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RESEARCH ARTICLE

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Triangulation study of needs assessment of people with severe mental illness in "follow-up" day hospital settings

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Abstract

Aim: The aim of research was to assess the needs of patients with severe mental illness (SMI) attending follow-up day hospital (DH) programmes from the patients', relatives' and experts' perspective.

Design: This triangulation research relies on three sources of information and two techniques of data collection.

Methods: Qualitative research was conducted comprising semi-structured interviews (n = 15) and focus groups (n = 4) in three sequential rounds, triangulating patients', relatives' and experts' views. A content analysis was carried out.

Results: Study reveals a diverse spectrum of needs of SMI patients in follow-up DH programmes. The analysis yielded six themes: optimal daily functioning, work and educational activities, social network inclusion, continuous treatment, support and guidance, long-term care. DH programmes should assess the needs of patients with SMI and be adapted according to the findings. In addition to clinical treatment, requirements for continuous treatment, psychological and social needs, therapeutic relationship in less-restrictive settings should be considered.

KEYWORDS
day hospitals, needs, patients, severe mental disorders

1 | INTRODUCTION

Psychiatric day hospitals (DH) provide care for patients with different psychiatric disorders who do not require 24-hour supervision after in-hospital treatment (Marshall, 2003; Marshall et al., 2001). Day hospitals are particularly important because they reduce coercion in comparison with inpatient units and thus enable trusting therapeutic relationships. Nursing care in day open care policy as "acceptance," "availability of staff," "real respect for the person," "ensuring patients' rights," "listening to the person" and "negotiation and not imposition" as quoted by Missouridou improve therapeutic alliance (Missouridou et al., 2021) and reduce stigma (Missouridou et al., 2022). The advantage of DH is that it can deliver a complex set of different modalities to a group of patients instead of each patient being treated by a small group of clinicians. DH enables patients to be more directly involved in decision-making about their treatment than in hospital settings (Šago et al., 2018) and provide a less-restrictive environment based on trust in therapeutic relationships. This is based on the open-door policy and enhance patients' self-determination and self-confidence and finally empowerment (Missouridou et al., 2021). Traditionally the establishment of trusting and safe environment is a psychiatric nurses' task (Missouridou et al., 2021; Peplau, 1997). Nurses may provide a caring relationship in a partnership with patients to help them cope with their problems

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(Shattell, 2004) and to provide systematic patient education according to patients' individual needs (Koivunen et al., 2012). The final aim of nursing care in DH settings is to enable reintegration into family and social networks (Pessoa Junior et al., 2014). Mental health nurses in DH perform individual care programme planning in DH and improve answers to patient' needs as an alternative to intensive psychiatric care, which bridges the gap between inpatient and outpatient treatment and provides recovery skills (Taube-Schiff et al., 2017).

Slovenia is a strongly institutionalized country with 2 million population and 6 psychiatric hospitals that all have their day hospitals financed by the government insurance agency. The culture of low restraint and open care policy were established later than in the neighbouring Italy, which followed the deinstitutionalization principle from 1986. Slovenia decided to upgrade psychiatric hospitals to improve care for people with mental disorders. The number of hospital beds however remained relatively low compared with other EU countries, predominantly due to trans-institutionalization to social care homes or discharges to family environment (WHO, 2015). One of the alternatives to hospitalization was also day hospital treatment that started to be develop already in the seventies.

The Slovenian Resolution on the National Mental Health Programme 2018–2028 to respond to the needs of people with mental health problems and their families should follow the ideas of de-institutionalization and community care, including day care in all its aspects (follow-up, rehabilitation and alternative to in-hospital treatment and ambulatory care) (Official Gazette, 2018). Health Education about community treatment and human rights of people with mental health problems is included in the basic education of staff employed in new community mental health centres from 2018 as well as in training of Registered Nurses, but there is still a lot of work to be done. There is a gap in the education of public mental health issues and human rights of people with disabilities.

