

**Older Adults Views of Day
Hospital Attendance and Social
Support Within the Day Hospital**

By

Graeme Duncan

D.Clin.Psychol

The University of Edinburgh

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Declaration

The research described in this thesis is the unaided work of the author, except where acknowledgement is made by reference. No part of this work has previously been accepted for another degree, nor is any part of it being concurrently submitted in candidature for another degree.

Graeme Duncan

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Abstract

Day hospitals have been a part of service delivery to older adults for almost fifty years. However, the experiences of attendees appear to have been under investigated. The aim of this study was to assess the views of older adults attending a psychogeriatric day hospital in Fife and to examine the social support within this day hospital and its links to psychological 'well-being'.

25 older adult day hospital attendees were interviewed with the use of a semi-structured interview. Specifically the interview examined the participants understanding of their referral; their attendance at groups; the level of satisfaction with staff; future coping; and overall satisfaction with the day hospital. Standardised measures of depression, stress, locus of control and life events were taken.

Overall participants were satisfied and the social element of the day hospital was the most important reason to attend. However, satisfaction was not independent from measures of psychological 'well-being'. The measure of depression was able to predict approval with the level of social support within the day hospital. However, the measure of stress could not. Gender differences were noted in the amount of actual emotional support perceived within the day hospital.

There are several implications in this study for the cost effectiveness of day hospitals. For example, if social elements are the most important factor then other services could meet this need. Also, the prolonged attendance of some participants

means that only a small number of patients will have access to this service. This study is cross sectional and it did not meet power. Therefore conclusions drawn need to be interpreted with caution.

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1. INTRODUCTION

1.1 History and Background

Day hospitals have been a part of service delivery for almost 50 years and have a long and honourable history (Murphy, 1994). Since the 1960s there has been a rapid development of geriatric day hospitals in the United Kingdom. Day hospitals provide multidisciplinary assessment and rehabilitation in an outpatient setting and they hold a significant position between in-patient units and home based services (Young & Langhorne, 1999). During the 1970s there was a concerted push in UK health policy for the establishment of day hospitals, with recommended targets per head of the population for both adult and geriatric services (Murphy, 1994). Geriatric and psychogeriatric day facilities expanded greatly during the 1970s and the 1980s: it is estimated that in 1990 there were as many as 20,000 regular attendees of older adult day hospitals with over 1.7 million annual places available (Fasey, 1994). Howard (1994) argues that the delivery of the health service has moved away from being provided through hospitals to being made available in the community. This has resulted in a different climate from which day hospitals were originally designed.

A national audit of all geriatric day hospitals by the Royal College of Physicians and the British Geriatrics Society noted that in 1992 42 per cent of patients were

referred for rehabilitation, 23 per cent for maintenance, 17 per cent for medical intervention, 7 per cent for social and respite care, and 7 per cent for assessment (Royal College of Physicians, 1994). These findings suggest that there had been some reduction in the level of maintenance and social care provided between 1980 and 1992. However, the report found that between 1980 and 1992 the aim of rehabilitation, which was to enable older adults to continue to live at home with the support of specialist multi-disciplinary assessment and care, had remained unchanged.

1.2 Day hospital functioning

According to Murphy (1994) day hospitals for the elderly vary in function and in the quality of service provided. At one end of the spectrum are those that mainly provide daily respite care for relatives of patients with a dementia. At the other end of the spectrum are day hospitals that offer assessment and specialist, time-limited treatment of patients with functional disorders. Daily respite care may also be provided by other services, such as day centres or through social services. An interesting point raised by Murphy (1994) is that older adults with depression are not always willing to attend day hospitals. In addition, he further argues that it is unlikely that day hospitals are able to provide an effective alternative to hospital admission for those patients who require close supervision.

There are seven key functions of the older adult psychiatric day hospital (Mosher & Burti, 1989). These are:

- An alternative to in-patient treatment.
- An assessment or short follow up tool.
- A place to provide carer support in dementia.
- A place to rehabilitate and review progress.
- A way to maintain community links.
- An alternative to long-term care.
- A way to maintain morale and recruitment in old age psychiatry.

Howard (1994) postulates that most psychogeriatricians would claim that they use the day hospital as an alternative to in-patient admission in two distinct ways: Firstly, treatment within the day hospital is ideal for patients who need more than out-patient treatment and who would otherwise require in-patient admission. Secondly, treatment within a day hospital facilitates a speedier discharge than from an in-patient unit as it acts as an intermediate stage to full discharge. Day hospitals, especially geriatric day hospitals, have been criticised because they provide for a client group whose problems tends to be of a chronic and relapsing nature. This leads to a drain on resources available for new referrals resulting in long waiting lists (Fasey, 1994). This may impact on staff morale as staff members may feel that they are providing little benefit to the patients that attend. On the other hand, Howard (1994) argues that the accumulation of patients with chronic problems is not necessarily a bad thing; indeed, he suggests that many patients would prefer to remain within their own homes with day hospital support rather than being in long term residential care. However, this assumes that treatment within both settings

remains at a comparable level. He also states that long-term day hospital care is an important means by which changes in chronic disabilities can be monitored and crises dealt with.

Howard (1994) further suggests that there is an increasing need for detailed assessments as patients are moved into new settings. He suggests that this is an unforeseen change in the role of day hospitals when they were established 20 to 30 years ago. Day hospitals co-ordinate assessments and provide a single point of access to services rather than multiple routes, which may confuse both the patient and the family. In addition, Howard (1994) goes on to argue that when a patient is confused or suffering from mania, for example, most families find it more acceptable to have short assessment periods within the day hospital rather than in an in-patient unit. Furthermore, community links tend to be maintained. Even short admissions to in-patient units may result in a disruption to social interactions. Attendance at a day hospital usually occurs on consistent days within a week, and this reduces the impact on the wider social setting.

Another role for the day hospital is carer support. Whilst most theorists agree that day hospitals do not reduce admission for patients with a dementia to in-patient units, they do reduce the burden on carers. Jerrom *et al.* (1991) argue that carers play a significant part in maintaining a patient's 'well-being' within the community and day hospitals are intrinsically linked to the morale of these carers. Howard (1994) postulates that the reason day hospitals do not reduce admission rates of dementia sufferers to in-patient units is because the progressive nature of dementia

results in an inevitable necessity for admission at a certain point in the disease's progression, regardless of previous contact with day services.

Rehabilitation is one of the traditional roles of day hospitals (Thompson, 1990). Gerard (1988) distinguishes between day centres and day hospitals and their roles in rehabilitation. Day hospitals incorporate high intensity activities, such as treatment of functional disorders and behavioural and cognitive symptoms of dementia, whereas day centres usually utilise low intensity activities, such as support and education of carers. However, it is likely that some low intensity activities will be carried out within both settings (Gerard, 1988).

A final role that day hospitals fulfil is to maintain service morale and recruitment. Staff working as part of a close team allows individuals to support each other and to disseminate skills between disciplines. This is something that is likely to be lacking for staff who work in isolation throughout the community (Howard, 1994).

However, Fasey (1994) suggests that the main aim of day hospitals is to provide assessment of problems, which is often conducted by staff who observe patients during the time that they attend. However, it has been suggested (e.g. Fasey, 1994) that these observations are likely to be unreliable as the patients are not in their usual environment and as such, may not be reflective of how the patient behaves or reacts in their own home or with their own family.

1.3 Criticism of day hospitals

Day hospitals have been criticised because they are not cost effective. Murphy (1994) argues that there are hundreds of day hospitals throughout the United Kingdom. They tend to be large buildings suitable for accommodating large numbers of patients and are usually only used during normal office hours. Thus, they are a vastly under-used resource. Fasey (1994) also states that day hospitals often require large capital investment, have recurring revenue costs and absorb large numbers of skilled staff. However, he does point out that some day hospitals provide overnight patient accommodation.

Murphy (1994) also, observes that most day hospitals are situated in large towns or cities and yet some serve rural catchments making them inaccessible to large areas of the population. Fasey (1994) further comments that transportation for patients is often unavailable and even where it is provided, patients in rural areas can travel for up to two to three hours. This can severely impact the amount of time spent at the day hospital.

Fasey (1994) has also questioned the social function of day hospitals for those patients with functional disorders (e.g. major depression, anxiety or psychotic disorders). He argues that attending the day hospital disrupts familiar routines and that patients with functional illnesses are not usually socially gregarious. Thus, he suggests that these patients often find the social side of day hospitals distasteful and he raises the question whether or not providing social support is an appropriate function for the service. However, it cannot be disputed that (irrespective of their

original role) day hospitals do provide some patients with implicit benefits, specifically in the form of social support.

1.4 Day hospital efficacy

1.4.1 Introduction.

Malone *et al.* (2002) suggest that reports of day hospital effectiveness are conflicting. Howard (1994) observes that the psychiatric day hospital for older adults has become an integral part of older adult psychiatry, so much so that the efficacy of the day hospital is often assumed unreservedly. Forster *et al.* (1999) raise concerns that the evidence for effectiveness is equivocal and expensive.

Research available to support the hypothesis that day hospitals are effective with older adults is virtually non-existent, especially with regard to treatment of affective problems. Indeed, Black (2000) argues that psychogeriatric day hospitals were originally established with little formal evaluation. Howard (1994) comments that evidence of effectiveness is available from younger populations, but it may be difficult to extrapolate the findings to an older adult population. Black (2000) also argues that the relevance of the research base supporting psychogeriatric day hospitals depends greatly on whether they will continue to provide the same services in the future as they have done in the past. Zarit, and colleagues (2003) note a long history of studies reporting that respite services have marginal or no effect. However, they suggest that this may be due to methodological problems

which compromise the effectiveness of tests used to measure the efficacy of these services. Malone *et al.* (2002) also note that the difficulty in finding suitable control groups to perform randomised controlled trials of day hospitals is a problem.

A recent review of treatment within psychiatric day hospitals conducted by Kaller *et al.* (2002) focused on the research findings of studies investigating acute treatments in psychiatric day hospitals. The review found that both patients and carers assess day hospitals as effective and that the treatment is at least as effective as in-patient units. The authors of the review also noted that a large variety of patients can access day hospitals and that significant savings are often present. However, they argue that the conclusions that may be drawn from these studies are limited due to the small numbers of subjects employed, the lack of randomisation and inadequate use of control groups. Therefore, more methodologically rigorous studies need to be conducted in order to ascertain conclusively the effectiveness of day hospitals.

Another systematic review of studies by Forster *et al.* (1999) examined twelve randomised controlled trials of day hospitals with a view to comparing the outcome of day hospital care with comprehensive care, domiciliary care or no formal care whatsoever. Across the twelve trials, 2867 elderly subjects were compared on measures of institutionalisation, disability and global "poor outcome". Death and use of resources were also included as outcome measures. It was found that there were no significant differences between day hospitals and other services on measures of disability or use of resources. They did find, however, that compared to

no comprehensive care those patients under the care of day hospitals had a lower risk of death and “poor outcome”. It was also noted that there was a trend for day hospitals to reduce hospital in-patient bed use and placements within institutional care. With regards to the expense, eight studies reported costs and the majority of these found that day hospitals were more expensive than other forms of care. However, it is worth noting that only two of the studies took into account the cost of long-term institutional care.

Malone *et al.* (2002) conducted a three-month follow-up study of patients discharged from a geriatric day hospital in order to determine whether mobility and functional ability were maintained after discharge. Measures were taken at admission, discharge and three-months after discharge. The results showed improvements between admission and discharge on measures of depression, mobility and cognition. Between discharge and the three-month follow-up it was found that there were no significant changes in levels of depression and functional status. However, a decline in measures of mobility and cognition was noted. Malone *et al.* (2002) concluded that improvements in mobility and functional status were not maintained three months following discharge. They suggested that possible reasons for the lack of positive findings were that the measures used were not sensitive enough and the outcome assessment was not blind. However, it is interesting to note that depression scores were reduced and maintained three-months after discharge, a point on which Malone and colleagues (2002) appear to place little importance. This study therefore provides limited support for day

hospitals as a suitable treatment of some mental illness such as depression. However, the follow-up period may be too short to make categorical conclusions.

In a recent study, Zank and Schacke (2002) assessed the effects of geriatric day care on patients and care-givers. The authors investigated older adult hospitals in Germany between 1994 and 1998. 148 participants were recruited from six day-care units and were matched with a sample from patients who had home-based care and did not attend the day care units. The authors considered the matched sample to be an ideal control cohort as they also received home-based care. Data was collected within ten days of commencing day care, six-months later, and nine-months thereafter. In addition, a six-month follow-up was conducted with care-givers by telephone after the third data set had been collected. The factors assessed in this study were: life satisfaction, perceived social support, depression, self-esteem, cognitive impairment and non-cognitive dementia symptoms. All measures were self-report, and completed with the assistance of an interviewer. Complete data from all three follow-up assessments were collected from only 83 of the initial 148 participants.

The results from the Zank and Schacke (2002) study indicated that there was a positive effect of attending the day care unit: either an improvement or a stabilisation in symptomatology was achieved for 'well-being' and dementia symptoms compared to the control cohort. The authors speculate that the reason for the lack of significant findings from the self-esteem scale may be because the questionnaire probably assesses deeper elements of the self-experience, which

might be more resistant to change. However, if this is the case then the scale is unlikely to have good ecological validity and therefore Zank and Schacke (2002) should have considered using a more valid measure of self-esteem.

Zank and Schacke (2002) also observed that non-cognitive symptoms of dementia, such as agitation, decreased in the day care sample in comparison to the control sample whose symptoms of agitation increased. They note that this decrease in agitation was achieved without the aid of medication. They do not state how they controlled for the effect of medication in this study.

Results relating to the cognitive symptoms of dementia need to be interpreted with some caution due to the large amount of missing data. Zank and Schacke (2002) also point out that the effects noted were mainly obtained from only one sub-measure. They conclude, however, that there is partial improvement in cognitive abilities compared to the control cohort.

The follow-up results showed a decline in general health in over half of the home care control group compared with less than a third of the treatment group. However, Zank and Schacke (2002) note that over 72 per cent of the treatment group were still undergoing treatment. Thus, no conclusions can be drawn about the lasting effects of the day care unit. They argue that improvement is partly due to compensation of perceived or actual social deficits. Interestingly, they failed to note any positive findings from their survey of care-givers. One explanation is that many of the day hospital patients' care-givers reported less of a burden at the start of the

study compared with care-givers of patients who received home-care only. However, if this is the case then significant differences between the two cohorts of care-givers at the first assessment point should have been reported. A second explanation offered for the lack of positive findings is that the sample size of care-givers was too small.

1.4.2 Day hospitals and Carers

A study by Zarit *et al.* (1998) assessed the effect that the use of day care had for family care-givers. They chose to examine only care-givers whose relatives attended the day care unit at least twice a week. They argued that a lower level of attendance at day services than this would not produce any significant psychological benefit. The comparison group consisted of care-givers whose relatives did not use day care and only had minimal amounts of input from other services. Measures were taken for both groups pre-treatment. Past service use was controlled for by eliminating those participants from the study whose relatives had been involved with more than a total of five days of day care prior to the study. Measurements were taken at three months and at twelve months.

In total 121 of the care-givers, recruited from the treatment group, completed the three-month analysis and only 73 care-givers completed the study at twelve months. Of the control group a sum of 203 completed the three-month analysis and 120 completed the twelve-month analysis. The study included measures of role capacity, overload, worry and strain, depression, anger and positive affect.

The results noted by Zarit *et al.* (1998) were that care-givers of relatives who attended a day care unit twice a week had lower levels of stress and their 'well-being' was better than that of the control group. They also found that these effects were evident at both the three-month and twelve-month assessment points. They surmised that the use of day care reduced exposure to a primary stressor and as such was likely to reduce the stress in the care-giver. Also, the use of day care affected care-givers' appraisal of primary stressors and consequently reduced stress and increased 'well-being'. Therefore, the benefits of day hospitals and day care units extend beyond the patient to other members of the patient's family. Interestingly, Zank and Schacke (2003) in commentary and response to concerns raised about the efficacy of their study suggest that the possible lack of positive findings for the care-givers may have been the result of differences in the health care systems used in their study compared to the Zarit *et al.* (1998) study. Here the focus was on day care facilities in the United States, whereas Zank and Schacke (2002) examined day care in Germany.

2.4.3 Productivity within day hospitals

Creed *et al.* (1991) report that in a randomised controlled trial of day and in-patient psychiatric treatment up to 40 per cent of older adult in-patients could be treated satisfactorily in a day hospital setting rather than being admitted as in-patients. Further to this, the overall benefits of the day hospital were equivalent to those of in-patient care at both three-month and twelve-month follow-up intervals.

Murphy (1994) argues that day hospitals have become ineffective because they have tried to 'mix and match' a wide variety of functions with a wide variety of patients with greatly differing needs. In addition, day hospitals have often taken on inappropriate roles in an attempt to fill service gaps rather than being based upon best practice. In Murphy's opinion this has led to a wasteful, inflexible, and unsatisfactory service to meet a range of needs that perhaps could be better met by other agencies. Furthermore, when the cost of day hospitals is considered against the alternative of providing visiting specialist professional treatment to day care facilities, supplied by social care organisations (private, voluntary or public), then they begin to appear expensive both to the public and the health service (Murphy, 1994).

Wimo *et al.* (1993) utilised a novel approach to assess the productivity of psychiatric geriatric day care in a study conducted in Sweden. They developed nine tests of productivity: a participation quotient, which measured the level of participation of patients during the study; a registration quotient, which measured whether over or under-registration for patients was practiced; a capacity quotient, which measured the level of capacity of the day care used during the study period; a turnover quotient, which measured the number of patients discharged against the number of patients at inclusion during the study period; an average number of visits per patient per week; degree of institutionalisation for participants during the study, which measured different kinds of short-term emergency and long-term care; mortality rates for participants during the study; a misjudgement quotient, which

measured the number of patients who left the study for a short period because of other reasons than sudden severe somatic disease or death; and a measure for reasons of discharge.

The findings from the study led Wimo *et al.* (1993) to conclude that the day care facilities were marginally under-prescribed when the participation quotient and the capacity quotient were compared with the over-registration quotient. They suggest that there was the possibility of a further over-registration rate of between 15 to 20 per cent. It appeared that in this part of Sweden patients only attended for 68 per cent of their prescribed attendance and that only 78 per cent of the capacity of the day hospitals was used. The authors also noted a 31 per cent turnover quotient and that this was low when compared to other studies (e.g. Gilleard *et al.* 1984; Rosin *et al.* 1985).

In particular Wimo *et al.* (1993) noted that the evidence from the majority of other studies indicated that psychogeriatric day care facilities had a high turnover, especially for patients with a dementia. Also, the findings for the average number of visits appear to be low at 1.6 when compared to other studies (e.g. Anauld *et al.*, 1982). However, they suggest that other studies (e.g. Levin *et al.*, 1989) have noted large variations in the average number of visits per week. However, this might have been linked to where the studies were conducted. The rates of institutionalisation are similar to other research (around 8 per cent). The mortality rate appeared low at 1.4 per cent when compared to other studies (e.g. 11 per cent - Engedal, 1989). The misjudgement quotient was also low at 12.2 per cent when compared to other studies (e.g. 25 per cent - Ineichen, 1989). The authors concluded that the day care

unit, which they studied, was quite productive. However, they indicated that conclusions about the productivity of psychogeriatric day care facilities as a whole are difficult to draw due to the lack of studies using their methodology.

Ineichen (1989) further argues that it is difficult to draw conclusions about the efficiency of day care psychogeriatric facilities due to the variety of services that exist. In particular there are many kinds of day care available in the United Kingdom but the purpose and structure of these facilities is not always clear to clients, service planners or researchers. Consequently, measures of productivity may show varying results, not as a result of efficiency but more as a function of not comparing like with like. Black (2000) also observes that researchers have been looking for evidence of how day hospitals have worked in the past. In particular he suggests that most researchers have focused on the role of rehabilitation, whilst not acknowledging the dramatic changes in the way older adults are now managed within current health and social services. He further states that there has been a significant change in the last 15 years with a reduction in the length of hospital stay and an increase in support within the home. He is therefore postulating that previous conclusions regarding the effectiveness of day hospitals may be flawed.

