The role of the psychogeriatric day hospital*

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In the current climate of the implications of the Community Care Act and health service reforms, defining the role and function of the psychogeriatric day hospital is crucial, particularly its distinction from day centre care. This paper describes this role and key issues in day hospital planning. It was presented to the Wessex Specialists in Old Age Psychiatry and accepted by them as a consensus document.

Twenty years ago the growing awareness of the old age mental illness problem prompted the government to issue guidelines of two to three places per day for 1000 elderly population for the day hospital, figures which were never reached (DHSS, 1975) although supported still by the Royal College of Physicians and Royal College of Psychiatrists in their report in 1989. This was the golden era of expansion in provision with the creation of services nationwide. Indeed so central to the theme of psychogeriatric services was the day hospital that some districts purported to operate with no need for in-patient beds. The main functions of the day hospitals have always been seen by consultant psychogeriatricians as assessment, treatment, and the maintenance of the person within the community.

An important divergence in approach began to show with the geriatric day hospitals striving to achieve rehabilitation to independent living or, failing that, rapid discharge to some form of social care, as opposed to psychogeriatric day hospitals where numbers of patients were attending for four or five days a week for long periods, forcing the hospital into the role of social care as well. Without effective joint planning of resources with local authorities the blurring of day centre and day hospital roles occurred. The apparent overlap and lack of definition has been criticised by Ball (1993) who argues that the age of the day hospital may well be over as new forms of care provision are evolved and evaluated in the new political climate. Arguing that the day hospital model is limited, Ball urges greater audit of their function. Day hospitals for the elderly mentally ill have grown despite the paucity of research evidence of their efficacy (Macdonald *et al*, 1982). Research is needed to show which diagnostic groups would benefit; outcome measures for interventions made or support given; the mix of staff skills and the community support required for success (Beats *et al*, 1993).

What is clear is that day care provision is the most common form of respite support of carers with dementia (Moriarty *et al*, 1992). Ninety per cent of carers in their series considered that it made their lives better and over one half wanted more of it. The availability of day care is a critical factor in the development of community care. It is essential that the role of the day hospital and its distinction from day centre care be clearly defined both in its patient mix and the staff ratio and skills. The provision of services for the elderly mentally ill should be 'needs led'.

The characteristics of patients' needs most likely to be met in a psychogeriatric day hospital

Functional illness

(a) Assessment and management of acute functional illness, especially depressive illness where patients need skilled professional intervention, psychotherapy (dynamic, supportive or cognitive), anxiety management, social skills training, speech therapy, art therapy and close supervision of medication where the patient may not be suitable (or refuse) in-patient care. Participation in specialised group activities, e.g. bereavement, will enhance the patient's ability to express and share feelings with other patients. A system of case review and goal setting will encourage progress.

(b) Maintenance treatment of high risk or vulnerable patients whose needs of regular management review demand day hospital attendance over long periods, and with it may avoid a move to more sheltered and dependent care.

(c) Enablement of patients being discharged from in-patient care, continuation of

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treatment model using the day hospital facility for offering greater patient independence and self-determination, often as part of a graded programme in vulnerable patients who have experienced a prolonged illness and admission.

Organic illness

(a) Assessment and management of patients suffering from dementia, where diagnosis needs to be clarified by detailed medical, nursing and remedial therapy evaluation and thus the setting up by case review of a management package in partnership with local authority involvement. In patients with acute confusional illnesses, a day hospital may provide the environment for improvement by resolution of the underlying cause (usually physical or sometimes depression).

(b) Provision of long-term support for those cases of severe dementia assessed in (a) and found to have continued high dependency needs of skilled day hospital care:
   (i) behaviour disturbance e.g. challenging, severe restlessness, stealing etc.
   (ii) behaviour dependency e.g. incontinence of urine, inappropriate micturition, inability to feed self, dress, comprehend instructions, or need for enemas to contain faecal incontinence.

   The aims of the attendance are the provision of high levels of care, maintenance of skills where possible and the provision of respite to the carers.