2 | BACKGROUND

People with severe mental illness (SMI) often have multiple complex clinical and social needs, such as those related to accommodation, employment and life skills (Burns et al., 2007; Isaacs, Beauchamp, Sutton, & Kocaali, 2019; Jones et al., 2014; Phelan et al., 1995), and the need for information and participation in treatment (Siu et al., 2016). One of the key needs reported by Voogt et al. (2015) during hospitalization is that of maintaining autonomy. Other needs expressed by patients with SMI are to reduce psychological distress, improve daytime activities; socialize; be able to express oneself sexually and have intimate relationships; improve physical health; reduce psychotic symptoms, obtain information about treatment; improve their financial situation; get or retain employment (Isaacs et al., 2019b; Macpherson et al., 2003; Ponizovsky et al., 2014; Ritsner et al., 2012; Trauer et al., 2008; Uygur & Danaci, 2019). The largest proportion of unmet needs relate to the social field (Cialkowska-Kuzminska et al., 2014). Peer-reviewed studies assessing the needs showed that the average number of unmet needs in psychiatric patients ranged from 3.3 to 8.6 among the list of 22 needs and that the number varied according to psychiatric diagnosis. The needs of SMI patients ranged above 6 (Joska & Flisher, 2005).

Very little is known about specific needs of patients that follow DH programmes. This results in different indications and recommendations for DH, mostly relying on expert opinion (Zeeck et al., 2009). Patients' views on treatment in DH soon after admission should be considered important (Priebe et al., 2011), and patients' perspectives should serve as valuable input in developing treatment plans. These should include understanding of the needs of both patients and their carers (Cialkowska-Kuzminska et al., 2014). Other DH researchers suggest focusing on understanding the perspective of both users and relatives (Taube-Schiff et al., 2017).

A comprehensive needs assessment tool is recommended to identify staff and patients' perceptions of priority needs and to ensure that care is explicitly targeted at reducing unmet needs of SMI patients (Macpherson et al., 2003). Qualitative research providing an in-depth analysis of patients' perspectives on DH and hospital treatment is recommended, since it offers important insight beyond quantitative questionnaires (Mortl & von Wietersheim, 2008). In nursing, qualitative methodology is commonly used in psychiatry, gerontology and public health (Elo & Kyngäs, 2008). In mental health, it can provide new insights for poorly understood and complex areas, such as understanding subjective experiences of mental disorders and their treatment (Crowe et al., 2015). The Slovenian Resolution on the National Mental Health Programme 2018–2028 recommends research involving users and providers in identifying their needs (Official Gazette, 2018).

Slovenia has four DH settings for patients with SMI, organized as separate units in psychiatric hospitals on secondary and tertiary level. They are connected with various outpatient facilities, among them non-governmental (NGO) day centres (DC), which provide prolonged rehabilitation services. One of the largest is Šent – The Slovenian Association for Mental Health.

The programme of the DH in Slovenia is designed as a structured schedule of therapeutic and everyday skills, predominantly group training activities taking place every day until late afternoon with psychoeducational and psychotherapeutic programmes included. Treatment duration for patient with SMI is not limited; it depends on individual therapeutic goals, and it is on average 4 to 12 weeks long. The programmes are implemented by a multidisciplinary team, which includes psychiatrists, Registered Nurses, occupational therapists, clinical psychologists, art therapists and social workers. Patients are referred to DH by psychiatrists who consult other staff member regarding treatment plan. DH should enable a transition from the hospital to the home environment. It should provide additional time for stabilization of symptoms to avoid inpatient treatment. DH simulates the home environment (living room, kitchen, laundry, etc.). The content of treatment varies according to patients' needs. All treatment procedures are individually tailored. Some patients attend the activities every day, others are engaged at different intervals, but all patients leave DH in the afternoon and sleep at home. In DH

psychoeducation is performed regarding causes of mental disorders, their signs and treatment as well as rehabilitation possibilities for patents and relatives separately. Groups and individual counselling led by nurses are performed regularly. These groups provide information, as well as mutual support and promote self-help among members in DH. Social and everyday skills training is a regular therapeutic procedure in every DH. The main goal of all activities, however, is providing a safe therapeutic environment allowing transition to lower intensity services in the community.

Needs-based treatment in DH is possible with needs identification. This paper presents a comprehensive method to assess the needs of patients with SMI in follow up DH settings and its findings.