Black (2000) also suggests that in order for day hospitals to survive, their role must evolve to meet the current health needs of older adults. Furthermore, he argues that there needs to be a move away from the traditional role of slow stream rehabilitation to more appropriate tasks, such as the provision of a mechanism by which frail patients with unstable medical conditions may avoid hospital admission. In arguing this point Black has disregarded the many functions that day hospitals

are able to provide and likens the value of the day hospital to an extension of a depleted primary care service. As discussed above there are many functions of day hospitals and the importance of these functions is likely to differ between service users and service providers.

Ineichen (1989) argues that productivity is not an appropriate measure of the effectiveness of day hospitals. Another approach must therefore be used. Patients must be assessed to see how using the day hospital services benefit them (or otherwise). The impact of these services on patients may be evaluated by comparing it with traditional in-patient treatment, particularly with regard to patients' perceptions of day hospitals, how supportive the service is and how it affects the psychological 'well-being' of patients.

1.5 User views of day hospitals

Stephenson *et al.* (1995) comment that any evaluation of day hospitals must take the attitudes of both patients and carers into account. Over the last decade there has been a political agenda to increase the value placed upon user opinion. Stephenson and colleagues point to government initiatives such as 'The Patients Charter' as evidence of this political drive. More recently, the NHS white paper entitled 'A first Class Service' (1998) outlines the principles of clinical governance and is the linchpin to deliverance of quality care in the NHS. The aim of clinical governance is to provide a health service that continually strives to improve the overall standard

of care, whilst reducing variation in outcome and access to services. The white paper sets out seven key principles through which this is to be achieved. These are:

- Continuing professional development.
- Cost effectiveness.
- Multidisciplinary activity.
- Accountability.
- Clinical effectiveness.
- Management liaison.
- Risk management.
- User involvement.

This white paper places great emphasis on the importance of user involvement, not only with the establishment, but also as an ongoing assessment of services from the user's perspective.

In spite of the political effort to place greater value on the appraisal of services by user's, little research or evaluation in this area has been conducted. Stephenson *et al.* (1995) observe that there is little information available regarding the satisfaction of day hospital users. It is possible that many studies of user views are conducted as part of an audit and are therefore never published. However, it is also possible that the "Good Samaritan" effect leads researchers to believe (incorrectly) that others are conducting research or an audit in a particular area. The majority of published

articles available report user views of adult psychiatric day hospitals rather than geriatric psychiatric day hospitals.

Dalrymple and Laidlaw (1998) conducted a study investigating user views of a psychogeriatric day hospital in Fife. Using a semi-structured interview they aimed to evaluate the expectations and experiences of older adult attendees. Four main areas were assessed: the participants' understanding of the reason for their referral to the day hospital; the expectations and needs of participants for group activities; the participants' perception of the levels of contact with staff; and the participants' perception of their ability to cope with their difficulties following discharge from the day hospital. In total 23 participants were recruited.

Dalrymple and Laidlaw (1998) noted from their results that the majority of the attendees had a good understanding of the reason for their referral. But, a significant minority were unaware of the reason for their referral. They also noted that most of the participants did not report that their expectations had been met, nor did they know what to expect from the day hospital. A significant number were not involved in group activities. All participants reported that they were happy with the level of contact with staff and the majority were satisfied with the day hospital. However, they were not generally confident about the future with only 34 per cent either confident or very confident about coping with their problems. In addition, the majority of users surveyed were worried about discharge from the day hospital. The

authors conclude from their study that the function of the day hospital is in question as the average number of patients who participate in groups is minimal. Furthermore they highlight the need to take care in explaining the referral to older adults. They further observed that most participants report social factors as being the most helpful function of the day hospital. Dalrymple and Laidlaw (1998) suggest that this raises questions about the cost effectiveness of day hospitals and whether there may be more appropriate venues better suited to delivering this social function.

Stephenson *et al.* (1995) interviewed both patients and their carers using an idiosyncratic questionnaire that was developed from a review of literature and focused upon overall satisfaction with day hospital attendance. It also contained more specific questions relating to other elements of service provision such as ambulance transportation. The study collected both quantitative and qualitative data. In total 194 patients were asked to participate, of which 92 patients completed the interview.

Stephenson *et al.* (1995) reported that from this sample 88 per cent enjoyed attending the day hospital and 85 per cent believed that it was worthwhile. 97 per cent liked meeting people at the day hospital and if given the choice to be treated at home, within an in-patient ward or at the day hospital, 69 per cent preferred the latter option. The highest levels of dissatisfaction related to the amount of treatment provided and transport available to the hospital. In total 94 carers completed the

carer survey and the results indicated that 94 per cent of them believed that the day hospital had been of direct benefit to them. The authors suggest that their study may be considered to be flawed in that the sample of day hospital attendees surveyed were more likely to have been frequent rather than infrequent attendees, which may have given rise to a sampling bias. If so there is risk that the results of the survey reflect a relationship between satisfaction with service and frequency of attendance. It is possible that those patients who do not attend are dissatisfied with the service.

A more recent study, which assessed the satisfaction of older adults who attend a day hospital, was conducted by Baumgarten *et al.* (2002). 212 older adults were recruited and randomly assigned to either a waiting list condition or treatment at the day hospital. Measures were taken of both the participant and carer's perceptions of the day hospital. In addition, outcome variables of psychological 'well-being' were taken. The results showed that day hospital users and their carers had positive perceptions of the day hospital. However, there was little evidence of an effect of attendance upon psychological 'well-being'. The authors conclude that the discrepancy between user perception and outcome measures may be because any benefit achieved might not be represented in the outcome measures used in the study, or that any effect on psychological 'well-being' may not be apparent within a short period of three months. Indeed, attending a day hospital may not impact directly or immediately on psychological 'well-being'. However, attendance may positively alter a patient's perception of 'well-being'. Thus, aspects of the day hospital may provide a buffering effect.

A study by Caan *et al.* (1996) audited user's views of adult psychiatric day hospitals in an inner city setting. They developed a satisfaction questionnaire, which was used to guide interviews (rather than being self-report) so those with a high level of disability were not excluded from the study. Altogether, 23 patients participated in the study. The interviews were repeated the following year with a further 54 patients. Both occasional and regular attendees were included in the study.

Cann *et al.* (1996) found from the combined data analysis for both years that attendees often cited specific staff or co-attendees, who were used as confidantes for, praise. It was also noted that irregular attendees gave fewer reasons for attending than regular attendees.

Participants also rated staff on a five-point adjective scale of satisfaction. The authors considered ratings of helpful and very helpful as a positive rating. Overall, positive rating of helpfulness rose from 68 per cent in 1992 to 79 per cent in 1993. Interestingly, there were differing views of professional groups and their degree of helpfulness. For example, occupational therapists were rated more helpful than consultants and nurses were rated more helpful than psychologists. Participants considered the consultant psychiatrists the least helpful. However, it was noted that the perceived level of helpfulness was linked to the perceived level of availability to the staff.

The most commonly requested group by day hospital attendees was the social skills group. In response to the comments, day hospital staff changed the format of the

groups to allow more social contact. It was noted in the 1993 survey that the percentage of patients reporting that they were satisfied with the service they received had risen from 71 per cent in 1992 to 91 per cent in 1993.

75 per cent of patients reported that they believed that their mental health had improved as a direct result of attendance at the day hospital. Caan *et al.* (1996) observed that user satisfaction studies generally produce positive responses, an effect which may be due to a selection bias. For example, patients who value the service may be more inclined to stay in treatment than those who decline to engage. However, the authors indicated that following feedback from the original audit in 1992 certain changes were implemented for the 1993 study. The measures used in the study were sensitive to change, showing improvements in satisfaction with specific areas that had been addressed. The changes implemented related to primary nursing and group work. A surprising finding was that there was a minimal level of support from community care agencies. It was concluded that there is significant value in accessing user views of day hospitals and that psychiatric patients have coherent and informative views.

Another study, which focused on the user's views of their experience of attending a psychiatric day hospital, was conducted in the late 1980's by Rothwell, and colleagues (1989). At the time this study was classed as revolutionary in the assessment of efficacy of day hospitals. The authors argued that there had been a reluctance to assess user views based upon the assumption that psychiatric disorders

can prevent patients from having a realistic view of their situation. The aim of the Rothwell *et al.* study was to investigate the feasibility and potential value of systematically obtaining user feedback from two psychiatric day hospitals. The day hospitals surveyed had two differing roles, one for acute short-term attendance, the other catering for more long-term attendees. Questionnaires were sent to patients just recently discharged from attending the day hospital on a short-term basis with a total of 89 replies. Interviews rather than questionnaires were carried out with 42 current attendees at the second day hospital. There were fewer participants in this group as the hospital catered for those with longer term needs.

The results of the Rothwell *et al.* (1989) study showed that patients who had attended the day hospital on a short-term basis rated “talking to nurses” as the most helpful aspect of the day hospital. Patient reports of what they found most helpful fell into three broad areas: specific therapies, talking to staff, and the general environment. Results from the day hospital that catered for longer-term attendees showed that patients found activities, which provided vocational and material resources, such as work placements and help with money, most helpful. Interestingly it was noted that there was a correlation between age and positive ratings of helpfulness. This indicates that older patients generally rated activities as more helpful compared to younger patients.

Rothwell *et al.* (1989) suggest that, despite the differing methods employed to assess user views, the results highlighted the differing aims of the two day hospitals. The focus of intervention for short-term patients is usually aimed at therapy and

symptom reduction and a key factor in this is the therapeutic alliance between the patient and the health worker. It is not therefore surprising that the results from the short-term attendance day hospital point to social aspects and staff relationships as being most helpful to attendees. The authors argue that rehabilitation is a wider system focusing on the provision of graded environments such as work placements, which was the aim of the second day hospital. A point, they feel was noted by the patients

Rothwell *et al.* (1989) also included an assessment of the test retest reliability of the survey. In this assessment they noted that there was high overall reliability and conclude that consumer surveys are a valuable way to assess the performance and practice of a day hospital.

Rothwell (1990) conducted more detailed analysis of the data from the Rothwell *et al.* (1989) study. In particular, Rothwell (1990) carried out a factor analysis on the findings from the short-term attendance day hospitals in order to determine whether there was an underlying pattern in the results from the first study and if any factors obtained could differentiate sub-groups of attendees.

The analysis revealed two factors: the first reflected attendees' general experience of the day hospital and correlated highly with overall satisfaction and the second differentiated between social contact with staff and medication. This second factor also correlated with marital status and number of children. Rothwell (1990) argues that this is valid as people who have established family systems might be expected

to choose therapeutic activities that are more relationship based. In criticism of satisfaction studies, Rothwell suggests that patients may often give a positive view of treatment in order not to offend staff working with them.

1.6 Social Support

1.6.1 Introduction to social support in day hospitals

Social support appears to hold significant value to those patients who attend day hospitals, be they from an adult or older adult population. Handen (1991) argues that the impact of social support has been more strongly felt amongst older adults compared with any other part of the population.

1.6.2 Definitions of social support

Handen (1991) suggests that before the influence of social support upon 'well-being' can be understood, "social support" must be defined carefully and accurately.

Both Davis (1996) and Handen (1991) believe that many of the definitions of social support cover such a wide range of contexts as to be virtually useless, at least from a research point of view. To illustrate this broad range, Cobb (1976) defines social support as "information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations" and Thoits (1982)

describes social support as “the degree to which a person’s basic social needs are gratified through interactions with others”. Furthermore, Bierhoff (1996) describes social support as “the giving and receiving of help that relationships offer when coping with stressful life events and daily troubles”.

Handen (1991) argues that in an attempt to overcome definitional problems theorists and researchers must divide social support into a variety of different factors. For example, Bierhoff (1996) states that in general a distinction between the perceived availability and actual received support can be drawn. The ‘Significant Others Scale’ developed by Power *et al.* (1988) attempts to measure the most distinguishable aspects of social support. This scale measures structural aspects (such as, which significant relationships do or do not exist), and functional aspects (such as, levels of perceived emotional or practical aspects of support). Also included in the scale is a measure of under or over provision of support and the actual quality of this support.

1.6.3 Social support and psychological well-being

There are many theories as to the relationship between social support and psychological and physical ‘well-being’. Handen (1991) observes that there is considerable literature relating to the positive effects of social support on psychological ‘well-being’ and the protective effect it has against depression. Furthermore, the variance in psychological functioning that can be explained by social support lies between 8 and 13 per cent among older adults. Thus, social

support appears to have a significant influence upon the overall psychological and physical health of this population.

Generally, Bienhoff (1996) supports Handen's view that social support seems to provide a certain degree of psychological protection when stressful life events occur. Furthermore social support also appears to exert a generally positive effect on psychological 'well-being', which is not confined to times of stress.

Schwarzer and Leppin (1992) conducted a meta-analysis of 70 studies on the relationship between social support and depression. The findings from this analysis indicated a significant negative correlation between social support and depression. In particular, cognitive or emotional support from others was found to be a strong predictor of depression rather than practical support.

1.6.4 The buffering effect versus the direct model

Whilst relationships have been noted between social support and stress, it is difficult to disentangle cause from effect (Cohen & Wills, 1985). Cohen and Wills (1985) propose two hypotheses to account for these relationships. Firstly, they hypothesise that social support relates only to people under stress and as such provides a filter between input of the stressor and the experience of stress (the stress-buffering hypothesis). Alternatively, social resources may have a beneficial effect irrespective of whether a person is under stress. Davis (1996) terms this

model the “direct effect” model and suggests that the effect of social support is realised through the intervening variables of self-esteem or perceived control.

Cohen and Wills (1985) suggest that the generalised effects of the “direct effect” model may occur because a larger social network may provide an individual with regular positive experiences and a set of stable socially rewarding roles. However, they fail to take into account the fact that social network size does not necessarily reflect adequate quality of social support. Cohen and Wills (1985) also argue that the generalized effect of social support may exist as it provides a sense of predictability. If the “direct effect” model of social support is accepted then it holds that if the level of support increases the degree of ‘well-being’ should also increase, irrespective of the existing level of support. However, the evidence available indicates that social support is not a linear relationship, in that as levels of support increase, psychological ‘well-being’ does not increase at a comparable rate.

Cohen and Wills (1985) further argue that there may be a smaller window of effect than first thought. Thus, there is likely to be a minimum value at which social support begins to take effect and a maximum value at which social support fails to provide any additional benefit. Davis (1996) observes that the direct effects of social support are likely to be seen in community samples where the prevalence of stressful events is low.

Cohen and Wills (1985) prefer the hypothesis that social support has a stress buffering effect. The buffering model suggests that social support acts to lessen the

impact of a threatening event (Davis, 1996). Handen (1991) additionally argues that the buffering effect of social support probably moderates the impact of life transitions. A factor which is pertinent to older adults as they are likely to go through several major life transitions in a relatively short period. Lazarus (1985) comments that it is through the appraisal of available resources to meet a perceived threat that a person either experiences stress or not. It follows therefore that the appraisal of social resources may impact on the process of the stress reaction. If a person perceives that greater social resources are available to them they are likely to appraise stressful events as less threatening, as the event is likely to appear to have less of an impact on the person both physically and psychologically (Lazarus, 1985).

Cohen and Wills (1985) comment that although a single stressful event may not place great demands upon an individual, the occurrence of multiple events draws on all of an individual's available resources and the potential impact on psychological and physiological aspects becomes apparent.

Cohen & Wills (1985) propose that social support works on two levels. Firstly, they argue that support may intervene in the stress process either by interrupting (as such, preventing) or attenuating a stress response. They suggest that it is the perception that others can and will provide necessary resources that impacts on the appraisal of stress. Secondly, adequate support may intervene between the experience of stress and its consequences such as physical or psychological decline. This may occur through a process of either eliminating the stress reaction or by

directly influencing its consequences. For example, social support may alleviate the impact of stress by providing a solution to problems or by reducing the perceived relevance of the problem to the individual. Thoits (1986) also argues that it is the ability of significant others to provide guidance in stress management that ultimately leads to effective social support.

1.6.5 Investigating the models of social support

Wethington and Kessler (1986) conducted a systematic review of literature on social support and concluded that the stress-buffering effect between social support and psychological 'well-being' was evident. Importantly, they noted that this effect was most consistently found when support was measured as a perception that one's network is ready to provide aid and assistance if needed. They further comment that personality characteristics may affect the ability of an individual to develop supportive networks.

The buffering effects of social support may be more readily observed in clinical populations. However, Davis (1996) notes that unpublished data from a survey of rural community older adults found evidence for only a "direct effect" model in older adults. He suggests that this implies that social support provides a direct influence regardless of a stressor and this influence results in beneficial outcomes. It is likely that Lazarus (1985) is correct in his assumptions that individuals view social support as a coping resource. However, it is possible that social support exerts a direct effect as life is inherently threatening. From this, it could be

hypothesised that individuals continually appraise their situations, whether at a conscious or non-conscious level, and the awareness of social support reduces or lessens the impact of perceived stressors. Thus, in the absence of significant daily hassles, smaller problems, no matter how small, could accumulate over time and impact on a person's 'well-being'.

Cohen and Wills (1985) further argue that social support can be defined by four sub-categories or 'support resources' that are available to individuals. The first of these is esteem support. Cobb (1976) defines this as the knowledge that a person is esteemed and accepted. Esteem is increased in an individual by them being informed that they are valued and by experiencing that they are accepted despite difficulties or personal faults (Cohen & Wills, 1985). Power *et al.* (1988) also refer to esteem support as 'emotional support'.

The second support resource according to Cohen and Wills (1985) is informational support, which can be defined as help in determining, understanding, and coping with a problematic event.

The third resource is social companionship, which is spending time with others in recreational activities. Cohen and Wills (1985) suggest that this may reduce stress by satisfying a need for contact with others. Also, it may be used as a cognitive distraction from worrying about problems, or it may directly increase the possibility of a positive mood.

The fourth and final resource suggested by Cohen and Wills (1985) is instrumental support, which is support that is concrete. For example, this may be financial aid, material resources or necessary services. This type of social support may help to reduce stress by reducing overall problem levels or by freeing up time for the individual to allow for activities such as relaxation, or entertainment. Power *et al.* (1988) call this type of support 'practical support'.

Although Cohen and Wills (1985) suggest that these four distinct categories of social resources exist, they argue that in a naturalistic setting they do not exist in isolation. They indicate that it is probable that the greater the social companionship the greater the access is to both practical and emotional support.

Handen (1991) notes that despite many theorists accepting Cohen and Wills (1985) "stress buffering" hypothesis, only a few researchers have attempted to explain the interactions present and how this may lead to changes in 'well-being'. For example, Pearlin *et al.* (1981) argue that social support increases self-esteem and feelings of mastery over one's environment. This then results in an enhanced positive affect and then a reduction in the effects that environmental stressors can have. However, Davis (1996) indicates that it is unclear if the cathartic effect of being able to release emotion is beneficial, or more simply the gains in self-esteem arise from knowing that people care.

However, the buffering hypothesis is still being questioned and investigated. A recent study by Wade and Kendler (2000) assessed 2163 female pairs of twins over

two time periods. A semi-structured interview was employed to assess levels of social support, depression, and significant life events. Specifically they were interested in examining the interactions between social support and stressful life events. From the results, they concluded that there was little evidence of a “stress buffering” effect of social support.