(c) Treatment possibilities in dementia; advances in drug treatments in dementia, particularly agents like THA with its need for close supervision and regular checks on liver function tests, may place the psychogeriatric day hospital at the front of services being developed to meet this likely new and large demand.

Key issues in day hospital planning

Siting and transport

The establishment of day hospital facilities need not be hidebound by the blueprint devised in the 1970s. The primary concern should be accessibility to the patients. In densely populated areas the day hospital may occupy a fixed venue and the provision of care can be varied daily to suit patient mix and therapy needs, e.g. the separation of functional from organic patients attending on different days, each requiring a different treatment programme. Ideally there should be separate functional and organic day hospitals.

In less populated areas, zoning of attenders by their accessibility to transport will determine a variable patient mix on each day. The 'travelling day hospital' at Moorgreen Hospital and that in Portsmouth, take the patient and staff to a temporary day hospital, each day a different venue and different patients. This model works very well especially in more rural situations.

The type of transport is crucial and should be appropriate to the mobility needs of the patients needing to come. Very dependent patients may need two man vehicles with a tail lift or wheel chair facilities. Depressed immobile patients may need the specialist input of the psychogeriatric day hospital.

Flexibility

The day hospital should be responsive to patient and carer need in both individual treatment package and respite. Some patients with specific treatment programmes may require attendance for only part of days, e.g. to attend for psychotherapy groups, administration of depot injections etc. Patients with dementia may need to be brought early or picked up late by carers to fit in with demands of employment. Extension of day hospital opening to include weekends provides carers with the opportunity of seeing their families and is valued particularly for offspring carers. Provision on bank holidays should also be evaluated. A particular advantage of a day hospital is the opportunity for the professionals to extend the therapeutic environment to the patient's home by home visits on non-attendance days.

Liaison

The potential for liaison between other forms of day care exists: the geriatric day hospital where the focus may be on immobility; the specialised day centre where staff from the psychogeriatric day hospital will visit and train coordinators and volunteers to cope with more dependent attenders; and day centres, both local authority and independent/private.

Close links in the coordination of planning of these different services will permit seamless care where agreed criteria for attendance allow no one to fall between services – a day hospital being the venue for treatment and enablement plus the support of the most dependent population.

Scale of provision

A feature of Moriarty & Levin's findings was that although the most common form of respite, the majority of patients attended for two or less days in a week and a significant number attended two or more different venues, e.g. day hospital one

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day, day centre another. This may be because patients' needs may be met in this complex way but is more likely a reflection of the scarcity of provision so that each care manager is obtaining support wherever possible. Jolley & Arie (1992) suggest that the scale of provision depends on local factors such as bed and day centre availability. It is certain that to function as it should as a treatment and rehabilitation centre the day hospital must have access to some in-patient beds and day centre places. The recommendation of two to three places per day per 1000 elderly population by the joint colleges has not been challenged nor met within the Wessex Region. It is for each unit to identify the scale of need.

Staffing requirements – day hospital

The following is the ideal staffing requirement for a day hospital catering for 25 day places. It is estimated that there will be 80% occupancy due to patients away in hospital, respite care, illness etc. Twenty patients will attend daily.

Where population density permits there should ideally be separate functional and organic day hospitals. Days could, less ideally, be divided into organic and functional in less populous areas with specific programmes for each. The actual staffing levels will remain the same though the skill requirement will be different.

For a five day week day hospital

1.0 WTE nurse manager	G Grade
1.0 WTE nurse	E Grade
1.3 WTE nurse	D Grade

3 support workers A Grade covering hours of attendance of patients

1.0 WTE senior OT

Medical: non-consultant (under supervision of named consultant) five sessions and one session for community follow-up and liaison

Admin/clerical	0.8 WTE HCO
Clinical psychologist	As required from the service
Art therapist	
Physiotherapy	
Chiropody	
Psychotherapy supervision	

The day hospital as a resource centre

The day hospital is a prime venue and is in a key position to act in a central role in providing information and advice in care of the elderly mentally ill. Its greater access to community patients and primary health care teams will enable the development of this role partly through the case conference system and teaching sessions. The siting of community psychogeriatric nurses' offices in or close to the day hospital and using it as a venue for carers support groups will help also.