2.1 | Research question

The research question is: What are the needs of patients with severe mental illness attending follow-up day hospital?

3 | THE STUDY

3.1 | Design

The research was carried out through a triangulation of data sources and techniques (Wilson, 2014). This type of research provides a comprehensive insight into the study topic (Wilson, 2014; Williamson, 2005). The three sources of information in this study were patients/users ($N = 9$) in DH and DC, their relatives ($N = 7$) and professionals working in DH and DC ($N = 8$). The data collection was carried out in three sequential rounds in the form of individual interviews and focus groups (Table 1).

The aim of the first round was to identify the needs of current DH patients, their relatives and DH staff. Fifteen individual semi-structured interviews were performed. The aim of the second round was to identify the needs recognized in the post-hospitalization period. Focus groups with patients attending DC of non-governmental organizations (providing daytime activities, leisure and counselling), their relatives and experts were performed. The aim of the third round was to review the list of identified needs in the context of DH service provision with DH professionals. It consisted of focus group with DH experts.

3.2 | Methods

Data collection followed the guidelines of semi-structured interview guides and topic guides for focus groups (Hopf, 2004; Johnson & Rowlands, 2012). Focus groups included participants and researchers only. The duration of interviews was from 17 to 52 min and of focus group from 48 to 75 min.

For the first round, a semi-structured questionnaire for individual interviews with DH patients, relatives and experts was prepared, with open-ended questions based on prior findings (Agrest et al., 2018; Hemmings et al., 2009; Nikendei et al., 2016; Slade et al., 1998). The questionnaire contained four sets of questions about needs, options to address them in DH, limitations and suggestions. The second-round focus groups questions were based on the findings from the first-round interviews, checking the first-round results (Table 2). For the third round, a focus group with DH experts was performed to get them acquainted with the outcomes of the first two rounds and to discuss the actual implementation possibilities.

3.3 | Study sites and participants

The study was performed in a day hospital setting at the Psychiatric Hospital in Slovenia and in the NGO Day Centre in the nearby location.

A purposive sampling strategy was used to recruit the members of the three groups (Coyne, 1997). Each sampling unit was selected with a specific purpose – to use the experience and information of patients with SMI attending a DH and NGO DC, of professionals and of relatives of patients from same settings. Due to COVID-19 pandemic situation, the sample was gathered from attending members of DH and DC settings in Slovenia. The sample size was determined in advance, with the possibility of increasing the number until saturation of the data was reached (Coyne, 1997). The inclusion criteria

TABLE 1 Study design

Participants		Data collection technique	Analysis	Outcome
1st round	DH patients DH relatives DH experts	Semi-structured individual interviews	Text coding, category design	Identification of the basic set of needs
2nd round	DC users DC relatives DC experts	Discussion in three focus groups	Review of categories	Set of needs discussed from the first round
3rd round	DH experts	Discussion in one focus group	Getting acquainted about categories and themes and assessment of actual implementation possibilities	List of needs to be addressed in DH

TABLE 2 Semi-structured interview guide

1st round	1. Needs Think about your/patients' needs and describe them. What areas are currently in need of help? Describe an example. 2. Needs - to which can day hospital answer (DH)? What do you expect from treatment in a DH? What needs can DB address? What is your experience? Please describe in which areas DH answered your/patients' needs? If you compare your/patients' situation before treatment and after, how would you describe it? Describe an example. 3. Barriers in DH What has been hindering treating at the DH? What did you not find helpful in DH programme? What do you think are the advantages and disadvantages of DH treatment in meeting your/patients' needs? Describe an example. 4. Treatment in DH – suggestions What do you think about the DH programme? What would you like to say on the DH programme? What would you change, what do you miss in DH treatment? What treatment activities should be available within the DH? Would you like to add anything else in connection with the interview?
2nd round	*According to the list of patient' needs in DH* (from the first round): What is your opinion regarding the recognized needs of patients with severe mental disorders? Based on your experience, which needs would you like to complement, widen, rename? What needs of people with severe mental illness could be met in a DH setting? Tell why? Can you explain? Would you like to add anything to the discussion?
3rd round	*According to the list of patient' needs in DH* (from the second round): What is your opinion regarding the recognized needs of patients with severe mental illness? Based on your experience, which needs would you like to add, complement, widen, rename? Could these needs be met in a DH setting? Name or. rename groups of related needs

