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WINDSOR WESTERN HOSPITAL CENTRE'S
RIVERVIEW DAY HOSPITAL:
A FORMATIVE EVALUATION

by

Lynn T. Murphy

A Thesis
submitted to the Faculty of Graduate Studies
through the School of Social Work in
partial fulfillment of the requirements for
the Degree of Master of Social Work at
the University of Windsor

Windsor, Ontario, Canada

1981

UMI Number: EC54747

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1981

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RESEARCH COMMITTEE

Professor Forrest C. Hansen, Chairman

Professor Bernhard J. Kroeker, Member

Doctor Ann Henderson Diemer, Member

ABSTRACT

The primary purpose of this research project was to carry out an evaluative study of the day hospital program operating under the auspices of Windsor Western Hospital Centre. The project was therefore classified as evaluation research and further subtyped as formative research.

A review of the literature was presented on the North American model of day hospital programs, goals and philosophy of operation as well as the advantages and problems of the day hospital. This review was intended to serve as a basis for the research methodology, and as a reference point for discussion of the program under investigation.

Accessibility sampling procedures were employed in selecting the sample, Riverview Day Hospital program. Data collection methods included questionnaires and interviews. The researcher used both qualitative and quantitative approaches to the measurement of the important variables that describe the program's operation.

The major findings in this research project, based primarily on statistics which were obtained by computer analytic

procedures, were that the majority of respondents indicated that their needs were met in the program and, thus, that the major program components met with their satisfaction; similarly, they indicated that they were satisfied with the services offered through the day hospital program. However, consistent with the experience of other day hospitals, portal-to-portal transport of day-patients via the Sunshine Bus was identified as a problem area.

The first of two basic research questions posed for study was specific to the conduct of an evaluability assessment, whereas the second was framed in formative terms. In response to the research questions, the researcher concluded that Windsor Western's Riverview Day Hospital program met the preconditions of an evaluable program, and that data collected in monitoring the program's operation verified the decision-making system's understanding of the program.

The researcher recommended that the Riverview Day Hospital program be expanded to meet the needs of the target population, and that a research component be incorporated into the program. Further research to establish the cause-and-effect relationship between the program goals and outcomes was recommended as well as research regarding other medical and social aspects for the advancement of knowledge and practice.

ACKNOWLEDGEMENTS

The author wishes to acknowledge the members of her research committee: Professor Forrest C. Hansen and Professor Bernhard J. Kroeker of the School of Social Work, and Doctor Ann Henderson Diemer of the Department of Sociology. The time, knowledge and experience, they shared were greatly appreciated.

Deep gratitude is offered to Professor Hansen for his genuine interest, enduring patience, and guidance throughout the course of this research project. Special thanks are also extended to Professor Kroeker and Dr. Diemer for their support, and editorial comments which vastly improved the quality of this thesis.

The research project could not have been completed without the consent of Mr. Garnet E. Pickard, Executive Director of Windsor Western Hospital Centre, or the cooperation of the patients in the Riverview Day Hospital program. The author also wishes to acknowledge the cooperation received from Ms. Kathryn L. Meseck, who initiated this project, and Ms. Janet C. Brosseau, whose assistance in collecting the data greatly facilitated research efforts. Thank you for your

contributions to this endeavor.

Finally, sincere thanks are extended to her colleagues who provided moral support, and to her friends and family whose conviction in her ability served as an added dimension of confidence.

DEDICATION

This thesis is dedicated to:
Professor Gretta Riddell Dixon,
whose example as a human being
and professional will remain a
source of personal inspiration.

TABLE OF CONTENTS

ABSTRACT	v
ACKNOWLEDGEMENTS	vii
DEDICATION	ix
LIST OF TABLES	xii
LIST OF APPENDICES	xiv
CHAPTER	
I PROBLEM IDENTIFICATION AND FORMULATION	1
Problem Identification	
Problem Formulation	
The Role of the Program Director in Evaluation	
II REVIEW OF THE LITERATURE	13
History of the Day Hospital	
The British Model	
The North American Model	
Identification of Target Group in Ontario	
Day Hospital Goals and Philosophy of Operation	
Advantages and Problems of the Day Hospital	
The Role of the Social Worker in a Day Hospital	
III RESEARCH DESIGN	41
Classification of Research Design	
Research Questions	
Population Selection	
Sampling Strategy	
Instrumentation	
Data Collection Methods	
Guttman Health Scale	
Srole's Anomie Scale	
Data Collection Techniques	
Assumptions and Limitations	
Reliability and Validity	
Analysis of the Data	

