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Day care and a hostel – a cost effective approach*

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In order to plan a comprehensive psychiatric service for County Clare, it was necessary to divide the county into four sectors, North, East, South and West. The area I am discussing is the West Sector, which covers 800 square kilometres and has a population of 20,000. Kilrush town is the capital of the West Sector situated 50 kilometres from the main hospital in Ennis. Psychiatric morbidity was noted to be high in this rural area. Prior to opening a Day Hospital in Kilrush (May 1986) we were using 15 beds in the acute unit. Now we are using, on average, five beds at any given time.

The total treatment model includes a supervised hostel where beds were used during the first three years for crisis intervention and assessment (Fig. 1). Work placements in various local businesses and industries, and a horticultural training programme located in the grounds of the day hospital, have been substituted for sheltered workshop activity. The resource groups have been used in place of a day centre.

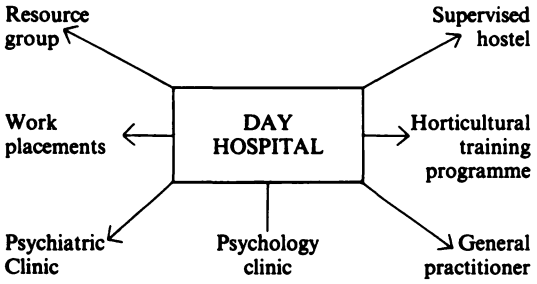

FIG. 1 Treatment model

The philosophy of the Day Hospital is to focus on the treatment of acute psychiatric illness, with a multidisciplinary approach. The clinical team includes the consultant psychiatrist, clinical psychologist, senior house officer, occupational therapist (all part-time), the nursing officer, community psychiatric nurse and two staff nurses (all full-time). Building up team identity was a major task in the initial stages. Nursing staff had spent several years working in a segregated setting. Interprofessional rivalries surfaced, as staff members were uncertain of their roles. Training sessions were vital in the transition from institutional to community psychiatry. From the beginning, two hourly psychotherapy seminars on a two-weekly basis were facilitated by the clinical psychologist. Emphasis has been on individual, marital and family therapy. Video feedback and role play is used.

Strict criteria for admission, assessment and after care have proved invaluable. No patient is admitted to the Day Hospital without prior discussion by the multidisciplinary team and approval by the consultant psychiatrist. This includes emergency referrals who are accepted at the time of referral but not formally admitted until approval at the weekly team meeting. Each patient is then assigned a nurse therapist who acts as an 'anchor' for the patient. Assessment of all patients takes three weeks and includes a nursing, occupational therapist, psychological and psychiatric/medical assessment. The latter is carried out by the senior house officer, in liaison with the patient's GP.

Total assessment is followed by a discussion on the direction of subsequent therapy. A primary therapist is then assigned to each patient. The primary therapist acts as overall co-ordinator of the patient's therapy and progress. No patient is discharged without discussion at the multidisciplinary team meeting and approval by the consultant psychiatrist. The nurse therapist sends an immediate report to the GP on the day of the patient's discharge. This is followed by a report from the senior house officer, including a psychodynamic formulation.

In addition to catering for the in-patients attending the generalised programme described, we found it necessary to cater for 'extern' clients who needed to attend only on certain days for individual programmes, for example, assertiveness training or grief counselling. Their progress is also monitored at the weekly team meetings, and each has a nurse therapist. In these cases, the primary therapist may also be the nurse therapist, but not necessarily so.

Day to day micro-issues at the Day Hospital are dealt with at a weekly unit meeting chaired by the nursing officer. The home economics instructress, occupational therapist and hostel supervisor also attend. A very active West Clare Mental Health

*Based on a talk given at the International Conference on Law and Mental Health, Jerusalem, 27 June 1989.

Association has been responsible for providing transport to and from the Day Hospital. They have also been responsible for initiating a horticultural training scheme which will provide seven jobs. Bedding plants and shrubs are sold to local industry.

In the past three years we have treated 166 in-patients, 86 'externs' and 17 families. There have been 369 casual externs, all self-referrals, and associated with these 135 relatives, making a total of 773. The high numbers of self-referrals (an underestimate, as statistics on these were kept only towards the end of the second year), are taken care of initially by the nursing staff. Provision of a second staff nurse to the sector was essential to allow for quality care, and to prevent 'burn-out'.

GPs are vitally important to the successful operation of any community psychiatric service. The GP is usually the first person to become aware of a person's problem and the GP is the key person in the after-care. GPs have referred 66% of our in-patients, and 89% of the 'externs'. In addition we see 1,968 out-patients per year, 183 new patients, and 1,785 returns in the out-patient department above the day hospital. In the first three years, seven patient referrals were sent for 24-hour treatment at the main hospital as there was not adequate staff coverage after 5.00 p.m. and relatives were unable to cope. One of these patients was a disturbed psychogeriatric, three were suicidal, one suffered cardiac ischaemia presenting as confusion and two of the patients were manic. A total of 149 patients were admitted in one year directly to the main hospital so in total we are seeing over six times the amount of psychiatric morbidity as adapted from Goldberg & Huxley (1980). In this rural area, GP practices are single-handed. Instead of consulting within individual practices, it is more practical to expand our out-patient facilities and offer domiciliary visits on request from individual GPs.

