neurotic to incapable?

These three example treatments illustrate the complexities of our responsibilities. The readership may hope for early classification outside the Law Courts. To do our best and be wrong is bad enough, but to do our best to a patient who is sure we are wrong, and be wrong, is worse, and in such circumstances it is even more difficult to be right. On the other hand we are presented with the problems in such circumstances, and we have to handle them.

J. A. FLOWERDEW

Shrewsbury Hospital
Bicton Heath, Shrewsbury

Sorting out the confusion in psychiatric day care

DEAR SIR

Philip Vaughan, in his recent article (*Bulletin*, October 1983, **7**, 184–5), rightly highlights the current confusion over the functions of psychiatric day care in this country. However, there is, in fact, evidence in the literature which could dispel the confusion.

There are numerous studies demonstrating the value of day hospital care as an alternative to in-patient admission,[1,2,3] although none is as impressive as the study Vaughan cites.[4]

Family burden has been specifically investigated in an important controlled study by Herz and colleagues in the United States, in which day care was used in conjunction with a policy of brief hospital admission for acutely ill patients.[5] Burden was lower for the families of patients offered a combination of brief in-patient admission and transitional day care than for families of those offered standard (prolonged) in-patient treatment. Similar findings are reported by Hirsch in the UK.[6] Turning to day care for the chronic (psychiatric) patient, there is abundant evidence as to its utility in both improving the quality of life and preventing relapse in schizophrenic patients.[7] Interestingly, the most effective units are those concentrating on 'recreational' rather than 'therapeutic' activities.

Much less researched is the use of day care for neurotic illnesses. However, one controlled study showed no advantage of day care as opposed to out-patient treatment for newly-presenting neurotic patients.[8] Its authors concluded that out-patient treatment was to be preferred. (There is, however, evidence that for chronic neurotic disorders a community psychiatric nursing service may be preferable to psychiatric out-patient care.[9])

One reason for the difficulty in rationally planning psychiatric day care within a district is the artificial distinction between hospital and social service provision. There needs to be close communication between day hospitals and day centres, with the opportunity for interchange of both patients and skills between units. The need for communication also applies to residential facilities, as local authorities take on responsibility for many who, in the past, would have occupied a long-stay hospital bed.

Perhaps the future lies in a Mental Illness Service, distinct from both Health and Local Authorities.

FRANK HOLLOWAY

King's College Hospital
Denmark Hill, London SE5

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DEAR SIR

Phillip J. Vaughan (*Bulletin*, October 1983, **7**, 184–5) rightly draws attention to the confusion surrounding day care. He points to the enormous variety of kinds of day hospital serving almost every kind of patient, and observes that day hospitals frequently offer treatment that is hardly different from that offered in nearby in-patient units. The style often reflects the ideas and personality of the consultant in charge rather than 'a systematized part of a complete whole'. However, exactly the same comments can be made about in-patient care.

There is very little research of an adequate standard addressing the questions that Mr Vaughan raises, so units are bound to evolve according to hunch and habit. Braun *et al.*[1] reviewed controlled outcome studies of alternatives to hospital admission, modifications of conventional hospitalization, and alternatives to long-term hospitalization for the period 1966 to 1978. They found only two studies of day care, seven studies of other alternatives to hospital admission, and six studies of modifications of hospital admission.