately admitted for short periods of time who could have been diverted to other services and whose needs, at the time of admission, were not sufficiently acute to merit occupation of an acute bed'. Instead they could 'have been more appropriately dealt with by alternative service provision such as an acute day hospital placement'. In this study the decision to admit to acute beds was often taken by inexperienced medical staff, with less than one-third made by consultants. Furthermore, only 47% of patients were assessed on admission, resulting in a missed opportunity to direct these patients to alternative forms of care.

7.6 Limitations

The present study has a number of limitations. Drawing from experience and the literature review it was felt that there is no representative day hospital and a quest for such would be futile. Hence the participating day hospitals were limited in their representativeness of day services on a national level. Furthermore, the completion of the Referral Questionnaire relied on the subjective judgement of the referring agent and there was evidence that a few consultant psychiatrists asked a registrar to fill in this form on their behalf. This process probably slightly increased the risk of gathering inaccurate information. The researchers questioned the reliability of the Day Therapy Appropriateness Scale. It was felt that the scale is weighted towards the selection of patients with relatively mild levels of disturbance. In addition, it was not practical to train the participating nurses in the administration of the BPRS-E. The completion of rating scales, such as the BPRS-E, with patients who are unfamiliar to staff is not always an easy task. In such situations assumptions are often made that the individuals being assessed can and will accurately describe their current symptoms and behaviour, a premise that cannot be always supported. Lastly, the utility of the patient satisfaction results is questionable. Fischer (1983) points out patients who rate themselves as satisfied often do so knowing little about alternative forms of care.

7.7 Conclusions

- Many psychiatric day hospitals were occupying premises unsuitable for acute day hospital services
- Many patients spent up to four hours travelling to and from day hospital and day centre services each day
- Day hospitals were generally not providing a service for acutely ill patients
- A comprehensive range of treatments was not available in day hospitals
- Services provided in day hospitals in Health Board B were predominantly of a counselling type
- No day hospital provided *in situ* ECT
- There was a lack of activity in some day hospitals and day centres. Some nurses found it difficult to think of new activities, were engaged in administrative work and/or felt they had too many patients to care for
- Medical consultant presence in day hospitals was limited
- There was a dearth of psychologists, occupational therapists and social workers in day hospitals
- There were very limited community-based crisis intervention services for patients outside office hours
- Almost 50% of patients were assessed prior to referral to a day hospital by a consultant psychiatrist
- The majority of patients were assessed in an outpatient clinic or in an acute psychiatric hospital prior to referral to a day hospital
- Most frequently day hospital patients were female, aged between 18 and 29 years old, with some secondary education and were not living alone
- Most patients attending day hospitals were experiencing relatively mild mental illness
- A substantial number of patients, who were inappropriately attending a day hospital, were chronically ill. This was partially due to a lack of day centre provision
- The majority of day hospital patients were satisfied with the treatment, staff, activities and food provided
- Many mental health professionals, particularly in Health Board B, had limited perceptions of the role of a day hospital and what type of illness could be treated at such a facility



CHAPTER EIGHT

Guidelines and Recommendations

CHAPTER EIGHT

Guidelines and Recommendations

Following a discussion of extant and needed information which could inform mental health service planning, this chapter presents two tentative sets of guidelines – first in relation to location, design, provision, patient capacity and staffing of day hospitals and day centres and then to training, admission, assessment and discharge policies. This is followed by recommendations, based on the results of the present study, in relation to location, design, provision, patient capacity, staffing, treatment, activities, education, research and planning. Given that much of the desired information for planning purposes is unavailable, the research team has taken an eclectic approach to existing information and supplemented this with their experience of the mental health services. Thus, the guidelines and recommendations should not be viewed as definitive or inflexible, rather as reasoned judgements given the current state of knowledge.

8.1 Planning mental health services and their environments: extant and needed information

Planning the future of services requires, in the first instance, gathering comprehensive information regarding the needs of the population, service provision and service utilisation. Information that can be useful in assessing population needs, include population characteristics associated with psychiatric morbidity, number of treated individuals, place and type of treatment and the number of untreated individuals who are in need of treatment. Service provision data include quantifying the service components, identifying the capacity of each component, assessing the quality of each unit, determining the geographic suitability of each premises and the co-ordination of service units. Details of service utilisation such as the number of clinical contacts, number of treatment episodes, rates per 100,000 population per year, plus data on outcome and costs can also be very informative.

Unfortunately, not all of the above information is readily available at present. Traditionally research in the mental health area has received little funding. This is a situation that needs to be addressed in the short term. Some valuable databases exist, however, and some provide invaluable current and historical information regarding mental health service provision and use.

Data on the utilisation of psychiatric inpatient services has been available from the National Psychiatric In-Patient Reporting System (NPIRS) since 1971 (Daly and Walsh, 2001). The system produces the *Activities of Irish Psychiatric Services,* which reports on an annual basis. The same system produces decennial censuses of patients in Irish psychiatric hospitals and units, where the last such report dealing with the year 2001 was published in 2002 (Daly and Walsh, 2002).

Population health indicators are available on a nationwide basis from the Public Health Information System (PHIS) maintained by the Department of Health and Children. This database provides health information by health board area. However, it is difficult to use such information to plan on a local level, as the information is not available by psychiatric catchment areas or for each sector within the catchment areas. The work of the Small Area Health Research Unit, based in the Department of Community Health and General Practice, Trinity College Dublin carries out valuable studies on health information at a local level.

More detailed information relating to the entire range of psychiatric services, community-based as well as inpatient, is available from the Two County Psychiatric Case Register, maintained by the Health Research Board and the St Loman's (Dublin South West) Psychiatric Case Register maintained by the South Western Area Health Board. Both registers were established in 1973 and constitute longitudinal

and person-linked databases. They record information across the entire spectrum of psychiatric services including inpatient facilities, day hospitals, day centres, hostels and domiciliary visits for the geographic areas they cover. In addition, these registers provide a breakdown of the demographic characteristics of patients utilising inpatient or community facilities (O'Hare and Walsh, 1987).

Recently, health boards have been investigating the benefits of identifying performance indicators in mental health services, *inter alia.* The Mental Health Research Division of the Health Research Board is collaborating with the health boards in the production of quarterly performance indicators. This initiative will provide much needed decision-support for clinical and management purposes.

The National Health Strategy (2001) heralded the publication of the National Health Information Strategy (2001), which will make recommendations to improve and extend information technology to deal with existing deficiencies in the health area, *inter alia.* Human and organisational issues in the uptake and use of these technologies will need to be addressed to facilitate successful implementation.

A dearth of information, which could inform the planning and design of *health service facilities and environments* in Ireland, also exists. This deficit exists, however, in spite of the development of a range of methodologies, which can facilitate the production of more user-friendly, cost-effective, efficient, and economical health buildings. A document published by the European Foundation for the Improvement of Living and Working Conditions, entitled *Building for People in Hospitals: Workers and Consumers* (Moran *et al.*, 1990), puts forward a framework along with methods and procedures, which when implemented can achieve more user-friendly and efficient health environments. The document stresses the importance of involving both staff and patients in the planning process. It outlines methods and procedures appropriate for all eight stages of the design process, ranging from planning through the design and 'building in use' stages (see Appendix 11). The framework is useful for all parties involved in the production and use of health facilities and could be adopted by planning and building management groups in the future (see Appendix 11). There is a strong argument for the application of the type of systematic approach outlined to buildings financed out of the public purse.

The initiatives outlined above highlight the importance of supporting a knowledge-based approach to healthcare planning and delivery, which will facilitate better quality of services, ensure more effective delivery of health services and create a high-quality training environment for health professionals.

8.2 Utilising the available information to propose guidelines for day hospital and day centre services

It is unlikely that the information required for health service planning purposes, referred to earlier, will be available for such planning exercises in the very near future. Therefore, we provide two sets of guidelines based on the findings of the present study, information available from databases managed by the Health Research Board and the experience of the research team. *First, guidelines are put forward relating to location, design, provision, patient capacity and staffing for day hospitals and day centres. Second, guidelines relating to training, admission, assessment and discharge policies are provided.* We acknowledge that day hospital and day centre services will vary according to local need and circumstances. Thus, these guidelines are tentative and flexible and *inter alia,* are presented as a stimulus to discussion regarding the future development of services.

8.3 Guidelines

8.3.1 Suggested proposals for planning in relation to location and design, provision/capacity and staffing for day hospitals and day centres

DAY HOSPITALS

Location and Design

The day hospital would be best located in the largest populated area within each sector. It should be open at least five days a week. Transport should be provided for patients in rural communities and as far as possible take no longer than one hour to complete a one-way journey.

The day hospital should ideally be situated on the ground floor of a community mental health centre or a generic health centre. If the day hospital is to be a freestanding building then it should preferably be a one-storey building. The structure of the premises and provision of privacy should be in accordance with the needs of patients and staff (see Appendix 11). The provision of patient areas should preferably include a large day area that could be used for a variety of specified functions, an occupational therapy room of substantial size and a dining room large enough to accommodate all patients who attend on a full-day basis at one sitting. It is essential that one of the above rooms be of sufficient size to accommodate a patient who is agitated, restless or distressed. Patient rooms should be situated adjacent to each other and be decorated in an attractive and homely style. The provision of a shower room and a laundry room is also important.

