

Understand me; believe in me; accept me as I am: perceptions of psychiatry of later life service

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Context. The emergence of mental health services for older people is a relatively recent development in Ireland. Therefore, it is important to determine strengths and limitations of this modern-day care service. A starting point is to enquire from those who have been in receipt of their service and/or their respective carers.

Aim. This study aims to identify and describe the perceptions and experiences of past service users (SUs) and their carers, while in receipt of services from an acute mental health day hospital for Psychiatry of Later Life and to explore their needs/supports.

Methods. A qualitative, exploratory, descriptive design was employed. Purposive sampling achieved a sample of 13 SUs and six carers. Inclusion criteria set were that the SU had a diagnosis of a psychiatric disorder; had the capacity to make an informed consent and communicate verbally and the SU was discharged from the service between January and July 2011. Finally, carers of SUs in receipt of the service during this time were also included. Data were subjected to thematic, field analysis.

Findings. 'Person centredness' emerged as an overarching theme. Six inter-related subthemes revealing how SUs and carers viewed their care emerged from the interviews: 'therapeutic engagement'; 'preservation of self-integrity'; 'collaborative care'; 'integrated care'; 'social gains'; and 'the relationship between the expectation, subsequent engagement and the perceived outcome of care'.

Conclusions. Findings concluded that high levels of care exist within this service. Strengths lie in the development of a therapeutic relationship, preservation of self-integrity, social gains and robust elements of person-centred holistic, integrated and collaborative care.

Recommendations support the enhancement of a cohesive planned approach to admission, discharge/transition (integrated pathway).

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Introduction/Background

According to the Department of Health and Children (DoHC 2006), as life-expectancy in Ireland increases, there is a growing need to consider the specific mental health needs of older people, thereby providing a comprehensive, dignified, equitable, accessible appropriate and relevant service. Despite this cognisance of what is required, the emergence of mental health services for older persons (MHSOP) is a relatively recent and ongoing development in Ireland. Before this, their care was provided for by the generic services that were not always attuned to their mental health needs (DoHC 2006).

Therefore, their unique requirements were not always met, primarily because of an over-medicalised view of ageing (DoHC 2006).

However, current Irish policy states that anyone aged 65 years or over with primary mental health disorders, or with secondary behavioural and affective problems arising from dementia should have access to specialist MHSOP (DoHC 2006). Home care is the preferred position with day-care support supplementing carer's efforts. Such day-care is a critical component of a comprehensive MHSOP in most developed countries (Padoani *et al.* 2000; Bramesfeld 2003). One such support is that of mental health day hospitals for older people.

The initial reference to a mental health day-hospital in an Irish context was made by the Department of Health (1984), when it stated that their function is to provide intensive treatment equivalent to that available in an inpatient hospital. A subsequent policy concurred

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and added that day-hospitals offer an alternative to inpatient admission, estimating that 25–33% is prevented from admission to hospital (DoHC 2006). It is acknowledged across all mental health services, that day-hospitals are being used to divert acute admissions; facilitate faster discharge from inpatient units; or provide a graded discharge programme from inpatient facilities (Mental Health Commission (MHC) 2010; Health Service Executive (HSE) 2012a).

Numerous international studies offer a mixed picture regarding day-hospital service provision and effectiveness. Regarding provision, it is acknowledged that old age psychiatry day-hospitals are not homogenous in nature (Kallert *et al.* 2004a) with a large variation in the timeframe (short to long-term) of attendance for attendees (Audit Commission 2000). The roles include systematic assessment and care-planning; rehabilitation; carer involvement and individualised care. They also encourage independence and choice for people with dementia (Reilly *et al.* 2006). Studies examining functions provided by adult mental health day-hospitals revealed a range of interventions such as social support and rehabilitation; short-term acute symptom relief; crisis interventions, psychotherapy, post-hospital care and long-term rehabilitation (Kallert *et al.* 2004a; Seidler *et al.* 2006). Others remind us that day-hospitals are viewed as cost effective alternatives to hospitalisation and outpatient care (Kallert *et al.* 2004b; Canuto *et al.* 2008).

