benefit of an individual social services review of their progress and the suitability of the placement. The Community Care Act made the social services of individual boroughs responsible for life-long provision of care to vulnerable clients. In our resident group, 30% are provided for by boroughs other than Lambeth. This makes liaison between health and social services departments more difficult, as they are geographically separated and regular contact is hard to coordinate. It also raises issues for patients who are uprooted and may lose their connections with a place, friends and family; they may also lose continuity of care. The homes showed marked variation in where they sourced their residents, with one home recruiting 100% of residents from outside the trust catchment area and another taking 75% from the local district. This might relate to economic variables, such as the relative ability of social services providers to meet varying costs of the homes.

The care homes explored in this study are a private sector initiative and their development in particular locations seems somewhat arbitrary. Certain locations need more local residential care homes: for example, the King's Fund Report (Johnson *et al*, 1997) on London's mental health services indicates a serious lack of placement in Southwark. The Lambeth catchment area is rich in placement provision and so has to provide, from existing services, for a large number of high-need patients from neighbouring boroughs. Given the ever growing need for supported and supervised accommodation, it is time that health and social services and the private sector looked at the development of future care homes in partnership, with the aim of providing residential care to clients local to their existing health and social service teams. This would bring care provision closer to home and could also lead to rationalisation of the workload and resource provision associated with these high-need clients.

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JOCELYN CATTY AND TOM BURNS

Mental health day centres

Their clients and role

AIMS AND METHOD
Mental health day centres have been little researched. We carried out a 1-week census at the four day centres run by a London borough.

RESULTS
The centres catered for a group with long-standing mental health problems, mostly under community mental health team care. A surprising number were suffering from physical ill health. They attended the centres primarily for social reasons or to participate in creative groups such as music and art. Very few were concurrently attending day hospitals.

CLINICAL IMPLICATIONS
Further work is essential to understand the distinction between NHS day hospitals and Social Services day centres in terms of utilisation and client group. This client group's needs, particularly for physical health care, require urgent attention.

The local authority mental health resource centre ('day centre') has received little attention in research literature, and there have been few attempts to distinguish it from the NHS day hospital in terms of function or client group. Studies of 'day care' in general tend either to concentrate on day hospital or out-patient care (Cann *et al*, 1996; Holmes *et al*, 1998), or fail to distinguish between types of care (Holloway, 1988). The few studies of day centres have focused on management practices (Shepherd & Richardson, 1979) and therapeutic community principles (Blake *et al*, 1984), and have found day centres to cater for a chronically ill client group (Vaughan, 1985; Wain-

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wright *et al*, 1988). There is still little clarity, however, about the services offered by day centres and their clients' needs.

The study

We undertook a census of users of day centres across the whole of one London borough, to understand better their current use and role.

Setting

The four centres (A–D) are funded by the Social Services, but run by the Family Welfare Association (FWA) and the local branch of Mind. They accept clients by referral only (predominantly from community mental health teams (CMHTs)), except at one (D), where non-referred clients are allowed to use the café.They are open for 6 days a week and some evenings, offering clients a 'drop-in' facility and cheap food, as well as therapeutic groups and members' meetings. Clients are encouraged to attend at least one group a week and are allocated a 'named worker'.

While the centres largely work to the same model, they differ in their setting, history and staffing. Centre A, run by the FWA, operated an individual counselling service prior to its purchase by Social Services and is located in a former day hospital. Centre B, run by Mind, shares its premises with Mind's local housing team and is available for their tenants' use as well as referred clients'. Centre C (Mind) merged two client groups when purchased: its own and that of a recently closed Social Services day centre. Centre D (FWA) runs culture-specific groups and outreach for Black and Asian people. FWA staff are predominantly social workers (although Centre D also employs staff with outreach experience), while Mind staff have a wide variety of backgrounds and qualifications, from psychiatric nursing to care work (paid or voluntary). Art, music and dance therapists also visit the Mind centres.