Psychiatrists and allied professions will require office accommodation. Offices should be utilised interchangeably to avoid underutilisation. Community psychiatric nurses and outreach teams will require office space and could share an open plan office and have access to a confidential interview room. The administrative function will require two rooms, one for administration work and one secure room for the storage of records. In addition, a receptionist/administrative assistant will require accommodation in the entrance foyer of the premises.

Provision/Capacity and Staffing

According to our calculations approximately 11 day hospital places are required for a sector with a population of 35,000 (see Appendix 12 for calculations). Treatments and activities such as psychotherapy or occupational therapy should be available to non-acute patients in day hospital premises. Psychiatric outpatient clinics should not be held in day hospitals but in generic health centres due to the number of patients seen at these clinics and to promote integration between mental health and primary healthcare services. Sector headquarters should be based in the same premises as the day hospital where this is possible.

The sector consultant psychiatrist should have a substantial presence and continuous availability in the day hospital premises supported by a non-consultant hospital doctor; both would of course be available for acute inpatient care, home care and outreach activity in the sector. Psychology, social work and occupational therapy personnel should form part of the day hospital and community mental health centre staffing and work out of the premises on a continuous availability/presence basis. Household staff will also be required.

DAY CENTRES

Location and Design

The day centre should be located in the largest populated area of the sector. There may be a need for two day centres in some sectors. It should be open at least five days a week. Transport should be provided for patients in rural communities and as far as possible take no longer than one hour to complete a one-way journey.

The design of a day centre will bear many similarities to the day hospital design. However, the day centre should not be located in the same building as a day hospital. The day centre should be a freestanding one-storey building. The structure of the premises and provision of privacy should be conducive to the needs of patients and staff (See Appendix 11). The provision of patient areas should, at a minimum, include a large day area and a dining room large enough to accommodate all patients at one sitting. These rooms should be situated adjacent to each other and decorated in an attractive and homely style. The provision of a shower room and a laundry room is essential. One staff office and an interview room will also be required.

Provision/Capacity and Staffing

According to our calculations 55 day centre places are required for a sector with a population of 35,000 (see Appendix 12 for calculations). This may mean having one large or two smaller day centres in each sector. The day centre should have a supervisory nurse and care assistants to cater for the needs of patients.

8.3.2 Suggested initiatives for training, admission, assessment and discharge policies

Staff Training

All mental health professionals should be aware of how important the provision of day services is in the treatment of patients with mental health disorders. Comprehensive training should be provided at undergraduate and postgraduate levels regarding provision of services and the appropriate utilisation of each service in different circumstances. The necessity of keeping accurate records should also be cited. Ongoing training should also be provided for professionals working in mental healthcare in order to educate for change and development. Training could include workshops or visits to services that are highly regarded for their innovation and effectiveness.

Admission Policies

An admission policy should be available for each day hospital in order to determine the suitability of patients for admission. An admission policy is also required for each day centre, stating the type and severity of disability the centre is designed to cater for. The information provided should be comprehensive, clearly stated and be agreed among relevant staff. The agreed policy should be electronically recorded, be readily available to all professional staff and be accessible to the public. Admission policies are particularly useful for junior staff and registrars who move to different service components every six months. It is advisable that the implementation of admission policies is monitored through the use of an audit.

Assessment Procedures

Assessments should be carried out by the multidisciplinary team before deciding the most appropriate form of care. It is important that assessments are carried out or monitored by consultant psychiatrists. Assessments should be conducted for all patients regardless of whether they are known to the service or not. Judgments regarding referral should be made on the basis of the assessment results and clinical experience. Acute inpatients should be reviewed frequently and be discharged to home care or transferred to day hospital care once an assessment and clinical judgment deems these options appropriate. Outpatients should be assessed at outpatient clinics in the community and only the most severely ill should be considered for inpatient care. Patients who are acutely ill and do not need 24-hour care should be considered for home treatment and/or day hospital care. Any patient whom clinicians feel may benefit from attending a day centre should also be assessed.

Discharge Policies

Discharge policies are important, as patients should be officially discharged from a day hospital or a day centre when they no longer require this form of care. Appropriate records should be kept of the discharge. Discharge plans should be particularly focused towards patients who may have difficulty functioning without formal structure and routine. Discharge plans should be designed to help patients create their own structure and routine in their daily living.

Monitoring of Policies

In order for mental health day care services to be efficient and effective, the above policies need to be actively monitored on a continuous basis. One way to ensure that clinicians are abiding by policies is to conduct a regular audit. These audits should address the standard of record keeping *inter alia.* Review meetings should be held on a regular basis, audit results be presented and an opportunity should be available for all professional staff to provide comment through an open forum. Policies and practice can then be revised as necessary.

8.4 A challenge for the future

One of the major challenges facing the future of the mental health services is whether to continue to increase day hospital places or whether to plan the provision of day hospital places in conjunction with the establishment and development of assertive outreach. The National Health Strategy (2001) promises that a national policy framework for the 'further modernisation of the mental health services' will be prepared to update *Planning for the Future.* Perhaps this framework will address the balance of provision of day care and home care treatment.

If the main focus was to shift to the development of home care treatment and community-based interventions, then fewer day hospital places will be needed than are recommended at present. This may also mean that fewer day hospital premises would be required. The provision of home care treatment would also involve a major change for professionals. In particular, staff would be faced with a much changed and challenging role. There would also be implications for administrators, who would need to work in conjunction with staff and unions to implement the required changes as smoothly as possible.

The services are currently in transition and striking the balance between day hospital and assertive outreach provision is a challenge for every service. It is difficult to best-guess the direction that services will take in this regard but, in any case, it is not likely to be an either/or situation so that day hospital provision will continue to exist side by side with tentative steps towards assertive outreach/home care arrangements. Regardless of the balance of home care or day hospital provision, difficulties with premises, inappropriate placement of patients and level of staffing at day hospitals will have to be addressed in the short term. Irrespective of any changes in the delivery of care for acute patients, the demand for day centre places would be expected to remain the same. This means that an increase in day centre places is crucial and difficulties with premises and level of nursing staff will also have to be addressed.

8.5 Recommendations

The recommendations, made below, are tentative and based on the experience of this study and additional background material. Thus, they should not be viewed as definitive or inflexible recommendations.

1. Location and Design

1.1 There should be a day hospital and day centre in each sector

1.2 The day hospital and day centre should be sited in the largest centre of population in the sector

1.3 Patients should not spend more than an hour travelling to or from a day service

1.4 The day hospital should be located in the same building as an integral part of a community mental health centre or a generic health centre

1.5 Sector headquarters should be based in the same building as the day hospital, although this may not always be possible

1.6 Psychiatric outpatient clinics should not be held in the day hospital, but rather in generic health centres

1.7 Where psychiatric outpatient clinics and day hospitals are situated in generic health centres, the outpatient clinic should be a separate entity, independent of the day hospital

1.8 The day centre should not be located in the same premises as the day hospital; these two services serve different purposes and should be situated apart

1.9 Day services should be located on ground floor level, if possible

1.10 The size of day hospital and day centre buildings must relate to the necessary and appropriate use of the building in relation to activity generated by the number of patients attending and the number of staff working there

1.11 The design of such buildings should be informed by an user-orientated brief drawn up by a suitably qualified person experienced in user needs in relation to buildings.

2. Provision/Capacity & Staffing

2.1 There should be approximately two day care places per 1,000 population. A high proportion (1.57 per 1,000) of day care places should be day centre places. These figures are tentative and general and need adjustment to take account of local levels of socio-economic deprivation

2.2 The development of multidisciplinary teams is important in order to ensure comprehensive treatment programmes. Thus, it is recommended that the number of and range of professionals available to day hospital patients be reviewed and augmented where necessary.