Because of the 'chronic' nature of much of psychiatric illness, and in our determination to reserve the day hospital for treatment of acute psychiatric illness, we found a great need to develop alternatives for the 'chronic' population. In October 1986, we set up a resource management committee which included the area Adult Vocational Education Officer and the Clare-Care Social Worker. A resource person was appointed, assisted by a volunteer, to manage a group in Kilrush. In February 1988 we selected a further resource person who, together with a volunteer, manages a resource group in Kilkee, a seaside resort 64 kilometres from the main hospital in Ennis. These groups are a tremendous social outlet for the chronic population. On average, 17 clients attend the groups weekly.

In the first three years of operation, 12 patients have been put in various work placements, including local hotels, hospitals and businesses for a period between six weeks and 21 weeks. The aim of the work programme is to restore dignity and encourage discipline in the patient. The staff work in close liaison with the employer, and are able to recommend open or sheltered employment, and refer to the appropriate agencies. Two clients obtained full-time employment as a result of these work placements in the first three years. Responsibility for insurance and wages are taken by the Mid-Western Health Board.

Sixty patients were admitted to the Supervised Hostel in the first three years. Assessment and crisis beds in the supervised hostel have proved invaluable in the setting up of the community psychiatric services and facilitating discharge of long-stay patients from the main institution.

With the treatment model so far described, the readmission rate has been low. A total of four men and four women have been readmitted to the day hospital. To illustrate: a 43-year-old married female paranoid schizophrenic with three children had spent four months out of every year in the main hospital since her early 20s. She has been out of the main hospital for three years and has had no admissions to the day hospital for the past year. She attends the resource group weekly.

A 34-year-old single male schizoaffective patient was admitted almost every year to the main hospital since age 23 years. He is working now in a local furniture factory, following a successful six week placement. He has had no admissions to the day hospital in the past two years.

A 31-year-old female paranoid schizophrenic was admitted to the day hospital and supervised hostel for 15 months. She had frequent admissions since age 18 years, often in a locked ward for unmanageable behaviour. She is now living at home and attending a workshop in Ennis. She has had no admissions to hospital for the past 21 months.

A 46-year-old male manic depressive and alcoholic was admitted 36 times to the main hospital in the two years prior to admission to the day hospital and supervised hostel. He was typical of the 'revolving-door' patient. Several work placements prepared him for the workshop in Ennis which he is now attending. He remains in the supervised hostel.

The estimated annual costs of the treatment model described is £140,891. The total pay budget is £82,977 and the non pay budget is £57,914. Taking into account the high rate of psychiatric morbidity reviewed, the impact on admissions to the main hospital and the low readmission rate, the operation is without doubt cost effective.

Comment

The policy to treat acute psychiatric illness in the day hospital has proved effective. Firm guidelines regarding admissions, assessment and discharge, and

flexibility between the different parts of the treatment modality, ensure provision of both a generalised and specialised programme working in parallel.

To combat the perpetuating factors involved in psychiatric illness, which in the majority of cases proved to be social isolation and unemployment, the resource groups, work placements and horticultural training programme have been of great value. They have also contributed to the low readmission rate. The on-going psychotherapy supervision available to staff ensures both quality care for patients and high morale for staff, both vital ingredients to successful community psychiatry.

Treating patients in the community over a 24-hour period highlights legal implications for staff and patients. The legal problem should be reviewed at a national level.

Acknowledgement

I would like to thank Dr P. O'Beirne, Chief Psychiatrist, Our Lady's Hospital, Ennis, and all the staff members at Kilrush Day Hospital for their valuable help in setting up the service.

Reference

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Conflict: not caring for people

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The publication *Caring for People: Community Care in the Next Decade and Beyond* (DoH, 1989) sets out the Government's plans for community care and is the much awaited response of Government to Sir Roy Griffiths' report on community care. Many health districts have been doing all, if not more, than is recommended in the White Paper but this has been rather costly as far as the DSS funding is concerned. It should be remembered that the high cost of community care to the DSS was one major reason for Sir Roy being asked to investigate and report on such care.

I think it might be worthwhile to look at what has been happening in my health district and then consider what effects the implementation of the White Paper will have upon our practice and the consequences for all districts.

The Brighton service

What is now Brighton Health District has had a special service for elderly people with mental illness since 1966. By 1987 the district was self sufficient, with a complex of services distributed between three units, each serving a specific sector.

From its inception the service was based on the principle of treating, helping and supporting elderly people in their own homes. It was accepted that in-patient care was sometimes necessary and that some individuals needed a protected environment for the rest of their lives. It was considered that the latter should be accommodated in small units within their communities. These units should be provided by the social services department and the health service with old people's homes and the health service nursing homes. But the NHS nursing homes never materialised and local authority social services homes were sometimes inappropriate to the needs of clients. Because of this, private and voluntary facilities were used.

Long-stay hospital facilities have been avoided because their quality tends to be poor and they are usually provided far from the patient's community. A survey of Health Advisory Service reports on