Regarding effectiveness, Lariviere *et al.* (2011) found that day-hospital SUs were more satisfied on several dimensions of services that is symptom management, self-esteem and social participation. Secker *et al.* (2001) found that day-hospitals reduced user's need for help with benefits and occupation. In a study surveying clients and caregiver's attitudes to both day-hospitals and day-care services, Furness *et al.* (2000) found that carers also benefit from the respite that day-hospital attendance provides. Ashaye *et al.* (1999) found that SUs, who attended old-age psychiatry day-hospitals, had the lowest disability scores, measured on Health of the Nations assessment scales. Regarding benefits for mood disorders, many studies revealed improvements in depression with the supplementary positive experiences of acceptance, support and social stimulation (Davies & Philpot 2004; MacKenzie 2006; Garlipp *et al.* 2007).

Although it must be recognised that ample literature exists regarding outcome measures referred to in the previous paragraph, a lesser emphasis exists regarding other contemporary areas of care provision. These include mental health promotion; relationship building; SU involvement; stigma reduction; recovery aspects such as: person-centredness; empowerment; hope inspiring relationships; access and inclusion; education, research, evaluation; multidisciplinary therapy; and family support, all aspects highlighted in various mental health policy

reports (DoHC 2006; Higgins 2008; MHC 2010; HSE 2012a; HSE 2012b). As day-hospitals for older people with mental health needs are relatively new in an Irish context, it is timely to determine the presence or absence of these variables. A starting point is to enquire from those who have been in receipt of this service and/or their respective carers.

Methodology

Aim

This study aims to identify and describe the perceptions and experiences of SUs and their carers while in receipt of services from an acute mental health day-hospital for Psychiatry of Later Life and to explore their needs and associated supports throughout this experience.

Objectives

The objectives of the study were as follows:

- To ascertain past SU's perspectives of the care received while attending this service.
- To explore carer's perspectives of the care received by the person they are caring for.
- To explore carer's perspectives of the support they received when caring for the attendee.
- To explore with both sets of participants the strengths of this service.
- To explore with both sets of participants the areas that requires further development/improvement of this service.

Study design

Qualitative methods offer an opportunity to gain rich knowledge and insight into the person's experience (Holloway & Wheeler 1996) and are most useful in research that is exploratory and in-depth in nature (Greenhalgh 1997). In order to understand perceptions and insights for this study, a qualitative exploratory descriptive design was employed.

Recruitment and sampling

Purposive sampling was utilised, achieving an initial sample size of 20 SUs; 10 carers, with 13 service users and six carers eventually consenting to interview. The remaining potential participants decided not to take part as they did not want to revisit their experience of attending the day-hospital. Potential participants meeting the inclusion criteria were informed of the aims of the study by one of the researchers and clinical nurse manager at the day-hospital (G.S.) and formally invited to take part by a letter of invitation and a clear information sheet by the other researchers (T.O.G; U.G.M.).

Inclusion criteria

- The SU had a diagnosis of a psychiatric disorder.
- The SU had to fully understand the purpose and nature of the study and be able to communicate verbally, therefore, a SU could have a mild to moderate cognitive impairment as determined by the Mini Mental State Examination assessment scale.
- The SU was discharged from the service between January and July 2011. Hence, they were not availing of services at time of interview and therefore contributed without fear of compromised care or the risk of providing socially desirable responses.
- Primary carers of SUs who met the SU inclusion criteria as clearly defined above.

Exclusion criteria

- Those SUs who attended for a 'stand alone' medical, occupational therapy or nursing assessment were excluded because they had spent a short time in the service.
- Those who are attending the service at the time of the interview as they may have felt obligated to partake.
- Those with severe cognitive impairment as determined by the MMSE assessment scale.

Ethical considerations

The study was governed by the principles of beneficence, non-maleficence, fidelity, justice, veracity, and confidentiality (International Council of Nurses (ICN) 2003). Potential participants were given an information sheet 2 weeks before the interview, with consent established immediately before each interview. To protect confidentiality, recordings were given code numbers and participants were given pseudonyms. Data were stored in keeping with the Data Protection Act, 2003. Ethical approval was sought and granted.