IV DATA ANALYSIS 77

- Research Question I
 - Sub-Question A
 - Sub-Question B
 - Sub-Question C
- Research Question II
 - Findings Based on Members of the Patient Sample
 - Socio-Demographic Characteristics
 - A. Age
 - B. Ethnic Origin
 - C. Sex and Marital Status
 - D. Living Arrangement
 - E. Employment
 - F. Income and Education
 - Patients' Schedule of Activities
 - Referrals to Program
 - A. Referral Source
 - B. Reason for Referral
 - Patients' Health Status
 - A. Reported Functional Health
 - B. Psycho-Social Health
 - Need Satisfaction in Program
 - A. Health Needs
 - B. Psychological Needs
 - C. Socialization Needs
 - D. Nutritional Needs
 - E. Transportation Needs
 - Program Activities and Scheduling of Activities
 - Improvement of Overall Health
 - Services Offered through Program
 - Referrals through Program
 - Attendance in Program
 - A. Days-Per-Week Attended
 - B. Days-Per-Month Absent
 - Reasons for seeking Admission to Program
 - Reasons for Continuation in Program
 - Additional Comments Provided by Patients
 - Alternate Living Arrangements
 - Findings Related to Evaluative Research Question

V RECOMMENDATIONS 130

VI SUMMARY 139

APPENDICES 142

BIBLIOGRAPHY 176

VITA AUCTORIS 182

LIST OF TABLES

Table I:	Minimum Services of Day Care Facilities: Day Care Centres and Day Hospitals	26
Table II:	Ontario's Elderly Population: Showing Distribution by Age Group in 1976, with Projections for 1981 and 1986	27
Table III:	Day Care Facilities: Major Service Objective and Type of Client	35
Table IV:	Methodological Characteristics of Formative Research and Summative Research	47
Table V:	Riverview Day Hospital Program: Schedule of Activities and Frequency of Staff Involved	79
Table VI:	Marital Status of Day-Patients related to Sex: Showing Frequency and Percentage	90
Table VII:	Frequency Distribution of Respondents' Annual Income related to (a)Education and (b)Marital Status.	93
Table VIII:	Day-Patients' Guttman Health Scale Scores: Showing Frequency and Percentage	97
Table IX:	Day-Patients' Srole Anomie Scale Scores: Showing Frequency and Percentage	98
Table X:	Patients' Level of Satisfaction with Health Component of the Day Hospital Program: Showing Frequency and Percentage	101

Table XI:		
	Patients' Level of Satisfaction with Psychological Component of the Day Hospital Program: Showing Frequency and Percentage	102
Table XII:		
	Patients' Need Satisfaction in the Day Hospital Program: Showing Frequency Distribution	104
Table XIII:		
	Day-Patients' Level of Satisfaction with Program Activities and Scheduling of Activities: Showing Frequency and Percentage	106
Table XIV:		
	Patients' Level of Satisfaction regarding Day Hospital Program contributing to Improvement of Overall Health	107
Table XV:		
	Patients' Level of Satisfaction regarding Day Hospital Services: Showing Frequency Distribution and Mean Rank	109
Table XVI:		
	Table of Frequencies showing Number of Days-Per-Month Respondents were Not Present at the Day Hospital and Reasons for Absence	112
Table XVII:		
	Rationale provided by Respondents for seeking Admission to the Day Hospital Program	115
Table XVIII:		
	Rationale provided by Respondents for Continuation in the Day Hospital Program	117
Table XIX:		
	Institution specified as Alternate Living Arrangement and Rationale regarding Respondents' Perceived Need	119

LIST OF APPENDICES

APPENDIX A 143
 (1)Participants in the Ontario Campaign for Community-
 Based Services

APPENDIX B 145
 (1)Covering Letter for Questionnaire to Director of
 Riverview Day Hospital, Windsor Western Hospital
 Centre - Riverview Unit
 (2)Questionnaire: Director of Riverview Day Hospital

APPENDIX C 160
 (1)Covering Letter for Questionnaire to Riverview Day
 Hospital Patients, Windsor Western Hospital Centre
 - Riverview Unit
 (2)Questionnaire: Riverview Day Hospital Patients

APPENDIX D 169
 (1)Outline of Categories for Systematically Recording
 Data
 (2)Form for Systematized Recording

APPENDIX E 172
 (1)The Developmental Model: A Standard Summary and
 Analysis of Development Expenditure(s)
 (2)Development Analysis Score Sheet

CHAPTER I

PROBLEM IDENTIFICATION AND FORMULATION

In the case of this research project, true are the words of Polansky (1975, 30; underlining omitted): "The challenge . . . is not so much to find something that needs work as to phrase it into a question that can be studied with hope of adding to relevant knowledge."