Methods

A 1-week census of users was conducted at each day centre. Data were collected for the whole census population on attendance, age, gender, diagnosis, CMHT or other referrer and area of residence ('local' described those living in the same postal district as the centre). In addition, short, structured interviews were conducted with clients who were willing and available, covering: self-ascribed ethnicity, duration of illness, duration of attendance at the centre, contact with the CMHT keyworker, attendance at other facilities, living arrangements, employment, physical health and views on the centre. Interviewees were also asked about their formal one-to-one contact (not chatting) with centre staff. The number of sessions attended (morning, afternoon or evening) was recorded, rather than hours, with Sunday counted as a single session. At Centre D, people using only the café were excluded.

Differences between centres and between those interviewed and those not interviewed were tested for significance using Pearson's χ-squared tests for categorical data, with Fisher's exact correction where necessary, and Mann–Whitney U or Kruskal–Wallis tests for non-parametric data. Differences are not statistically significant unless otherwise stated.

Findings

Response rate

During the census 170 clients attended the centres. Of those, 109 (64%) were interviewed, 12 refused and the remainder (49) could not be interviewed because of lack of interviewer time. There was no significant difference between those interviewed and those not interviewed in age (50.9 and 47.7 years respectively, P=0.10) or gender (41.3% and 44.3% female, respectively, P=0.89). Those interviewed were, however, likely to attend more frequently, with a mean of 4.8 sessions, compared to 2.6 for those not interviewed (P<0.001). Those interviewed were also less likely to be suffering from schizophrenia (36.4%) than those not interviewed (45.2%), while more of them were diagnosed as having depression (20.9% compared to 17.7%), although this was not statistically significant.

Clients (Table 1)

The client group had slightly more ment than women, with a mean age of 49.8 years. Centre B, however, had more men (68.9%), while Centre D had more women (60%). The most common diagnosis was schizophrenia (40%), with depression (20%) and bipolar affective disorder (11.2%) the next most common. Centre B had more clients with psychosis (66.6%). Of interviewed clients, 78.6% where White, 14.3% were Black and 6.4% were Asian. Centre D, however, had at least twice as many Black and Asian clients as any other centre (24% and 16%, respectively). Most clients were not working (81.7%) and just over half (55%) were living alone. Centre B clients accounted for most of those living in sheltered accommodation (21.2% of Centre B clients; 8.3% of all clients), and this difference was significant when analysed against the other categories together (P=0.02).

Of those interviewed, 66% reported physical health problems, ranging from 57.2% at Centre D to 70.8% at Centre A. Of these physical health problems, 76.4% were identified as chronic and 4.2% as acute, all at Centre A. Chronic conditions were most likely to be muscular/skeletal (58.2%) or respiratory (12.7%), but a range of others was represented.

Attendance (Table 2)

The average attendance was 24 clients per centre per day and the mean attendance per client was four sessions a week, which varied from 2.4 at Centre D to 4.6 at Centre B (P=0.003). The mean groups attended (including at Centre D) was one per client, with a range of 0–5. There

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was no difference between centres in the number of groups attended, but when the proportion of groups attended to groups available in the census week was calculated, the mean varied from 6% at Centre C and 9% at Centre B to 22% at Centre A and 26% at Centre D. Clients at Centre D were included only if they attended a group, but the difference was significant (*P*=0.02) even when Centre D was excluded. Forty-six per cent of clients at Centres A, B and C attended no groups, a figure that would be higher if meetings were excluded.

More than half of all the clients (59.3%) were 'local' to the centre they attended, but this varied from 71.8% at Centre C to only 39.1% at Centre D (*P*=0.008). Those interviewed had been attending for a mean f 56.1 months (4.7 years), ranging from 1 day to 17 years. Clients at Centre C had been attending for longer than those at the other centres (*P*-0.03). Few interviewed (3.8%) had attended a day hospital in the previous month and only 8.6% had visited a centre other than the one at which they were seen.