1.6.6 The effects of life events on social support

Thoits (1982) argues that life events themselves may lead to changes in social support. She goes on to state the importance of the interactions between changes in life and changes in social support. Interestingly, life events are measured by the number of significant events experienced by an individual over the last six to twelve months. A large number of these events are often linked to changes in the persons social sphere (e.g. death of a spouse, retirement etc). Handen (1991) suggests that this is a flaw of many studies focussing on social support as they are often conducted after the event has occurred and as such it becomes difficult to evaluate the impact of social support on ‘well-being’ as the level of support may have recently changed. More importantly Lazarus (1990) argues that life event measures remove the appraisal aspect of the stress process. He argues that stress is a subjective experience and that to give values, even global values, to a possible significant event removes the individual from the equation. As an example, it is possible that to one person the death of a spouse may be a release from an unhappy marriage and as such this will not be perceived or appraised by them as being extremely stressful. Davis (1996) states that the various functions of social support

and social networks coexist and vary within individual older adults. It is important therefore, to attempt to separate the nature of the relationships present (Davis, 1996).

1.6.7 Depression and social support

A study by Chi and Chou (2001) examined the association between support and depressive symptomatology in older adults. They recruited 1106 older adults and measures were taken of depression, network size and composition, frequency of social contact, quality and amount of social support, functional disability, help given to others, and socio-demographic data. The authors employed multiple regression models and the results indicated that satisfaction with social support was the most important predictor of depression. This was also true when functional disability and socio-demographic variables had been controlled for.

It was further noted that material aid and instrumental support had a stronger relationship with depression than emotional support. Chi and Chou (2001) concluded that researchers should take into account all aspects of social support. However, they are aware that the results from this study may not extend to other cultural groups, as the participants were all Chinese older adults. Furthermore they suggest that implications about causality and temporal relationships need to be assessed in a longitudinal design rather than by a cross-sectional design as used in their study.

A study by Oxman *et al.* (1992) focussed on the effects of social support on depression in older adults. They claim that older adults with larger social networks, which provide contact and emotional support report higher levels of satisfaction and less loneliness than older adults who do not have such networks. A total of 1962 participants from a non-institutional setting were recruited. Information was gathered at two time periods, separated by three years. The same interview was utilised on both occasions. Factors that were assessed within this study included: depression, social network (including structural characteristics) and social support, the perceived adequacy of both tangible and emotional support, functional disability, socio-demographics and a change score that focussed on possible losses of function.

The results from this study indicated that the level of emotional and tangible support was significantly associated with symptoms of depression three years later. The higher the level of perceived support the lower the symptoms of depression were. In fact Oxman *et al.* (1992) also noted that the perceived level of social support still had an impact on depression when additional determinants of depression, such as functional disability and socio-demographic factors were included.

Interestingly, it was noted that perceived emotional support had a stronger association with depressive symptoms than perceived tangible support. Oxman *et al.* (1992) suggested that this finding is fundamental because functional disability is usually higher in older adults and it is logical to assume that tangible support would

be of greater benefit. A further finding was that close relationships were more likely to increase depression through loss as opposed to preventing depression by gaining or maintaining intimacy.

Another interesting finding noted by Oxman *et al.* (1992) was that both perceived emotional and tangible support had stronger associations with depressive symptoms than social network. This finding can possibly be explained by the friendship patterns noted in the Potts (1997) study below.

There are several limitations with Oxman *et al.*'s (1992) study. Firstly, implications regarding causality may be dubious. The levels of social support were assessed in 1982 and depression was assessed three years later. There is a high possibility for confounding variables, which were not measured - a fact noted by the authors. They also comment that in the later study the self-report format may have been influenced by psychological traits and states. For example, personality characteristics may influence perception and the ability to engage in effective social support. However, whilst they argue this point, the processes through which it could occur is not clear. If personality characteristics are important in perception and ability to engage social support then it is unlikely to directly effect the outcome measure of depression.

Potts (1997) examined the levels of social support and depression in older adults living alone. In particular she focussed upon the importance of friends within and outside of a retirement community. She felt that retirement communities could

isolate the elderly from the outside and therefore significant levels of support. In total data from 99 residents of one retirement community in California was collected. Of these over 80 per cent were female. The standardised questionnaires utilised in this study looked at the perceived quality, network size and confidential relationships regarding social support. Two parallel sets of measures were used to assess social support from both within the retirement community and from other social support sources. In addition, measurements of depression and physical health were also used along with qualitative measures, which focused upon satisfaction with social support.

From this study Potts (1997) noted that participants significantly rated their network quality higher for friends within the retirement community compared with their friends outside. However, she observed that the perceived quality of a confidant relationship showed the opposite, where scores were significantly higher for friends who were outside of the retirement community. It was further observed that women reported higher levels of confidant relationships outside of the retirement community than men.

Interestingly Potts (1997) found that higher levels of social support from friends who lived outside the retirement community were associated with lower levels of depression. However, levels of social support from friends within the retirement community did not appear to have an effect on depression.

Potts (1997) concluded that these results are consistent with friendship patterns among the elderly in age-segregated settings. Thus, the frequency of contact is not necessarily related to emotional closeness. She goes on to argue that this may, in part, be due to restrictions in socialising outside of the retirement community and casual friends may be more constant companions rather than close friends, whose availability in terms of geographical distance becomes more difficult as one gets older. There was no evidence to support the hypothesis that the length of time within the community would balance the effects of social support between the retirement and larger community.

There are several limitations evident in this study. Firstly, the sample comes from only one geographical location and as such findings may not be generalised to other locations. Secondly, the design of this study was cross-sectional, which means that casual inferences could not be made. Potts (1997) fails to note that the study is also limited in that it does not compare older adults living outside the retirement community with those living within the retirement community. Had this been done, friendship patterns in older adults could have been directly examined.

In another study, Dean *et al.* (1990) investigated the effects of social support on depression in the elderly from various sources. Information was gathered from 1174 older adults by a semi-structured interview. The interview assessed: depression symptoms, disability, undesirable life events, financial strains and expressive social support. The expressive social support assessment looked at four sources. These were: spouse, children, other relatives and friends.

The results from this study were as expected. Undesirable life events, financial strain, and disability were significant associated with depression. Support from friends had a strong effect on alleviating depressive symptoms. Whereas, support from the participant's children only had a limited effect, support from relatives had no effect at all. The most obvious explanation for this finding is that friendships are based on choice rather than obligation (Dean *et al.* 1990). However, caution should be exercised about oversimplifying and generalising these findings.

Dean *et al.* (1990) also noted that little support from available sources had a tendency to increase the risk of depression. Whereas, the absence of available support (e.g. being widowed) did not. It was also found that expressive support had a significant association with depression. They argue that there was no evidence to support the "buffering effect" in that stressors did not interact with expressive social support and as such they suggest that social support has a "direct effect". However, it could be argued that, as this was a cross sectional design utilising self-reporting, one cannot rule out the possibility that social support had already had a "buffering effect" whereby reducing the perceived number and or levels of stressors reported. The findings from this study are similar to those by Oxman *et al.* (1992) in that it is not the addition of support by itself that has an impact on levels of depression, but rather the absence of support.

Dean *et al.* (1990) go on to argue that this finding is not a rejection of the "stress-buffering" hypothesis (discussed above) but is more a result of the questionnaires

used in their study. They suggest that if other questionnaires had been used to assess support directly associated with particular stressors then it is likely that the buffering effect would have been demonstrated.

A more recent study by Mui (2001) examined the effects of life stresses and social support on depression in older Korean Americans. In total 67 participants were selected from senior centres. The areas examined were: depression, perceived health status, number of stressful life events, coping resources and socio-demographic variables. It was found that poor perceived health had a significant relationship with depression. Furthermore living alone was also associated with higher scores for depression.

Mui (2001) reports that perceived dissatisfaction with the quality of help from family members and fewer friends were associated with higher depression scores. She argues that the association of depression with perceived quality of help from the family is a function of the Korean culture and the expectation of elders within this community. She also makes other claims regarding reasons for the findings based upon the ethnic background of the group. Although, she fails to provide evidence for this and the findings are consistent with other ethnic groups such as those discussed in the studies above. Thus, the results may need to be treated with caution. She further suggests that it is possible that the self-selecting basis of the study could have confounded the findings.

An earlier study by Burnette and Mui (1996) focussed upon older females who live alone. In total 2506 participants were recruited and interviewed by telephone. Areas of interest included: health and functioning; social and psychological stressors; informal and formal support; and socio-demographic factors. It was noted that older women seemed to have better levels of psychological 'well-being'. Health problems were significantly related to higher levels of depression. Also greater levels of perceived support from children and increased knowledge of services were significantly associated with psychological 'well-being'. Living alone related to higher levels of depression in women in their 70's. Whilst Burnette and Mui (1996) have made a good attempt at assessing the relationship between social support and 'well-being' they do not acknowledge that cohort effects may be present.

1.6.8 Social support and day hospitals

In the study by Cann *et al.* (1996), where users views of adult psychiatric day hospitals in an inner city setting were audited over two years, it was reported that the reason given most often for attending day hospital was to meet friends, with 54 out of the 77 patients interviewed selecting this response. It was also noted in the results that a small minority of patients interviewed had ever attended alternative day centres and only a few had had any contact with an outside professional such as community psychiatric nurses, general practitioners or social workers. When patients were asked if they benefited from sharing the day care with different sorts of patients with various differing problems, the majority of answers were positive (55 per cent). Because of these findings from the 1992 audit, groups within the day

care unit were adapted by staff to include a more social component. During the 1993 audit it was found that the changes had raised the overall helpfulness rating of the group work. Interestingly, those patients who did not select any groups were less likely to perceive the day hospital as helpful.

Caan *et al.* (1996) have also argued that finding social factors to be the most frequent and important response given for attending the day hospital raises the question as to whether this is an appropriate use of resources. They suggest that it may be possible to replace expensive health teams with non-clinical drop-in facilities. However, they acknowledge that there is likely to be more benefit to the patients than just the social aspects. The fact that the patients highlight this factor as the most important might reflect the more patient centred approach adopted by staff. To support these results, they argue that irregular attendees reported fewer reasons for attending the day hospital, possibly because these patients had different levels of social support elsewhere in the community. However, another possible reason for this could be that irregular attendees have poor social attributes and as such the social aspects of the day hospital environment would not adequately provide for their needs.

A study by McCarten-Quinn *et al.* (1996) examined the satisfaction of older adults with services provided by a health board in Northern Ireland. The authors of this study focussed on what they termed “community units”. They assessed four of these units, which provided community health and personal social services. They also assessed the views of the older adults’ carers. Interviews were conducted with

patients who attended the day care facilities and informal discussions were held with their carers in order to develop a measure of service satisfaction.

McCarten-Quinn *et al.* (1996) noted that the majority of comments centred on six categories. These were: support, empathy, integration, information, maintenance and social elements. McCarten-Quinn *et al.* (1996) reported that after the questionnaires were designed, a sample of approximately 700 elderly people were identified. Only 410 of these were actually interviewed. The interviews were carried out in the participant's home as it was felt that postal interviews presented difficulties for this group.

The carer survey also utilised the same six areas but with different statements relating more to how they perceived the service met their needs as carers. The carers selected were from a random sample whose relatives were not part of the user survey. This was done to prevent client-carer interaction. Approximately 600 carers were contacted via a postal survey and a total of 202 completed questionnaires were returned.

The results from the McCarten-Quinn *et al.* (1996) study indicated that the patients were particularly dissatisfied with the amount of information that they receive, the level of social support and way in which their social needs were met. Interestingly, this was reflected across all localities. The results from the carers' survey also reflected the same pattern noted by the patients. It is worth noting that overall the carers were less satisfied with services than the patients. In fact the difference

appeared to be almost 30 per cent. It was concluded that this survey was costly and time consuming and the authors were unsure if such surveys are warranted due to the cost. However, they noted that the findings would need to be examined further.

1.6.9 Gender differences with social support

Chappell *et al.* (1990) investigated gender differences in helping networks for older adults who attended a day hospital or an older adult centre. In particular they were interested in the effects across three illness situations. These were, common ailments, hypothetical short-term health emergencies, and functional disabilities. 200 participants were interviewed from day hospitals and 148 participants from older adult day centres. Participants were matched by age, sex, and ethnic origin. Measurements were taken of social network size, actual support across the three illness situations and demographic variables. The findings from the study indicated that women were more likely than men to receive assistance from family members (other than a spouse) and they were also more likely to receive support from friends as well. It was further noted that women tended to be the people who provided most of the support and had larger networks. However, there were several problems with this study. It relied on recall of information from the participants and the authors did not take into account that men may not admit to support in these situations, as it may appear to detract from their masculinity.

The effect of gender differences in social support among older adults was also investigated by Krause and Keith (1989). A total sample of 265 older adults were interviewed and then re-interviewed approximately a year later. Measures were taken of social support, stressful life events, chronic financial strain, personal control, social desirability and demographic variables. The results indicated that as the number of life events increased both male and female older adults were equally likely to become more involved with social support. The only noticeable differences in gender concerned financial strain.

Krause (1986) examined the effects of social support and 'well-being' among older adults. Participants were recruited randomly from a community sample. 78 per cent of the sample completed interviews totalling 351 participants. Measurements were taken of social support, life events, symptoms of depression, and demographic variables. The results from this study indicated that none of the social support variables had a significant relationship with depressive symptomatology. Life events were separated into four categories. These were bereavement, crime and legal matters, network crisis and financial problems. It was noted that a significant relationship existed between bereavement and the level of social support. Interestingly, bereavement had a significant positive relationship with positive affect among those participants who depended heavily upon others. It was also noted that social support had a negative relationship with depression when crime and legal matters were examined as stressors.

The results indicated that the effect of a network crisis stressor was lower on those who had more integrated networks. The financial support stressor did not have a significant relationship with 'well-being'. It is possible that the lack of findings here may have been due to other confounding variables such as gender. Krause (1986) concluded that social support buffers the impact of stress on psychological 'well-being' in specific ways. However, the study utilised a cross-sectional design and as such causality cannot be assumed.

1.6.10 Review of social support and psychological well-being

From the studies by Dean *et al.* (1990), Oxman *et al.* (1992), Potts (1997), and more recently by Chi and Chou (2001), and Mui (2001) there appears to be a significant link between social support and psychological 'well-being'. As noted earlier, day hospitals implicitly provide a supportive function, possibly in the place of inadequate external social support. This is not mentioned as an original aim in the Royal College of Physician's (1994) report on psychogeriatric day hospitals. This may be because they were intended to provide a therapeutic range of treatment options.

When Zank and Schacke (2002) investigated the effects of geriatric day care on patients and care-givers, they noted highly significant effects between 'well-being' and life satisfaction, depression & perceived social support.

Zank and Schacke (2002) argue that the positive effects of the day care unit are the result of the optimising environment of the unit. They hypothesis that patients or

care-givers select a supportive environment that allows them to maximise abilities and compensate for their deficits. In fact, in their study just over half of the patients who attended the day care unit did not have any care giving relatives. This in itself is an important finding regarding the availability of social support for attending day hospitals.

1.7 Locus of Control

Whilst there is little doubt from the evidence examined above that social support is important in the well-being of individuals, little attention has been placed upon the factors involved in receiving support. It is possible that the impact or the use of social resources is influenced by personality characteristics. Indeed, House (1981) comments that information about the determinants of social support may be critical in developing effective interventions to enhance the quality of support in people who have low support.

Lu (1995) argues that one area which has received a large amount of attention from researchers is that of perceived control. Perceived control or locus of control (Rotter, 1966) can be defined as a generalized belief or perception held by an individual about the extent to which aspects of their lives are determined by internal or external factors.

Internal factors may be such things as ability and personal initiative whereas external factors could be such things as fate, or powerful others (Lu, 1995). Ross & Sastry (1999) argue that a sense of personal control has social causes and emotional consequences. They suggest that distress tends to be greater among people who believe that they have little influence over the things that happen to them.

Lu (1995) observes that the link between locus of control and stress reactions have been well established. More specifically an internal locus of control has been found to relate to better psychological outcome. Also Parks (1984), notes that locus of control may be connected to the utilisation of active coping strategies. Indeed, Blaney and Ganellen (1990) examined the effects of locus of control as a component of the construct of 'hardiness'. In particular they investigated the interactions with social support. They hypothesised that individuals with an internal locus of control would be more willing to seek social support and therefore were more likely to receive help. They further postulate that help-seeking behaviour is a form of active coping and the gains made from social support may explain the differences in 'well-being' for people who have an internal locus of control compared to those who have an external locus of control.

1.7.1 Factors affecting receipt of social support

Schaefer *et al.* (1981) argue that social support research needs to take into account the great width and variety of support. In particular they comment that more focussed hypotheses need to be generated surrounding the relationship between

social support and positive outcomes. Lu (1995) attempted to identify potential factors that determine the use of social support. She utilised a cross sectional design with a sample of 581 adult subjects taken randomly from a town in Taiwan. The areas examined were: social support (which looked at emotional, practical, information and companionship support), locus of control, extraversion, demographics, and social resources (which examined the number of confidants).

The results from the study indicated that a positive relationship existed between levels of social support and persons who were younger, better educated, and female. Lu (1995) further noted that a relationship existed between the level of social support and whether the person had an internal locus of control and was more extraverted. Furthermore, being married was not correlated with support received, whereas the number of confidants was.

Lu (1995) believed that the relationship between education and social support is somewhat surprising. She hypothesised that one possible explanation for this is that better educated people have increased access to various information and services and therefore tend to have an integrated, active social network which is better equipped to provide support. It is also possible that better educated people are more aware of the social support transaction and as such are more active in seeking adequate levels of support. Furthermore, locus of control may act as an intervening variable. She further argues that better educated people have a stronger sense of internal control resulting from their education, which has fostered independence and personal mastery. This then has a positive impact upon self-efficacy.

Lu (1995) also noted that extraversion was an important predictor of whether a person received support. She argued that extraverts not only had a stronger tendency to actively seek social support, but also had a higher level of internal control and more access to social resources. She concluded that whilst these findings are interesting the cross sectional nature of this study does not allow for conclusion to be drawn regarding causality.

1.7.2 Empirical validity of locus of control and social support

As with most of the studies that investigate locus of control undergraduates have been used as the main focus group. Obviously, this limits the conclusion that can be drawn for older adults. However, this area appears to be under-investigated with older people and as such the results of these studies should to be used tentatively when considering psychogeriatric day hospitals.

Studies by Lefcourt *et al.* (1984) have noted that a relationship between internal locus of control and social support existed. They argue that the effect of social support is not universal. In that some supports may be more effective than others and some people may make better use of the resources available to them. They conducted two studies to assess this relationship. The first of these studies recruited 46 undergraduate students. Areas of interest included: life events stress, social support received, locus of control, affiliation or autonomy and mood. The results indicated that those participants who had an internal locus of control were less likely to have had negative life events and mood disturbance. It was also noted that

the relationship of life events to mood disturbance was weaker in internal compared to external locus of control. In particular, they noted that with increasing negative experiences, individuals with an internal locus of control who had adequate levels of social support exhibited a decrease in mood disturbance.

The second study conducted by Lefcourt *et al.* (1984) increased the sample size. Again, undergraduate students were recruited and on this occasion a total of 99 participants were assessed. Later, a third study was conducted to assess the reliability of the moderator effects.

The results from both the second and third studies reflected the findings in the original study with only minor variations, none of which were significant. Lefcourt *et al.* (1984) concluded that those participants who were generally less sociable appeared to benefit the most from the presence of social support. They also suggested that locus of control by itself does not have a direct effect upon stress. However, through interaction with social support they noted moderation of stress levels. Furthermore, individuals with an internal locus of control may regard themselves as responsible for their predicament and therefore draw more useful support from close companions.

There are several problems with the results of this study however, in that the measure of locus of control is specific to the undergraduates (e.g. goal oriented) and it is possible that these findings may not extend to a wider social setting or be applicable to other cohorts. Also, the finding that less sociable individuals, those

with an internal locus of control, benefited most from the presence of social support appears a little paradoxical. Lefcourt *et al.* (1984) noted that a higher level of social support with people who have an internal locus of control was related to lower levels of mood disturbance. Surely, if a person is less sociable then the opportunity for social support is less. One possible explanation concerns the amount of social support in relation to a person's current levels. If you give the same amount of support to two people, one of who has low levels of support and the other who has high levels of support then the impact on 'well-being' is unlikely to be the same. Support probably has a bell shaped relationship with 'well-being' rather than a direct linear relationship.