for patients were (1) being included in a day hospital or day centre (2) aged between 18–65, (3) being diagnosed with at least one of the disorders listed in the International Code of Disease (ICD) 10 as F20-F39 and (4) consent to participate in the research. The inclusion criteria for relatives were (1) having a relative included in a day hospital or day centre and (2) consent to participate in the research. Inclusion criteria for experts were (1) being an active healthcare provider in day hospital or day centre and (2) consent to participate in the research. The exclusion criteria for patients were: (1) acute psychosis, (2) history of head injury, (3) organic neurological disorder or infection, (4) primarily addiction diagnosis, (5) severe mental retardation and (6) compromising illness/disability with predominantly physical needs. The participants were contacted by telephone and face-to-face.

Twenty-four participants were enrolled in the study. Fifteen of the participants who were involved in a DH programme (5 patients, 5 relatives and 5 experts) were enrolled in the first round; nine participants who were involved in a DC programme (4 patients, 2 relatives, 3 experts) in the second round. There were three female and two male patients in DH with a mean age of 37 (minimum 29, maximum 46), three of whom were single and lived with their parents. One of them was partly employed and partly retired, while the other four were unemployed. The average number of admissions to a psychiatric hospital was 2.8 (minimum 2, maximum 4). All participating relatives were female with a mean age of 53; two of them had a university degree, one had secondary school education, while two undertook short-term vocational education. All of them were parents of DH patients living in the same household. The professional DH workers were all female with an average of 5.5 years of experience working in a DH setting (minimum 2, maximum 8). One was a Registered Nurse, one an occupational therapist, two were psychiatrists and one was a clinical psychologist. On average, they were 44.6 years old (minimum 34, maximum 61). Patients included in DC were three females and one male with a mean age of 49 (minimum 46, maximum 57), two of whom were living with their parents, one with their family and one alone. One of the patients was unemployed, while the others were retired. On average, they have been attending the DC programme for 8 years (minimum 2, maximum 15). Both participating relatives were parents, one female and one male, with a mean age of 73. Both had secondary school education, and both live together with their adult child. The DC experts were all female with an average of 13.3 years of work experience in DC (minimum 12, maximum 16), one was a nursing assistant, and two were social workers. They were on average 44.6 years old (minimum 36, maximum 47). The same DH experts were enrolled in the third round as in the first round.

3.4 | Data analysis

The first-round interviews were conducted by TT, MSc and VS, PhD, who were trained in performing focus groups and interviews, and had no personal or therapeutic connections to the patients and relatives. However, the interviewers had professional acquaintance with some of the mental health workers, because there is a small mental health professional community in Slovenia. The second-round focus groups ($N = 2–5$) were moderated by TT. The participants were asked to discuss a set of needs that had been identified in the first round. The third-round focus group was conducted by TT and discussed the set of needs established in the second round as well as possibilities

to fulfil them in DH. All the interviews and discussions in the focus groups were recorded. An experienced person – a Master of Social Science – made the transcripts of the recordings. Each transcript was double-checked by a moderator.

The interviews and focus group transcripts were analysed using the content analysis. The researchers classified extensive texts into smaller content categories. They followed the method with an initial phase of preparation and organization, including open coding, category formation and abstraction (Elo & Kyngäs, 2008; Saldaña, 2013; Schreier, 2012). The Atlas.ti software 9 for an open coding process (Friese, 2019) was used to analyse the text. Transcripts of the interviews were read several times and parts of the texts that were related to the research objectives were used for further processing, based on a theoretical framework of patient needs. In the qualitative synthesis, codes and categories were classified according to their meaning (Saldaña, 2013). TT and SLB independently analysed the text and formed categories on which they reached a consensus. In case of any discordance, the issue was discussed with the other research team members until a satisfactory inter-rater agreement was achieved. In the second round, the set of needs from the first round was discussed. Participants were given a list of categories and codes in advance. Additional codes appeared, but the number and content of the categories did not change, and the participants of each focus group eventually reached a consensus through discussion and confirmed the list of needs at the category level. TT and VS reviewed the set of needs for each participant group separately and joined them at the category level into one common list. In the third round, the expert group received a list with a set of needs from the second round. Through the discussions, the expert panel named the categories of needs and derived the main themes, according to the actual possibilities of DH setting. The data collection process with outcomes is summarized in Table 3.