Individual care (Table 2)

Of all the clients, 66.9% were currently in the care of CMHTs, more (86.2%) at Centre A (*P*=0.004). One-quarter were not seen by either CMHTs or other mental

Table 1. Client characteristics

Characteristics	Total (n=170)[1]	Day centre				Test statistics
		A (n=29)	B (n=45)	C (n=71)	D (n=25)	
Gender (%)						
Female	43.5	48.3	31.1	43.7	60.0	P=0.15
Age (years)						
Mean (s.d.)	49.8 (12.4)	53.2 (13.3)	49.6 (10.2)	48.1 (11.9)	50.5 (15.7)	P=0.49
Range	21–88	35–88	24–72	21–75	28–80	
Diagnosis (%)						
Psychotic illness	52.4	48.3	66.6	45.8	44.0	P=0.10
Neurotic illness	31.8	30.9	15.6	32.0	24.0	
Other	6.0	20.6	8.8	9.8	8.0	
Ethnicity (%)	**n=109**	**n=24**	**n=33**	**n=38**	**n=14**	
White	78.6	82.8	81.8	84.6	60.0	P=0.09
Black	14.3	17.2	9.1	10.3	24.0	
Asian	6.4	0	6.1	5.2	16.0	
Other	0.8	0	3.0	0	0	
Not employed (%)	81.7	87.5	78.8	76.3	92.9	P=0.51
Living circumstances (%)						
Alone	55.0	75.0	48.5	47.4	57.1	P=0.22[2]
Partner	12.9	12.5	12.1	13.2	14.2	
Parents	6.4	4.2	6.1	2.6	21.4	
Staffed hostel	9.2	0	9.1	15.8	7.1	
Sheltered flat[3]	8.3	4.2	21.2	2.6	0	
Other	8.2	4.2	3.0	18.4	0	
Physical health (%)						
Any physical problem	66.1	70.8	69.7	63.2	57.2	P=0.22
Chronic problem	50.2	45.8	57.6	50.0	42.9	
Acute/transitory problem	2.8	12.5	0	0	0	
Chronic physical problem (%)[4]	**n=55**	**n=11**	**n=19**	**n=19**	**n=6**	
Respiratory	12.7	18.2	5.3	15.8	16.7	P=0.85
Muscular/skeletal	58.2	45.5	63.2	52.6	83.3	
Neurological	7.3	0	15.8	0	16.7	
Endocrine	7.3	9.1	5.3	10.5	0	
Circulatory	7.3	0	10.5	10.5	0	
Genito-urinary	5.5	9.1	5.3	5.3	0	
Digestive	7.3	18.2	5.3	0	0	
Sensory	5.5	9.1	5.3	5.3	0	
Allergenic	3.6	0	5.3	5.3	0	

1. Two people each attended the Centres B and C during the census period. For the analysis, one was allocated to each centre.

2. Alone *v.* not alone.

3. There was a significant difference between centres for living in sheltered accommodation *v.* all other categories (*P*=0.02).

4. Some people had more than one chronic condition, so percentages added up to over 100.

Figures in **bold** show numbers for whom information was available.

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health organisations. Clients who were interviewed had been in contact with psychiatric services for a mean of 17.8 years, longer at Centre B (22.3 years).

Of those interviewed, 56% said they had a CMHT keyworker, but this ranged from 21.4% at Centre D to 70.8% at Centre A (*P*=0.007). Of the 61 interviewed clients who had CMHT keyworkers, 24.6% reported contact at least weekly (35% at B), 32.8% every 2 or 3 weeks (66.7% at D) and 13.1% monthly (20% at B); 11.5% said they had 'rare' or 'no' contact (ranging from 0 at D to 19% at C). These figures were exceeded by those for having had contact in the previous week (34%) and month (79.7%). Clients at Centre B were more likely to have seen their CMHT keyworker in the previous month (*P*=0.02). Fifteen per cent of interviewed clients had had one-to-one contact with their centre named worker in the previous week and 32.1% in the previous month. About 20% thought they had care plans drawn up by the centre, with more of these at Centres A and C (*P*=0.002).