1.7.3 Locus of control and social support

Ross and Mirowsky (1989) suggest that there are three possible theoretical views surrounding the relationship between social support and locus of control. The first of these is displacement. They argue that social support detracts from an individual's perceived control and this results in displacing active problem solving. Thus, they suggest that people who have a greater internal locus of control are probably more effective in problem solving than those who turn to others and consequently are less likely to seek or need social support. The second theoretical point of view is that social support facilitates problem solving. They propose that the emphasis is not that the person relies on another rather that they perceive that support is available and as such this gives the person the courage to act. The third view is that support can be substituted from one resource to another to reduce

distress. They argue that according to this view, support and perceived control are interchangeable. Thus, one resource fills the breach if another is absent. Perceived control provides confidence in one's abilities and social support provides confidence regarding one's worth.

Ross and Sastry (1999) suggest that a belief that an individual has control over their own life, may be the most important of all the beliefs surrounding self and society that might affect stress. They further hypothesise that women have a lower sense of control and compensate for this by being more external than men. This is, they suggest, due to economic dependency, restricted opportunities, and role overload.

1.7.4 Locus of control and age

Ross and Sastry (1999) state that age can impact on locus of control, in that the older the person the less perceived control they have. However, studies regarding this have not been conclusive. For example, a review of studies by Lachman (1986) noted that one third of studies comparing age and locus of control found evidence of older adults having lower levels of control, one third found no associations, and one third found high levels of perceived control. Lachman (1986) notes however, that there are often methodological problems regarding studies of this nature. For example, older adults are often examined in isolation to other age groups. Also, comparison groups are often unrepresentative (e.g. college students and undergraduates). Mirowsky (1995) suggests that levels of perceived control declines during later life. In particular, he proposes that levels of perceived control

remain stable until about the age of 50 and then take a dramatic decline. In fact a study by Mirowsky (1995) noted that this was the case and the most important explanation for the decline was linked to education. Krause (1999) argues that there is evidence that both feelings of personal control and cognitive impairment follow a similar declining path.

Rodin (1986) argues that differences in age and locus of control may exist and that there are three possible explanations for this. These are: a loss of meaningful relationships, a deterioration of health and physical functioning and dependency created and enforced through contact with health professionals who prefer compliant patients. Wolinsky and Stump (1996) argue that there is likely to be a more relevant reason for possible differences in age and locus of control. They comment that this difference may be simply due to a cohort effect. They further observe that older adults often have lower levels of education, which may explain some of the association between age and perceived control.

Sandler and Lakey (1982) investigated the effects of locus of control on the relationship between negative life events and 'well-being'. In particular they looked at perceptions of control over these events and the receipt of social support. A total of 93 college undergraduates were recruited and they completed measures of locus of control, social support, life events, anxiety, and depression. The results noted indicated significant relationships between locus of control (externality), negative life events and anxiety. Interestingly, no significant relationships were found for perceived control of these events and locus of control. Also, no significant

associations were noted between perceived control of negative life events and 'well-being'. However, a significant relationship was found between locus of control and social support concerning both receipt and the impact of this support. Externality was positively related to the quality of support received, but the impact of this support was obtained in internals and not in externals (those with an external locus of control). This reflects the findings of Martin, and Saleh (1984). Sandler and Lakey (1982) concluded that more support is not necessarily equivalent to better support.

Johnson and Sarason (1978) investigated the impact of locus of control as a moderating variable of life stress and depression. They argue that locus of control influences the impact of a life change, be it positive or negative. They suggest that the impact of change in a person's environment is more likely to have negative effects for those persons who have an external locus of control because they are likely to perceive an inability to exert control over these changes.

Johnson and Sarason (1978) examined this hypothesis in 124 undergraduates. Measures were taken of life experiences, locus of control, anxiety and depression. Significant relationships were noted between negative life events and measures of anxiety and depression. Interestingly, these results were only found in those participants who had an external locus of control. They conclude that this provides support for their hypothesis that locus of control acts as a mediating variable in the relationship between negative life changes, depression and anxiety. Thus, it is argued by Johnson and Sarason (1978) that an individual who experiences high

levels of change, and perceives that they have little control over this, is more likely to have an increased negative impact on their psychological 'well-being'. However, it is important to note that the findings from this study are cross sectional and thus any causal relationships cannot be adequately assumed.

However, the impact of locus of control as a moderator of life stress may not be as clear as Johnson and Sarason (1978) suggest. Other authors (e.g. Bell *et al.* 1996) have suggested that the moderating effects of locus of control can vary based upon the event. For example, Bell, *et al.* (1996) argue that with relatively frequent natural disasters an external locus of control is more beneficial than an internal locus of control as there is often little that can be done to prevent the disaster occurring. They further hypothesise that an internal locus of control is better suited to disasters where the exposure to stress is short.

All of the above studies cite the multidimensionality of social support and from these investigations it is apparent that locus of control has a very important role. Even if locus of control is not the casual factor, Lu (1995), Sandler and Lakey (1982), and Lefcourt *et al.* (1984) have shown that there is a clear correlation between locus of control and social support. This means that locus of control can be a good indicator of how an individual may use the support available to them. In turn this may permit treatment, services available and even day hospital policy to be adapted to meet the needs of those attending.

1.8 Psychological well-being

At this juncture it is probably wise to mention the prevalence and incidence of mental health disorders in older adults. Blazer (2002) states that depression is generally considered to be the most common psychiatric disorder amongst older adults. However, recent evidence suggests that anxiety may in fact be more common (Laidlaw *et al.* 2003). Zarit and Zarit (1998) comment that depression has long been regarded as a defining characteristic of late life.

Probably the most extensive and therefore the most reliable research available on mental health disorders are available from the Epidemiological Catchment Area survey (Robins & Reiger, 1991). The findings from this survey revealed that rates of most mental health disorders were lower in older adults. The lifetime prevalence for depression for those aged 65 or over was 2 per cent. This is compared with adults aged 30-44 years of age where the lifetime prevalence was 10 per cent. However, the rates of depression in older adults vary depending upon the sample used. For example Katz, *et al.* (1989) identified a prevalence rate among nursing home residents of 18 to 20 per cent.

Laidlaw *et al.* (2003) argue that generalised anxiety disorder and simple phobias are quite common in older adults. Robins and Reiger, (1991) report that there is an overall prevalence rate of 5.5 per cent for anxiety disorders in older adults. They also indicate that phobias are the most common anxiety disorder for women. Furthermore, women are twice as likely to experience anxiety as men. However, Robins and Reiger, (1991) fail to report the generalised anxiety disorder rates.

Krause (1999) argues however, that there are several problems with prevalence rates for older adults. The first of these is that prevalence rates are often based on community samples where many older adults with mental health problems no longer resided. Second, some disorders have co-morbidity with either physical or cognitive impairments, making diagnosis difficult. Third, a lot of the scales used often rely on the respondents recalling their psychiatric history. Finally, it is possible that rates of mental health problems could be higher in younger age groups, as people with mental health difficulties are more prone to die at an earlier age.

For the purpose of this study psychological 'well-being' can be defined as the absence of depression or stress. Whilst there may be other factors involved within the concept of psychological 'well-being', it would not be practical within the confines of this study to try and formulate a stringent construct. Both the measures of psychological 'well-being' used within this study have been standardised. More specifically the Beck Depression Inventory-II (Beck, 1996) has been standardised on adults over the age of 65 years (Gallagher, 1986; Gallagher *et al.* 1982). The Perceived Stress Scale (Cohen *et al.* 1983) has been standardised on an adult population, which included older adults (Cohen & Williamson, 1988).

2 AIMS / HYPOTHESES

The primary aim of this study was to assess the views of user on their experience of attending an older adult psychiatric day hospital. A secondary aim was to assess the impact of levels of perceived social support within the day hospital. The third aim was to see if locus of control within older adults is related to the use of social support within a day hospital.

Hypotheses

1. The measure of participant's overall satisfaction with the day hospital will be an independent construct.
2. It will be possible to predict psychological 'well-being' as measured by the Beck Depression Inventory-II and the Perceived Stress Scale by the level of perceived social support, as measured by the Significant Others Scale.
3. Social support within the day hospital will have a buffering effect upon psychological 'well-being'.
4. Male participants will report lower levels of depression, stress and social support within the day hospital when compared to female participants.
5. The usage of social support, as measured by discrepancy analysis on the Significant Others Scale, will be able to predict the locus of control as measured by the Locus of Control Scale.

3. Methodology

3.1 Design

The study employed a survey design to investigate the association of certain factors with levels of perceived social support and 'well-being'.

3.2 Participants

The participants were recruited from an older adult psychiatric day hospital in the Kirkcaldy area. The day hospital served a patient population of 24,557 older adults. Only patients with functional psychiatric problems, such as major depression or anxiety were recruited. In total 6 males and 19 females took part, and the mean age of the whole sample was 76.2 years. All participants met the criteria below.

Inclusion:

- Participants had to have been under the care of the Westfield day hospital.
- Participants had to have been able to make informed consent.
- Participants had to have been able to speak and read English at a sufficient level as to allow informed consent.

Exclusion:

- Participants referred, were not to have had a diagnosis of an organic based mental illness;

- Participants referred, were not to have had a diagnosis of substance abuse;
- Participants referred, were not to have had a significant organic based disorder that was detectable by a mini mental state exam of 23 or less.

3.3 Ethical concerns

The impact of the study also needed to be taken into account. It was possible that discussing issues surrounding social support and their level of distress could have produced an emotional reaction. In addition, it was decided if a participant had significant problems, then with their consent this would be fed back to the staff. If any of the questions produced a significant emotional reaction or the patient displayed discomfort or fatigue then the interview was terminated and they were removed from the study. This happened only on one occasion.

3.4 Procedure

The study aims were achieved by conducting a single interview. The patients who attended the day hospital were separated into specific days, based on the type of problem they had. The study only accessed those days where there were patients with functional problems. The nurse asked those patients who attended the day hospital, on a functional problem day, if they wished to take part in a study looking at their levels of social support and their views of attending the day hospital. If the patient was interested, the nurse explained that they were required to complete a semi-structured interview and four short questionnaires. The patients were then

asked if they wished to find out more. If they agreed, they were then introduced to the researcher. This did not imply consent. Potential participants were then invited to attend for a private interview to discuss the research study and their willingness to participate. Here, the researcher explained in more detail what was required of the patient. Also, at this time the patient was given an information pack. Included in this pack was an information sheet (appendix 1) explaining the study and a consent form (appendix 2). The researcher encouraged the patients to take the pack away before committing to the study. In addition, any questions the patients had were answered.

If the patient consented to participate, a semi-structured interview was conducted followed by the completion of the remaining questionnaires. This lasted between 50 minutes to 80 minutes, depending on how much the participant had to say. If at any time a participant was deemed unsuitable they were withdrawn from the study. Participants were deemed unsuitable if they did not meet the inclusion/exclusion criteria or if any of the questions produced a significant emotional reaction or the patient displayed discomfort or fatigue. All information gathered was coded to maintain anonymity and the completed questionnaires were kept in a locked cabinet (in the locked and alarmed psychology department).

3.4.1 Questionnaires

Measures that were used included a semi-structured interview, the Beck Depression Inventory-II, the Perceived Stress Scale, Significant Others Scale, the Locus of Control Scale and the Holmes-Rahe social readjustment scale.

3.4.2 Semi-structured Interview

The Semi-Structured Interview (appendix 3) had been designed (to last no more than 60 minutes) to question participants on the important aspects of their expectations and experiences of attending an older adult psychiatric day hospital. During the interview, standard socio-demographic information, e.g. marital status, age etc was collected. Participants were not asked about socio-economic status. The interview schedule covered five main areas of enquiry relevant to the day hospital. This included understanding of their referral; involvement with group activities; contact with staff; level of satisfaction; and confidence in coping with the future. In addition to the semi-structured interview, participants also completed a number of standardised self-report measures.

3.4.3 Standardised Self-Report Measures

Significant Others Scale- Short Version (Power *et al.* 1988)

This scale was originally developed by Power *et al.* (1988) for an adult population (appendix 4). However, Lam and Power, (1991) later used it with older people. It

has both good internal consistency and reliability. This measure was used to determine the perceived form and function of social support, in actuality and in an ideal sense, for a range of key individuals in the respondent's life. The estimated time to complete the measure was five – ten minutes.

The Beck Depression Inventory-II (Beck 1996)

This is a 21-item self-report instrument for measuring the severity of depression in adults and adolescents aged 13 years and older. It was developed for the assessment of symptoms corresponding to criteria for the diagnosis of depressive disorder listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder, 4th Edition (DSM-IV: 1994). The scale required users to choose one of four statements which best applied to how the user had been feeling over the past two weeks. The version used can be completed in five –ten minutes. The Scale has been standardised on adults over the age of 65 years (Gallagher, 1986; Gallagher, Nies & Thompson, 1982) and has both good reliability and validity making it a suitable measure for this study (appendix 5).

The Perceived Stress Scale (Cohen et al. 1983)

This scale measures the degree to which situations in one's life are appraised as stressful (appendix 6). This is a 14 item self-report questionnaire. Each item refers to subjective appraisals of events occurring within a one-month time frame. Items are scored from 0 "never" to 4 "very often", with seven items being scored in the reverse direction. Thus there is a possible range of 0 to 56. The higher the score the more perceived stress is indicated. An example of an item within this scale is "In

the last month, how often have you felt that you were on top of things?”. The scale has good validity and reliability and has been standardised on a general adult population that included adults over the age of 65 (Cohen & Williamson, 1988).

The Locus of Control Scale (Rotter, 1966)

This scale investigates the beliefs about control a person has over his/her environment and life (appendix 7). The scale is a 29 item forced choice questionnaire. There are only two choices for each item. In addition to this, there are four filler questions. Scoring is achieved by summing the responses to obtain a total score, in the range of 0 to 25. It is scored in the external direction, the higher the score the more external an individual. An example of an external statement is “many of the unhappy things in people’s lives are partly due to bad luck”. Whereas an internal alternative could be “People’s misfortunes result from the mistakes they made”. This scale was originally developed for use with an adult population. It has good reliability, internal consistency and validity and has been standardised across a number of populations, cultures, & clinical settings (Dag, 1991; Piontkowski & Ruppelt, 1981; O’Brien & Kabanoff, 1981; & Harper *et al.* 1990).

Holmes-Rahe Social Readjustment Scale (Holmes & Rahe, 1967)

This scale consists of 41 life events, commonly reported as stressful, that have been identified from clinical experiences (appendix 8). The items are change events that precipitate movement from one equilibrium or steady state to another. Events addressed include family constellation, marriage, occupation, economics, residence, group and peers relationships, education, religion, recreation and health. Each event

is given a score and the participant is required to choose the events that have occurred over the past year. The participant can indicate as many events as they wish. A total score is achieved by summing all the items chosen. The Holmes-Rahe Social Readjustment Scale is a valid and reliable scale and it has been standardised on a general adult population (Scully *et al.*2000).

4. RESULTS

4.1 Statistical analysis

Once all of the data had been collated it was input into SPSS 11 for statistical manipulation and analysis.

4.1.1 Power

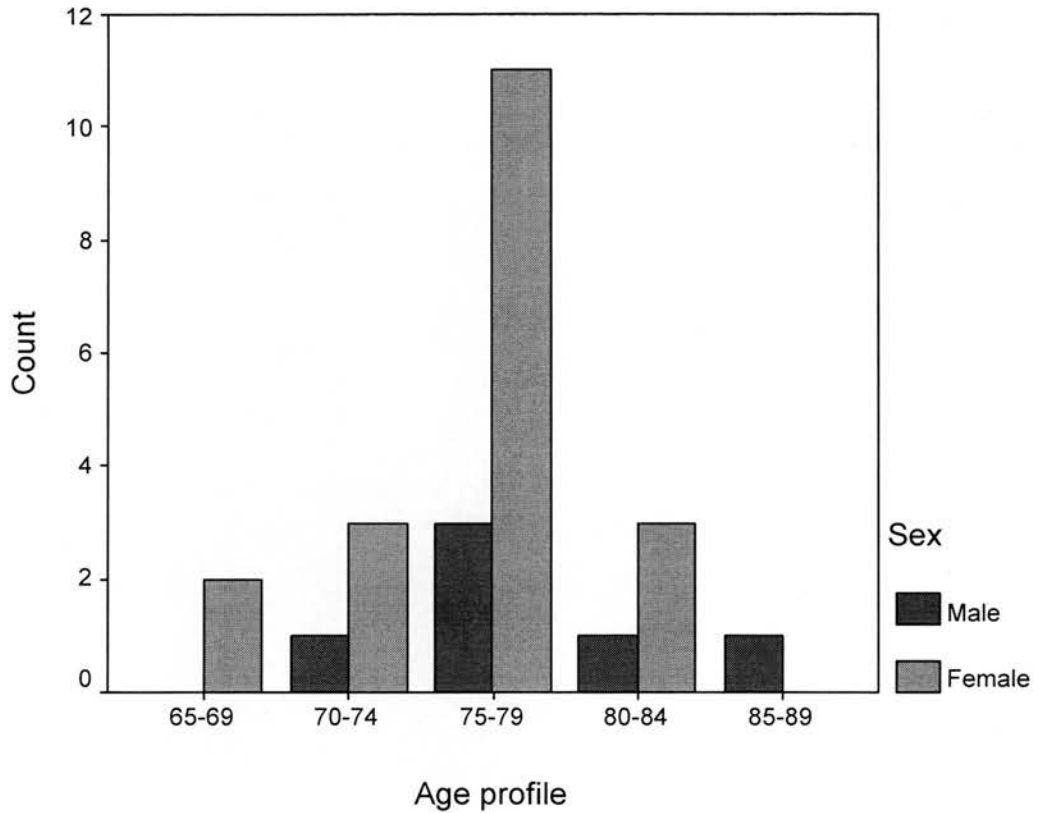
Before the procedure was implemented the required sample size for power 0.8 was calculated. As there were no suitable papers available for an estimate of effect size the required sample size was estimated using Cohen's (1992) tables. As this was an exploratory based study a large effect size was assumed and a sample size for a power of 0.8 with multiple regression with two predictor variables was examined on Cohen's tables. From this, it was determined that an approximate sample of 30 participants would be needed.

4.1.2 Sample

In total, it was only possible to recruit 25 participants for this study (6 male and 19 female). The mean age of the whole cohort was 76.2 years with a range of 66 years to 85 years. The mean age for males was 78.17 years with a standard deviation of 5.193 years. The age range for male participants was 70-85 years of age. The mean age for female participants was 75.63 with a standard deviation of 4.609 years and a

range of 66-83 years. Interestingly, female attendees appeared to be younger than the male attendees, see graph G1.

Graph 1 Age range of participants.



It was noted that 64 per cent of the participants were widowed, 16 per cent married, 12 per cent single, and 8 per cent were divorced. In addition the mean number of children was 2.28 (SD=1.792) with a minimum of 0 to a maximum of 6. In total 72 per cent reported lived on their own. The mean number of years spent in formal education by the participants was 10.04 years (SD=1.925) with a minimum of 9 years and a maximum of 15 years. The majority of participants (72 per cent) only had nine years of formal education.

4.1.3 Exploratory analysis

In order to assess the normality of the data set, exploratory data analysis was undertaken. Distributions were examined visually and tests were made for skewness and kurtosis. The results suggested that the distribution for the Beck Depression Inventory lay within normal parameters.

