

SERVICE UTILISATION BY FORMER LONG-STAY PSYCHIATRIC PATIENTS IN NORTHERN IRELAND

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SUMMARY

The shift from hospital to community care for people with mental health problems places continuing demands on community-based services. However, comparatively little is known about the patterns of service use among those previously resident in psychiatric hospitals. In this study, a total of 145 former long-stay psychiatric patients in Northern Ireland (NI) – most with a diagnosis of schizophrenia and aged under 60 – were followed up one year after discharge to identify the type and frequency of service use during the previous six months. Although a wide range of services was used, GPs, CPNs and social workers respectively were central to client care outside hospital. However, access to, and use of, services – influenced, in part, by the unique integrated health and social services structure in NI – varied widely across types and sectors of accommodation. The findings have implications both for the successful management of community placement for former long-stay patients and for the planning and implementation of services for future more dependent cohorts.

INTRODUCTION

Effective community care for people with mental health problems relies on comprehensive, flexible and co-ordinated services (Royal College of Psychiatrists, 1987; Huxley, 1990; Shepherd, 1992). It is important to identify patterns of service utilisation (as well as assessing client needs) in an attempt to aid service planning and delivery, particularly for those who have previously been in long-stay hospital care, many of whom may require a high level of support after discharge. However, few studies have focused specifically on service use among former long-stay patients despite the fact that the different levels and types of services used are likely to have an impact on patient outcome.

In its 1987–1992 Regional Strategy, the Department of Health and Social Services in Northern Ireland (NI) set specific targets of a 20% reduction, by 1992, in the numbers of people in long-stay hospitals (DHSS, 1986). These reductions were achieved before 1992 following the allocation of special ‘bridging funds’ – totalling approximately £33.5 million over six years – to each of the four integrated Health and Social Services Boards. Following a further reduction of 30% between 1992 and 1997, the current Regional Strategy (1997–2002) states that “the strategic goal should be that long-term institutional care should no longer be provided in traditional psychiatric environments” (DHSS (NI), 1996). However, little was known about the services used by former patients and the level of demand likely to be placed

on different services – within an integrated health and social care system – by community care initiatives.

This study – which describes patterns of service utilisation for former long-stay patients – was carried out as part of a larger evaluation of community care for those discharged from six psychiatric and three mental handicap hospitals in Northern Ireland between 1987 and 1992 (see Donnelly *et al.* 1994 and Beecham *et al.* 1996 for a discussion of outcomes and cost-effectiveness). During this period, 509 long-stay psychiatric patients left hospital but this study focuses on those discharged during 1990 – when the study began – and 1992.

METHOD

The Service Interview (SI) – developed by PSSRU (Beecham & Knapp, 1992) and widely used throughout the UK – collects information on the frequency and type of services received by former patients. The SI is completed by a researcher in conjunction with a keyworker or other care professional (as opposed to the individual client) who has a detailed knowledge of the services received by the former patient to which he/she has responsibility. Most of the interviewees were CPNs or other nursing staff (39), care assistants (25) or social workers (12). Service use was assessed during the period between six and twelve months after discharge (Beecham & Knapp, 1992). This six-month period was selected, firstly, because it reflected a longer term picture (i.e. service provision during the first six months after discharge might not be typical) and, secondly, because services received could be more easily recalled at the one-year follow-up.

Interviewees are asked to provide information on: (a) whether or not the former hospital resident has been in contact with any of approximately 25 listed services; (b) how often the service was used (e.g. weekly/monthly); and (c) whether or not the service was provided at home or elsewhere. Frequency of use and duration of contact categories were open-ended. Interviewees were also asked to rate broadly (on a scale from one (high) to three (low)) their satisfaction with the availability/accessibility of services received (e.g. 'usually sufficient' to 'usually inadequate') and their quality/appropriateness (e.g. 'usually helpful/appropriate' to 'generally unhelpful/inappropriate') as well as to indicate any unmet need for services (i.e. whether or not the service was needed but *not* received) and – from a given list – gaps in service provision (e.g. poor communication between staff). Additional information on other care staff inputs (e.g. care review meetings) was also obtained in order to assess the extent to which services were tailored to individual need.