Data collection

Data were gathered via one-to-one interviews, over a 3-month period. One researcher (G.S.) arranged the interviews, while the others (T.O.G. and U.G.M.), unknown to participants, conducted separate one-to-one interviews. A separate semi-structured interview guide was developed for both sets of participants. Reference to current literature, study aims and review by three experts in the field, ensured the tool's content credibility. Interviews started by asking the participant, *Tell me about your experiences of _____ (name of service)*. A range of follow up questions was then used (Table 1). Interviews, of duration of 20 minutes to 1.5 hours, were recorded and took place in a private, comfortable room in the day-hospital.

Table 1. Themes of questions for semi-structured interviews

Expectations of the day service
Experience of the day programme
Inclusion in care plan
Achievement of goals/meeting needs
Positive aspects of experience
Aspects of the experience that could be improved

Data analysis

N Vivo v9 (QSR International 2011) facilitated data management, coding and retrieval. The transcripts were read and re-read, interpreted and selected text coded under nodes/themes which were given a title. Then, titles of the nodes were refined and those which seemed to follow an orderly pattern were combined to formulate higher-order themes/nodes (Burnard 1991). This process continued until no new concepts emanated and data saturation was achieved.

Robustness of data analysis

Specific actions were taken to augment credibility of the findings (Graneheim & Lundman 2004). During the interview, the interviewers continually sought validation of their interpretation of the participant's narratives. All 19 transcripts were read independently by all members of the team. A sample of the transcripts were interpreted and analysed independently by two researchers (U.G.M. & T.O.G.) and the findings were compared and consensus reached, thereby ensuring confirmability. Subsequent themes and subthemes were created through constant dialogue. In order to gain participant validation, an abstract of the researcher's interpretation of the interviews was returned to four of the participants by mail and then followed-up with a telephone call after 3 days.

Findings

In order to provide a better understanding of the findings and enhance their transferability to other settings, an overview of the day-hospital service is provided. The day-hospital is part of an overall psychiatry of later life service which involves all aspects of a multi-disciplinary team approach. This team is composed of a team coordinator, consultant psychiatrist, a senior registrar, a registrar, four community mental health nurses, clinical nurse manager in the day hospital, an occupational therapist, a social worker, administration and household staff. There are 550–580 referrals to the overall later life service each year, with 110–120 individuals availing of the day hospital on an annual basis. Their attendance per week varies per individual

from 1 to 4 days. Their diagnoses range from new onset functional mental illness such as depression and anxiety, and also people with cognitive impairment with associated behavioral and psychological problems.

It provides a comprehensive range of group and individual activities/interventions including: advocacy; anxiety management; medication; coping with depression; self-esteem; leisure engagement; physical activities, chair exercises, community walks; lifestyle redesign; reminiscence/memory; art; independent living skills; home safety and fall prevention groups. Standardised assessments, individual goals and needs form part of the recovery care-plan and are reviewed regularly by the MTD.

Characteristics of the sample

Demographic data indicated that 23% (3) of SUs were male and 77% female (10). The carers were 50% male (3) and 50% female (3). The age range of the SUs was from 68 years to 88 years with a mean age of 78. Carers ranged from 45 to 75 with a mean age of 63. The SU’s duration of stay in the service ranged from 2 to 9 months. The relationship of carers with SUs was husband (1); wife (2); sister (1); and son (2).

Themes

An over-arching theme to emanate from the findings was ‘person-centredness’. It became evident that this concept is clearly embedded in the culture of the organisation. An absolute value for each person was reflected as evidenced through the tasks like asking a person how they like their ‘cup of tea’ to more significant decisions around their care.

Six further subthemes emerged under the theme of ‘person-centredness’, namely, ‘therapeutic rapport’; ‘preservation of self-integrity’; ‘collaborative care’; ‘integrated care’; ‘social gains’ and ‘the link between expectation, engagement and outcome’ (Fig. 1). It is important to highlight that each of these sub-themes are all inter-related and overlap with each other.