The findings from the Perceived Stress Scale did not. Whilst the skewness of the results were within acceptable limits (skewness = 0.814, SE = 0.464) the kurtosis of the distribution was not within normal limits (kurtosis = 1.909, SE = 0.902). In addition, there were also three outliers. Therefore, in order to obtain a homogeneous variance the results from the Perceived Stress Scale were transformed using a logarithmic transformation. Whilst this did bring both the skewness and kurtosis into normal parameters it produced four outliers. Therefore, a square root transformation was conducted instead. This again resulted in normal parameter skewness and kurtosis but left four outliers. Howell (1997) argues, that whilst it is acceptable to try several transformations it is not acceptable to utilise all transformations. Therefore, as the variance within the perceived stress scores were now normally distributed, it was decided to see if the outliers were in any relevant respect different from other participants. There did not appear to be any clear differences on other measures and demographics. All four of the outliers fell at both extremes outside the median, with two outliers at either end. According to Howell (1997) one option open is to remove the outliers from the data set. However, as the data set was rather limited in size and removing four participants would constitute

the subtraction of 16 per cent of the data it was decided to allow the outliers to remain a part of the total data set.

It was also found that whilst the locus of control scores fell within normal parameters for homogeneous variance (skewness = -0.868, SE = 0.464, Kurtosis = 1.154, SE = 0.902) there was one outlier. This outlier had a particularly low locus of control score. Again, logarithmic transformation was utilised. However, this produced an unacceptable kurtosis level (Kurtosis = 5.178, SE = 0.902) and an additional two outliers emerged. Square root and logarithmic transformations to the base 10 also failed to produce the desired effects. Analysis of the single outlier from the original data did not show any other apparent differences. Thus, the outlier remained part of the data set, which was not transformed.

Analysis of the life events score as measured by the Holmes-Rahe Social Readjustment Scale showed that the skewness (-0.072, SE = 0.464) and kurtosis (-1.148, SE = 0.902) were within acceptable parameters. In addition, there were no outliers.

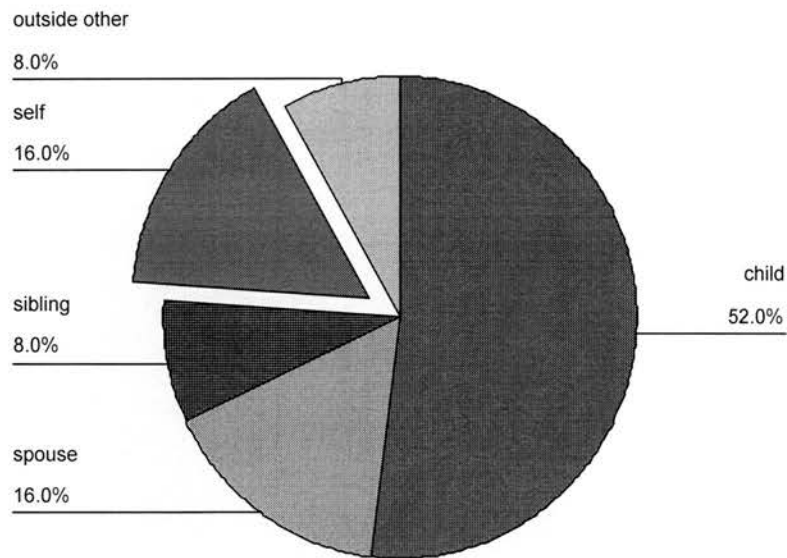
4.1.4 Data Results

The primary aim of the study was to elicit the user's views of their experience of attending a day hospital. The first section of the semi-structured interview examined demographic variables. Participants were asked who their main support was and their responses were later grouped into one of five categories. These were: child,

spouse, sibling, self, and outside other. The majority of participants, 52 per cent, had a child as their main support as shown in the graph G2 below. In 16 per cent of the sample the main support was their husband or wife, for 8 per cent it was a sibling, another 8 per cent had an outside family member as their main support and interestingly, 16 per cent classified themselves as their main support.

As there were possibilities for recent changes in support, the results from the Holmes-Rahe Social Readjustment Scale were examined. This scale measured significant life events that had occurred in the last year, including bereavement or divorce. No participants reported divorce or the death of a spouse in the last year. The mean length of stay in the day hospital was 57 weeks with a standard deviation of 69.5 weeks. The minimum stay was of two weeks and the maximum was 270 weeks. In total, 72 per cent of the sample had had at least one previous admission, but unfortunately information regarding the actual number of readmissions and the frequency of attendance was unavailable.

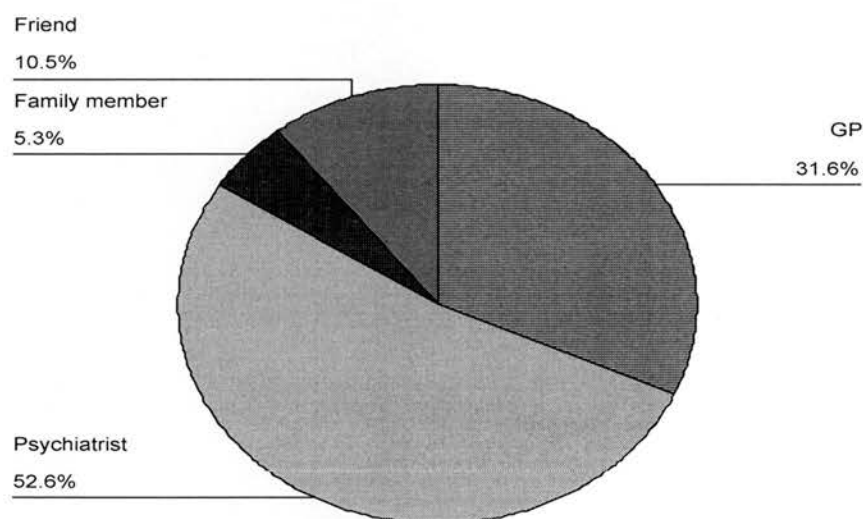
Graph G2 categorisation of the participants' main support.



The second section of the semi-structured interview examined the participants understanding of their referral to the day hospital. The majority of participants who were aware of being referred (77.3 per cent) believed that their referral had been adequately explained. Whereas, 22.7 per cent felt that this was not the case. Interestingly, 12 per cent of the overall sample was unaware of being referred to the day hospital. In graph G3 below most participants were informed about the referral by their psychiatrist, although 24 per cent were not sure who had told them. The majority of participants were either happy or very happy to attend the day hospital (56 per cent). Only 4 per cent of the sample was very unhappy with attending. The reasons given for this unhappiness included: nervousness, and a belief that they would be sitting all day.

Participants responded mainly positively (44 per cent) to whether the day hospital had lived up to their expectations. However, 28 per cent reported that it hadn't and the reasons for this ranged from 'wanting more activities' to 'just being better', although 72 per cent of the participants indicated that they enjoyed being part of the day hospital and 12 per cent were unsure. Interestingly, 28 per cent had no expectations regarding the day hospital.

Graph G3 Who informed the participants about the day hospital¹.



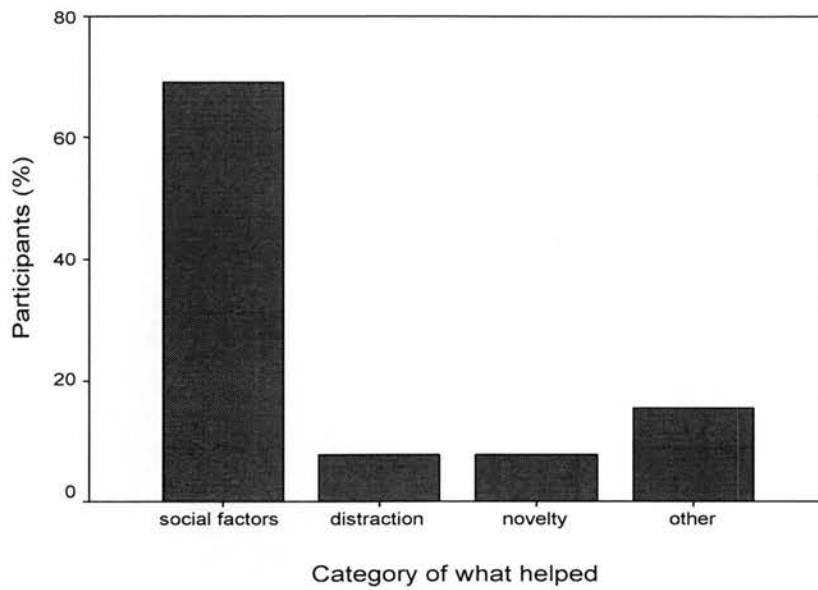
The third section of the semi-structured interview examined the participant's attendance of groups. In total, only 56 per cent believed that they participated in groups run by the day hospital. 4 per cent were unsure.

¹ 24 per cent of participants were unsure who had told them about the day hospital.

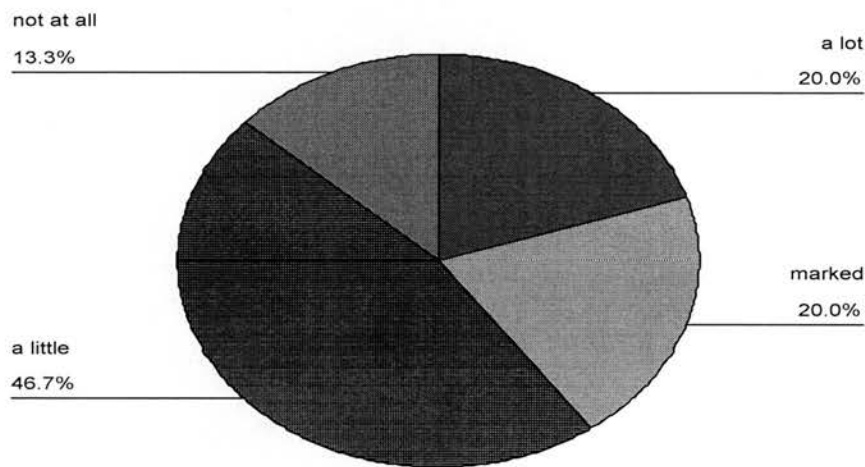
Of those who believed that they took part in the groups, five participants reported membership of only one group and ten participants reported membership of two groups. Just over half (53.3 per cent) of those who attended the groups felt that they were suited to their problems. The remainder felt that the groups were either ‘sort of suited’ or ‘not suited at all’. However, 78.6 per cent felt that the groups were what they had expected. Only 7.1 per cent did not know what to expect from the groups and 14.3 per cent reported that they had not meet their expectations. 86.7 per cent stated that they enjoyed the groups and the majority of participants (86.7 per cent) found that they were either helpful or very helpful.

When the participants were asked how the groups had helped them, the reasons ranged from “distraction” to being able to “speak their mind”. It was decided to group these responses into one of four categories. The categories were: social reasons, distraction, novelty and other. When analysed the majority (69.2 per cent) felt that a social element helped. The graph below (Graph G4) shows a breakdown of participant’s responses once they had been categorised. Only one participant gave an indication of things that didn’t help as part of the groups. This was inactivity. Overall 86.7 per cent of the participants felt that their difficulties had either changed a little, had a marked change, or a lot of change since starting the groups. Graph G5 below shows a breakdown of the participants’ responses to how much they perceived their problems had or had not improved since taking part in the groups. Only 13.3 per cent of attendees felt that there had not been a change in their difficulties.

Graph G4 Participants' response to what helped from the groups².



Graph G5 Participants' response to how much their problems had improved since taking part in the groups².

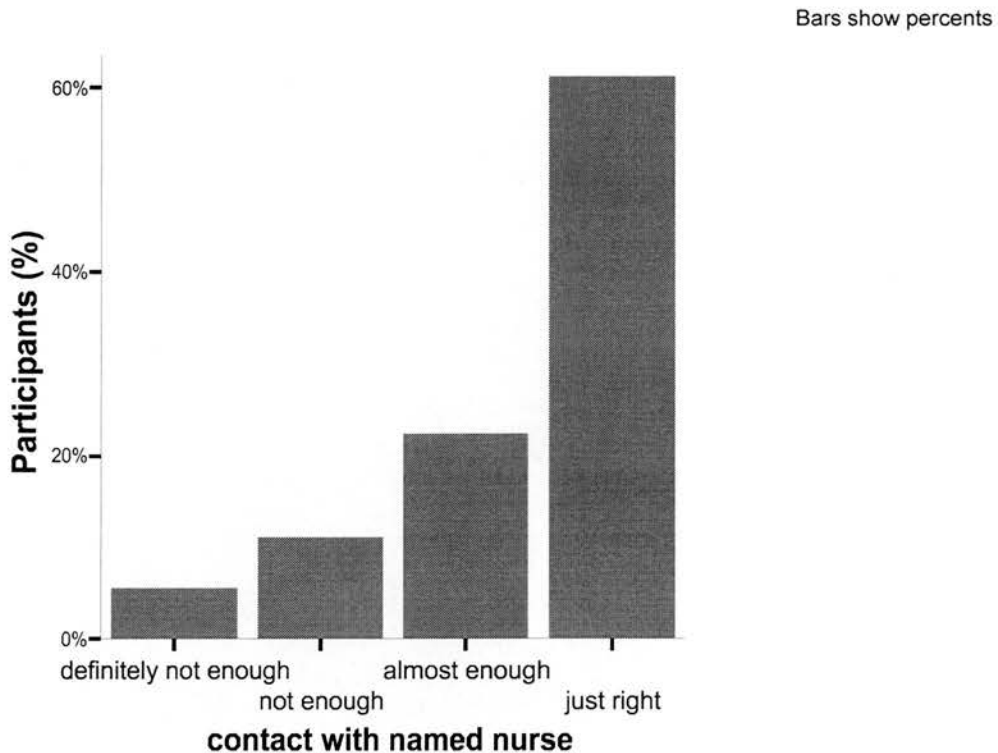


The fourth section of the interview focused on the level of contact with the staff. Overall 72 per cent of the participants felt that they had just the right amount of

² Just under half of the participants, 44 per cent, believed that they did not take part in any groups.

contact with staff and all were happy with this contact. Interestingly, 16 per cent felt that they did not have enough contact with staff. When questioned about the contact they had with their named nurse it was noted that 28 per cent of the participants were unaware that they had a named nurse. Of those that knew who their named nurse was 61.1 per cent felt that the contact was just right. A breakdown of the satisfaction of the participants' contact with their named nurse can be seen in the graph G6 below. The majority (81.3 per cent) were happy with the contact they had and 93.8 per cent rated the relationship as good. In addition to this, the majority of participants (52 per cent) felt that staff had understood the nature of their difficulties perfectly and 40 per cent felt that their difficulties had been mostly understood. However, 8 per cent felt that the nursing staff had not understood the nature of their difficulties.

Graph G6 Participants' satisfaction with the amount of contact with their named nurse³.

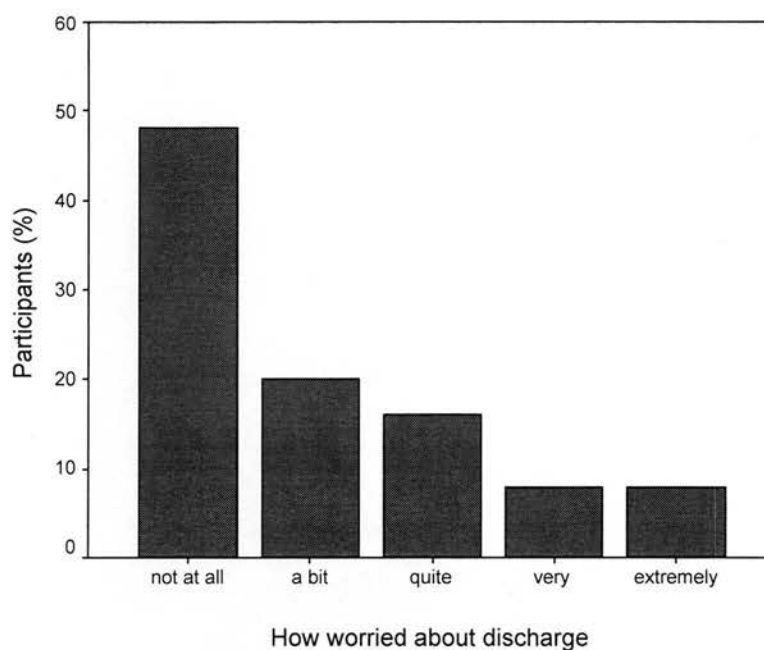


The fifth section of the semi-structured interview dealt with the level of satisfaction that patients had with the day hospital. As this section formed the basis for one of the hypotheses it is dealt with later. The final section of the semi-structured interview examined the participant's confidence about coping in the future. As shown in Graph G7, the majority of participants (48 per cent) were not worried about being discharged from the day hospital. However, 8 per cent were very worried and 8 per cent were extremely worried about being discharged. Furthermore, 64 per cent of participants were reasonably confident of coping in the

³ 28 per cent of the participants were unaware that they had a named nurse.

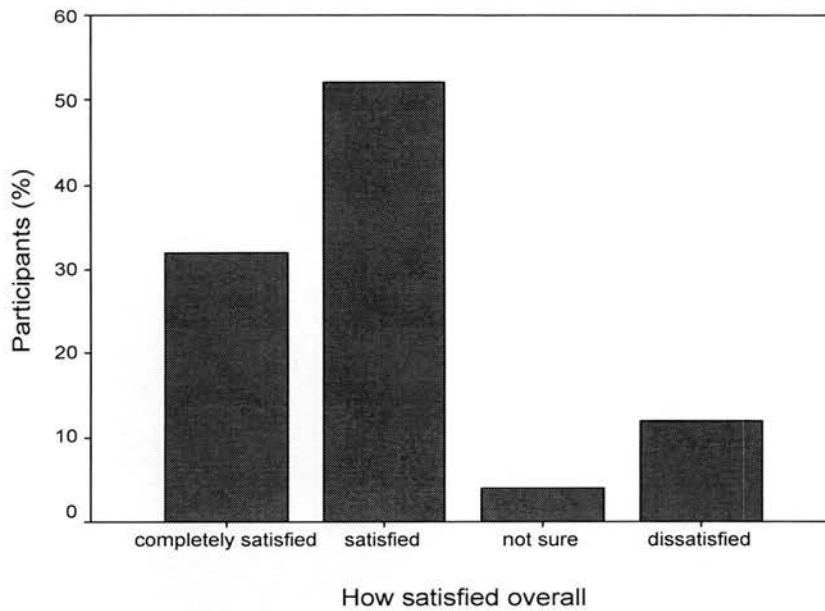
future and 16 per cent were very confident. However, 8 per cent were not terribly confident and 12 per cent were not confident about coping in the future at all.

Graph G7 Participants' concerns about discharge.



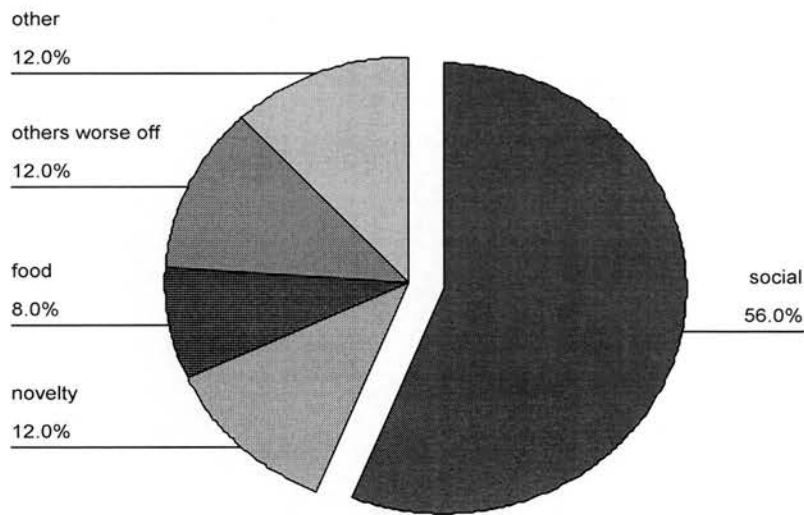
As stated earlier, participants' satisfaction with the day hospital was also measured. This was assessed in the semi-structured interview by using a five point forced choice adjective scale. Participants were asked to rate their overall satisfaction with attending the day hospital. As shown in graph G8 below the majority (52 per cent) were satisfied with the day hospital. In fact 32 per cent were completely satisfied. However, one participant was unsure and 12 per cent of the sample was dissatisfied with the day hospital. Although, nobody reported being completely dissatisfied.