3. Treatment and Activities

3.1 Day hospitals should be committed to treating acutely and severely ill patients

3.2 A comprehensive range of short-term time-limited treatments should be available to acutely ill patients in day hospitals

3.3 Day hospitals and day centres should provide suitable therapeutic activities to occupy patients who attend on a full or part-time basis; patients should not be left idle or bored

3.4 Non-medical treatments such as psychotherapy should be available to non-acute patients in day hospital premises

3.5 The provision of an adequate and appropriate out-of-hours assessment service is important in order to ensure that a patient is placed in the most appropriate form of care

3.6 There should be no waiting lists for day hospitals.

4. Education, Research and Planning

4.1 Day care staff should be fully aware of the role of each component of the mental health service. Staff should attend workshops and conferences in order to keep up-to-date with the latest developments in mental healthcare

4.2 Each day hospital should establish and implement a mission statement and a range of policies, including admission and discharge policies, in order to clarify the role of the day hospital. A regular audit should be conducted to investigate whether the policies are being adhered to and accurate records should be available which can support an audit

4.3 Research is required to gather further information about population needs for planning purposes

4.4 Comprehensive databases need to be established regarding the usage of each component of the mental health service. The development of databases is essential for planning purposes and staff will need to be trained in their operation

4.5 The balance of day hospital and home care provision should be examined along with developing models of care

4.6 Day care services should have a uniform national goal that can be adjusted according to local needs

4.7 The future of day care needs to be discussed and evaluated from a national perspective.

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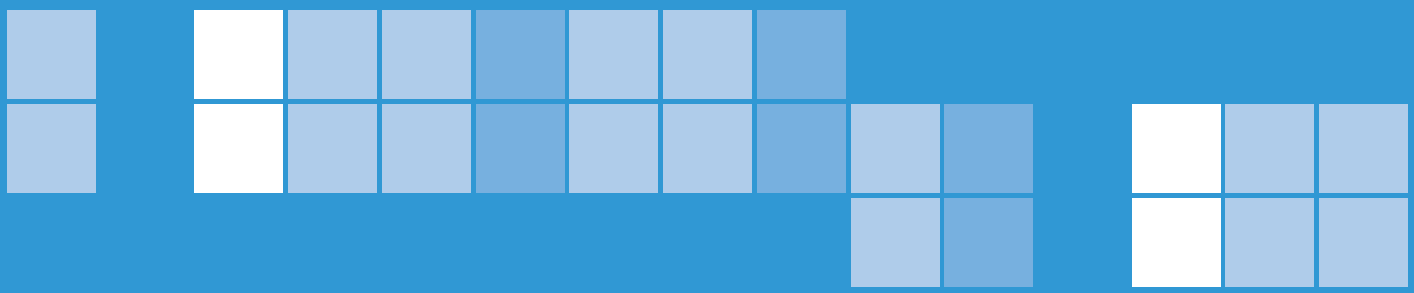


APPENDIX 1

Characteristics of the Psychiatric Services in Two Participating Health Boards

CHARACTERISTICS OF THE PSYCHIATRIC SERVICES IN TWO PARTICIPATING HEALTH BOARDS

This appendix is intended to supplement the information reported in the methodology chapter. This additional information should provide the reader with a comprehensive picture of the psychiatric services in the two participating health boards. Information regarding the provision and activity of inpatient and community mental health services reported below was gathered from three main sources - National Psychiatric In-Patient Reporting System (NPIRS), *Report of the Inspector of Mental Hospitals,* and Health Board Service Plans.

Health Board A: Joyce, O'Casey and Synge

Inpatient care

In Health Board A, inpatient care was provided in each of the catchment areas. In Joyce, inpatient care was provided in a general hospital unit, which contained 51 beds. Beds were also provided by a private hospital on a contract basis. In 2000, 34 beds were contracted mainly for long-term care. In O'Casey, inpatient care was provided at two hospitals. Fifty beds were provided in an acute unit in a general hospital and 20 rehabilitation beds in a long-stay psychiatric hospital. In Synge, a 30-bed integrated psychiatric unit was provided at a general hospital. Long-term care was provided in community residences.

Table 1 shows acute inpatient admissions, discharges, deaths, age, population diagnosis and length of stay for the latest available figures for the year 2000 in each catchment area in Health Board A.

Table 1. Health Board A: Acute inpatient admissions, discharges, deaths, age, diagnosis and length of stay in 2000 by catchment area. *Numbers and percentages.*

	Joyce	O'Casey	Synge
Age (all admissions)			
Under 20	11 (4.5%)	36 (5.6%)	23 (4.0%)
20–44 years	143 (58.8%)	359 (55.9%)	342 (59.2%)
45–64 years	71 (29.2%)	201 (31.3%)	186 (32.2%)
65 years and over	15 (6.2%)	46 (7.2%)	27 (4.7%)
Unspecified	3 (1.2%)	0 (0.0%)	0 (0.0%)
Diagnosis (all admissions)			
Organic psychosis	3 (1.2%)	6 (0.9%)	5 (0.9)
Schizophrenia	63 (25.9%)	197 (30.7%)	155 (26.8)
Other psychosis	3 (1.2%)	12 (1.9%)	4 (0.7)
Depressive disorders	37 (15.2%)	158 (24.6%)	224 (38.8%)
Mania	42 (17.3%)	89 (13.9%)	71 (12.3%)
Neurosis	6 (2.5%)	57 (8.9%)	41 (7.1%)
Personality disorders	30 (12.3%)	52 (8.1%)	15 (2.6%)
Alcoholic disorders	19 (7.8%)	31 (4.8%)	39 (6.7%)
Drug dependence	13 (5.3%)	31 (4.8%)	15 (2.6%)
Mental handicap	1 (0.4%)	4 (0.6%)	5 (0.9%)
Unspecified	26 (10.7%)	5 (0.8%)	4 (0.7%)
Length of stay			
Under 1 week	61 (23.1%)	193 (31%)	223 (39.3%)
1–2 weeks	52 (19.7%)	101 (16.2%)	135 (23.8%)
2–4 weeks	51 (19.3%)	123 (19.7%)	114 (20.1%)
1–3 months	68 (25.8%)	152 (24.4%)	81 (14.3%)
3 months – 1 year	28 (10.6%)	54 (8.7%)	9 (1.6%)
1 year and over	4 (1.5%)	0 (0.0%)	6 (1.1%)
Total	264 (100%)	623 (100%)	568 (100%)

Source: NPIRS. Daly and Walsh, 2001

Community facilities: outpatient clinics, day services and community residences

Tables 2–4 provide the community data for the three catchment areas combined in Health Board A for 2000.

Table 2. Activity of outpatient clinics in Health Board A for 2000. ***Numbers and rates per 10,000 population over 15 years.***

Outpatient	New	Return	Total
Attendances			
Number	1,529.0	31,763.0	33,294.0
Rate	39.9	830.8	870.8

Source: Service Plan 2001

Table 3. Places in day hospitals and day centres in Health Board A for 2000. ***Numbers and rates per 10,000 population over 15 years.***

	No. Places	No. Attendances	No. Persons
Day hospital			
Number	128.0	24,907.0	4,586.0
Rate	3.3	651.4	
Day centre			
Number	110.0	10,482.0	107.0
Rate	2.8	274.1	

Source: Service Plan 2001

Table 4. Places in community residences by level of support in Health Board A for 2000. ***Numbers and rates per 10,000 population over 15 years.***

Hostels	No. of Hostels	No. of Places
High		
Number	6	97.0
Rate		2.5
Medium		
Number	14	59.0
Rate		1.5
Low		
Number	7	63.0
Rate		1.6

Source: Service Plan 2001

Staffing and cost of psychiatric services

Tables 5–6 indicate the level of staffing for 2000 and the budget for 1999 for the three catchment areas in Health Board A.

Table 5. Staff by catchment area for 2000.

	Joyce	O'Casey	Synge
Medical	N/A	25.0	15.0
Administrative	N/A	28.5	6.0
Nursing	N/A	221.5	54.0
Non-nursing	N/A	51.0	2.0
Other professionals	N/A	16.5	11.0

Source: Report of the Inspector of Mental Hospitals 2001
N/A = Information not available at the time of the inspection

Table 6. Budget by catchment area for 1999.

	Joyce	O'Casey	Synge
Per capita budget	N/A	£13 million	£4 million

Source: Report of the Inspector of Mental Hospitals 2001
N/A = Information not available at the time of the inspection

Health Board B: Yeats and Shaw

Inpatient care

In Yeats, 108 beds were provided in one male and three integrated wards in a psychiatric hospital. In Shaw, 187 beds were provided in a psychiatric hospital in four male and three female wards. Details of admissions, discharges, deaths, age, population diagnosis and length of stay for the year 1999 for each catchment area are displayed in Table 7.

Table 7. Admissions, discharges and deaths, age, diagnosis and length of stay in 2000 according to catchment area. *Numbers and percentages*.

	Yeats	Shaw
Age (all admissions)		
Under 20	36 (4.9%)	27 (3.4%)
20–44 years	426 (58.4%)	377 (46.9%)
45–64 years	219 (30.0%)	303 (37.7%)
65 years and over	48 (6.6%)	97 (12.1%)
Unspecified	0 (0.0%)	0 (0.0%)
Diagnosis (all admissions)		
Organic psychosis	11 (1.5%)	13 (1.6%)
Schizophrenia	113 (15.5%)	167 (20.8%)
Other psychosis	7 (1.0%)	6 (0.7%)
Depressive disorders	193 (26.5%)	217 (27.0%)
Mania	61 (8.4%)	39 (4.9%)
Neurosis	39 (5.3%)	48 (6.0%)
Personality disorders	33 (4.5%)	62 (7.7%)
Alcoholic disorders	225 (30.9%)	210 (26.1%)
Drug dependence	32 (4.4%)	41 (5.1%)
Mental handicap	9 (1.2%)	1 (0.1%)
Unspecified	6 (0.8%)	0 (0.0%)
Length of stay		
Under 1 week	284 (38.9%)	264 (33.5%)
1–2 weeks	171 (23.4%)	193 (24.5%)
2–4 weeks	138 (18.9%)	142 (18.0%)
1–3 months	102 (14.0%)	125 (15.9%)
3 months – 1 year	27 (3.7%)	60 (7.6%)
1 year and over	8 (1.0%)	3 (0.3%)
Total	730 (100%)	787 (100%)

Source: NPIRS. Daly and Walsh, 2001

Community facilities: Outpatient clinics, day services and community residences

Tables 8–10 indicate the activity in community care for the two catchment areas combined in Health Board B for 2002.