Therapeutic rapport (Fig. 2). A most notable finding was the overriding personal and professional attributes and skills ascribed to staff (Table 2), alongside the presence of the fundamental aspects underpinning the therapeutic engagement such as empathy, congruence and unconditional positive regard (Rogers 1951). The trust, respect, dignity and understanding are exemplified by these expressed assertions:

- Being listened to
- Being told the truth
- Being understood
- Being given hope and a belief in myself



Fig. 1. Themes.

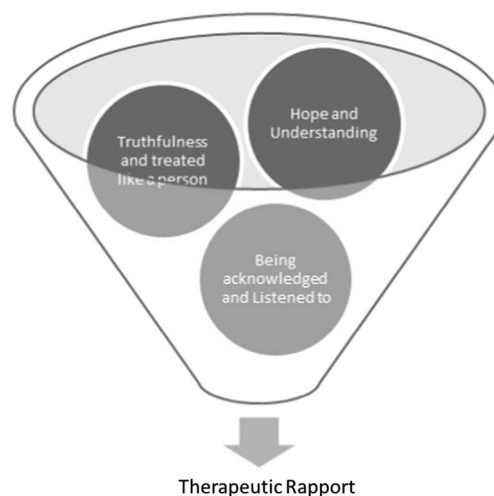


Fig. 2. Therapeutic rapport.

Preservation of self-integrity. This encapsulates the participant’s preservation of their ‘sense of self’ despite being under the care of mental health services; care traditionally associated with stigma. Contributing factors to this ‘self-preservation’ included the aesthetically pleasing physical environment of the private, community-based setting with its ‘homely’ atmosphere, in addition to the perception of an open door and the blend of personal and professional attributes of staff.

Substantiating quotes include:

I was not treated as a patient.

I felt accepted and respected.

Finally, all participants appreciated that they did not have to go through the formal referral channels if they need to re-engage with the service, post-discharge.

The nurse said to me – look, if you think ___ is getting in trouble, then ring me. This meant I had that ‘back

Table 2. Attributes and skills of staff

Personal attributes	Professional attributes	Skills
<ul style="list-style-type: none"> ● Genuine interest ● Empathetic ● Gentle ● Caring ● Non-judgemental ● Honesty ● Relaxed ● Approachable ● Good humoured ● Special kind of person 	<ul style="list-style-type: none"> ● Specialist knowledge ● Confident practitioners ● Experts ● Accessible ● Transparent/open ● Ability to see behind the façade ● Make information understandable 	<ul style="list-style-type: none"> ● Attentive ● Good listener ● Facilitator ● Empowerment

up' without having to go through all the hoops again.
(Carer 1)

The concept of collaborative care emanated from references participants made to their inclusion in their care-plan, with various standpoints being expressed. Here, this participant alludes to the importance of autonomy and unrestricted care.

there was great freedom to do what you wanted, that suited me because my concentration was so poor.
(SU 3)

Others referred to times when they would have appreciated greater input into their care. Referring to the activities available (*gardening, cookery, exercises, art, and relaxation*), some felt that these did not suit their needs.

one cap doesn't fit all. (Carer 4)

I don't like drawing and painting, so that activity didn't suit me. (SU 4)

Here one stated that the service could be more flexible.

My experience was wonderful in that the service was available here, but not good in that they didn't fit in with the personality and emotions of my husband. Better to have had an outreach service in the community. (Carer 3)

A divergent set of views were also evident with regard to collaboration with the person and their family. Some felt a strong sense of partnership in the care provided.

We as a family felt that our father's needs were acknowledged and our own concerns were taken on board. (Carer 2)

I found the one-to-one meetings with ____ (nurse) very useful. (SU 1)

Despite the fact that both the SUs and/or their carers are provided with a copy of their care-plan, some participants were unaware of their existence.

The notion of integrated care transpired from the need to provide a more seamless approach to care with other disciplines and services.