Client views (Table 3)

Clients expressed a wide range of views on the centres. The most attractive aspects were company (59.6%), food (13.8%) and the groups (11.9%). Company was particularly popular at D (71.4%). Negative social aspects – tension or aggression – were mentioned by 11% as their least favourite aspect. Among those who attended groups, art and music were the most popular, music significantly (*P*=0.001). A few volunteered the information that they avoided the groups entirely. About 65% were happy with time available to talk to staff (this included some who said they preferred not to speak to staff) and 14.7% were unhappy with the time available. More people (78.6%) were happy with staff contact at Centre D, where fewer of the clients had had recent staff contact.

Discussion

Day centres cater for a variety of needs, providing a sense of purpose and belonging for their clients. Several called their centre a a "lifeline" or reported that it "makes [them] feel wanted", and some viewed the centre as a commitment "like work". The average daily attendance was higher than the mean of 20 people per facility per day for the NHS region, and the opening hours were longer than in most day facilities in the region (Beecham *et al* 1998). Clients' duration of contact with psychiatric services was close to the 17.6 years for long-term clients known to the local mental health services (MHS) (Perkins & Bird, 1998).

The different circumstances of each centre had an impact on their client groups. The client group at Centre B had been in contact with psychiatric services for longer, perhaps because of the centre's history as a drop-in and its association with the housing project (which also accounted for the greater proportion of its clients living in sheltered accommodation), and were more likely to have psychotic illness. While this client group was more male-dominated, Centre D had more women. That fewer

Table 2. Client attendance and individual care

Attendance and care	Total (*n*=170)[1]	Day centre				Test statistics
		A (*n*=29)	B (*n*=45)	C (*n*=71)	D (*n*=25)	
Sessions attended (per week)						
Mean (s.d.)	4.0 (2.9)	3.3 (2.7)	4.6 (2.6)	4.4 (3.2)	2.4 (2.5)	*P*=0.003
Range	0–13	0–9	1–10	1–13	0–8	
Groups attended (per week)						
Mean (s.d.)	1.0 (1.1)	1.0 (1.1)	0.8 (0.9)	1.0 (1.2)	1.6 (1.4)	*P*=0.07
Range	0–5	0–4	0–4	0–5	0–5	
Under CMHT	66.9	86.2	66.7	64.8	40.0	*P*=0.004
Duration of attendance at centre (months)	***n*=109**	***n*=24**	***n*=33**	***n*=38**	***n*=14**	
Mean (s.d.)	56.1 (50.2)	45.7 (50.9)	44.8 (46.7)	73.2 (54.7)	55.1 (35.2)	*P*=0.03
Range	0–204	2–144	0–180	2–204	24–108	
Duration of contact with psychiatric services (years)						
Mean (s.d.)	18.7 (12.8)	18.7 (13.2)	22.3 (13.4)	15.9 (10.7)	17.4 (16.2)	*P*=0.32
Range	0–47	0–47	1–44	0–39	2–40	
Live local to centre (%)	59.3	64.3	46.7	71.8	39.1	*P*=0.008
Had centre worker contact in last month (%)	32.1	37.5	21.2	44.7	14.3	*P*=0.08
Have care plan (%)[2]	20.2	33.3	3.0	31.6	12.5	*P*=0.002
Have CMHT keyworker (%)	56.0	70.8	60.6	55.3	21.4	*P*=0.007
Keyworker contact	***n*=61**	***n*=17**	***n*=20**	***n*=21**	***n*=3**	
In past month (%)	79.7	82.4	95.0	57.1	66.7	*P*=0.02

1. Two people each attended both Centres B and C during the census period. For the analysis, one was allocated to each centre.