Table 8. Activity of outpatient clinics in Health Board B for 2000. ***Numbers and rates per 10,000 population over 15 years.***

Outpatients	New	Return	Total
Number	664.0	10,610.0	11,270.0
Rate	44.5	711.8	755.8

Source: Service Plan 2001

Table 9. Health Board B: Places in day hospitals and day centres in Health Board B for 2000. ***Numbers and rates per 10,000 population over 15 years.***

	No. New Referrals	No. Registered	Total Attendances
Day hospital			
Number	887.0	360.0	9,049.0
Rate	59.4	24.0	606.8
Day centre			
Number	72.0	214.0	23,644.0
Rate	4.8	14.3	1585.6

Source: Service Plan 2001

Table 10. Places in community residences in Health Board B for 2000. ***Numbers and rates per 10,000 population over 15 years.***

	No. Places	No. of Residents
Number	206.0	238
Rate	13.8	

Source: Service Plan 2001

Staffing and cost of psychiatric services

Tables 11–12 indicate the level of staffing for 2000 and the budget for 1999 for the two catchment areas combined in Health Board B.

Table 11. Staff by catchment area for 2000.

	Yeats	Shaw
Medical	11.0	9.0
Administrative	13.5	13.8
Nursing	120.9	186.8
Non-nursing	70.5	123.2
Other professionals	**12.0**	**8.7**

Source: Report of the Inspector of Mental Hospitals 2001

Table 12. Budget by catchment area for 1999.

	Yeats	Shaw
Per capita budget	£7.4 million	£9.7 million

Source: Report of the Inspector of Mental Hospitals 2001

APPENDIX 2

General Day Hospital Questionnaire

GENERAL DAY HOSPITAL QUESTIONNAIRE

TO BE COMPLETED BY RESEARCHER WITH NURSING OFFICER WHERE APPROPRIATE

Main Hospital _____

Address _____

Exact Sector Served _____

Population Served _____

Day Hospital _____

Address _____

Exact Sector Served _____

Population Served _____

PART ONE: PREMISES

Description of Grounds/Immediate Surrounding Area

_____

_____

_____

_____

_____

Description of Building:

Cleanliness, Physical Appeal, Appropriateness, Floor Level, Part of larger centre.

_____

_____

_____

_____

_____

Date: ____/____/____ Day Hospital Name: _____

Please tick one of the following

Owned by Health Board ☐

Rented / Leased ☐

Is this building classified as a temporary premises? Yes ☐ No ☐

IF ANSWER IS YES, ANSWER QUESTIONS IN BOX, IF NO, SKIP TO BELOW THE BOX

How long has the day hospital occupied this building? _____

What plans are in place for relocation? _____

_____

_____

Has a time frame been set to achieve these plans? Yes ☐ No ☐

If yes, please elaborate _____

_____

_____

Is there anything delaying these plans? Yes ☐ No ☐

If yes, please elaborate _____

_____

_____

Are other services operating from the same building? Yes ☐ No ☐

If yes, please elaborate _____

_____

_____

Size of Premises _____

Number of Rooms _____

Number of Offices _____

Date: ____/____/____ Day Hospital Name: _____

Purpose of Each Room

_____

_____

_____

_____

_____

Occupancy of Rooms during Each Weekday Morning and Afternoon

_____

_____

_____

_____

_____

Occupancy of Rooms on Weeknights

_____

_____

Occupancy of Rooms during Weekends

_____

_____

Size of Largest Room _____

Size of External Space _____

Size of Internal Courtyard (if applicable) _____

Extra Space Needed (please elaborate): _____

PART TWO: PATIENT INFORMATION

Date: ____/____/____ Day Hospital Name: _____

Number of patients 'on the books' ☐

Number of patients with files left open ☐

Number of patients attending full-time (if applic.) ☐

Number of patients attending part-time (if applic.) ☐

Number of in-patients ☐

Number of patients suitable for day centre ☐

Number of patients waiting for other placement ☐

Capacity of the day hospital ☐

Average daily attendance ☐

Average daily non-attendees ☐

Number of attendances per person per week (give range) ☐

Day Hospital Opening Times _____

Operates on a full/half day basis Yes ☐ No ☐

Operates on an appointment basis Yes ☐ No ☐

Provision of midday meal Yes ☐ No ☐

Mode of transport to hospital Bus ☐

Train ☐

Minibus ☐

Taxi ☐

PART THREE: REFERRAL PROCESS

Date: ____/____/____ Day Hospital Name: _____

From where do you accept a referral? Please tick the appropriate box(es)

General Practitioner ☐ Out-Patient Department ☐

Sector Consultant Psychiatrist ☐ Sector Registrar Psychiatrist ☐

Other (please specify) _____

Is there a formal referral process? Yes ☐ No ☐

If yes, please outline _____

Is there a referral form? Yes ☐ No ☐

If yes, who is required to complete it? _____

Is there a formal assessment once referred? Yes ☐ No ☐

If yes, who is required to complete it? _____

If no, how is the appropriateness of a referral decided? _____

_____

Is there a waiting list? Yes ☐ No ☐

If yes, how long is it? _____

Do patients simultaneously attend other services? Yes ☐ No ☐

(i.e., out-patients or in-patient wards) If yes, please elaborate which services patients mainly attend

_____

To where are patients discharged? Please tick the appropriate box(es)

Home ☐ Specialised Programme ☐

Hostel ☐ In-patient Ward ☐

Out-patients ☐ Day Centre ☐

Other _____

PART FOUR: STAFFING

Date: ____/____/____ Day Hospital Name: _____

Please list day hospital staff members and state whether he/she is full-time,

part-time or sessional, plus his/her availability _____

Please list staff that offer their services to the day hospital and state their availability

If there is counselling available who provides it? _____

Has the individual(s) a counselling qualification? If yes please specify _____

Date: ____/____/____ Day Hospital Name: _____

What other staff are available at the day hospital? Please include administration /bus driver, etc.

_____

_____

How long has each staff member been employed in his/her present position?

Please list individually.

_____

_____

_____

_____

What extra staff is required? _____

_____

_____

_____

Are staff members compensating for other skill shortages? Yes ☐ No ☐

If yes, please elaborate as specifically as possible _____

_____

_____

Do staff claim expenses from this building? Yes ☐ No ☐

If yes, please list staff that do so _____

_____

_____

Is there a day centre for this sector? Yes ☐ No ☐

If yes, is it located in the same premise as the day hospital? Yes ☐ No ☐

Date: ____/____/____ Day Hospital Name: _____

Is the day hospital staff shared with the day centre staff? Yes ☐ No ☐

If yes, who is shared and does this ever pose a problem? _____

_____

_____

_____

Are there staff shortages? If yes, does this ever impose safety implications? For example, during holiday periods, etc. Yes ☐ No ☐

If yes, please elaborate _____

_____

_____

Is there a home-based team operating in this sector? Yes ☐ No ☐

If yes, please describe the team and its working hours including such details as staffing numbers and skills available _____

_____

_____

_____

If there is a home-based team are its members based in the day hospital? Yes ☐ No ☐

PART FIVE: TREATMENT AVAILABLE

Date: ____/____/____ Day Hospital Name: _____

Please tick which of the following treatments are provided

Occupational Therapy ☐ Individual Behaviour Therapy ☐

Anxiety Management ☐ Group Behaviour Therapy ☐

Supportive Counselling ☐ Individual Cognitive Therapy ☐

Addiction Counselling ☐ Group Cognitive Therapy ☐

Alcohol Counselling ☐ ECT ☐

Other(s) (specify): _____

_____

Is there difficulty accessing any of the above treatments? Yes ☐ No ☐

If yes, please elaborate _____

_____

_____

Are the same treatments available for day hospital patients as for in-patients?

If no, please elaborate below. Yes ☐ No ☐

_____

_____

Is the same medical record folder used in the day hospital as for the main hospital?

Yes ☐ No ☐

How often do staff members write in it?

Daily ☐ Weekly ☐ Other _____

Are there day hospital nursing notes? Yes ☐ No ☐

If yes, how often are they written in?

Daily ☐ Weekly ☐ Other _____

Date: ____/____/____ Day Hospital Name: _____

Is there an individual treatment plan for each patient with a clear aim? Yes ☐ No ☐

If yes, does it have a clearly defined beginning and end? Yes ☐ No ☐

_____

_____

Are treatment plans reviewed? Yes ☐ No ☐

If yes, how often and by whom? _____

_____

Is it difficult to schedule a programme that is at a level to meet each patient's needs?