3.5 | Ethics

The study has been approved by the Medical Ethics Commission of the Republic of Slovenia (0120-82/2019/13). The participating institutions and all the participants provided written consent and gave their permission to record their interviews and discussions. The authors informed them about the purpose and process of the research and that participation is voluntary. Data are presented without any personal details to protect participants' anonymity. The researchers have signed a declaration committing to ethical research standards.

4 | RESULTS

From the analysed interviews from the first round, 138 codes with a total frequency of 960 were identified. On the basis of these codes, 15 categories were formed of the needs in the patients' group, 16 in the relatives' group and 17 in the experts' group. All the categories were confirmed in the second round. Finally, in the third round, 19 categories were formed, from which six main themes were derived – the areas of patient needs' (Table 4). The content of the main themes with representative quotes from the participants is shown below. A quote was selected from each of the six main themes that most eloquently describes the meaning of the group of needs.

There are often tensions between individuals with mental health problems, carers and professionals (Misouridou & Papadatou, 2017), but we did not observe any of them.

Patients, relatives and experts felt that patients need help in daytime activities and self-care, as well as in getting used to independent living.

> "The first important thing is the day structure in the day hospital. It is important to know in the morning, what your tasks are, so the day isn't empty. I was at home at that time, I didn't have a job. Moreover, if I hadn't gone to the day hospital, maybe I would still be at home, would not leave home, and wouldn't have any company."
>
> (PAT/3)

Patients need help in arranging their employment and completing their educational level.

TABLE 3 Data collection process with outcomes

Participants		*N*	Data collection technique	Data collection Time period	Outcome
Qualitative part					
1st round	DH patients	5	15 individual interviews	21.1–11.2.2020	Measurement of a set of needs – text coding, category design
	DH relatives	5		27.1–6.2.2020	
	DH experts	5		14.1–5.2.2020	
2nd round	DC users	4	Discussion in three focus groups	10.6.2020	Set of needs discussed from the first round – confirmation of categories
	DC relatives	2		10.6.2020	
	DC experts	3		10.6.2020	
3rd round	DH experts	5	Focus group discussion	19.6.2020	Adapted list of addressable needs in DH

TABLE 4 Day hospital SMI patients' needs – main themes with categories

Main theme	Category
Optimal daily functioning	Improved everyday functioning at home
	Structure of daytime activities
	Gradual transmission of everyday functioning to home setting
	Day activities skills training
	Self-care
	Independent living
Work and educational activity	Settled employment and education
	Integration in supported employment or other vocational rehabilitation
Social network inclusion	Improvement of social network
	Belonging and social acceptance
Continuous treatment	Consolidation and maintenance of symptom-free periods
	Prolonged treatment
	Checking medication effectiveness
Support and guidance	Motivation and purpose
	Support and guidance by DH team
	Belonging and acceptance by therapeutic group
	Cooperation with relatives
	Coping with stigma
Long-term care	Treatment continuity after discharge

> "This is a basic thing, and the highest goal is to get a job somewhere and to be independent, just like everyone else."
>
> (REL/1)

Another need identified for patients is to be involved in different social networks and to gain a sense of belonging.

> "In my opinion, one of my basic needs is good relationships or good mutual feelings which make me feel accepted and capable of creative work and of an individual expression in the group."
>
> (PAT/4)

The need for continuous medical treatment is about taking medication, education about the disease and coping with symptoms.

