Comment

These surveys provided a great deal of information which had a more local application and could be used to monitor changes as they were introduced. It is disappointing that more GPs did not participate, and indeed could not be persuaded to do so despite repeated efforts. In general further contacts, e.g. telephone calls, were answered politely but not accompanied by completion of the questionnaire. Hostile responses were rare but noteworthy; one doctor expressed the view that he "never replies to outsiders". There clearly is a danger of fatigue on repeated surveys but it was refreshing to see that nearly 40 family doctors were still willing to be involved in the assessment of their local psychiatric services.

It was felt at the outset that anonymity of individual replies would allow for a more accurate reflection of the quality of the service and this of course can easily be preserved by different units carrying out audits for one another. It is of interest to note few GPs would comment directly on the work of individual therapists but did demonstrate a willingness to be open in other equally important areas which can prove very valuable to the unit as a whole. It is obviously important to keep such audits in perspective, particularly as family doctors may have a limited understanding of all aspects of the service. The total cost of both surveys was under £100 which would make this method of audit one of the cheapest available.

Audit of psychiatric services by the GPs who use them is a practical and cheap way of assessing certain aspects of those services. Repeated at regular intervals, for example, three to five years, it might provide a profile of progress that alerts the psychiatrist to problems before they become too serious. The surveys themselves could be specifically designed for local purposes and undoubtedly would develop greater sophistication and precision as they became more widespread. Clearly it is time for psychiatrists to take this on board before an alternative financially-based audit procedure is forced upon us.

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Psychogeriatric day hospitals: open to audit?

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Day care has been called one of psychiatry's gifts to medicine. The British psychiatric day hospital movement began in the post war years and its philosophy continues to flourish with the decline of institutional care.

Psychogeriatric services often have a day hospital as the cornerstone of multidisciplinary care for the elderly mentally ill. Those who work in psychogeriatric day hospitals do so with a sense of purpose and an impression of benefit. The question of benefit has come to have moral, social, financial and political implications. A sense of 'doing good' is no longer sufficient justification for a service and psychogeriatric day hospitals are likely to become increasingly open to scrutiny.

How can their quality of care be evaluated? Literature over the last 20 years has described and examined the psychogeriatric day hospital movement. It is reviewed here according to Donabedian's three components of any health care service. He described 'structure' as encompassing staffing, building and organisation, 'process' (the activities of health care) and 'outcome' (the results of intervention) (Donabedian, 1966).

Structure

One of the most detailed descriptions of psychogeriatric day hospital structure is provided by a national survey of day care for the elderly mentally ill undertaken by Peace in the late 1970s (Peace, 1982). Her findings reflect the under resourcing of old age psychiatry that continues to the present day. Most psychogeriatric day hospitals have been established by the impetus of a single consultant, the service evolving through local demand rather than coordinated policy. Very few are housed in purpose designed buildings. This leads to difficulties in nursing observation and of access for the infirm. Although psychogeriatric day hospitals have been shown to have a relatively high staff:patient ratio in comparison with other day care facilities, reliance is often placed on relatively untrained nurses. Secretarial and remedial staffing is often scanty.

The development of the psychogeriatric day hospital has been paralleled by the expansion of local authority day care. Although both may provide care for the elderly mentally ill, central policy and funding perpetuate the historical separation of these services.

Process

Descriptive studies of psychogeriatric day hospital care outline the process of this service. Peace's survey found that most day hospitals for the elderly mentally ill share a fairly simple routine. On the surface this comprises social activities, occupational diversions, medical and nursing care. In fact psychogeriatric day hospital care performs wider functions including assessment, treatment, rehabilitation, maintenance of community living and support of families.

Psychiatric day hospitals provide relatively long-term support for a group of the elderly mentally ill, largely patients with mild or moderate dementia, chronic neurotic difficulties in old age and those with affective illness. This is in contrast to day hospitals in other specialities which generate momentum by a continuous turnover of patients.

The cost of day care for the elderly mentally ill becomes increasingly relevant within the financial constraint imposed on the NHS. Such considerations can no longer be dismissed as irrelevant to the practice of medicine. Studies attempting to determine the cost of day care reveal that this is a complex issue. Dependent elderly people supported in the community by day hospitals generally use other services and agencies with budgets of their own. In his study, Ross found that when this is taken into account, the total cost of community care for these people is more expensive than hospital or local authority long-term care (Ross, 1976).

Outcome

The results of caring for the elderly mentally ill are difficult to evaluate. While most health care services aim for recovery from illness or minimising of disability, neither may be possible in this population.

Studies show that psychogeriatric day hospitals do not slow or reverse the progression of dementia, although patients' relatives may see a transient improvement at the start of day hospital attendance. Interestingly, attenders seem to become more likeable in the eyes of relatives without an objective change in disability or disturbed behaviour.

One of the greatest benefits of day care is the support given to relatives. As the majority of the demented elderly live in the community, the burden placed on their relatives is considerable. The positive effect of day hospital care is reflected in the higher number of demented day hospital attenders returning home after an in-patient stay as compared with non-attenders.

Despite hopes to the contrary, psychogeriatric day hospitals do not remove the need for in-patient care for all dementia sufferers.

Comment

Day hospitals for the elderly mentally ill support a heterogeneous population. A group of them become long-term attenders. The service lacks coordinated plans for expansion and operates with limited resources. Community care provided in this way may be relatively expensive. While day hospital routine may appear basic and standardised, the individual's experience of day hospital care remains largely unexplored. Benefits of the service are more easily assessed in carers than in the users themselves.

Psychogeriatric day hospitals are becoming increasingly open to audit. It is important that evaluations of quality are directed towards the relevant aspects of day hospital care. Future attempts at quality assurance must consider structure, process and outcome in reaching balanced conclusions.

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A full list of references is available from the author.

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