Yes ☐ No ☐

If yes, please elaborate _____

_____

Does the day hospital run a programme, which incorporates day hospital activities and day centre activities for particular patients, if it is felt necessary? Yes ☐ No ☐

If yes, please elaborate _____

_____

How often does the CPN(s) visit patients?

_____

_____

Where do patients attend for prescriptions? Is this service provided at:

Day Hospital	Yes	☐	No	☐
Out-patients	Yes	☐	No	☐
General Practitioner	Yes	☐	No	☐

Other (specify) _____

Date: ____/____/____ Day Hospital Name: _____

Is emphasis laid on dealing with

acute patiente ☐

or the 'worried well'? ☐

How much input does the patient have with regard to their treatment programme?

_____

_____

_____

_____

Please list the *activities* provided

_____

_____

_____

_____

What other appropriate treatment facilities are available in the community?

_____

_____

_____

_____

Any Other Comments: _____

_____

_____

_____

_____

PART SIX: COMMUNICATION AND CO-ORDINATION WITHIN THE SERVICES

Date: ____/____/____ Day Hospital Name: _____

Are there regular meetings among staff at the day hospital? Yes ☐ No ☐

If yes, who is required to attend? _____

How often do they occur? _____

Are there regular meetings/visits with the main hospital staff? Yes ☐ No ☐

If yes, who is required to attend? _____

How often and where do they occur? _____

What is communication like between the day hospital and referral sources?

_____

_____

_____

What is communication like between the day hospital and discharge services?

_____

_____

_____

What is communication like among staff at the day hospital?

_____

_____

_____

How satisfied are you about this level of communication? (include above three areas)

_____

_____

_____

Date: ____/____/____ Day Hospital Name: _____

How do you think it could be improved? (include above three areas)

_____

_____

Does the day hospital have electronic mail? Yes ☐ No ☐

If no, are there plans to get this facility? Yes ☐ No ☐

If there are plans when is this likely to occur? _____

Does the main in-patient hospital have electronic mail? Yes ☐ No ☐

If no, are there plans to get this facility? Yes ☐ No ☐

If there are plans when is this likely to occur? _____

Is there a yearly plan for the day hospital? Yes ☐ No ☐

If yes, please give details of plans _____

_____

_____

_____

Is there a five-year plan for the day hospital? Yes ☐ No ☐

If yes, please give details of plans _____

_____

_____

_____

How often are these plans reviewed? _____

_____

Are they formally monitored? Yes ☐ No ☐

If yes, by whom? _____

Date: ____/____/____ Day Hospital Name: _____

Are there obstacles, for example lack of time, in the way of planning?

_____

_____

_____

_____

Any Other Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX 3
Referral Questionnaire

REFERRAL QUESTIONNAIRE

TO BE COMPLETED BY THE DOCTOR FOR PATIENTS ACCEPTED TO THE DAY HOSPITAL BETWEEN , ___/___/___ , AND, ___/___/___

Hospital Name: _____ Patient/Chart Number: _____

BEFORE BEING ACCEPTED TO THE DAY HOSPITAL

1. Was this patient assessed prior to referral to the day hospital? Yes ☐ No ☐

IF YES, ANSWER 2 & 3. IF NO, SKIP 2 & 3 AND GO TO 4

2. Who assessed this patient? NCHD ☐ Consultant ☐

Other (specify) _____

3. Where did the assessment take place?

General Hospital ☐ Out-patients ☐ A&E Department ☐

Psychiatric Hospital (catchment area) ☐ Other Psychiatric Hospital ☐

Other (specify) _____

4. Who was the referral agent?

Consultant ☐ Self-referral ☐ G. P. ☐

Relative ☐ NCHD ☐ CPN ☐

Other (specify) _____

5. What was the stated reason for referral? _____

_____

AT POINT OF ACCEPTANCE TO THE DAY HOSPITAL

6. Was the decision to admit made by one person or was there consultation with other staff members?

Consulted with ☐ Made by one person ☐

7. What were the factors influencing the decision to admit? *Please rate the following factors from 1 to 5; where 1 is not relevant and 5 is a major factor in the decision to admit.*

Psychiatric Symptoms ☐ Social Factors ☐ Domestic Factors ☐

Prevention of Relapse ☐ Observation ☐ Alcohol Difficulties ☐

Other (specify) _____

Social Factors: social deprivation or social disadvantage such as unemployment, poverty, poor housing, etc
Domestic Factors: domestic problems of physical, sexual or emotional violence or abuse

8. Please give any other reasons/details regarding the decision to admit the patient

_____

_____

9. Is the acceptance at the day hospital:

An alternative to in-patient care	Yes ☐	No ☐
To facilitate re-entry to the community from an in-patient setting	Yes ☐	No ☐
To provide a maintenance setting for a chronic illness	Yes ☐	No ☐
An alternative to day centre care due to its full capacity	Yes ☐	No ☐

Other (specify) _____

DIAGNOSIS DETAILS	**PRIMARY DIAGNOSIS**	**SECONDARY DIAGNOSIS**	**NOT PRESENT**
Organic Psychosis	☐	☐	☐
Schizophrenia	☐	☐	☐
Other Psychosis	☐	☐	☐
Depressive Disorders	☐	☐	☐
Mania	☐	☐	☐
Neuroses	☐	☐	☐
Personality Disorders	☐	☐	☐
Alcoholic Disorders	☐	☐	☐
Drug Dependence	☐	☐	☐
Mental Handicap	☐	☐	☐
Unspecified	☐	☐	☐
Phase of Illness:	Acute ☐	Chronic ☐	Neither ☐

APPENDIX 4

Patient Clinical and Demographic Information Questionnaire

PATIENT CLINICAL AND DEMOGRAPHIC INFORMATION

TO BE COMPLETED BY RESEARCHER WITH NURSING OFFICER

Day Hospital Name: _____ Admission: _____

Patient/chart number: _____ Date: _____

DEMOGRAPHIC

Gender: Male ☐ Female ☐

Date of Birth: ____/____/____

Marital Status:	Single	☐	Married/cohabiting	☐
	Separated/Divorced	☐	Widowed	☐
Living Arrangements:	Alone	☐	With Spouse	☐
	With parents/family	☐	With Friends	☐
	Hostel	☐	Other	☐
Accommodation:	Home (own)	☐	Home (not own)	☐
	Hostel	☐	Other	☐
Education:	Some Primary	☐	Completed Primary	☐
	Some Secondary	☐	Complete Secondary	☐
	Some Post secondary	☐	certificate/diploma	☐
	One or more university degree			☐
	Other _____			

Employment status immediately prior to attendance

Employment Fulltime	☐	Employed Part-time	☐
Unemployment	☐	Homemaker	☐
Study/Training	☐	Retired	☐
Volunteer	☐	Other	☐

Occupation _____

PSYCHIATRIC HISTORY

Number of acceptances to day hospital where registered _____

Previous in-patient hospitalisation Yes ☐ No ☐

Number of admissions in the past five years _____

In-patient admissions while day patient Yes ☐ No ☐

Day hospital attendances while in-patient Yes ☐ No ☐

Reasons for last in-patient admission:

Recurrence of Symptoms ☐ Depression/Suicidal Ideas ☐

Unable to Cope ☐ Other ☐

If other please specify _____

Previous treatment by out-patient department Yes ☐ No ☐

SECTOR AREA AND CATCHMENT AREA

Is the patient's current address within the day hospital catchment area? Yes ☐ No ☐

If no, what catchment area are they from (name or number)? _____

If no, why was the patient not in their own catchment area hospital? _____

_____

_____

Any Other Comments: _____

_____

_____

_____

_____

APPENDIX 5

Day Therapy Appropriateness Scale

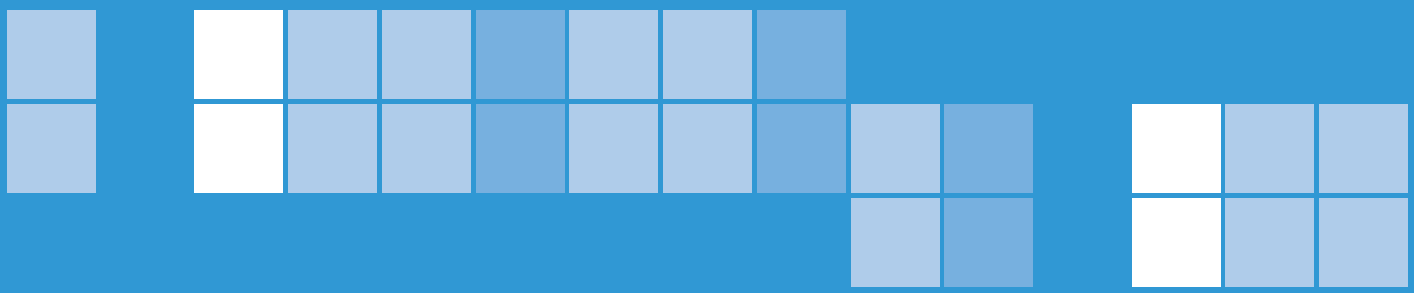
DAY THERAPY APPROPRIATENESS SCALE

Hospital Name:_____ Patient/Chart Number: _____

Date of Admission: _____ Date: _____

Directions: Rate the patient on each of the seven items listed below. For each item select the point value which most accurately describes the patient. In some instances, a point value between those provided might be most appropriate. Place the appropriate point value in the item score column to the right.