> "DH seems to me to be one part of the hospital, of the healthcare system. It is there where we can improve our focus on the symptoms themselves; how to deal and live with them, how to handle medication, it helps that we can get more involved in this part. Our role in this is very important."
>
> (EXP/4)

Patients also expressed the need for motivation, the need to finding meaning of existence and setting life goals. From staff, they expect support, respect, guidance and care for their dignity, provision of reliable relationships, including having a say in treatment. Patients need support from relatives as well as cooperation and knowledge about their problems. They also need help to cope with stigma.

> "It seems to me that the therapeutic relationship is well established here. A person can feel accepted, can talk about their problems, and feel that they won't be judged."
>
> (PAT/4)

Long-term care after discharge from DH involves help in liaising with other services – both governmental and non-governmental – help in approaching support groups, and/or other services.

> "To offer more possibilities in a more automatic way, to communicate further treatment. For example, a patient could come to your day centre, group, or something else. In DH, we worked on these areas; we noticed these problems; patients should be supported in these areas. It is also important to have agreement on recovery among services."
>
> (EXP/2)

5 | DISCUSSION

Day hospital is one of the psychiatric treatment modalities used in many healthcare systems for decades, with a general lack of assessment. To the best of the authors' knowledge, this is the first study that explored the needs of patients with SMI in DH through triangulation of patients, their relatives and psychiatric nursing staff and other experts. The main purpose of this study was to identify and analyse the needs of psychiatric patients who are involved in psychiatric DH programmes. Studies taking into account the points of views of patients, relatives and experts are essential in order to understand different perspectives of meeting the needs.

The research took place in the time of the COVID-19 pandemics. Even though none of the participants was infected, the pandemic influenced the needs of individuals with mental health problems a lot: psychiatric patients could only get basic psychiatric medical treatment during 2020. All patients stopped attending DH for closure reasons in March 2020. One of the DH was opened from May until October 2020 and two of them were closed until the end of the 2020. DC were also closed for some several months from March 2020 on. Patients in DH were regularly questioned about COVID-19 symptoms, risk contacts, body temperature was measured, and they had to use facial masks in the time of the research.

The population of patients participating in this study reflected many characteristics of SMI patients (WHO, 2014; van der Post et al., 2019). They often live with their parents, have low incomes or do not have any money of their own, are frequently unemployed or partially or fully retired due to their medical condition. They tend to have a weak social network and most of them have been admitted to a psychiatric hospital several times. Their basic life needs are rather similar to the needs of people without mental disorders. Above all, patients with SMI need to be empowered about everyday functioning, they want to work and be independent, to be accepted and loved, they want support and protection of fundamental rights and many indicated the need for medical treatment.

They need to practice daily activities, important for strengthening cognitive functions, improving self-care, and care for a household, social skills, use of transport and daily skills are discovered to be important. This is consistent with other research that identified everyday performance as one of the recovery indicators and that DH facilitates recovery (Agrest et al., 2018), prevents relapses and improves daily functioning (Stiekema et al., 2020). In this study, DH patients also expect improvement of their performance and to be able to live independently.

The patients' needs to be employed is about being socially included and to have access to financial means important for quality of life. DH is expected to link them to vocational rehabilitation and employment services as well as with services to enable them to complete their education. Mental health nurses might have a role in supporting vocational rehabilitation (Jackel et al., 2020; Rezaie & Phillips, 2020). Hasegawaa et al. (2018) suggest that chances for future employment can be promoted through improvements in social functioning during early-stage treatment.

The patients in this study also recognized the need for organized activities to re-establish social networks and improving communication skills, which is supported by the findings by Anderson et al. (2015). The patients' need of belonging and acceptance is a general human need that has been emphasized in the process of research. The limited social networks of individuals with SMI are, for many, a major problem, associated with their disability and stigma. The need for continuous support in social inclusion (Koenders et al., 2017) is therefore one of the essential needs and rights of this group. Measures targeting an increase in patients' networks and education of social isolation are found to be effective (Anderson et al., 2015).