RESULTS

Background characteristics and community destinations

In total, 188 former psychiatric patients were discharged from the six hospitals between April 1990 (when data collection started) and June 1992. After 12 months, 79% (149/188) were still living in the community, 18% (33/188) had been re-admitted to hospital mainly due to a relapse or deterioration in mental state and behavioural problems such as aggression and six people (3%) had died from natural causes. Service utilisation data were available for 145 of

TABLE 1
Receipt of services by type of community accommodation

Type of accommodation	Percentage of people receiving service ¹										
	G P	C P N	S W	C O N S	C H I R	D E N T	O P T	O T	O T H	P S Y	P H Y S
<i>Private</i>											
Nursing home (n = 14)	78	7	29	43	71	21	14	21	7	-	7
Residential home (n = 33)	45	27	39	54	54	33	27	27	3	3	-
<i>Statutory</i>											
Hostel/Res. Home (n = 28)	75	46	61	39	25	25	18	11	21	-	-
<i>Voluntary</i>											
Hostel/Group home/Residential home (n = 37)	59	57	46	19	22	38	32	-	3	-	-
Sheltered housing (n = 10)	60	90	50	60	10	10	-	30	10	30	-
<i>Independent Living</i> ² (n = 23)	56	69	35	4	22	26	-	4	13	-	-
TOTAL (n = 145)	61	48	44	34	32	29	19	13	8	3	1

Notes: ¹GP = General Practitioner; CPN = Community Psychiatric Nurse; SW = social worker; CONS = consultant (or medical specialist); CHIR = chiropodist; DENT = dentist; OPT = optician; OT = occupational therapist; OTH = mainly speech therapists, but also dietitians; PSY = psychologist, PHYS = physiotherapist.

²Almost three-quarters of this group were living with their families.

those still living in the community, most of whom had a diagnosis of schizophrenia (116/145, 80%) and were living in highly supportive accommodation such as private nursing and residential homes (112/145; 77%) (see Table 1). Most of those discharged were males aged under 60 who had spent between one and five years in hospital (Donnelly *et al.* 1994). For example, 73% of those who left hospital in 1992 were males, 41% were aged between 40 and 59 years and 54% had spent five years or less in hospital.

Use of 'core' services

Table 1 presents information about the number of people in different community settings who received a range of professional services. The most commonly used or 'core' services included General Practitioners (GPs), Community Psychiatric Nurses (CPNs), social workers, consultants and chiropodists.

General Practitioner (GP)

GP services were used by more people than any other service during the six-month period (88/145, 61%). Over a third had six or more GP 'contacts' and, on average, former patients were seen on five occasions. Almost two-thirds of contacts entailed a surgery rather than a domiciliary visit. Substantially more people living in private nursing homes and statutory settings than elsewhere had seen a GP while those living independently and in private residential homes were least likely to have received the service (Table 1).

Community Psychiatric Nurse (CPN)

Almost half of the sample (69/145) had been in contact with a CPN at least once and the service was also the most intensively used with former patients being seen, on average, 17

times, mostly during a domiciliary visit (75%, 52/69). A high proportion (59%, 41/69) had seen a CPN at least once a fortnight, over half of whom had weekly contact. However, just over a quarter of the sample (18/69) had six or fewer contacts in the six month period. The high level of contact with CPNs was due, in part, to the administration of depot injections which many of these patients were receiving. There was considerable variation in CPN use by accommodation type (Table 1); for example, about a third of people in private sector accommodation had seen a CPN compared to nine of the ten people in voluntary sheltered housing and over two-thirds of those in independent living.

Social Worker

Almost half of the former patients (64/145) had been in contact with a social worker during the six-month period; 56% (36/64) of whom had been seen on six or more occasions. On average, people had seen a social worker 7 times in the previous six months. Those in private nursing home care were less likely to be seen by a social worker than any other group while the greatest number of social work contacts was recorded for statutory setting residents (Table 1). However, only about a third of those living independently – most of whom were residing with their families – had seen a social worker during the same period.

Consultant

Over a third of the sample (49/145) had seen a consultant (i.e. usually a psychiatrist) over and above any outpatient or day patient attendances at local hospitals. Seven per cent (10/145) had attended either an outpatient centre or a day hospital during the same period. However, 84% (41/49) had three or fewer contacts within the six-month period. Although more people living in voluntary sheltered housing (60%, 6/10) than in any other type of accommodation had seen a consultant, the great majority of those living in other voluntary settings (81%, 30/37) and in independent living (96%, 22/23) had not received any consultant care during the previous six months (Table 1).