	Point Value	Item Score
1. Duration of Problem		
a. Current episode represents recent crisis. No history of previous difficulties	5	
b. Current episode represents recent crisis, but patient has experienced similar difficulties in the past	3	1._____
c. Current episode is reflection of chronic or long-term problem - no recent crisis	1	
2. Behaviour		
a. No overt psychotic or disruptive acting-out behaviour present	5	
b. Psychotic behaviour present but no disruptive behaviour evident	3	2._____
c. Disruptive, acting-out behaviour present.	1	
3. Suicide or Homicide		
a. Little suicidal or homicidal ideation – potential low	5	
b. Suicidal or homicidal ideation present but no recent attempt and no specific plan	3	3._____
c. Recent attempt and continued ideation with plan - high potential	1	
4. Alcohol or Drug Involvement		
a. No history of addiction or dependency	5	
b. History of addiction or dependency but not a recent problem	3	4._____
c. Recent problem of addiction or dependency	1	
5. Motivation		
a. Patient is highly motivated to be in treatment	5	
b. Patient has adequate motivation to be in treatment	3	5._____
c. Patient has little motivation to be in treatment	1	
6. Support System		
a. Lives with emotionally supportive family, spouse or close friend	5	
b. Lives in somewhat supportive environment or lives alone and has emotionally supportive family or friends living nearby	3	6._____
c. Does not live with emotionally supportive family or friends and none living nearby	1	
7. Transportation		
a. Able to drive a car to the centre each day	3	
b. Can arrange to get ride to and from the centre each day or is willing to take public transport	2	7._____
c. Transportation to and from the centre is uncertain	1	
Item Score Total		_____



APPENDIX 6

Brief Psychiatric Rating Scale

BRIEF PSYCHIATRIC RATING SCALE

Hospital _____ Date of Admission _____

Patient/chart no. _____ Date of Assessment _____

Instructions: This form consists of 24 symptom constructs, each to be rated on a 7-point scale of severity ranging from 'not present' to 'extremely severe'. If a specific symptom is not rated, mark 'NA' (not assessed). Circle the number headed by the term that best describes the patient's present condition.

1	2	3	4	5	6	7
Not present	Very mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe

1. Somatic concern	NA	1	2	3	4	5	6	7
2. Anxiety	NA	1	2	3	4	5	6	7
3. Depression	NA	1	2	3	4	5	6	7
4. Guilt	NA	1	2	3	4	5	6	7
5. Hostility	NA	1	2	3	4	5	6	7
6. Suspiciousness	NA	1	2	3	4	5	6	7
7. Unusual thought content	NA	1	2	3	4	5	6	7
8. Grandiosity	NA	1	2	3	4	5	6	7
9. Hallucinations	NA	1	2	3	4	5	6	7
10. Disorientation	NA	1	2	3	4	5	6	7
11. Conceptual disorganisation	NA	1	2	3	4	5	6	7
12. Excitement	NA	1	2	3	4	5	6	7
13. Motor retardation	NA	1	2	3	4	5	6	7
14. Blunted effect	NA	1	2	3	4	5	6	7
15. Tension	NA	1	2	3	4	5	6	7
16. Mannerisms & posturing	NA	1	2	3	4	5	6	7
17. Uncooperativeness	NA	1	2	3	4	5	6	7
18. Emotionally withdrawn	NA	1	2	3	4	5	6	7
19. Suicidality	NA	1	2	3	4	5	6	7
20. Self-neglect	NA	1	2	3	4	5	6	7
21. Bizarre	NA	1	2	3	4	5	6	7
22. Elated mood	NA	1	2	3	4	5	6	7
23. Motor hyperactivity	NA	1	2	3	4	5	6	7
24. Distractibility	NA	1	2	3	4	5	6	7

APPENDIX 7

Service Satisfaction Questionnaire

SERVICE SATISFACTION QUESTIONNAIRE

Day Hospital Name:_____

Male ☐ Female ☐

Age: 16–19 ☐ 20–24 ☐ 25–34 ☐ 35–44 ☐ 45–54 ☐ 55–64 ☐ 65+ ☐

Instructions: Tick the number which shows if you agree or disagree with the statement. Suppose that you mildly agreed with the statement 'I like the food' at the day hospital. Then you would tick number 4. Your answers will be treated confidently. **Please Complete the Whole Form.**

1	2	3	4	5	6
Strongly Disagree	Mildly Disagree	Unsure	Mildly Agree	Strongly Agree	Not Applic.

1.	The staff at the Day Hospital take my problems seriously	1	2	3	4	5	
2.	The treatments are good	1	2	3	4	5	
3.	I have a say and choice about the treatments I receive	1	2	3	4	5	
4.	If I have an appointment, I always have to wait a long time	1	2	3	4	5	n/a
5.	I am always able to speak to a member of staff in private within working hours	1	2	3	4	5	
6.	I like the things that I do at the Day Hospital	1	2	3	4	5	
7.	The rooms are dirty and untidy	1	2	3	4	5	
8.	I can always see/contact the staff member I want to speak to within working hours	1	2	3	4	5	
9.	I find the activities offered to me at the Day Hospital worthwhile	1	2	3	4	5	n/a
10.	There is sufficient transport to get to the Day Hospital	1	2	3	4	5	
11.	I like talking to other patients who go to the Day Hospital	1	2	3	4	5	
12.	I like telling people that I go to the Day Hospital	1	2	3	4	5	
13.	The staff are available when I want to speak to them	1	2	3	4	5	
14.	It costs too much to travel to the Day Hospital	1	2	3	4	5	n/a
15.	I have been told about the good/bad effects of my treatment	1	2	3	4	5	
16.	Staff are interested in my views about the treatments I receive	1	2	3	4	5	
17.	I like the food at the Day Hospital	1	2	3	4	5	n/a
18.	I feel that I am treated with respect	1	2	3	4	5	

1	2	3	4	5	6
Strongly Disagree	Mildly Disagree	Unsure	Mildly Agree	Strongly Agree	Not Applic.

19.	I have been told about all the treatments available to me at the Day Hospital	1	2	3	4	5	
20.	I know what I am attending the Day Hospital for	1	2	3	4	5	
21.	I am counselled in a comfortable room	1	2	3	4	5	n/a
22.	I was concerned about not being given a choice of a male or female therapist	1	2	3	4	5	n/a
23.	It is not easy to move about the Day Hospital if you are disabled	1	2	3	4	5	
24.	The reception area is nice to wait in	1	2	3	4	5	
25.	The staff know what they are doing	1	2	3	4	5	
26.	The dining area is nice to eat in	1	2	3	4	5	n/a
27.	I feel I can turn treatment down if I don't want it	1	2	3	4	5	
28.	The individual counselling is useful	1	2	3	4	5	n/a
29.	My medication is useful	1	2	3	4	5	n/a
30.	I cannot have one to one counselling if I want it	1	2	3	4	5	
31.	The reception staff are welcoming	1	2	3	4	5	
32.	The Day Hospital is too far from where I live	1	2	3	4	5	
33.	I am not worried about breaking the rules at the Day Hospital	1	2	3	4	5	

You have now finished the questionnaire. Thank you for you help.

Adapted from Turpin and Sturmey (1988) by Newnes, Ashman, Holmes, Waltho, Community Link and Shropshire Adocacy Forum.

APPENDIX 8

Consumer Opinions Questionnaire

CONSUMER OPINIONS QUESTIONNAIRE

Day Hospital Name:_____

Male ☐ Female ☐

Age: 16–19 ☐ 20–24 ☐ 25–34 ☐ 35–44 ☐ 45–54 ☐ 55–64 ☐ 65+ ☐

1. *For patients referred from the in-patient ward,* if given the choice would you have preferred to have attended the day hospital for your treatment needs without ever having to stay on the in-patient wards?

   Yes ☐ No ☐

2. *For patients attending half days only,* would you like to see the day hospital hours extended?

   Yes ☐ No ☐

3. *For patients attending full days,* do you feel that the hours of the day hospital are too long?