Here, a carer, referred to 'family strain' where internal tension placed additional burden on the participant:

My father was not attending the centre. But other family members were telling him that he didn't have to go ... so my father was getting mixed messages and I was hitting my head against a brick wall.
(Carer 5)

While this participant's sense of frustration and concerns were recognised within the service, he felt that a more proactive approach could have been used to address these issues within the family dynamic.

I felt that the dots should have been joined up... all singing off the same hymn sheet. (Carer 5)

Social gains

Expected and unexpected social gains emerged here. The expected gains was the opportunity to socialise.

The social contact for my mother was so important. Otherwise, she would have gone in to herself. (Carer 6)

Unexpectedly, many referred to the benefits stemming from social exchanges with fellow SUs. For example, through sharing illness related stories and reciprocal interchange between SUs, a sense of hope was instilled or received by either party.

Hearing other people's stories made me feel that I was not the only one that this has happened to. For the first time I felt hopeful. (SU 8)

The link between expectation, therapeutic engagement and outcome

A link became apparent between the participant's expectation of the service, subsequent engagement and the perceived outcome of care. Some participants had clear expectations regarding their care. Through therapeutic engagement, their expectations were realised and outcomes were met. Here a SU refers to coming to the service with an expectation around medication management, she found the related information sessions very useful and was therefore more inclined to comply. This positively influenced her mental health.

When I arrived here, I needed to know what the tablets were for...the talks on the drugs were excellent...I am now happier taking the tablets. (SU 2)

Most participants had unclear, non-specific expectations, which often resulted in anxiety about attending the service. However, through engagement, many expressed satisfaction with their care outcomes.

I didn't know what to expect ... but I only hoped to get better, which I did. (SU 5)

Here a carer is referring to his wife who had a long history of disengagement and poor outcomes, resulting in him having low expectations. However, his wife engaged which favourably impacted on outcomes.

*I went in blind faith to the service and I remember been relieved that she was willing to see the doctor and then started coming every day. I became a believer that day...I can face the rest of my life with a great equanimity.
(Carer 1)*

On the other hand, others had specific expectations. However, as a consequence of disengagement, they perceived that outcomes were unmet.

The following quote illustrates this in the context of her husband as a SU.

*I was very vulnerable when ___ (SU) came first...my expectation was that he would come one day a week and then build it up gradually. But he didn't want to attend and only availed of the service for a short time and that left me living life again from day to day.
(Carer 3)*

Discussion

Person-centred care highlights the importance of the person being part of their care in an inclusive, psychosocial environment with professionals who recognise a person's unique personality and heritage (McCance et al. 2011; Røsvik et al. 2011). Embracing this notion in practice involves four aspects: recognition of the value

for all human lives regardless of age or cognitive ability; the integration of individualised care into service systems; taking time to get to know the person and their unique perspective; and the promotion of a supportive social culture of care which enables people to feel connected (Brooker 2007). These findings highlight the permeation of a person-centred approach throughout the culture of the mental health day-hospital, focusing on the individual's strengths, needs and interests, regardless of age or cognitive ability. Fundamental to this being the relationships formed between the SUs, carers and staff.

The therapeutic relationship has been conceptualised as a central tenet to the task of healing (Safran & Segal 1996). Mastering interpersonal engagement is the starting point of any therapy (Butler et al. 2011). Forchuk et al. (1998) agree with this study's findings stating that this rapport is dependent on the attitude of staff with friendliness, interest, caring, understanding, having a passion for work and treating the SU as a human being as central requirements. It is apparent that this service gives precedence to the importance of this therapeutic rapport making reference to listening, trust, understanding and hope. Previous literature found the presence of positive outcomes associated with stronger therapeutic alliance such as lower client perceived problems and symptom severity (Neale & Rosenheck 1995); higher general and social functioning (Svensson & Hansson 1999); greater medication compliance and fewer required medications (Dolder et al. 2003); better attitudes towards treatment (Day et al. 2005); and lower drop-out rates (Frank & Gunderson 1990). Given that the unique emphasis of day-hospital care is to support people with an acute mental illness in a day care setting, the relevance of these aforesaid attributes take on even great significance so as to ensure sustained engagement, thus minimising the need of inpatient care.