Staff-perceived availability and appropriateness of 'core' services

Comparatively few of the above services were rated by staff as unsatisfactory in terms of availability/accessibility or quality/appropriateness. For example, social work services were rated as only 'sometimes insufficient' or 'sometimes unhelpful/inappropriate' in three cases (5%) owing to 'delay, scarcity, or rationing of service', 'attitudes of service providers' and 'poor communication between staff'. For two people (3%), CPN services were perceived as being only 'sometimes sufficient' and 'sometimes unhelpful/inappropriate' as a result of general unavailability (that is, delay, scarcity, or rationing by providers). Both GP and chiropody services were perceived to be satisfactory in all but one case (due to 'poor review of client need' and 'unavailability of the service' respectively) while consultant services were rated as satisfactory on all counts.

Other care staff inputs

Care review meetings – involving, for example, care planning, service packaging, monitoring and reassessment – had been organised for almost three-quarters of former patients during the previous six months, although most of these had taken place less than once a month. Although staff from the residential setting (where applicable) had been present in 78% of cases, at least

TABLE 2
Day care and work activities

Type of activity in previous six months	Number of people (n = 145)	%
DAY CENTRES		
Total attending	37	25
Mental health resource centre	19	51
Generic day centre	13	35
Type not known	5	13
At least one weekly visit	35	92
CLUBS		
Total attending	36	25
At least one weekly visit	30	83
WORK		
Open employment	4	3
Sheltered employment	13	9
Adult training centre	15	10
Workshop	20	14

one professional, usually a psychiatrist, had been in attendance at 88% of meetings, two had been present in more than two-thirds of cases and three had attended 53% of meetings. The professions most frequently represented included psychiatrists, GPs, CPNs and social workers.

Ninety per cent of the sample had received regular one-to-one support and almost half (48%, 63/131) had benefited from between one and four hours of individual attention each week. However, care staff indicated that almost a quarter of former patients (35/145) required more support of this kind (e.g. social skills training). Importantly, the majority of people also had a nominated keyworker (70%, 101/145) with whom they usually met at least once a week.

Overall, comparatively few people in the sample had used *hospital services* during the previous six months. Fifteen per cent (22) had required psychiatric hospital care, 5% (7) had attended the outpatient clinic, while 2% (3) had attended a day hospital. A larger proportion of clients had used general hospital services, particularly outpatient clinics which were attended by 20% (29/145) of people (5% (8) had been admitted to general hospital inpatient care). Thus, almost a quarter of the group had at least one outpatient attendance at either a general or psychiatric hospital during the previous six months.

Day care services and work activities

Attendance at day centres and clubs is shown in Table 2. The findings would suggest that clubs generally served as a substitute for, or alternative to, day centres. Of the 25% who visited day centres, almost a quarter (23%) were involved in day centre activity four to five times a week. On average, clients visited day centres twice weekly. More than a third of people (36%) were engaged in some form of regular work activity a year after discharge, ranging from open employment (3%) to workshop and industrial therapy activity (14%) (Table 2).

Service “packages”

‘Packages’ of care comprise, not only the type of accommodation in which former patients are placed, but also the various combinations of other services received which tend to be related to individual need and the supply pattern of services. Ideally, an in-depth analysis of each package of care is required to identify clearly the factors which determine the shape of an individual’s service profile, particularly since these should be tailored to suit individual need. The SI data were analysed further to identify any patterns in service volume (i.e. the number of services received) by type of accommodation setting.

People had received a mean total of four services during the previous six months. Forty-two per cent (61/145) had received three or fewer services, while 29% (42/145) had been in contact with six or more different services. Three people had not been in contact with any professionals, while two had received 9 and 11 services respectively. The varying pattern of service use is best illustrated by the three case histories provided below. The first of these is a fairly typical case; that is, a woman who had received an average number of services (four), was close to the average age of the sample (53 years) and, like most of the group, had a diagnosis of schizophrenia. This is juxtaposed to a further two descriptions of people who had received very high and very low levels of support (i.e. more than eight or less than two services respectively). The cut-offs for ‘high’ and ‘low’ service use were determined on the basis of patterns in the data which showed that all but 3% of clients had received between 1 and 9 services.