Graph G8 Participants' level of satisfaction with the day hospital.



Participants were also asked what they liked the most about attending the day hospital. Responses included “distraction”, “good meals”, and to “see others worse” than they were. The responses were grouped into one of five categories. These were: social, novelty, food, others worse off, and other. The ‘other’ category included responses of “distraction”, “the help from staff” and one participant who was unsure what they had liked best about attending the day hospital. As shown in graph G9 the most frequently reported factor for what participants liked most about the day hospital, was a social factor. In total, 56 per cent indicated that this was the factor that they most liked. The other factors all collected the same percentage of response (12 per cent) apart from the food factor, which was chosen by two participants. Interestingly, only one participant mentioned the help that they received from the staff was what they liked most about attending the day hospital.

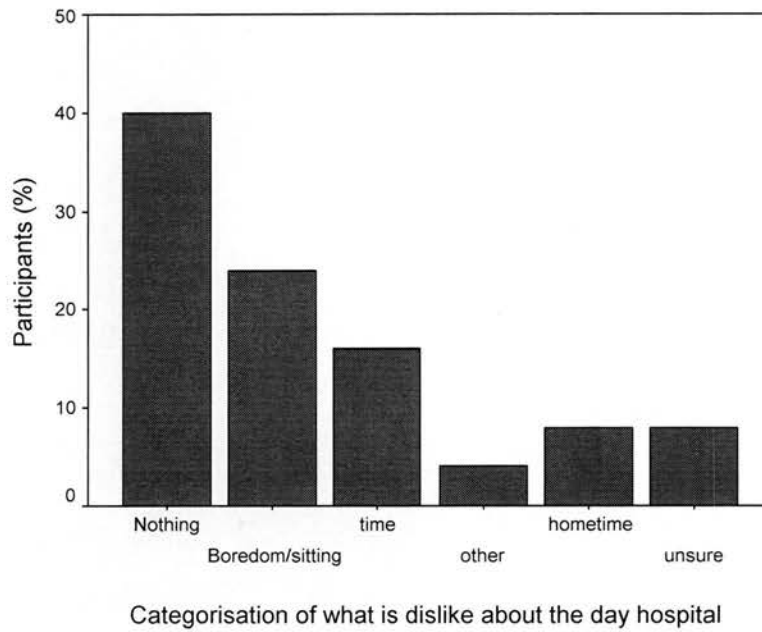
Graph G9 What participants liked most about attending the day hospital.



Participants were also asked what they liked the least about attending the day hospital. Responses included “getting up early”, “going home”, and “sitting around”. Again, to aid analysis these responses were grouped into one of six categories. These were: nothing, boredom / sitting, time, home time, unsure and other. Time referred to the start time of the day hospital or the day of the week that they were scheduled to visit. As shown in graph G10 below, 40 per cent felt that there was nothing that they did not like about the day hospital. This constituted the largest group. However, 24 per cent of the participants gave a response that indicated boredom. Actual responses included “sitting sleeping” and “being bored in the afternoon”. Also, 16 per cent disliked either the day they attended or the time at which the day hospital started. Interestingly, two participants did not like going home. However, it was unclear if this response referred to the travelling aspect of

going home or if they preferred to be at the hospital instead of being at home. Furthermore, two participants were unsure if there was anything that they did not like with regards to the day hospital.

Graph G10 What participants didn't like about attending the day hospital.

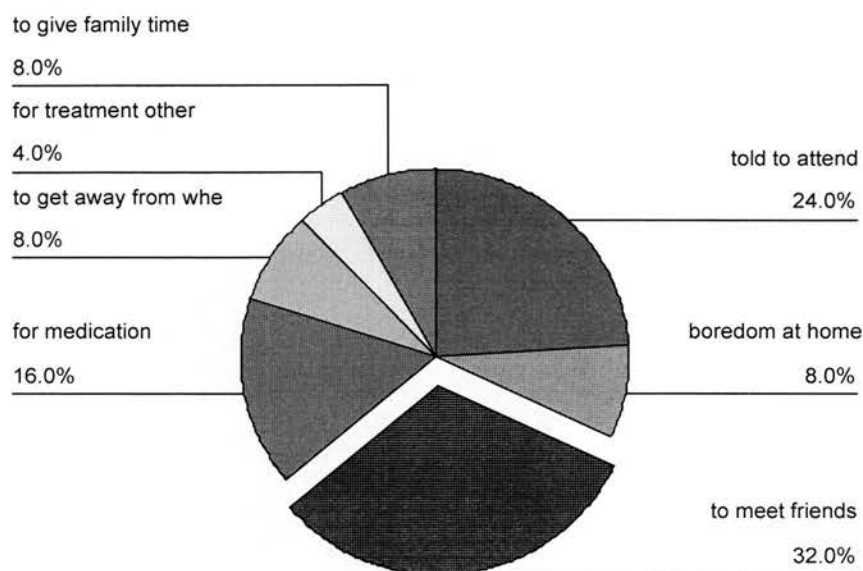


Participants were also asked to choose which of eleven factors were the most important to them when attending the day hospital. The factors that they could choose from included:

1. Lunch.
2. Because they had been told to attend.
3. Boredom at home.
4. To have a break from their family.
5. To meet friends.
6. For medication
7. To keep warm in winter.
8. To sort out their benefit money.
9. To get away from where they lived.
10. For treatment other than medication.
11. To give their family time off.

As shown in graph G11 below, the factor chosen by most participants was a social factor, 'to meet friends'. This accounted for 32 per cent of the responses. The next most popular factor, accounting for 20 per cent, was 'because they had been told to attend'. 'To get away from where they lived' and 'boredom at home' had equal numbers of participants choosing them (12 per cent each). 8 per cent of participants came to the day hospital 'to give their families time off'. Interestingly, only 12 per cent felt that the most important reason they came to the day hospital was 'for medication' and only one participant chose 'treatment other than medication'.

Graph G11. The most important factor for participants attending the day hospital.



It was noted by staff however, that the patient's reasons for attending may have changed over time and that this may well have reflected where the participant was, in relation to his or her treatment programme. Thus, it could be hypothesised that a person who had only recently been referred would have been more likely to hold the opinion that the most important reason for attending was either for 'treatment' or because 'they have been told to attend'. Whereas, participants who had attended for some time and were those more likely to have built up peer groups, meaning that 'treatment' or 'being told to attend' may no longer have been important factors. Therefore, it was important to examine this element.

To do this a one-way analysis of variance was conducted with 'the length of time attending the day hospital' as the dependent variable and the 'most important reason

for attending the day hospital' as the grouping variable. However, there were some small groups present. This required some categories to be combined to increase the number of subjects in each group. The revised list included: to get away from home, for treatment, to meet friends, and because they had been told to attend. The results did not indicate that the most important reasons given for attending the day hospital was significantly different on the measure of the length of stay within the day hospital ($p=0.66$, $F(3, 21) = 0.545$). Thus, there was insufficient evidence to suggest that the most important reason to attend, within this sample, was affected by the length of stay in the day hospital. However, it should be noted that the distribution in length of time attending the day hospital, whilst within normal parameters (skewness = 1.666, SE = 0.464, Kurtosis = 2.325, SE = 0.902), has five outliers. These outliers have a longer attendance at the day hospital and as such sit outside the median. Thus, only limited conclusions can be drawn.

4.2 Analysis of hypotheses

4.2.1 Hypothesis 1

“The measure of participant’s overall satisfaction with the day hospital will be an independent construct”. Whilst a measure of satisfaction is an important construct it was wise to assess whether satisfaction as measured by this semi-structured interview is independent or whether it is measuring other interactions such as the participant’s mood. To assess this a regression analysis was conducted to see if satisfaction could be predicted by measures of psychological ‘well-being’. The results suggest that overall satisfaction within the day hospital could be predicted by measures of psychological ‘well-being’. The equation was significant ($p < 0.007$, $r = 0.602$) and this accounted for 36.3 per cent of the variance. The results can be seen in table 1 below.

Table 1 Regression analysis of the measure of overall satisfaction with psychological ‘well-being’ as the predictor variables.

Model	Unstandardised Coefficients		Standardised Coefficients	t	Sig.
	B	Std Error	Beta		
Constant	-3.020	1.527		-1.978	.061
Beck Depression Inventory	4.145E-03	.016	.048	.252	.803
Perceived Stress Scale Log transformed	1.560	.512	.579	3.045	.006

^a. Dependent Variable: how satisfied overall

A partial correlation to remove the effect of the psychological ‘well-being’ measures was conducted on the measure of overall satisfaction with variables from the semi-

structured interview to ascertain if overall satisfaction was related to other aspects of the user views. Variables were selected from the semi-structured interview from each of the five sub-sections. These were: length of attendance at the day hospital, whether the referral was explained, whether the participants were happy to attend, whether they were involved in any groups, whether they were happy with the contact with staff and how confident they felt about the future. The results did not produce any significant correlations. However, an almost significant correlation was noted between whether the participant felt the referral had been explained and their overall satisfaction ($r = 0.4439$, $p = 0.50$). However, this only explains 19.7 per cent of the variance.

4.2.2 Hypothesis 2

“It will be possible to predict psychological ‘well-being’ as measured by the Beck Depression Inventory-II and the Perceived Stress Scale by perceived social support, as measured by the Significant Others Scale”. In order to ascertain this, a regression analysis was conducted on the Beck Depression Inventory-II scores with the variables ‘actual emotional’ and ‘actual practical’ perceived support. These variables were measured by asking participants to think specifically of the support found within the day hospital. It was noted however, that a significant regression equation did not exist ($p=0.103$, $r = 0.432$, $r^2 = 0.186$). This has low power at 0.186. Interpolating from the table A15.7 Clark-Carter, (1997) a sample size of approximately 47 would have been needed to achieve a power of 0.8 with the effect size noted. As a measure of perceived social support outside the day hospital was also taken it was decided to

examine the relationship between 'actual practical' and 'actual emotional' perceived support and the Beck Depression Inventory-II scores, whilst partialing out the effects of 'actual practical' and 'actual emotional' perceived support outside the day hospital. To do this a partial correlation was conducted. It was noted that the Beck Depression Inventory-II had a significant relationship with perceived practical support within the day hospital ($p=0.035$, $r = -0.4511$, $r^2 = 0.204$). However, it did not have a significant relationship with perceived emotional support.

A regression analysis was also conducted upon the scores from the Perceived Stress Scale with the variables 'actual emotional' and 'actual practical' perceived support. Again, it was found that a significant regression equation did not exist ($p = 0.768$, $r = 1.54$, $r^2 = 0.024$). This has low power at 0.024. Interpolating from the table A15.7 Clark-Carter, (1997) a sample size of approximately 350 would have been needed to achieve a power of 0.8 with the effect size noted. It was also decided to partial out the effect of the perceived social support outside the day hospital to see if this was confounding the regression analysis. However, there did not appear to be any significant relationships when outside support was controlled for.

The lack of significant findings prompted further inspection and it was decided that possibly the variable of discrepancy analysis, which measured the difference between ideal and perceived actual support may have been more predictive of 'well-being'. A regression analysis was conducted upon the Beck Depression Inventory-II for the variables of perceived discrepancy emotional and practical support within the day hospital. This produced a highly significant regression equation ($p<0.0001$, $r = 0.723$,

$r^2 = 0.523$). Furthermore, it explained 52.3 per cent of the variance. The results from the regression analysis can be seen in Table 2 below.

Table 2 Regression analysis of Beck Depression Inventory-II scores with perceived discrepancy emotional and practical support within the day hospital as the predictor variables.

Model	Unstandardised Coefficients		Standardised Coefficients	t	Sig.
	B	Std Error	Beta		
(Constant)	12.191	1.772		6.880	.000
Discrepancy emotional within hospital	2.607	1.515	.261	1.721	.099
Discrepancy practical within hospital	-4.078	.837	-.739	-4.874	.000

^a. Dependent Variable: Beck Depression Inventory

When the Perceived Stress Scale scores were input into a regression analysis with the perceived discrepancy emotional and practical support scores, from within the day hospital, it was noted that the equation was not significant ($p = 0.345$, $r = 0.304$, $r^2 = 0.092$). This has low power at 0.092. Interpolating from the table A15.7 Clark-Carter, (1997) a sample size of approximately 90 would have been needed to achieve a power of 0.8 with the effect size noted.

4.2.3 Hypothesis 3

“Social support within the day hospital will have a buffering effect upon psychological well being”. This means that the effect of factors that increase

depression (e.g. life event scores) would be reduced if social support within the day hospital was high. To assess this hypothesis an initial correlation was conducted between the life events score and the Beck Depression-II scores. If social support was having an effect on the impact of the life events scores on depression either a non-significant correlation or a weak significant correlation would be expected. Indeed, this correlation was not significant ($p=0.090$, $r=0.346$, $r^2=0.12$). The second part of this analysis required the partialing out of the effects of social support within the day hospital (actual perceived support) upon the life events and depression correlation. However, the correlation was not significant ($p=0.210$, $r=0.271$, $r^2=0.073$). This suggests that the social support variables were not having a buffering effect upon the life events and depression correlation within this sample.

To assess the buffering hypothesis on the Perceived Stress Scale a correlation was conducted between the life events scores and the perceived stress scores. If social support was having an effect on the impact on the life events scores on perceived stress either a non-significant correlation or a weak significant correlation would be expected. Indeed, this correlation was not significant ($p=0.50$, $r=0.141$, $r^2=0.012$). The second part of this analysis required the partialing out of the effects of social support within the day hospital (actual perceived support) upon the life events and depression correlation. However, the correlation was not significant ($p=0.515$, $r=0.1429$, $r^2=0.02$). This suggests that the social support variables were not having a buffering effect upon the life events and perceived stress correlation within this sample. It is possible that the life event scores were being confounded by other factors. An examination of a correlation matrix that included the main demographic variables, the

main responses on the semi-structured interview, and the scores from the self-report questionnaires did not show any significant relationships with the life events scores.

4.2.4 Hypothesis 4

“Male participants will report lower levels of depression, stress and social support within the day hospital when compared to female participants”. To ascertain the validity of this hypothesis a multivariate analysis of variance was conducted with gender as the independent variable and psychological ‘well-being’ and social support within the day hospital as the dependent variables. The overall F was not significant, ($F(9, 15)=1.385$, $p=0.277$, $\text{Eta sq} = 0.454$, Observed power = 0.439). However it was noted that one factor did have a significant effect ($F(1, 23)=5.755$, $p = 0.025$, $\text{Eta sq} = 0.20$, Observed power = 0.632). This factor was a measure of perceived actual emotional support within the day hospital. The mean scores (male=8.93, female=11.83) suggest that females had a tendency to report more emotional support than males.

4.2.5 Hypothesis 5

“The usage of social support, as measured by discrepancy analysis on the significant others scale, will be able to predict locus of control as measured by the Locus of Control Scale”. To assess this hypothesis a multiple regression analysis was conducted with locus of control as the dependent variable and the social support variables as predictor variables. The value of r^2 was low and not significant. ($p =$

0.941, $r = 0.074$, $r^2 = 0.06$). With such a low r^2 the power of this test was low, 0.06. Interpolating from the table A15.7 in Clark-Carter (1997) showed that a sample size of approximately 190 would have been required to achieve a power of 0.8 with the effect size noted.

5. DISCUSSION

5.1 Review of the semi-structured interview

Since the 1960's, the impact of day hospitals upon the climate of psychiatric care for older adults has been significant (Fasey, 1994). With the political impetus of clinical governance, user views have again become important. This current study has demonstrated that it is possible to gain an insight into users experiences of attending an older adult day hospital. In an effort to assist the interpretation of the results from the present study a direct comparison will be made with prior research conducted by Dalrymple and Laidlaw (1998). This decision reflects the fact that both studies have included participants in similar cohorts from the same day hospital. In particular, Dalrymple and Laidlaw (1998) also noted that the majority of attendees were female and lived alone. However, males tended to be younger than those surveyed in the current study.

5.1.1 User views of the day hospital

The first aim of this study was to elicit user views of their experience of attending the day hospital. In total 32 participants were approached, but 22 per cent declined to participate. According to the nursing staff the main reasons for refusal was a fear of being discharged from the day hospital, or a belief on the part of the participant that they were being assessed for some other purpose.

As noted in the results the mean length of stay within the day hospital was approximately two months. Considering the function of day hospitals, this would seem to be a reasonable length of treatment. Indeed, the Royal College of Psychiatrists (1994) report states that psychogeriatric day hospitals should aim to enable elderly people to continue to live at home by providing specialist multi-disciplinary care arranged on a short-term basis. Results of the current inquiry identified some participants who had been attending for approximately five years. This finding does not adequately reflect the ethos of the day hospital as a form of transition from in-patient to community settings. Additionally, when the number of participants who had been readmitted was examined it was noted that 72 per cent had previously attended. Unfortunately, information was not available as to the exact number of times participants had been readmitted, but it does seem to indicate that a 'revolving door' system operates within this day hospital.

5.1.2 Participants understanding of referral

The second section of the semi-structured interview examined the participant's understanding of their referral. Similar to the findings of Dalrymple and Laidlaw (1998) the majority of participants appeared to have an understanding of the reasons for attending the day hospital. However, a small number were unaware of being referred. Several reasons could account for this latter finding. Firstly, patients are often brought down to the day hospital whilst they are still in the in-patient unit. Thus, it is possible that they view their time at the day hospital as an extension of the in-patient unit and as such became confused about the referral. Furthermore, it is

possible that the reasons and process of referral were poorly explained by staff. Equally, understanding of the referral in these participants may have been impeded by their level of cognitive functioning. Results do not support explanations relating to cognitive functioning as all participants within the study had a mini mental state exam of 23 or above. Whatever the reason, the current findings have implications for staff in that they are obliged to assess whether the potential user of the day hospital has understood their referral. If this recommendation is applied routinely attendees will become active agents in the referral process which is likely to increase feelings of self-efficacy.

5.1.3 User expectations

With regards to attending the day hospital, it was noted that the majority of participants had their expectations met. However, a large majority did not know what to expect. If the referral process were completed successfully, patients would have been aware of what to expect from the day hospital. This is similar to the findings from the Dalrymple and Laidlaw (1998) study, where it was noted that 30 per cent of participants felt that their expectations were not met and 30 per cent did not have any expectations. The large numbers of participants who did not know what to expect is a significant finding as the results from the Dalrymple and Laidlaw (1998) study were fed back to the staff with the aim of improving the experience of the attendees. An explanation for the lack of change is that communication of what could be expected within the day hospital has not improved. One alternative explanation to this is that although communication has improved participants had forgotten what information

they had been given. Another alliterative is that the participants' expectations had not been met, as their ideas of what the day hospital could offer were unrealistic. Thus, no amount of information or improvement in communication would have shifted these ideals.

Although 28 per cent reported that their expectations were not met, 72 per cent of the overall cohort were happy with their experience of being a part of the day hospital and 12 per cent were unsure. This implies that understanding the referral process and pre-conceptions do not appear to significantly affect the attendee's experience of the day hospital.

5.1.4 User involvement in groups

Similar to the findings of Dalrymple and Laidlaw's (1998) study it was found that a significant proportion of the participants reported not being involved in any groups (39 per cent). In this study, 44 per cent of participants believed that they were not taking part in any groups. Of those who were involved, more believed that these groups were suited to their problems (53.3 per cent), compared to the 31 per cent of participants noted in the Dalrymple and Laidlaw (1998) study.

Furthermore, the majority of those taking part in groups reported that they were helpful. In fact, only 13.3 per cent of participants felt that their difficulties had not improved and this is a lower percentage than reported by Dalrymple and Laidlaw

(1998). This difference suggests that there has been some improvement in the type, quality or delivery of the groups over the past five years.

Whilst these are interesting findings it is important to note that the staff within the day hospital argue that all participants are involved in at least one group. Examples where participants believed that they were not taking part may be accounted for in a number of ways. Firstly, it might be advocated that they were using a different schema to define group work. Secondly, attendees of the day hospital either go away into small group activities or they remain in the main hall where they take part in a quizzes or an exercise group. Participants who did not leave the main hall may have felt that they are not a part of a specific group, as they did not leave their chair.