Steele (1988) and Reeve et al. (2009) describe self-integrity as a phenomenal experience of the self, capable of free choice and of controlling outcomes in one's life. Stigma and discrimination are considered the greatest barriers to preserving self-integrity (DoHC 2006). In fact, this document contends that this perceived infringement can have an even greater effect on the life of SUs than their mental health problem. Moreover, discrimination can lead to relapses and can intensify existing symptoms (Link et al. 1997). This study advances this notion by proposing that the aesthetically pleasing physical environment of the day hospital with its discrete community-based location, as well as the non-judgemental attitudes of staff ensures that stigma does not inhibit older people's engagement in acute mental day-hospital care.

Collaborative care (CC) is viewed as a recovery-oriented process which supports personal involvement

of the patient, carers, the nurse, and other care providers in shared decision making and mutual understanding of roles, expectations and responsibilities (Stringer *et al.* 2011; Trjntje *et al.* 2011). Through the delivery of prompt, combined expertise, optimal patient outcomes are achieved (Trjntje *et al.* 2011). Bauer *et al.*'s (2006) study revealed that CC facilitates a better patient experience resulting in improved patient social functioning, quality of life and treatment satisfaction. In order to maximise collaboration, mental health practitioners must recognise that relationship building is the foundation for CC (Bischoff *et al.* 2012).

A significant issue to emerge from this study concerns the lack of SU's awareness of the existence of their care-plan. A need exists for participants to be given an opportunity to contribute to their care-plan. Butterworth (2012) purports the importance of involving SUs in their care by giving them an opportunity to agree therapeutic goals, care and being consulted when this care is being reviewed. Not all SUs will have the capacity for this level of involvement. If the person lacks capacity or declines to be involved this should be noted.

Integrated care is the integration of all the providers involved in the person's care (Vijayalakshmy *et al.* 2011). This is a key objective identified in the Vision for Change policy (DoHC 2006). The current study found that the realities of integrated care across organisational boundaries to be more informal which in some cases resulted in less continuity of care. The DoHC (2006) highlights the need for a more formalised linkage. Changing organisational structures of services should facilitate the seamless, continuity of care to meet the full range of needs of individuals. Current policy prioritises the provision of multi-disciplinary mental health care. This, coupled with the possible presence of co-morbidities in this population, reinforces the need for an integrative care approach, especially for those attending day-hospital where acuity of their condition requires the need for multiple disciplines in their care pathway.

According to Hunter (2004), conceptualisations of mental health are shifting from focusing on individual pathologies towards greater awareness of the importance of social relationships and social context. This study found these aspects to be particularly relevant, where expected and unexpected social gains emerged. Many referred in particular to a sense of hope being instilled or received from others. Furthermore, attendance at a day-hospital enables SUs to maintain social connectedness in their own community.

Expectation in this context refers to the degree participants anticipated how their care might proceed, what outcomes might be achieved or what their expectations might be of the service. Many authors (Coulter 2006; Eldh *et al.* 2006) recognise the need to encourage SUs to raise their expectation of involvement. By the same token,

Boaz *et al.* (1999) reported that some older people are less keen to get involved. Hence, it should not be assumed that all SUs want to have an active role (Lyttle & Ryan 2010). With some exceptions, many older people have low expectations of involvement in their care (Bentley 2003) and the expectation depends upon the condition of the person and the tasks involved (Belcher *et al.* 2006). Watsford *et al.* (2013) and Cheng-Hsui *et al.* (2012) note the connection between expectations of SUs and the eventual outcome of care, with an unrealistic and unmet expectation leading to poorer engagement and outcomes. Watsford *et al.* (2013) advocate for people to be better informed about what to expect in care.