Case history 1 A ‘typical’ service user

‘Sheila’ is 55 years old and has a diagnosis of schizophrenia. She had been discharged in April 1991 – after spending four years in a large psychiatric hospital located just outside Belfast – before moving into her present accommodation, a small (11-place) low-staffed voluntary group home. In the six months before the interview, Sheila had been in contact with four services. She had attended the general hospital outpatient clinic on two occasions and had seen a dentist once. She had also attended, on four days a week, a local day centre run by the local Health and Social Services Board. In addition, she had been visited regularly by a CPN for about 10 minutes, three times a week. Although Sheila did not have a nominated keyworker whom she met on a regular basis, she had received about two hours per week of one-to-one support. A care-review meeting had taken place once a month during which Sheila had been assessed by three members of in-house staff, together with a CPN and social worker.

Case history 2 A ‘low’ service user

‘Sharon’ is a 29 year-old female with schizophrenia who had spent about a year in hospital before her discharge in early 1992 when she went to live with her mother in her family home in the country. During the six months preceding the interview, she had not received any form of medication, nor had she received any services. The social worker who completed the Service Interview indicated that Sharon had neither received nor required any direct individual support and, although she had a keyworker, no meetings had actually taken place between Sharon and her keyworker in the previous six months. In addition, no formal procedures for case review, or individual care planning had been implemented.

Case history 3 A 'high' service user

'Paul', a 33 year-old suffering from schizophrenia, had spent 7 years in hospital and at the time of interview, was living in a small low-staffed residential home run by a voluntary organisation. His medication included two antipsychotic drugs (one of which was a depot injection) and a small daily dose of a drug used to reduce the symptoms of drug-induced Parkinsonism which may occur after prolonged use of neuroleptic medication. Paul had been in contact with a total of 9 mainly 'outside' or non-domiciliary services in the previous six months. He had attended a workshop five days a week and had visited a club twice in six months. He had seen a consultant on one occasion at the nearby general hospital outpatient clinic. He had also been in contact with a number of different services at the local health centre; namely a CPN (twice), a chiropodist (once), a dentist (once) and an optician (twice). In addition, he had been enrolled on a weekly adult literacy course (lasting two hours) at a technical college located 15 miles from where he was living. Paul had been in contact with only one service at his home – he had been part of a group receiving a half-hour talk on oral hygiene. The professional carer who completed the Service Interview indicated that she had spent six hours per week on one-to-one support work with Paul whom she had met three times a week. Paul had also attended a case review meeting on one occasion in the previous six months. This had involved discussion with a social worker and two members of staff (including the care assistant).

DISCUSSION

This study was carried out primarily to ascertain the amount and type of services received by former psychiatric inpatients one year after discharge from long-stay hospital care. It focuses, therefore, on providing a broad picture of service delivery within the integrated health and social services system in Northern Ireland, rather than examining the more specific effects of sociodemographic or other potentially influential factors on patterns of service receipt. The findings indicate that former long-stay psychiatric patients – many of whom had a diagnosis of schizophrenia – received a wide range of community-based services, although GPs, social workers and CPNs tended to be the nucleus of client care outside hospital. In addition, the pattern of service use for the, albeit reduced, sample of 76 people who were still living in the community *two years* later revealed a similar level of contact with 'core' services. These findings are comparable to those reported in the English Care in the Community evaluation (Knapp *et al.* 1992) where, for example, 83% of former long-stay patients had seen a GP at least once during the previous month while 61% received inputs from nursing staff, most of whom were CPNs who usually administered depot injections.

The pivotal role of GPs supports evidence from elsewhere that GPs are often at the "front line" in the treatment of people with mental health problems (Wright, 1992) and that the success of community care depends to a large extent on their continuing capacity to provide primary care to mentally disabled people (House of Commons Social Services Committee, 1985). Melzer *et al.* (1991) also reported that 49%–62% of their sample of people with schizophrenia (one year after discharge) had seen a GP during a three-month period. The findings reported here and elsewhere have important implications, therefore, for the adequate resourcing and support for future cohorts of patients who are likely to be more dependent. For

example, it will mean that GPs will need additional special training and that mental health professionals will need to form closer working alliances with primary care providers. It also raises questions about: (a) the willingness of GPs, particularly those in fund-holding arrangements, to take on 'difficult' cases (although this study indicates that most former patients had a GP); and (b) the implementation of specific practice policies for the care of people with long-term mental health problems which previous research has identified to be lacking (Kendrick *et al.* 1991).