5.1.5 User contact with staff

Interestingly, it was noted that all the participants were happy with the level of staff contact. However, 28 per cent felt that a change in the amount of contact with staff (more or less) would be an improvement. This suggested that whilst the staff may not have had enough time to spend with the attendees they made up for this in the quality of the relationship. Unfortunately direct comparisons with Dalrymple and Laidlaw (1998) are not possible as the findings from this section of the semi-structured interview were not reported and the original data is no longer available.

A substantial minority of those surveyed were unaware that they had a named nurse, even after the interviewer had reformulated the question to ask them if there was a

specific nurse they spent most of their time with. Various explanations may account for this finding. Firstly, these particular individuals may not have had enough time to establish a suitable relationship with their nurse. Furthermore, it may have been that those who were unaware of their named nurse represent one nurse's caseload, which might have been effected by staff changes. This is unlikely however, as the majority of those who were unaware of who their named nurse was, were also naive that they should have been assigned one. In fact, some of these participants had difficulties understanding the concept and even when the time was taken to explain the role of a named nurse they were still unable to identify any staff members that met this role.

The results potentially highlight the need for staff to make named nurses roles/identities more explicit at admission. It is more probable however, that staff within this day hospital were so easily accessible that no single member of staff stood out. Indeed, of those that were able to recall who their named nurse was, almost all felt that their relationship was good. However, a small minority felt that staff had not understood the nature of their difficulties.

5.1.6 Coping with the future

The study noted that the majority of participants were not worried about being discharged from the day hospital. This is similar to the findings of Dalrymple and Laidlaw (1998) who noted that 43 per cent of participants were not worried and 14 per cent were extremely worried. It is likely that the results from the current study

would have been different, based upon the indications given by staff, if those participants who had refused to take part had been included.

Dalrymple and Laidlaw (1998) also noted that only 28 per cent of participants reported being reasonably confident about coping in the future. In addition 7 per cent were very confident, 21 per cent were not very confident, 7 per cent were not confident at all, and the majority (35 per cent) were unsure. In this study no participants were unsure. This may indicate that the cohort had experienced something different. A possible explanation is that there could have been a change in treatment between 1998 and the commencement of this study. Staff, were unable however to report any significant changes that might explain the adjustment in self-efficacy.

Another explanation is a cohort effect. Ross, and Sastry (1999) have reported that younger cohorts have a stronger sense of control, thus increasing the amount of confidence in their ability to cope. However the cohort in this study only differed in that male participants tended to be marginally older.

Even though the results of this study are encouraging, in that they are similar to those of Dalrymple and Laidlaw (1998), which suggests reliability, there is some evidence that attendees may become dependant on the day hospital. For example, concerns about being discharged, coupled with prolonged attendance and repeat readmissions points to attendees becoming more reliant upon the day hospital.

5.1.7 User levels of satisfaction

Participants in the present study reported a substantial level of satisfaction with the day hospital. These results appear to be lower than those reported in the comparison study (Dalrymple and Laidlaw, 1998) where it was reported that 86 per cent of the participants were very satisfied with the day hospital and only 14 per cent were not satisfied. This compares to the current study where 36 per cent reported being very satisfied, 52 per cent were satisfied, 8 per cent unsure, and 12 per cent were not satisfied.

A direct comparison should not really be made here as Dalrymple and Laidlaw (1998) used a three-point unbalanced scale and the current study used a five-point balanced Likert scale. It would appear that in their study an anchoring effect may have been present, in that participants may have been more likely to choose a response at either end of the scale. When the satisfaction scores were reduced in this study to satisfied, unsure or dissatisfied, as similarly represented in the Dalrymple & Laidlaw (1998) study, then the results are comparable.

Additionally, the current results are comparable to the findings from other sources. McCarten-Quinn *et al.* (1996) noted in their study of 189 older adults that 81 per cent were satisfied with their care. Caan *et al.* (1996) also noted a high satisfaction level of 79 per cent in a study of 96 older adult day care patients. Further more, Stephenson, *et al.* (1995) found that 88 per cent of older adults liked attending a day hospital.

However, it could be questioned whether liking attendance of the day hospital is the same as being satisfied with the level of care and services provided.

5.1.8 Social factors within the day hospital.

Caan *et al.* (1996) noted that social factors were important to the attendees of older adult day hospitals and Rothwell (1990) found that social elements were a distinct factor in a consumer survey of day hospital attendees. The results from this study also indicated that the majority of participants rated social factors as the most important reason to attend. Once again, this is comparable to Dalrymple and Laidlaw's (1998) study where 56 per cent of participants stated that they found mixing with others the most helpful. They also noted that 22 per cent of participants felt that getting out of the home was the most important factor in attending the day hospital.

Quite surprisingly, only one participant in the current study mentioned the help that they had received from staff. It is possible that the staff within this day hospital provided such a relaxed level of care that attendees were unaware that support and treatment of their difficulties was occurring. Of course, it is also plausible that the participants were unaware of the help and facilities that were available to them.

A categorisation of what participants found least helpful revealed that the majority of participants did not report anything. Nonetheless, a large proportion (26 per cent) complained of boredom or sitting around. This has often been highlighted as a problem with day hospitals. Mosher & Burti (1989) have argued that a day hospital

environment can become stagnant. Another explanation is that those participants who reported dissatisfaction were more infirm and, as such, may not get access to as many groups. It is also possible however, that the groups under stimulated these participants. This under stimulated is a difficult problem for day hospitals to deal with. The limited number of staff available means that attendees are often required to spend time in groups rather than have continuous one to one contact with staff. Therefore, the staff are required to engage and mentally stimulate as many attendees as is possible. This can often be difficult due to the variability in intellectual capacity and the range of mental health difficulties. Nevertheless, it was noted in the interviews that several participants suggested that the least exciting part of the day was after lunch. One possible way to overcome this is for the staff to provide further stimulating activities after lunch for those attendees who may benefit from them.

It was also noted in the results of this study that when participants were asked to choose which of eleven factors, as defined by Caan *et al.* (1996), were the most important when attending the day hospital, the most common factor appeared to be a social one. This supports the findings from the Cann *et al.* (1996) study where they noted that social factors were the most important reason to attend a day hospital. They also found that when participants were asked an open ended question about the most important reason for attending the day hospital the majority of responses included idiosyncratic answers relating to internal states such as “to feel happier”.

Only 16 per cent of participants felt that treatment was the most important reason to attend. This suggests that attendees may have had a different agenda for the usage of

the day hospital compared to the staff. Then again, it is also possible that the reason to attend could have been influenced by how long the participant has been a part of the day hospital. For example, a newly referred attendee is likely to attend because they have been told to, or for some form of treatment. When they have attended for several weeks it is probable that they will have developed a peer network and their difficulties may be improving. This may mean that they then place more importance on the effects of socialising rather than formal treatment. Interestingly, analysis did not suggest that this interaction existed.

Only 24 per cent of all participants said that they attended because they had been told to attend. This indicates an underlying element of low self-efficacy and possibly a case of “doctor knows best”. However, as was discussed earlier, it may also indicate that these participants have not had their referral to the day hospital explained properly. It is also possible that they have a lack of insight into their difficulties. Regardless of the reason, it again highlights the need for staff to assess a potential attendees understanding of their referral and the possible benefits to attendance that this understanding may bring.

5.1.9 Summary of the semi-structured interview

The overall findings from the semi-structured interview highlight several important issues regarding the function of day hospitals. According to the Royal College of Physicians (1994) report, the original aim of day hospitals was to provide a therapeutic range of treatments. Indeed, Mosher and Burti (1989) state that there are

seven key functions. These are: as an alternative to in-patient treatment, as an assessment or follow-up tool, as a place to provide carer support in dementia, as a place to rehabilitate and review progress, as a way to maintain community links, as an alternative to long term care and as a way to maintain morale and recruitment in old age psychiatry. Several theorists agree with at least some of these functions, if not all (e.g. Howard, 1994; Black 2000; Sledge *et al.* 1996; Fasey, 1994).

Based upon the findings within this study questions about the relevance of the original aim of psychogeriatric day hospitals have to be raised. Fasey (1994) argues that day hospitals disrupt routines for attendees and many patients do not find the social side to their liking. However, the social element within this study seems to be the most important. If this is the case then the cost effectiveness of day hospitals has to be queried. Fasey (1994) further argues that for functional illnesses, day hospitals often become clogged with patients who have chronic difficulties and require multiple readmissions. This leads to a small number of patients gaining access to the day hospital. However if social factors are most beneficial, then it may be more effective to provide support through other avenues such as social services, which tend to be less costly. Murphy (1994) agrees with this view point and comments that day hospitals look expensive when compared to alternative forms of care such as visiting specialist professional care and social care organisations.

5.2 further discussion and explanation of research findings

5.2.1 Hypothesis 1

Whilst an attempt has been made to assess the attendees experience and satisfaction of attending an older adult day hospital, questions have been raised regarding the validity of such assessments. Sitzia (1999) argues that satisfaction questionnaires are neither reliable nor valid. Therefore, the first main hypothesis of the study was that a measure of a participant's satisfaction would be an independent construct. However, it was noted in the results that satisfaction could be predicted by the level of psychological 'well-being'. This suggests that the level of psychological 'well-being' or mood is linked to overall satisfaction. This correlation only accounts for 36.3 per cent of the variance and thus points to other interactions being present. The validity of this measure needs to be investigated by checking the stability of satisfaction over time, when compared to the stability of measures of psychological 'well-being' over time. Whilst a casual relationship cannot be assumed, the interaction between these variables implies that a measure of satisfaction may only be measuring the psychological 'well-being' of a participant.

When the influence of mood was partialled out and a correlation was conducted between selected variables from the semi-structured interview and the measure of overall satisfaction, it was noted that a very nearly significant interaction was present between whether the participants felt that the referral had been explained and their

overall satisfaction with the day hospital. Nonetheless, this explains only a small proportion of the variance.

The lack of findings with this hypothesis indicates that the measure of overall satisfaction is not a valid measure, being confounded by mood and other non-explicit variables. However, the nearly significant findings noted above underlies the importance that staff explain the referral and what will be involved in attending the day hospital. Furthermore, they should check the patient's understanding of this explanation.

5.2.2 Hypothesis 2

The second hypothesis of the study stated that it would be possible to predict psychological 'well-being' by measuring the perceived social support of patients attending the day hospital. Findings from the statistical analysis revealed that a significant prediction could not be made based upon these variables. However, when the effects of perceived social support outside the day hospital were removed it was found that a significant negative relationship existed between the depression scores and perceived practical support within the day hospital. This indicates that if participants report a lower level of practical support within the day hospital they are also likely to report higher levels of depression symptomatology. However, this is a cross-sectional study and causality cannot be assumed. When the perceived stress scores were analysed, it was noted that no significant relationships were present with the social support measures.

When further investigations were conducted on the depression scores it was found that a significant predictive equation was possible when discrepancy variables of social support were used. The discrepancy variables examined the average difference between the perceived level of support and an ideal level of support. In fact the equation accounted for over half of the variance in the depression scores. Again causality cannot be assumed. It is possible that as people become more depressed they require a higher level of support and therefore their ideal level of support becomes higher. Likewise, it is also possible that as the difference between the level of perceived support and ideal support grows a person begins to despair more and they become more depressed.

Interestingly, there were no significant findings for the perceived stress scores and the discrepancy support variables. There are several possible explanations for this. Firstly, it is possible that the transformation of the perceived stress scores has resulted in confounding data. Secondly, this scale may not be an adequate measure of stress in older adults. It was noted during the administration of this test that some questions had the appearance of ambiguity. For example, one of the questions asks, "in the last month, how often have you dealt with irritating life hassles?". This question could be interpreted in two ways. For example, it may be read as, how often have you had to face irritating hassles? On the other hand it could be read as, how often have you overcome or coped with irritating hassles. The scoring for this question would suggest that the latter interpretation is the correct one. However, it appears that most of the participants have

interpreted the question in the opposite direction. This will have had an impact on the results.

Although the Perceived Stress Scale is a well-validated measure with high internal consistency and has been standardised with a sample containing adults over 65 years old (Cohen & Williamson, 1988), it has to be questioned whether it is truly appropriate for use with older adults

Other studies however, have noted that psychological 'well-being' and social support have significant relationships. Chi and Chou (2001) found that in a study of older adults, social support variables had a significant relationship with the measure of depression, even after functional disability and socio-demographic variables had been controlled for. Another study by Oxman *et al.* (1992) indicated that, in cohort of older adults, perceived adequacy of emotional and tangible support was significantly associated with symptoms of depression. They found that the higher the perceived support the lower the depressive symptom scores.

5.2.3 Hypothesis 3

As stated in the introduction of this study, many theorists (e.g. Cohen & Wills, 1985; Davis, 1996; Handen, 1991) accept the argument that social support provides a buffering effect in times of stress upon psychological 'well-being'. The third hypothesis assessed whether this was in fact the case. Thus, it was hypothesised that social support within the day hospital would have a buffering effect upon

psychological 'well-being'. The findings nevertheless, did not support this hypothesis. Caution however needs to be exercised in over interpretation of these findings.

For this hypothesis to have been supported the psychological 'well-being' variables would have had to correlate with the measure of life events once the influence of the social support variables had been partialled out.

One possible explanation for this is that the Homes-Rahe Social Readjustment Scale (Holmes & Rahe, 1967) relies upon participants being able to recall what significant life events have happened within the last year. Whilst every effort was made to ensure a suitable level of cognitive functioning was present, some of the participants may have been unable to recall when, or if significant life events occurred. For example, lesser events such as changes in social activities may have placed greater demands on memory.

Further to this, a number of attendees of the day hospital had undergone electroconvulsive therapy (ECT). It is unclear as to why a large number of patients should be receiving ECT. This is a surprising finding as ECT is not seen as a treatment of choice and the level of symptomatology was not particularly high. It is possible that this day hospital may have been involved in research trial of ECT. Lezak (1995) argues that ECT can produce significant memory disturbances which tend not to be maintained, but do disrupt short-term memory. Therefore this may have had an impact on test results. Lezak (1995) also suggests that there is a natural reduction in

effectiveness of short-term memory as one ages. This should not be seen in the same light as dementia.

Another argument against using life event scores is that it rejects the subjective nature of stress. Lazarus (1990) argues that stress occurs when “Demands tax or exceed the person’s resources. It is an ongoing transaction or encounter, which is appraised by the person as involving harm, the threat of harm, or challenge” (Lazarus, 1990, P3). He further argues that challenge may be seen as a positive, optimistic, mobilised and keen attitude about conquering obstacles. Thus, he is acknowledging the subjective nature of stress. Once a person has appraised a transaction as stressful, the coping processes begin. These coping processes regulate and manage the troubled person-environment relationship. Consequently, coping processes will influence the person’s subsequent appraisal of new stressors and the resulting intensity of the stress reaction.

Whilst Cohen and Wills (1985) report that there are numerous studies to support the stress-buffering hypothesis (e.g. Wethington & Kessler, 1986; Pearlin *et al.* 1981). There are likewise many studies that support the direct effect model. Indeed, conclusions made by authors such as Wade and Kendler (2000); Oxman *et al.* (1992); and Dean *et al.* (1990) would seem to provide backing for social support having a direct effect on the impact of stress experienced by an individual.

However, it is possible that the lack of findings with this study may be due to low power. Of course, it is also possible that no findings exist. Whilst effect sizes were noted in the results and the number of participants required to achieve power, it also

possible that by increasing the numbers within the cohort one would not find significant result as they are potentially due to chance. With all the non-significant findings noted in this study increasing the number of participants to achieve power does not mean that this will result in significant findings. What it does imply is that more categorical conclusions can be drawn as the power of the statistical manipulation is increased reducing the likelihood of erroneous findings.

5.2.4 Hypothesis 4

It is possible that any specific impact from social support could also have been influenced by gender. Chappell *et al.* (1990) noted that significant differences existed between the genders on the amount and type of support for older adults within a day hospital. Therefore the fourth hypothesis stated that male participants would report lower levels of depression, stress and social support within the day hospital when compared to female participants. However, the only significant finding was that female participants tend to perceive higher levels of emotional support within the day hospital than male participants. This is similar to the findings of other studies. Reevy and Maslach (2001) noted that gender was linked to the amount of emotional support received.

The lack of significant difference of psychological 'well-being' between the sexes is surprising. Several studies have indicated that symptoms of depression are detected more frequently in females (Zarit & Zarit, 1998). For example, the Epidemiological study (Robins & Reiger, 1991) noted that the prevalence of depression was twice as

high for female older adults. Also, Henderson and colleagues (1993) found in their study that depression in female older adults was 3.5 times higher when compared to males. It is possible that the sample was unrepresentative of older adults. It is logical to anticipate that a clinical sample would have had a moderate to severely poor level of psychological 'well-being' as measured by the Beck Depression Inventory and the Perceived Stress Scale. However, in the current study the distribution of both the depression and stress scores were not skewed to the upper levels of the scales. Also, the mean level indicated a sample that was only mildly distressed on both scales.

One possible explanation for this is that the day hospital is effective, but that they have a tendency to retain patients that could be discharged. Indeed, the length of stay within the day hospital may suggest this. It is also plausible that whilst the severity of distress is relatively low, when the patients are discharged their distress may increase. Thus, the day hospital is serving a maintenance function and as such is possibly being more cost effective in retaining patients of low-level distress. Furthermore the retention of patients as part of the day hospital may be more humane, in that to cut ties with the patient may actually remove a significant part of their lives. It would have been interesting to note the frequency of attendance to see if severity of symptomatology was linked to the number of times the patients attended. It may be that staff decrease contact slowly, over time, as the patient's distress improves.

Another explanation is that the sample is biased in some way. For example, the mining communities in Fife may act differently to social support or mental health issues. Thus, the study needs to be replicated in other day hospitals to see if the level

of psychological 'well-being' remains the same. Also, the use of ECT may make this sample unrepresentative of general older adult clinical cohorts. Furthermore, it was noted that the sample had low levels of depression and stress for a clinical sample. Therefore, any conclusions drawn from this study may not be indicative of other day hospitals.

5.2.5 Hypothesis 5

The final hypothesis stated that the amount of social support used, as measured by discrepancy analysis on the significant others scale, will be able to predict a participants' locus of control as measured by the Locus of Control Scale. The findings of this study however did not provide support for this. This is in contrast to other studies. For example Lu, (1995) noted that a relationship exists between the amount of support received and whether an individual has an external locus of control.

Several points may explain the lack of findings with this hypothesis. Firstly, discrepancy analysis may not be a useful measure of the use of social support. After an extensive literature review there did not appear to be a dedicated standardised measure of the use of social support. Therefore, discrepancy measures were used as they measure the difference between ideal and perceived social support. In this study it was assumed that people who reported more ideal social support compared to perceived social support were less active in seeking support. However, it is now apparent that this assumption is wrong. It may be possible that a person actively seeks

support but the availability of support may be limited. Thus, the perceived and ideal levels of support are different but do not predict the utilisation of support.

Another possible explanation for the lack of findings is that the Locus of Control Scale may not be relevant to older adults. For example, a significant number of the statements refer to learning and schooling, an aspect of an older adult life that is likely to be irrelevant. Also, the scale itself required the participants to read a number of lengthy statements before making a choice. As stated earlier, Lezak (1995) suggests that the capacity of short-term memory reduces, as one gets older. Of course, this is not to suggest that all older adults are forgetful, just that it should be considered as a factor.

5.3 Critique of methodology

A possible explanation for the lack of findings with the final hypothesis and a methodological flaw in general relates to the duration of the interview. In total, each interview lasted around one hour. This included the time to complete all the questionnaires and the semi-structured interview. The interviews were conducted in one sitting wherever possible. As the Locus of Control Scale was administered last, the answers given may have been prone to fatigue effects. Indeed, whilst the skewness and kurtosis were within normal parameters a large number of participants achieved scores on the scale that were very close to the mean score. The scoring of the Locus of Control Scale is set so that the higher the score the more external a person is. If people were to randomly choose each statement it would be possible to

achieve a score close to the mean. Therefore it could be argued that this was in fact what had happened.