Engagement is more than merely attending for help (Scott & King 2007). It refers to the extent to which SUs actively participates in their care (Tetley *et al.* 2011). A quality therapeutic relationship is vital to SU engagement (Sahlsten *et al.* 2005; Belcher *et al.* 2006). Low engagement and disengagement from care is an enduring problem (Dadds 1997; Tetley *et al.* 2011), with premature treatment termination ultimately affecting treatment outcomes (Ben-Porath 2004; O'Brien *et al.* 2009).

Current findings coincide with these arguments. Two main nuances were discerned here. On the one hand, participants who had clear expectations about recovery and engaged fully, ultimately this had a positive influence on the expected outcome. On the other hand, if participants had unclear expectations leading to levels of anxiety and/or disengaged with the service, a link became apparent with poorer outcomes. There needs to be growing recognition of these findings that underscore the importance of setting out clear expectations for the SU, encouraging active engagement that may enhance subsequent outcomes. These findings lend credence to the enhancement of the current information leaflet/pack for SUs and carers, which would promote more active engagement in recovery.

While the researchers acknowledge that dealing with the SU who disengages from the day-hospital service is difficult and often complex, one way this can be addressed is through effective collaborative care that is well coordinated. In addition, the provision of an active outreach facility when the SU is at risk of disengagement should be considered.

Recommendations will be framed from practice, education and research perspectives.

Practice

- In the establishment of day-hospitals nationwide, SU feedback regarding the type of location and setting of premises must be implemented. To avoid stigma, day-hospitals should be placed in neutral, discreet, non-institutional-like settings.

- In order to meet the diverse and complex needs of this population, older people's services need to become aware of the existence of allied services in this area. Formalised links must be developed between the expanded range of current services, thereby, providing a seamless integration of services from the SU's perspective. The development of an integrated care pathway would improve the SU's care journey and is now being developed.
- When a person is perceived to be at risk of losing contact with the service, a proactive approach is very beneficial for example domiciliary visit should take place to re-engage with this person or to support the family. The provision of an outreach service can prevent potential disengagement.
- Day programmes need to be flexible to accommodate a range of holistic, therapeutic needs for each SU.
- An awareness of the existence of a care-plan needs to be ensured for both the SUs and carers. Appropriate input by all stakeholders, inclusive of the SUs and their carers should be ensured. If this is declined, this needs to be noted in the documentation.
- The current SU/carer information package needs to be reviewed to increase awareness of service, allay potential pre-admission anxieties and clarify expectations.

Education

- The formation of a therapeutic relationship must be framed within a discrete therapeutic communication skills module across all under-graduate multi-disciplinary curricula.
- To enhance greater integration both within the multi-disciplinary team and across statutory and non-statutory bodies, all professionals must be educated with regard to the relevance of other members.

Research

- Further qualitative research should be conducted drawing on a larger sample, inclusive of more male participants and day-hospitals in other regions.
- Further quantitative research could examine the cost-benefit analysis of the day-hospital.

Limitations

As this study was retrospective in nature, there is a possibility that the findings could be influenced by memory problems or biased retrieval. Also, no attempt should be made to generalise the findings as the participants were drawn from the same service, the study was confined to one geographical location and the sample composition was largely females. A broader approach incorporating male perspectives and involving other services could offer further insights from a

national perspective. Although these participants were previous SUs, there was the possibility that they may require care from this service in the future. Hence, there was the risk that socially desirable responses were given for fear of compromising likely future care.

Conclusion

Qualitative interviews from 19 (13 SUs and six carers) informed us that high levels of care and support exist within this day-hospital for Psychiatry of Later Life. An overriding theme of person-centredness was revealed. The value placed on the fundamental tenets of a therapeutic, non-judgmental engagement should not be overlooked. Cognizance of the service setting is vital in upholding self-integrity and reducing stigma. A continued focus on the elements of holistic, person-centred, collaborative, integrated care will promote engagement and sustain a needs-led approach. The availability of tailored information should ensure clarity regarding expectations of SUs and their carer, thus enabling them to envisage potential care outcomes. Further deliberation on the recommendations outlined would positively influence service development into the future.

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