The changing role of Ards Mental Health Day Hospital

Helen J. Harbinson

There has been a great deal of debate and uncertainty about the role of day hospitals. The current emphasis is on their use as an alternative to acute-in-patient care. There are, however, difficulties with this approach. This paper looks at developments in service provision in a day hospital in Northern Ireland, where the focus is on multidisciplinary assessment and group and sessional treatment, rather than day care.

Ards Mental Health Day Hospital opened in 1989. It is an attractive, single-storey, 40-place Unit, situated in the grounds of a district general hospital, close to the mental health in-patient unit. Before 1989 day care was provided in the form of occupational therapy in rather antiquated premises at the back of the hospital. The opening of a new day hospital, and the appointment of nursing, occupational therapy, and medical staff allowed an opportunity for a fresh look at the service.

A key change has been the development of a multidisciplinary team to assess and treat new referrals. The team consists of the day hospital sister, two members of nursing staff, an occupational therapist, a senior house officer, senior registrar, consultant, psychologist and social worker. All general practitioner referrals are allocated to particular members of the team on the basis of the information provided in the referral letter.

The aim is, as far as possible, to try and place each patient with the appropriate therapist at the outset. Each week four members of the team simultaneously see four new patients for approximately an hour and a half each. Afterwards the team meet to discuss the patients and a problem-orientated treatment plan is drawn up. The consultant sees the four patients individually the following week (while the other staff are assessing four further new patients) and finalises their treatment plans.

Staff inform patients of the clinic procedure prior to the initial appointment, and ask them to confirm attendance. Each member of the multidisciplinary team carries out a structured interview on a standard form, and this is included in the patient's notes, together with a type-written problem sheet and treatment plan. The team member who first sees the patient writes a brief letter to the general practitioner immediately afterwards, and the consultant also writes the following week.

Each patient is regularly discussed at fortnightly review meetings, and seen by the consultant prior to the conclusion of treatment, or more often if necessary.

There are advantages for all concerned in this system. The patient benefits from a thorough assessment, with consultant contact and supervision. The maximum waiting time is three weeks.

The GP refers to a team, rather than a specific mental health professional. This relieves the GP of the responsibility of making an accurate diagnosis, and deciding on an appropriate therapist, and also tends to reduce the stigma which both patients and GPs attach to referral to a psychiatrist. We also hope that referral to a team will discourage competition between providers of psychiatric services.

While the consultant retains overall responsibility, each member of the team is responsible for the treatment he or she carries out, and this degree of autonomy greatly adds to job satisfaction. There is also the opportunity for support and supervision from other team members. The consultant benefits by having time available to supervise the care of many patients, rather than carry out individual treatment with a few.

These are troubled times for day hospitals. A narrower definition of their role is emerging, with the focus on acute care (Creed *et al*, 1990). Clinicians and patients alike, however,

https://doi.org/10.1192/pb.19.11.663 Published online by Cambridge University Press

have proved resistant to the idea of day treatment, as opposed to in-patient treatment (Creed *et al*, 1989). In our case there are very real practical difficulties, because the catchment area is widespread and rural, and there is limited transport available. It could be argued that any patient well enough to travel to the day hospital is unlikely to require acute care.

Hoge *et al* (1992) suggest that future research should concentrate on day hospitalisation v. intensive out-patient intervention, rather than day hospitalisation v. in-patient care. We have found ourselves moving in the direction of using the day hospital as a focus for assessment and intensive treatment. Adequate accommodation for interviews and treatment, together with a wide range of therapies and therapists, make it eminently suitable for this.

What we offer is not the traditional treatment available at out-patient clinics, with patients reviewed at 15 minute intervals by junior psychiatrists, who change every six months. In the day hospital the same therapist sees a number of patients once a week or once a fortnight, for a minimum of an hour. In addition, we provide group sessions, occupational therapy, and a range of social and leisure activities. Once a month we hold a clinic with the local Disablement Employment Adviser and Job Placement Officer from Industrial Therapy. The patients' occupational histories are considered, together with their present level of functioning, and they are offered appropriate training schemes or employment opportunities.

Very few patients attend the day hospital five days a week. Most come for specific activities on particular days. We suggest that it is not necessary or desirable for a patient to attend 9 a.m. to 5 p.m., five days a week to obtain maximum benefit, or to prevent admission to the ward. The difficult and stressful times for patients are often not 9 a.m. to 5 p.m., but evenings and weekends, when day hospitals, even those which function as alternatives to in-patient treatment, are not open. We are able to cater for all patients, unless they are a danger to themselves or others, severely disturbed or in need of respite because of their social or family situation.

At present, 50 patients attend the day hospital under the care of the multidisciplinary team. Of these, 10 have a psychotic illness, 23 a neurotic disorder, 16 a personality disorder, and one an organic disorder. Twenty-three were admitted to the day hospital as an alternative to the in-patient unit. Forty are unable to work because of illness.

We use the FACE outcomes project to assess improvement in quality of life of patients following treatment (Quinn *et al*, 1992). Considering psychological, life skills, social and physical measures, for the last 45 patients discharged, 21 were rated on admission as very seriously and severely disabled, 14 as moderately disabled, and 10 as having a mild disability. Improvement was noted in all but six cases. Discharge ratings for the 45 patients were as follows: seven severely disabled, 11 moderately disabled, 19 mildly disabled, and eight with no problems.

There are particular aspects of the service with which both patients and GPs express satisfaction. These include the short waiting times for appointments and consultant assessment in every case. None of the patients has ever complained about having to come for assessment interviews on two successive weeks, and almost always both appointments are kept. Patients appreciate the information they receive before they attend, and GPs welcome prompt letters after each assessment.

Our mental health service is block funded, and costs per patient contact are not available as yet. It is obviously cheaper for patients to have most of their treatment sessions with staff other than the consultant. We anticipate that this, together with the increased numbers of patients seen, will more than compensate for the costly aspect of treatment, the regular team meetings.

The boundaries between day hospital care and intensive out-patient treatment are not clear-cut. The essence of a successful mental health service is multidisciplinary team assessment and treatment, a range of therapies, adequate facilities in which to carry them out, and the maintenance of the patient in the community with back-up beds as necessary. Rigid definitions of out-patient and day hospital treatment are best set aside in favour of a more flexible needs-led rather than service-led approach.

References

CREED, F., BLACK, D. & ANTHONY, P. (1989) Day hospital and community treatment for acute psychiatric illness, a

https://doi.org/10.1192/pb.19.11.663 Published online by Cambridge University Press

critical appraisal. *British Journal of Psychiatry*, **154**, 300–310.
—, —, —, *et al* (1990) Randomised controlled trial of day patient versus in-patient psychiatric treatment. *British Medical Journal*, **300**, 1033–1037.
HOGE, M. A., DAVIDSON, L., HILL, W. L., *et al* (1992) The promise of partial hospitalisation: a reassessment. *Hospital and Community Psychiatry*, **43**, 345–354.
QUINN, P., CROTHERS, M., DOLAN, A., *et al* (1992) FACE-ing up to quality. *International Journal of Health Care Quality Assurance*, **5**, 17–24.

Helen J. Harbinson, *Consultant Psychiatrist, Mental Health Unit, Ards Hospital, Church Street, Newtownards, Co Down BT23 4AS*

https://doi.org/10.1192/pb.19.11.663 Published online by Cambridge University Press