Fee paying

Local authority day centres charge for attendance to cover part of cost of transportation and meals. Private day facilities may charge £20–£30 per day. NHS day hospitals are free. There is a dilemma over discharge of patients from day hospitals to day centres, and carers and patients may refuse attendance because of this. This issue is not addressed in care management planning, where packages are means tested and passed on to clients. The principle of treatment and rehabilitation is crucial in the day hospital. In due course the Department of Health may seek ways of establishing a charging policy for hotel and transport services. It must be remembered that many attenders at psychogeriatric day hospitals are, at first, reluctant to attend. A charging policy, even a heavily subsidised one, may prove a significant barrier to patient attendance.

Physically dependent patients with psychiatric illness

A traditional demarcation between geriatric day hospital and psychogeriatric day hospital has been the mobility of the patient. It tends to overlook the physically dependent patients, e.g. stroke sufferers who may be experiencing severe grief and depressive reactions to their loss. Although responsive to training, the nurses in the geriatric day hospital may not have sufficient skills to cope with what may prove ultimately a significant barrier to rehabilitation. The psychogeriatric day hospital may in fact be the better venue, a flexible approach with good liaison between the units is essential. However, an unduly large minority of physically impaired patients will detract from the psychological care provided for the majority of patients.

Summary

(a) The day hospital is a prime venue for assessment, treatment and rehabilitation of patients.
(b) Its role in relation to day centres should be clearly defined.
(c) Its approach should be flexible and needs led.
(d) It can be situated in a fixed place or moveable to different locations.
(e) It is a centre for training and good liaison with other professionals and carers.

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(f) The scale of provision should be adequate to the local situation and the staffing levels appropriate to its treatment and rehabilitation role.
(g) The process and outcome should be subject to regular audit and review.

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Attitudes towards mental illness and the elderly*

Robert Cohen, David Kennard and Brice Pitt

Views of the elderly were obtained from a cross-section of the public using 12 semi-structured interviews in the form of stratified group discussions. As a group, the elderly were generally thought of in negative terms. Furthermore, they were held partly responsible for their perceived status, in particular by failing to keep physically active and to avoid mental deterioration and depression which were not considered conditions requiring treatment. In contrast, Alzheimer's disease was recognised as a disease, and sympathy was expressed for patient and carer. It was expected that responsibility for caring for the elderly mentally ill should pass to the State once the burden on carers became intolerable.

If community care is to succeed, the community has to care: the pious utterances of politicians of uncertain sincerity are not enough. With an ageing society, care in the later years will remain a lottery if those whom statutory planners presume will offer such informal care do not see themselves as having such duties or obligations. How, therefore, are the elderly seen by the community? The College has commissioned a qualitative study into public attitudes towards the elderly, which we report in this article.

*Report of the Royal College of Psychiatrists (Section for the Psychiatry of Old Age) study.

The study

Twelve semi-structured interviews in the form of group discussions lasting 1–1.5 hours were held throughout the country. Each group consisted of six to eight volunteers, with four groups in each of the age ranges 20–30, 45–55 and 60+. Of the four groups in each age band, two were male, two female, and two groups were of the social class ABC1 (people in professional and administrative occupations, employers in industry and non-manual skilled workers) and two of social class C2DE (people in manual skilled, partly skilled or unskilled occupations). Views on various aspects of the elderly were obtained.

Findings

Attitudes towards the old/elderly

Younger respondents described old age in terms of external appearance (wrinkled skin, white hair/baldness) and personality (grumpy, arrogant, intolerant of others), whereas older respondents described age in terms of life-style (degree of activity, independence, finances, employment, marital status). For younger respondents, old age started at 60–65, but for older respondents it was

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