It is also possible that the locus of control scale is not a valid measure for use with older adults and as such this may be an additional flaw with the study. Whilst, it has good reliability, internal consistency and validity and has been standardised across a number of populations, cultures, & clinical settings (Dag, 1991; Piontkowski & Ruppelt, 1981; O'Brien & Kabanoff, 1981; & Harper *et al.* 1990), it has not been validated for use with older adults. Brown and Granick (1981) have developed an abbreviated version of the Locus of Control Scale for use with older adults which could be used in future studies. However, this scale has not been standardised or validated yet.

A further methodological flaw is that all the scales apart from the semi-structured interview were self-report measures. This relies on the person being able to read the scale. The majority of participants required some form of corrective eyewear to see clearly. However, most did not have any eyewear with them. This meant that scales often had to be read to them. Furthermore, some hearing impairments appeared to be inadequately corrected. Both of these factors could invalidate the results. Also, memory difficulties may have affected the responses given. In fact memory problems appeared to play a significant part in this study. As stated earlier every effort was made to ensure that each participant had an appropriate level of functioning. However, the day hospital had used ECT and as stated above, the known effects of this treatment are short-term memory difficulties (Lezak, 1995).

An additional flaw may have been the use of the social support scale. Whilst Lam and Power (1991) have used it with older adults, in its present form many of the older adults found it difficult to complete. In particular, the layout of the scale confused many of the participants, as it was too small for their eyesight. Further to this, several participants had real difficulty grasping the concept of perceived actual and ideal support.

The fact that some participants had difficulty understanding or reading the questions has implications for the findings within this study. For example, there is an increased risk that some of the results are not valid, as the scales have been completed incorrectly. This suggests that any findings drawn from this study need to be interpreted with extreme caution. However, it is encouraging to note that participants did not appear to have difficulties understanding the concepts within the other questionnaires.

It is also worth considering whether a dissonance effect (Festinger, 1957) had been masking these results. For example, participants would often complain about family members during the semi-structured interview, but then give them a high rating on the scale. It may be easier to express irritations about family members during what could be perceived as a relatively informal interview, but when asked to state how they felt about the family member using a formal rating scale they may have been more wary. Mui (2001) suggests that family values are more prominent within older adult cohorts and as such, participants may have felt a need to defend their family.

Another interesting point is that a large number of participants were widowed (64 per cent). This may have confounded the support variables. Power *et al.* (1988) found that the amount of social support was influenced by the relationship to the individual. More specifically they noted in their study that individuals perceived and desired the most amount of support from spouses. Thus, when there are large numbers of the sample who are widowed it may be expected that there is less of an ideal level of support overall.

A further flaw of the study may have been the use of the Holmes-Rahe Social Readjustment scale (Holmes & Rahe, 1967). Whilst this scale has been extensively used in research and is well validated, it has not been standardised specifically on older adults. However, the standardisation sample did include older adults. Mensh (1983) produced a shortened version of the scale for use with older adults. Therefore, any replication of the study may be improved by using this scale.

A major problem with this study is that power was not met. Therefore any conclusions drawn should be treated with caution and not over generalised to other day hospitals. However, by increasing the power of the study it cannot be concluded that significant findings would result from those statistical manipulations where no significant finding were present.

Some of these flaws may well have been worked out if the study had been piloted. For example, the length of time taken to complete the questionnaires could have been taken into account and the methodology could have been adapted to remove the

fatigue effects. A possible way to overcome this is for participants to be presented with the self-report questionnaires at a second interview. Also, piloting the questionnaires may have highlighted any adaptations that were required such as increased font size.

5.4 Summary and conclusions

In conclusion, the results from this study suggest that participants were generally very satisfied with the day hospital and its staff. However, there appears to be areas that can be improved. Black (2000) argues that for day hospitals to survive they must evolve to meet the new challenges and the needs of older adults. To achieve this, older adults need to be involved in a consultation process to draw out the best of services. Also, this study provides support that levels of social support within the day hospital can be used to predict the level of depression. As such, it would be wise to be aware of the importance of social aspects when developing new services. It is important to note that this is only an association study and causality should not be assumed.

Future studies may look at the levels of social support for those attendees of a day hospital and compare it to older adults within the local community. It may be useful to investigate a reliable scale to measure the use of social support so that those with low support can more easily be identified. Then treatment or help can be given to allow these people access to the benefits of social support. If it were found that use of support was linked to locus of control this would have clinical implications. Therapy

could then be aimed at changing the locus of control and thus increasing the impact of support.

Other research may examine some of the responses noted in the semi-structured interview. For example, the fact that some participants reported that “knowing others were worse off than themselves” as being most helpful was interesting and research may look at why this should be the case and what level of benefit it may serve.

In general little research has been conducted in to the level of social support within day hospitals. Whilst this study cannot make causal assumptions it is perhaps the first step in more rigorous research into this area.

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Appendix 1

Enquiries to
Extension 336 or 217
Email psychology@fife-pct.scot.nhs.uk

Information Sheet

Version A 22/05/03

User views of their experience of a day hospital and their level of social support

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Consumers for Ethics in Research (CERES) publish a leaflet entitled 'Medical Research and You'. This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London, N16 0BW.

We are interested in finding out how you feel about the care and support you are receiving in the day hospital. We are also interested in your level of social support within the day hospital and how this might relate to your problems. You were chosen for this study as we are asking everyone who attends Westfield day Hospital to consider taking part.

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.



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Awarded for excellence
to Nutrition and Dietetic Department



Awarded for excellence
to Fife Community Dental Service

Chairman: Dr James Gallacher
Chief Executive: George J Brechin

If you wish to take part you will be offered an interview with the researcher that can take between 20 minutes to 1 hour depending on how much you have to say. Later in the same week your key worker will go over several questionnaires with you. This should only take between 20 to 30 minutes.

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you will be kept in a locked filing cabinet in the locked and alarmed psychology department. At the end of the study the information gained will be destroyed.

The results from the study will be published in a thesis at the University of Edinburgh and it will be held in the medical Library only. You will not be identified in any report/publication. The funding for this study comes from the University of Edinburgh.

If you wish to gather further information about the study or you wish to raise any concerns then please do not hesitate to contact Graeme Duncan Clinical Psychologist in training on Tel: 01324 574 370 However, if you wish to speak to someone other than the researcher please do not hesitate to contact Sheena Bailey Clinical Psychologist on Tel:01334652611 ext211.

Thank you for taking the time to read this information sheet and if you wish to take part in the study please sign the consent form and hand it back to the researcher.

You will be given a copy of the information sheet and a signed consent form to keep.

Appendix 2

Patient Identification Number for this trial:

CONSENT FORM

Title of Project:

User views of their experience of a day hospital and their level of social support

Name of Researcher:

Graeme Duncan

Please initial box

1. I confirm that I have read and understand the information sheet dated 22/05/03 for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.
3. I agree to take part in the above study.

Name of Patient

Date

Signature

Researcher

Date

Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

Appendix 3

Survey of Day Hospital Attendees
Semi-structured interview

We are interested in finding out how you feel about the care and support you are receiving in the day hospital. We hope that the information gathered will help us to improve the services that you receive. We are interested in your honest opinions, both positive and negative, about all aspects of your experience of the service. Any individual comments you make will not be shown to the people from whom you receive help and every effort will be made to ensure that they remain anonymous. Similarly, the service you receive will not be affected if you chose not to take part or if you express negative opinions. You do not have to answer any questions that you do not want to and you are free to finish the interview at any time.

Sex *Male* *Female* Age _____ Yrs

Marital Status

Married *Divorced* *Single* *Widowed*

Number of children _____ Number of years in formal education _____

How long have you been a part of the day hospital/ward _____

Do you live alone? Yes No

Who is your main support and what relationship do they have to you?

Has a significant life event occurred in the last year(see separate sheet) _____

1. Understanding of your referral

Who told you about the day hospital?

GP Psychiatrist Nurse Family member Friend

Do you feel that your referral to the day hospital was explained?

Yes No

How happy were you to agree to attend?

Very unhappy Unhappy Not bothered Happy Very happy

If you were not happy to attend please state why

Is it what you expected?

Yes No Don't know

If no, what did you expect?

Do you enjoy being apart of the day hospital?

Yes

No

Not sure

2. Attendance of Groups.

Are you involved in any groups at the day hospital/?

Yes

No

Not sure

If so how many are you involved with _____

What are they?

How suited to your problems are the groups you attend?

Very well

Sort of

Not at all

Do you receive the sort of help you had expected?

Yes, more or less

Didn't know what to expect

No

If no, what did you expect?

Do you enjoy attending the groups?

Yes

No

How helpful do you think the groups have been?

Very helpful

helpful

Not sure

Unhelpful

Very Unhelpful

If you found it helpful what was it that helped? _____

If you didn't find it helpful what would you change? _____

How much do you think your difficulties have improved since you took part in the groups?

A lot

Marked

A little

Not at all

Got worse

3. Contact with staff.

How much contact with the staff do you feel you have?

Definitely
Not enough

Not
enough

Not
bothered

almost
enough

Just right

Are you happy with this?

Yes

No

How much contact with your named nurse do you feel you have?

Definitely Not Not almost Just right
Not enough enough bothered enough

Are you happy with this?

Yes

No

How would you rate the quality of your relationship?

Good

In-between

Poor

How well do you feel that staff have understood the nature of your difficulties?

Understood perfectly

Mostly

Did not understand

4. Level of satisfaction

How satisfied overall do you feel about attending the day hospital

Completely Satisfied Not Dissatisfied Completely
satisfied sure dissatisfied

What do you like most about attending the day hospital?

What do you like least about attending the day hospital?

Which is the factor that is the most important reason for you attending the day hospital

Lunch	To meet friends	To get away from where I live
I have been told to attend	For medication	For treatment other than meds
Boredom at home	To keep warm in winter	To give my family time of
To have a break from my family	To sort out my benefit money	

5. Confidence about coping future?

Are you worried about the possibility of being discharged from the day hospital?

Not at A bit Quite Very Extremely
all

How confident do you feel about coping in the future?

Very Reasonably Not sure Not terribly Not at all

Appendix 4

SIGNIFICANT OTHERS SCALE (B)



Name:

Date: Record Number:

Instructions

Please list below up to seven people who may be important in the individual's life. Typical relationships include partner, mother, father, child, sibling, close friends, plus keyworker. For each person please circle a number from 1 to 7 to show how well he or she provides the type of help that is listed.

The second part of each question asks you to rate how individuals would like things to be if they were exactly as they hoped for. As before, please put a circle around one number between 1 and 7 to show what the rating is.

Person 1 –		Never		Sometimes		Always		
1	a) Can you trust, talk to frankly and share your feelings with this person?.....	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty? ..	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?.....	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 2 –		Never		Sometimes		Always		
1	a) Can you trust, talk to frankly and share your feelings with this person?.....	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty? ..	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?.....	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 3 –		Never		Sometimes		Always		
1	a) Can you trust, talk to frankly and share your feelings with this person?.....	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty? ..	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?.....	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

PLEASE CIRCLE ONE NUMBER ONLY FOR EACH QUESTION



Person 4 –		Never		Sometimes			Always	
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 5 –		Never		Sometimes			Always	
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 6 –		Never		Sometimes			Always	
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 7 –		Never		Sometimes			Always	
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he/she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him/her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

PLEASE CIRCLE ONE NUMBER ONLY FOR EACH QUESTION

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Appendix 5

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism

- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure

- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure

- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings

- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike

- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness

- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying

- 0 I don't cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

Subtotal Page 1

Continued on Back

. Agitation

- 0 I am no more restless or wound up than usual.
- 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated that it's hard to stay still.
- 3 I am so restless or agitated that I have to keep moving or doing something.

. Loss of Interest

- 0 I have not lost interest in other people or activities.
- 1 I am less interested in other people or things than before.
- 2 I have lost most of my interest in other people or things.
- 3 It's hard to get interested in anything.

. Indecisiveness

- 0 I make decisions about as well as ever.
- 1 I find it more difficult to make decisions than usual.
- 2 I have much greater difficulty in making decisions than I used to.
- 3 I have trouble making any decisions.

. Worthlessness

- 0 I do not feel I am worthless.
- 1 I don't consider myself as worthwhile and useful as I used to.
- 2 I feel more worthless as compared to other people.
- 3 I feel utterly worthless.

. Loss of Energy

- 0 I have as much energy as ever.
- 1 I have less energy than I used to have.
- 2 I don't have enough energy to do very much.
- 3 I don't have enough energy to do anything.

. Changes in Sleeping Pattern

- 0 I have not experienced any change in my sleeping pattern.

- 1a I sleep somewhat more than usual.
- 1b I sleep somewhat less than usual.

- 2a I sleep a lot more than usual.
- 2b I sleep a lot less than usual.

- 3a I sleep most of the day.
- 3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

- 0 I am no more irritable than usual.
- 1 I am more irritable than usual.
- 2 I am much more irritable than usual.
- 3 I am irritable all the time.

18. Changes in Appetite

- 0 I have not experienced any change in my appetite.

- 1a My appetite is somewhat less than usual.
- 1b My appetite is somewhat greater than usual.

- 2a My appetite is much less than before.
- 2b My appetite is much greater than usual.

- 3a I have no appetite at all.
- 3b I crave food all the time.

19. Concentration Difficulty

- 0 I can concentrate as well as ever.
- 1 I can't concentrate as well as usual.
- 2 It's hard to keep my mind on anything for very long.
- 3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

- 0 I am no more tired or fatigued than usual.
- 1 I get more tired or fatigued more easily than usual.
- 2 I am too tired or fatigued to do a lot of the things I used to do.
- 3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

Appendix 6

PERCEIVED STRESS SCALE



Name:

Date: Record Number:

Instructions

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is, don't try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

For each question choose from the following alternatives:

- 0 = never
- 1 = almost never
- 2 = sometimes
- 3 = fairly often
- 4 = very often

1. In the last month, how often have you been upset because of something that happened unexpectedly?
2. In the last month, how often have you felt that you were unable to control the important things in your life?
3. In the last month, how often have you felt nervous and stressed?
4. In the last month, how often have you dealt with irritating life hassles?
5. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?
6. In the last month, how often have you felt confident about your ability to handle your personal problems?
7. In the last month, how often have you felt that things were going your way?
8. In the last month, how often have you found that you could not cope with all the things you had to do?
9. In the last month, how often have you been able to control irritations in your life?
10. In the last month, how often have you felt that you were on top of things?
11. In the last month, how often have you been angered because of things that happened that were outside of your control?
12. In the last month, how often have you found yourself thinking about things that you have to accomplish?
13. In the last month, how often have you been able to control the way you spend your time?
14. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

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Appendix 7

Rotter's Locus of Control Scale

Please answer every question. Read both statements, part a and part b and choose one statement that best applies to you.

- 1 a. Children get into trouble because their parents punish them too much.
b. The trouble with most children nowadays is that their parents are too easy with them.
- 2 a. Many of the unhappy things in people's lives are partly due to bad luck.
b. People's misfortunes result from the mistakes they make.
- 3 a. One of the major reasons why we have wars is because people don't take enough interest in politics.
b. There will always be wars, no matter how hard people try to prevent them.
- 4 a. In the long run people get the respect they deserve in this world.
b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
- 5 a. The idea that teachers are unfair to students is nonsense.
b. Most students don't realize the extent to which their grades are influenced by accidental happenings.
- 6 a. Without the right breaks one cannot be an effective leader.
b. Capable people who fail to become leaders have not taken advantage of their opportunities.
- 7 a. No matter how hard you try some people just don't like you.
b. People who can't get others to like them don't understand how to get along with others.
- 8 a. Heredity plays the major role in determining one's personality.
b. It is one's experiences in life which determine what they're like.
- 9 a. I have often found that what is going to happen will happen.
b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

- 10 a. In the case of the well-prepared student there is rarely if ever, such a thing as an unfair test.
- b. Many times exam questions tend to be so unrelated to course work that studying is really useless.
- 11 a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
- b. Getting a good job depends mainly on being in the right place at the right time.
- 12 a. The average citizen can have an influence in government decisions.
- b. This world is run by the few people in power, and there is not much the little guy can do about it.
- 13 a. When I make plans I am almost certain that I can make them work.
- b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.
- 14 a. There are certain people who are just no good.
- b. There is some good in everybody.
- 15 a. In my case getting what I want has little or nothing to do with luck.
- b. Many times we might just as well decide what to do by flipping a coin.
- 16 a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
- b. Getting people to do the right thing depends upon ability luck has little or nothing to do with it.
- 17 a. As far as world affairs are concerned most of us are the victims of forces we can neither understand, nor control.
- b. By taking an active part in political and social affairs the people can control world events.
- 18 a. Most people don't realise the extent to which their lives are controlled by accidental happenings.
- b. There really is no such thing as "luck."
- 19 a. One should always be willing to admit mistakes.
- b. It is usually best to cover up one's mistakes.

- 20 a.** It is hard to know whether or not a person really likes you.
- b. How many friends you have depends upon how nice a person you are.
- 21 a.** In the long run the bad things that happen to us are balanced by the good ones.
- b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
- 22 a.** With enough effort we can wipe out political corruption.
- b. It is difficult for people to have much control over the things politicians do in the office.
- 23 a.** Sometimes I can't understand how teachers arrive at the grades they give.
- b. There is a direct connection between how hard I study and the grades I get.
- 24 a.** A good leader expects people to decide for themselves what they should do.
- b. A good leader makes it clear to everybody what their jobs are.
- 25 a.** Many times I feel that I have little influence over the things that happen to me.
- b. It is impossible for me to believe that chance or luck plays an important role in my life.
- 26 a.** People are lonely because they don't try to be friendly.
- b. There's not much use in trying too hard to please people, if they like you, they like you.
- 27 a.** There is too much emphasis on athletics in high school.
- b. Team sports are an excellent way to build character.
- 28 a.** What happens to me is my own doing.
- b. Sometimes I feel that I don't have enough control over the direction my life is taking.
- 29 a.** Most of the time I can't understand why politicians behave the way they do.
- b. In the long run the people are responsible for bad government on a national as well as on a local level.

Score one point for each of the following: 2.a, 3.b, 4.b, 5.b, 6.a, 7.a, 9.a, 10.b, 11.b, 12.b, 13.b, 15.b, 16.a, 17.a, 18.a, 20.a, 21.a, 22.b, 23.a, 25.a, 26.b, 28.b, 29.a.

Significant Life events

Death of spouse
Divorce
Marital separation from mate
Detention in jail or other institute
Death of close family member
Major personal injury or illness
Marriage
Fired from work
Marital reconciliation
Retirement
Major change in the health or behaviour of a family
Sexual difficulties
Gaining a new family member (e.g. birth, adoption, sibling moving back home)
Major Business re-adjustment (e.g. merger, reorganisation, bankruptcy)
Major change in financial status
Death of a close friend
Change to different line of work
Major change in the number of arguments with spouse
Taking out a loan or mortgage for a major purchase
Foreclosure on a mortgage or loan
Major change in responsibilities at work
Son or Daughter leaving home
Trouble with in-laws
Outstanding personal achievement
Spouse beginning or ceasing work outside home
Beginning or ceasing formal schooling
Major change in living conditions
Revision of personal habits (dress, manners, association, etc)
Trouble with boss
Major change in working hours or conditions
Change in residence
Major change in usual type and/or amount of recreation
Major change in church activities (a lot more or less than usual)
Major change in social activities (clubs, dancing, movies, visiting)
Tacking out a mortgage or loan for a lesser purchase (e.g. car, TV, freezer etc.)
Major change in sleeping habits
Major change in the number of family get-togethers
Major change in eating habits
Vacation
Christmas
Minor violations of the law (e.g parking fine)