The third round of discussions involved experts who assessed the list of needs regarding the DH setting limitations. The major category changes however were made regarding the importance of the theme "Continuous treatment" adding categories Prolonged (medication) treatment and Checking medication effectiveness which reflects their biological treatment orientation. Patients and their relatives did not rate the importance of these needs that highly. Experts also believe that medication adherence is needed for adequate rehabilitation. This is in line with the finding that compliance with medication helps to improve symptoms, although it has little impact on recovery and functioning (Alkan et al., 2020; Chien & Yip, 2013; Millan et al., 2016; Swartz et al., 2007). Besides prolonged treatment, psychoeducation and personal understanding of recovery is needed to reach the rehabilitation goals in all areas of functioning. Lariviere et al. (2009) also suggest that the focus of DH programmes is not only on reducing symptoms but also on empowering, helping patients to learn about themselves and their illness, improving their self-esteem, developing valuable life skills and reviving hope.

The patients involved in our study require a permanent and accessible professional team, which provides feelings of safety and continuity of relationships in the treatment process. This is supported by findings of Lariviere et al. (2009). Psychiatric patients in hospital settings value staff empathy, as well as caring, understanding, respectful and attentive relationships (Mistry et al., 2015).

In DH, patients also need acceptance by their peers. The sense of belonging, understanding, acceptance and usefulness improves self-image (Šago et al., 2018) and reduces isolation, as suggested by Agrest et al. (2018) and Lariviere et al. (2009). Cooperation of relatives in DH was recognized as an important need with the expectation that the DH staff acts as mediator among patients and relatives. DH services might improve knowledge and skills of families regarding coping and cooperation may reduce family member concerns (Jones et al., 2014). The systematic family approach also reduces stigma, increases knowledge and fosters skills (Koenders et al., 2017; Rezaie & Phillips, 2020).

Regarding our results, DH should provide a connection with other services after discharge. Care coordination has proven to be a comprehensive way to address the multiple and complex needs of people with SMI (Isaacs et al., 2019a). It prolongs the duration of service contact, which is positively correlated with higher rates of met needs and service satisfaction (Joska & Flisher, 2005).

5.1 | Limitations

In spite of the fact that DH programmes were intermittently closed due to epidemiologic situation and the researchers had to narrow the range of participants, the saturation in the interviews was nevertheless reached, as well as the agreement in the focus groups. This suggests a satisfactory number of participants. However, also the content of participants' discussions might be influenced by COVID-19 situation. It is well known that mental health disorders worsened during this time especially regarding anxiety and depression, and we also know that COVID-19 influenced mental health of health workers, albeit not that much as of patients (WHO, 2020). Pandemic was a possible selection bias also because of the limited public transport.

The limitation of the research is also organization of DH in Slovenia that differs in certain characteristics and patients' groups. It is not possible to generalize our results to all DH settings. Several hospitals do not work with all patients' groups and have not embraced the culture of the minimal coercion.

Moreover, the study only involved those patients and relatives who were motivated to participate. It did not assess the needs of

other patients, especially those who discontinued their treatment or their involvement in DH programmes. As they did not agree to participate in the study, very little is known about their needs. Identifying the needs of non-responders is an important challenge for both researchers and mental healthcare providers.

6 | CONCLUSION

The findings of this study contribute to understanding of the needs of patients with severe mental illness in day hospital settings. This will enable psychiatric nurses and other professionals working in day hospitals to improve their professional interventions. Patients with severe mental illness in day hospital programmes have a diverse spectrum of needs including optimal daily functioning, work and educational activities, social network inclusion, continuous treatment, support and guidance and long-term care. Besides medical treatment needs, psychological and social needs should be routinely considered regarding severe mental illness patients involved in day hospital programmes. Psychiatric nurses have achieved core competences to assess complex patient needs, and they have a central role in implementing measures in day hospital.

6.1 | Clinical implications

Needs assessment is a cornerstone quality of individual care planning in DH and other settings. The DH programmes should be adapted to patients' needs, focusing on functioning in daily life, work and educational activities, involvement in a social network, continuous treatment, support and guidance and long-term care. Needs of patients' relatives should be considered in care planning as well. Both individual interviews and focus groups can be used for research on DH users' needs.

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CONFLICT OF INTEREST

None.

DATA AVAILABILITY STATEMENT

The data set generated and analysed during the current study are not publicly available due to ethical reasons and protection of the participants' identity.

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