The large and frequent CPN input as well as the high level of contact with social workers are consistent with findings reported elsewhere; for example, Melzer *et al.* (1991) found that approximately 21%–23% of patients with schizophrenia had been in contact with a CPN on at least one occasion during the previous *three months* while 23%–34% had seen a social worker during the same period. This high level of contact indicates that both CPNs and social workers are important in the assembling and maintenance of 'packages' of care for former long-stay patients with schizophrenia and other chronic mental health problems. It also reflects the fact that the number of CPNs in Northern Ireland has increased fivefold since 1979 while 200 approved social workers have also been trained (DHSS, 1991). Despite the more limited role of community-based psychiatrists (but nonetheless higher than the 28% reported by Knapp *et al.* (1992)), the findings indicate a high level of contact with mental health service professionals which was clearly sustained beyond the critical first few months after discharge.

The variations in service utilisation by type and sector of accommodation (Table 1) may reflect, in part, the unique integrated health and social services structure in Northern Ireland. (Formal statistical tests were not undertaken due to the small number of people in each kind of setting.) This arrangement tends to facilitate the delivery of services to clients under statutory care; for example, more people in statutory settings than elsewhere (particularly private sector accommodation), had seen a social worker. By contrast, only 24% of the 129 people assessed by Knapp *et al.* (1992) had seen a social worker. These authors refer to CPN and social worker 'substitutability' to explain the low uptake of social work services. In the study reported here, the residents with access to on-site nursing care (i.e. in nursing homes) were also least likely to require a CPN. Conversely, while residents in private residential homes were less likely to use 'core' services, they were generally more likely than those living elsewhere to receive chiropody, dental and optician services (see Table 1). These may be provided 'en bloc' to groups of patients and the uptake and provision of some services may, therefore, be influenced partly by the way in which community settings are organised. Delivery of community care services in this way may have negative consequences in terms of poor integration and low independence. People in independent living settings had a comparatively low level of contact with 'core' services such as social workers and community-based consultants. Although this is worth bearing in mind for purposes of future monitoring, the findings from the larger evaluation indicate that those living independently had better skills than residents living elsewhere.

Although the ratings of service availability and quality/appropriateness were not based on detailed assessments, services provided to clients were generally perceived to be of acceptable quality and appropriateness. Unmet need for care was indicated only rarely, suggesting that an adequate range of services is perceived to be available to former long-stay patients. However, *client-based* interviews, while probably less reliable in terms of client

ability to recall service use accurately, might have provided a more useful insight into client need (i.e. how the former patients themselves felt about the services which they received and/or needed). It is worth noting, however, that in the larger evaluation, a survey of users' views – though not directly related to service use – indicated high levels of satisfaction with community care *overall* when compared to hospital life (see Donnelly *et al.* 1994). Further information on care reviews and keyworker arrangements suggests that services were well co-ordinated and that key professionals were attempting to tailor support packages to individual needs.

Although most former patients had received some form of regular, individually-based support, it was judged that a quarter of the sample needed more one-to-one support, particularly in areas related to the acquisition and development of social skills. This reflects the widely-held view that social isolation can be one of the potentially most serious difficulties of life in the community for people whose levels of competence and confidence are low. Regular daytime activity can, among other things, facilitate social interaction and the development of interpersonal skills. Consistent with this study, Conway *et al.* (1994) found that only 22% of their small sample of former inpatients had used day care services during the previous three months. More day care opportunities and activities would presumably help to meet the professionally perceived need for social skills development in the residents assessed in this study as well as enhancing their overall quality of life.

Good community-based care relies, to a large extent, on a high degree of co-ordination and inter-professional collaboration. Although the evidence from this study would suggest that an appropriate bedrock of reasonably co-ordinated services is already in place, little is known about the overall effectiveness of service packages (our study (see Beecham *et al.* 1996) reported that community care was more cost-effective than the hospital care it replaced although there was considerable variation between sectors of provision). However, the findings suggest that service utilisation among former psychiatric patients depends not only on their levels of dependency and, therefore, the type (and size) of setting to which they are discharged, but also organisational factors which influence the routine delivery of health and social services to different sectors of provision. This information will be of value to purchasers and providers in the longer term maintenance, planning and implementation of services both for early leavers and for the more dependent patients who will leave hospital in the future.

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