PROBLEM IDENTIFICATION

What needed to be studied was defined by the Director of Social Services, Windsor Western Hospital Centre - Riverview Unit, who identified the problem for research as "an evaluation of our day hospital program". As stated by Rutman in "Formative Research and Program Evaluability", Evaluation Research Methods (1977, 65):

It is now widely recognized that many evaluation studies attempt to determine whether a puny intervention is effective in solving complex and long-standing problems. The predictable findings of these studies is that the programs have failed to produce the expected results. It is beyond the scope of formative research to examine and explain the etiology of major problems which programs address. Nevertheless . . . some attention can be focused on the problem which the program aims to solve.

Succinctly stated, day hospital programs in Ontario, the population selected for study, address this problem: institutionalization of the aged.

PROBLEM FORMULATION

Problem formulation involves "the articulation of the precise problem to be investigated" (Tripodi, Fellin & Meyer, 1969, 3). The four major aspects of this process are identified and discussed in the following pages of this Chapter.

(1) The first consideration in the process of problem formulation is to identify a "felt need". Given that social work and human service are applied fields, it is not uncommon for studies to arise from "the concern of an agency, the community, or the professional social worker" (Wechsler, Reinherz & Dobbin, 1976, 5). As expressed by the Director of Social Services, the reason for requesting an evaluation stemmed from a concern with the "quality of the program"; whereas, the felt need in the institution was to develop a basis for future research and funding proposals. If funds are allocated to the program by the Ministry of Health, for example, staffing could be increased and, thus, the needs of the patients admitted to Riverview Day Hospital could be met more effectively; in order to improve the quality of services offered, additional funds are required to meet the program's

transportation and facility costs as well as other treatment-related expenditures.

(2) Although the initial conception of the problem did not take a global or all-encompassing form, the problem did have to be carefully examined and recast by narrowing and focusing. Reducing the problem to a manageable size is the second step in the process of problem formulation. The purpose for requesting an evaluation of the day hospital program determined the primary purpose of this study which, in turn, defined the type of evaluative research to be conducted. Stated more specifically, the basic purpose of an evaluability assessment and formative research is to determine the evaluability of a program. Hence, the researcher's intention was to ascertain whether the program adequately met the preconditions for a comprehensive evaluation; and, in the process of so doing, to increase the evaluability of the program by identifying the factors which appear to influence the program's operation and its outcomes.

Aside from simply determining whether a program adequately meets the preconditions for an effectiveness evaluation, formative research can be used to actually increase the evaluability of a program. In contrast to effectiveness evaluations which sit in judgment of programs, formative research is in their service. It is by identifying the factors which appear to influence the program's operation and its outcomes that formative research contributes to increasing program evaluability. (Rutman, 1977, 60-1)

(3)The next stage of problem formulation, examination of the problem in relation to the appropriate sequence, pertains to the amount of knowledge that is available around the problem and what studies have been carried out in the related field. Evaluations of other day hospital programs were not available to this researcher, and no previous study had been conducted on Windsor Western's day hospital program. Consequently, it was not only appropriate but logical that an evaluability assessment and formative research be carried out.

In "Planning an Evaluation Study", Evaluation Research Methods, Rutman outlines the sequential series of steps involved in producing the necessary groundwork for a follow-up study. The procedures for determining the evaluability of a program are recorded as follows:

The first step entails the identification of the primary intended users of the planned evaluation and from their point of view, determining what activities and objectives constitute the program. The second step involves collecting information on the intended program activities, goals, objectives, and the assumed causal relationship. . . . The third step includes a synthesis of the information which has been collected, resulting in the development of a 'rhetorical program model'. . . . In the fourth step, an attempt is made to determine the extent to which the program, as represented by the rhetorical model, is sufficiently unambiguous that evaluation is feasible and potentially useful. . . . The fifth step involves the feedback of the results of the analysis to the program managers/intended users and the iden-

tification of program components and objectives that are amenable to evaluation. (Rutman, 1977, 23-4; underlining added)

Whereas an evaluability assessment addresses the preconditions for evaluation research, formative research pursues the same focal concern by collecting data on the program's operation. In other words, "formative research assists in determining program evaluability by monitoring the actual operation of the program" (Rutman, 1977, 60). This same aspect of program evaluation -formative research- is referred to by Rossi, Freeman and Wright as "monitoring program implementation"; in Evaluation: A Systematic Approach, these authors state:

As a general guideline, monitoring is most successful when programs are kept as simple as possible. Programs which offer many different services and in which there is close tailoring of interventions to individual targets can be difficult to monitor. Furthermore, it is a problem to unravel the particular intervention modalities that impact favorably in terms of project goals. (1979, 142)

In "Past, Present, and Future Prospects of Evaluation Research", Improving Evaluations, Rossi (1979, 18) further specifies that although he may stress monitoring as an internally generated data system, "there are also types of monitoring that might be carried out by an external agency, i.e., on contract to a research firm or university".