   Yes ☐ No ☐

4. *For all patients,* would you like the day hospital services extended into the:

   Evening Yes ☐ No ☐

   Weekend Yes ☐ No ☐

If yes, what would you feel the benefits would be? _____

_____

_____

If yes, how often do you feel you would use these extended services?_____

_____

_____

_____

5. Before you were referred were you aware of this service? Yes ☐ No ☐

6. Are your needs being met? Yes ☐ No ☐

If no, please elaborate _____

_____

_____

7. How satisfied are you with the service?

Very satisfied ☐

Somewhat satisfied ☐

Uncertain ☐

Somewhat unsatisfied ☐

Very unsatisfied ☐

8. Are you receiving any support from a voluntary group? Yes ☐ No ☐

9. In your opinion, what level of disturbed behaviour is acceptable or tolerable at the day hospital?

_____

_____

10. Do you see the day hospital as a separate entity to the main hospital? Yes ☐ No ☐

11. Are there any disadvantages to you attending this service? Yes ☐ No ☐

If yes, please elaborate _____

_____

_____

_____

12. How do you think the day hospital could improve? _____

_____

_____

_____

Any other comments: _____

_____

_____

_____ *Thank for your help.*

APPENDIX 9

Questionnaire Regarding Staff Views

QUESTIONNAIRE REGARDING STAFF VIEWS

Position Held: _____ Date: ___ /___ /___

1. What is the role of a day centre? _____

_____

_____

_____

_____

_____

2. For who is a day centre appropriate? _____

_____

_____

_____

_____

3. What is the role of a day hospital? _____

_____

_____

_____

_____

4. Do you feel this hospital is fulfilling the role you described? Yes ☐ No ☐

If no, please elaborate _____

_____

_____

_____

_____

Position Held: _____ Date: ___ /___ /___

5. For who is a day hospital appropriate? _____

6. For who is a day hospital inappropriate? _____

7. Do you consider a day hospital as having a continuous role to play in continuing illness?

Yes ☐ No ☐

8. Do you believe a hospital should provide specific treatment inputs? Yes ☐ No ☐

Position Held: _____ Date: ___ /___ /___

9. How would you feel about providing a drop-in support service for day hospital patients (a) in the evenings after hours (b) at weekends?

(a) _____

_____

(b) _____

_____

10. How would you feel about providing a seven day week day hospital ?

_____

_____

11. What changes would you like see happen in relation to this day hospital?

_____

_____

_____

_____

12. Are there any obstacles in the way of achieving these changes?

_____

_____

_____

_____

_____

Other comments: _____

_____

_____

_____

APPENDIX 10

General Day Centre Questionnaire

GENERAL DAY CENTRE QUESTIONNAIRE

TO BE COMPLETED BY RESEARCHER WITH NURSING OFFICER WHERE APPROPRIATE

Main Hospital _____

Address _____

Exact Sector Served _____

Population Served _____

Day Centre _____

Address _____

Exact Sector Served _____

Population Served _____

PART ONE: PREMISES

Description of Grounds/Immediate Surrounding Area

_____

_____

_____

_____

_____

Description of Building: Cleanliness, Physical Appeal, Appropriateness, Floor Level, Part of larger centre.

_____

_____

_____

_____

_____

Date: ___/___/___ Day Centre Name: _____

1. Tick one of the following

Owned by Health Board ☐

Rented/Leased ☐

2. Is this building classified as a temporary premises? Yes ☐ No ☐

IF ANSWER IS YES, ANS Q. 3–6, IF NO SKIP TO BELOW THE BOX

3. How long has the day centre occupied this building? _____

4. What plans are in place for relocation? _____

_____

_____

5. Has a time frame been set to achieve these plans? Yes ☐ No ☐

If yes, please elaborate _____

_____

_____

6. Is there anything delaying these plans? Yes ☐ No ☐

If yes, please elaborate _____

_____

_____

7. Are there other services operating from the same building? Yes ☐ No ☐

If yes, please elaborate _____

_____

Size of Premises _____

Number of Rooms _____

Number of Offices _____

Date: ____/____/____ Day Centre Name: _____

Purpose of Each Room

_____

_____

_____

_____

_____

Occupancy of Rooms during Each Weekday Morning and Afternoon

_____

_____

_____

_____

_____

Occupancy of Rooms on Weeknights

_____

_____

Occupancy of Rooms during Weekends

_____

_____

Size of Largest Room _____

Description of External Space _____

Size of External Space _____

Size of Internal Courtyard (if applicable) _____

Extra space needed (please elaborate) _____

_____

_____

PART TWO: PATIENT INFORMATION

Date: ____/____/____ Day Centre Name: _____

1. Number of patients 'on the books' ☐
2. Number of patients full-time ☐
3. Number of patients part-time ☐
4. Number of in-patients ☐
5. Capacity of the day centre ☐
6. Average daily attendance ☐
7. Average daily non-attendees ☐
8. Number of attendances per person per week (give range) ☐
9. Day centre opening hours _____
10. Provision of midday meal Yes ☐ No ☐
11. Number of patients who attend for meals only ☐
12. Mode of transport to hospital
    - Bus ☐
    - Train ☐
    - Minibus ☐
    - Taxi ☐

PART THREE: REFERRAL PROCESS

Date: ____/____/____ Day Centre Name: _____

1. From where do you accept a referral? Please tick the appropriate box(es)

General Practitioner ☐ Out-Patient Department ☐

Sector Psychiatrist ☐ Other Psychiatrist ☐

Day Hospital ☐ Other (please specify) _____

2. Is there a formal referral process? Yes ☐ No ☐

If yes, please outline _____

_____

3. Is there a referral form? Yes ☐ No ☐

If yes, who is required to complete it? _____

4. Is there a formal assessment once referred? Yes ☐ No ☐

If yes, who is required to complete it? _____

If no, how is the appropriateness of a referral decided? _____

_____

5. Is there a waiting list? Yes ☐ No ☐

If yes, how long is it? _____

6. Do patients simultaneously attend other services? Yes ☐ No ☐

(i.e., out-patients or in-patient wards) If yes please elaborate which services patients attend

_____

7. To where are patients discharged? Please tick the appropriate box(es)

Home ☐ Hostel ☐

Specialised Programme ☐ In-patient Ward ☐

Day Hospital ☐ Out-patients ☐

Other _____

PART FOUR: STAFFING

Date: ____/____/____ Day Centre Name: _____

Please list day hospital staff members and state whether he/she is full-time,

part-time or sessional plus his/her availability _____

Please list staff that offer their services to the day hospital and state their availability

Date: ____/____/____ Day Centre Name: _____

1. What other staff are available at the day centre? Please include administration/bus driver, etc.

_____

_____

2. How long has each staff member been employed in his/her present position?

Please list individually.

_____

_____

_____

_____

_____

_____

3. What extra staff is required? _____

_____

_____

_____

4. Are staff members compensating for other skill shortages? Yes ☐ No ☐

If yes, please elaborate as specifically as possible _____

_____

_____

5. Do staff claim expenses from this building? Yes ☐ No ☐

If yes, please list staff that do so _____

_____

_____

6. Is day centre located in the same premise as the day hospital? Yes ☐ No ☐

Date: ____/____/____ Day Centre Name: _____

7. Is the day centre staff shared with the day hospital staff? Yes ☐ No ☐

If yes, who is shared and does this ever pose a problem? _____

_____

_____

_____

8. Are there staff shortages – does this ever impose safety implications? For example, during holiday periods, etc. Yes ☐ No ☐

If yes, please elaborate _____

_____

_____

_____

PART FIVE: ACTIVITIES AVAILABLE

Date: ____/____/____ Day Centre Name: _____

1. Do the patients take part in contract work? Yes ☐ No ☐

If yes, what type of work is it? _____

_____

_____

If yes, how much do patients get paid? _____

2. Please list other *activities* provided _____

_____

_____

_____

3. How much input does the patient have with regard to their daily programme?

_____

_____

_____

4. What other appropriate facilities are available in the community?

_____

_____

_____

5. Where do patients attend for prescriptions? Is this service provided at –

Day Centre Yes ☐ No ☐

Out-patients Yes ☐ No ☐

G.P. Yes ☐ No ☐

Other (specify) _____

Any Other Comments: _____

_____

_____

APPENDIX 11

A Participative Planning Process

A PARTICIPATIVE PLANNING PROCESS

This appendix outlines the eight stages in a framework which supports user-mediated involvement in building, planning and design published by the European Foundation for the Improvement of Living and Working Conditions in a document entitled *Building for People in Hospitals: Workers and Consumers* (Moran *et al.*, 1990). The objective of the framework is to facilitate buildings to meet the needs of their users. For each stage one or more main objectives are presented (O), examples of typical methodologies are provided (M) and the participants involved (P) in the process are specified. Most stages involve the participation of users and designers. The participation is best mediated by an environmental psychologist. Certain stages also require the participation of building committees, facility managers and/or building managers. The framework is illustrated below (see Figure 1.1).