2. Centre D, *n*=10 (referred clients only).

Figures in **bold** show numbers for whom information was available.

CMHT, community mental health team.

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Centre D clients had talked to staff in the previous month may have been owing to the division of the service into the drop-in café and the separate group programme, since talking to staff in the groups was not counted. The function of the café as somewhere for the clients to be sociable, too, may explain the fact that more of them were happy with the amount of time available to talk with staff, and more rated company as their favourite aspect.

Clients at Centre D were significantly less likely to be local to the centre, which may have been owing to the attraction of the café. That Centre C clients were more likely to be local, and had also attended for the longest, may have been owing to the long history of there being a Mind centre in this location. Centre B clients attended more often during the week than Centre A clients, although they attended fewer groups. The difference between centres in groups attended as a proportion of what was on offer may suggest a greater emphasis on group work by the FWA centres (A and D).

Fewer clients in the total day centre group had schizophrenia than did in the MHS user population in this borough (40% compared to 60.8%) and more had depression (20% compared to 13.4%), but the proportion with bipolar disorder was the same. The proportion of White clients matched the general borough popularion, but exceeded the proportion for long-term MHS patients. The proportion of Black clients exceeded the general population, but was less than the proportion for MHS patients. The proportion of Asian clients was closer to that in both the general population and the local MHS trust patient group (Perkins & Bird, 1998). These figures were accounted for by Centre D, however, which offers Black and Asian culture-specific groups and outreach and, therefore, had twice as many clients from these ethnic groups.

Group programme

At the time of the census, the group programme was newly implemented and the previous culture of the centres as predominantly 'drop-ins' still prevailed. Only 54% overall attended groups during the week and staff avoided insisting on group attendance, for fear of alienating clients. A significant minority of clients, particularly people who had previously attended another centre that had focused more on groups, felt bored or disappointed by this lack of emphasis on groups. Conversely, a few clients preferred not to have contact with staff at all, suggesting that they saw centres as somewhere to spend time relatively anonymously. It is a limitation of the study that those least willing to communicate with staff were less likely to be interviewed, so that more clients may have preferred anonymity than our findings suggest. All these factors highlight the problems in introducing a new system to a long-term, but heterogenous population.

Physical health

A substantial proportion of mental health patients has physical health problems that are not known to the MHS or are entirely undiagnosed (Koran *et al*, 1989; Fisher & Roberts, 1998), and the lack of knowledge about physical health by mental health workers is more striking for clients in the community than for in-patients (Perkins, 1994). Our proportion reporting physical health problems (66%) was greater than the 50% reported by the Camberwell Group to have 'a serious physical condition' (Brugha *et al*, 1988), although this finding matched ours for chronic problems (50%). More strikingly, it far exceeded the 13% estimate found by Beecham *et al* (1998) in a questionnaire study of all the day facilities across the whole of the NHS region using staff records. The needs of clients for physical health care would clearly merit further investigation.

CMHT contact

Total figures for frequency of keyworker contact were higher than those ascertained in a recent audit of patient contacts based on CMHT notes (Greenwood *et al*, 2000): more than double in the case of contact at least every 3 weeks and contact at least quarterly. This implies that either clients were overestimating the frequency of their contact with keyworkers or there is significant under-recording of contacts by professionals.

Use of other services

Many clients had used in-patient services before and a few of those on the books could be in hospital at any one time. Very few, however, were currently using day hospitals, although many had in the past. A study is currently underway to clarify the differences between day centres and day hospitals, to inform rational service planning. The current emphasis on forms of day care to substitute for hard-pressed in-patient services often fails to distinguish between the two. Given the drive to bridge the health and social care divide, day centres are achieving prominence in planning, yet very little is known about what they do. It is imperative that further research so conducted into the needs of this client group if mental health care planning is to be coherent and coordinated.

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