The first stage labelled the 'planning stage' involves the elicitation, clarification and negotiation of objectives of the building through methods such as drawings, film or focused group discussions. The second stage, the 'pre-briefing stage', examines buildings that share similar objectives with a view to identifying successful and unsuccessful elements. This stage often involves physically visiting and examining similar buildings. The 'briefing stage' involves eliciting the needs of the users from the users by means such as design games or spatial workshops. It is important that in the next stage, the 'pre-design stage', that the results of the proceeding research is communicated to the designer effectively and comprehensively. During the 'design stage' the designer should inform the user of the proposed design and a feedback–feedforward process should be initiated and continued until all parties are satisfied with the design result. In order to facilitate the 'occupancy stage', manuals and workshops should be provided. Building performance can be further improved by conducting an evaluation during the 'post occupancy stage'. In the last stage, the 'building in use stage', continuous audits are proposed, as no organisation is static. As objectives and goals change, the building will need to accommodate these changes.

Figure 1.1. Stages and Strategies : A Framework for User Input to the Built Environment

1 Planning Stage

O Elicitation, clarification & negotiation of objectives, policies...

M Brainstorming, Facilitated Workshops...

P Building Committee, Users, Designers, EP

2 Pre Briefing Stage

O Identify possible (un)successful design features in similar buildings/organisations

M Indicative Evaluations – Touring Interview...

P Management, Users, EP

3 Briefing Stage

O Identification of organisational, user etc. images, needs, aspirations. Formulation of design guidelines

M Place Briefing – Activity Analysis, Design Games...

P Representatives of all User Groups, EP

4 Pre Design Stage

O Communication & negotiation of brief, Liaise with designers

M Visual Presentation of Research Findings, Workshops...

P Designers, Users, EP

5 Design Stage

O Review organisational, social, behavioural implications of design proposals & decisions & Assess conformity to the brief

M Design Review Questions, Annotated Plans...

P Designers, Users, EP

Construction of Building

6 Occupancy Stage

O Guide efficient use of spaces provided & facilitate necessary adaptions

M Occupancy Manuals, Occupancy Seminars, Consultancy...

P Users, Facility Managers, EP

7 Post Occupancy Stage

O Feedback performance information – (un)successful design features

M P.O.E. – Socio-Spatial Performance Assessment...

P Users, Management, Designers, EP

8 Building in Use Stage

O Feedback information from ongoing monitoring & evaluation of building-in-use

M Person–Place Audits

P Users, Building Managers, Designers, EP

O: Chief Objective(s) M: Typical Methods P: Typical Participants EP: Environmental Psychologist

(Moran et al, 1990)

APPENDIX 12

Calculation of Number of Day Hospital and Day Centre Places Required

Sources of information

The number of day hospital places required was estimated on a national basis. The calculations will vary according to local circumstances. For this reason the number of day hospital places was also calculated for a sample catchment area. The name of this catchment area has been withheld for reasons of anonymity. Data were utilised from a number of sources each of which are outlined below.

Health Research Board - Activities of Irish Psychiatric Services, 2000

Data from the *Activities of Irish Psychiatric Services* 2000 published by the Health Research Board in 2001 were extracted (Daly and Walsh, 2001).

- There were 20,908 admissions to health board hospitals and units in 2000
- 93% (19,442) of admissions were for a period of three months or less
- There were 1,192 day hospital places in the Republic of Ireland in 2000
- There were 804 admissions to the sample catchment area inpatient hospital in 2000
- 90% (724) of the above admissions were for a period of three months or less.

Health Research Board - Irish Psychiatric Hospitals and Units Census, 2001

Data from a census of psychiatric hospitals and units conducted by the Health Research Board in 2001 were extracted (Daly and Walsh, 2002)

- Nationally, the average length of stay for patients hospitalised for up to three months was 26 days.

Health Research Board - The Present Study

- Only 6% of patients attending day hospitals from two health boards were suffering from an acute illness.

Information from the Literature

- According to reports in the literature between 30% and 40% of acutely ill patients could be solely treated in the day hospital (Creed *et al.*, 1990; Kluiter *et al.*, 1992; Schene *et al.*, 1993)
- The average length of stay in a Kildare day hospital was 30 days according to Joseph *et al.* (1996).

The Central Statistics Office - Population characteristics 1996

The latest information from the population census conducted by the Central Statistics Office relating to the population of Ireland for the year 1996 was employed (CSO, 1996).

- The total population of Ireland was 3,626,087.

Number of acute day hospital places required on a national basis

The number of required day hospital places was calculated using a medium-sized sector of 35,000 people. The percentages relating to service usage outlined above were applied to this population of 35,000. The method of calculation is outlined below. Please note the results are calculated for a year.

Number of Day Hospital Days Required per Year for Inappropriately Placed Inpatients

National number of admissions in health board hospitals and units, 2000	20,908
Number of admissions with a stay of three months or less, 2000	19,442
Number of admissions that could be treated solely in a day hospital (taking the mid-point of 30% and 40%)	35% of 19,442 = 6,805
Number of days required per year in the day hospital	6,805 x 30 = 204,150
Number of places required per day	204,150/252 = 810

Number of Day Hospital Days Required per Year for Discharged Inpatients

Number of inpatient admissions that could be transferred to day hospitals as a step-down facility	19,442 – 6,805 = 12,637
If the average inpatient stay is shortened from 26 to 20 days and each patient spends these 6 days in a day hospital then we assume 12,637 admissions per year will need a length of stay of 6 days	12,637 x 6 = 75, 822
Number of day hospital places required per day	75,822/252 = 301

Number of Day Hospital Places Required for Appropriately Placed Day Patients

National number of day hospital places in 1999	1, 192
Number of day hospital places appropriately used	6% of 1,192 = 72
Total number of places needed on a full-day basis	**810 + 301 + 72 = 1,183**
Number of places required per sector of 35,000	**1, 183/3,626,087 x 35,000 = 11**

Number of acute day hospital places required for a sample catchment area

Once again the number of required day hospital places was calculated using a medium-sized sector of 35,000 people. The percentages relating to service usage outlined above were applied to this population of 35,000. The method of calculation is outlined below. Please note the results are calculated for a year.

Number of Day Hospital Days Required per Year for Inappropriately Placed Inpatients

Number of admissions in 2000	804
Number of admissions with a stay of three months or less in 2000	724
Number of admissions that could be treated solely in a day hospital (taking the mid-point of 30% and 40%)	35% of 724 = 253
Number of days required per year in the day hospital	253 x 30 = 7,590
Number of places required per day	7,590/252 = 30

Number of day hospital days required per year for discharged inpatients

Number of inpatient admissions that could be transferred to day hospitals as a step-down facility	724 – 253 = 471
If the average inpatient stay is shortened from 26 to 20 days and the patient spent 6 days in a day hospital then we assume 471 admissions per year will need a length of stay of 6 days	471x 6 = 2,826
Number of day hospital places required per day	2,826/252 = 11

Number of Day Hospital Places Required for Appropriately Placed Day Patients

Average daily attendance	34
Number of appropriate attendances per day	6% of 34 = 2

Total number of places needed on a full-day basis for a population of 95,200	**30 + 11 + 2 = 43**
Number of places required per sector of 35,000	**43/95,200 x 35,000 = 16**

Calculation of the number of day centre places required

Sources of information

The sources of information used to calculate the number of day centre places are outlined below.

The Central Statistics Office – Population Characteristics 1996

The latest information from the population census conducted by the Central Statistics Office relating to the population of Ireland for the year 1999 was employed (CSO, 1996).

- The total population of Ireland was 3,626,087.

Activities of Irish Psychiatric Services, 2000 (Daly and Walsh, 2001)

- In 2000, there were 2,427 day centre places and 5,231 people availing of these places
- 17,516 persons attended a day hospital

Irish Psychiatric Hospitals and Units Census, 2001 (Daly & Walsh, 2002)

- 2,316 inpatients had a stay of one year or more.

The present study

- 32% of patients attending day hospitals were suffering from a chronic illness and were not experiencing acute symptoms.

Number of day centre places required on a national basis:

The number of day centre places required was also calculated using a medium size sector of 35,000 people. The percentages relating to service usage were applied to this population of 35,000. Please note the results below are calculated for a year.

Number of patients attending day hospitals who are better suited to day centre care	32% of 17,516 = 5,605
Total requiring day centre care	5,605 + 5,231 + 2,316 = 13,152
Percentage of total population requiring care	13,152/3,626,087 = 0.36%
Number of patients per sector requiring care	0.36% of 35,000 = 126
Level of care day centre patients received in 2000	2,316/5,231 = 0.44
If patients continued to receive this level of care, number of places needed per sector	126 x 0.44 = 55
Total number of day centre places	**55**

Total number of day care places required

Based on the national calculations outlined above, 11 day hospital and 55 day centre places are required for a population of 35,000. Thus, in total, 66 day care places are required for a population of 35,000. In terms of rates per 1,000 population, this would mean 1.88 day care places are required. This figure is fairly close to the figure recommended by the Inspector of Mental Hospitals. In 2001 the Inspector of Mental Hospitals suggested that the planning guideline be put at 1–1.5 day care places per 1,000 population (Department of Health and Children, 2001). More specifically, our calculations suggest that 0.31 day hospital places and 1.57 day centre places per 1,000 population are required. It is important to note that rates will vary according to local circumstances.