Formative research or program monitoring procedures are directed at answering questions about the actual implementation of operating programs. The primary purpose of carrying out such procedures, according to Epstein and Tripodi (1977, 56), is to enable administrators to make "rational and informed decisions about program operations". This type of research assists administrators' in that it not only verifies the decision-making system's understanding of the program, but it is also likely to reveal difficulties that they face in actually conceptualizing these preconditions. Furthermore, formative research can discover latent goals and unintended effects which may not be identified in an evaluability assessment.

In brief, both the evaluability assessment and formative research aim to determine the evaluability of a program and may, therefore, be considered prerequisites to a comprehensive evaluation employing rigorous methods of research. As summarized by Rutman (1977, 24-5), the results of both the evaluability assessment and formative research "represent efforts which contribute toward the planning of the evaluation research which is ultimately concerned with program effectiveness and efficiency".

(4)As noted in Social Work Research In The Human Services, the final consideration in the process pertains to the de-

cision about whether to hypothesize. In problem formulation, it is important to acknowledge the options open to the researcher, "but these depend on the suitability of the design selected to the problem at hand, and the availability of knowledge concerning that problem" (Wechsler, Reinherz & Dobbin, 1976, 8). Since this study was primarily directed towards establishing what the important variables are in the day hospital program, hypotheses could be posited and examined only in a follow-up study. Nonetheless, this evaluation does imply cause-effect relationships between the intervention strategy examined and its effects/outcomes. It has been demonstrated in other studies, according to Wechsler, Reinherz and Dobbin, that implicit hypotheses guide both the choice of variables for study and the subsequent analysis of the material.

Having completed the discussion of problem formulation, it would be appropriate to readdress the words of Polansky regarding the challenge of phrasing a research problem "into a question that can be studied with hope of adding to relevant knowledge". Considering that this study was done under the auspices of the University of Windsor's School of Social Work, the relevance of the research in relation to social work knowledge and practice warrants comment. Stated otherwise, there must be some evidence that the study will have "both generalizability and practical consequences for the

applied fields of social work and other human services" (Wechsler, Reinherz & Dobbin, 1976, 9).

Research in the social sciences is aimed primarily at building knowledge and understanding. The human service agency, on the other hand, is oriented towards action to deal with social problems. The basis of the relationship between the research and human services is the pursuit and application of knowledge. In agencies engaged in meeting human needs and solving social problems, these two -the pursuit and the application- are closely intertwined. In any case, each is essential to the other if the common goal is rational program development.

In social work, as in all other professions, the social worker uses knowledge and understanding that comes both from his own profession and from other disciplines. This is suggested in the very goals of the profession; as noted in The Assessment Of Social Research by Tripodi, Fellin and Meyer (1969, 10):

The goals of social work range from the development of social welfare programs and services in society to the enhancement of the social and psychological functioning of individuals, groups, and communities. Areas of practice within social work are designated typically as social casework, group work, community organization, and administration and policy development.

As the researcher's specialization in the master's year was administration, considerable attention has been focused upon this component of the day hospital program investigated. General comments regarding administrators' responsibilities in an organization are contained in the following paragraphs.

Although the administrators' function is not dealing directly with clients or patients but bringing together human and material resources, it is their responsibility to keep the organization functioning smoothly. Whatever the unit, corporation or hospital for example, administrators within are often most interested in efficiency; whereas, in response to external demands, they tend to be concerned with results. They are also likely to define success in terms of the achievement of particular agency objectives, with emphasis on developing ways of maximizing the output of the services provided. Although they are interested in what is occurring elsewhere in the field, their focus must be on the improvement of their agency's "competitive position". Relevant to this fact is Epstein and Tripodi's discussion pertaining to the utilization of research in Research Techniques For Program Planning, Monitoring, And Evaluation; regarding studies employing a "classical experimental model", in comparison to formative research, they state:

it is often of little use to program administrators who are, appropriately, more concerned with their own programs than with producing generalizable knowledge; who must make decisions during the operation of a program rather than after all the clients have been served; and who do not have the technical or material resources to implement such a study. (1977, 112-3)

Administrators' perceived need for information is frequently limited by their experience of what has been made available in the past, rather than what might be useful if it can be obtained. When well designed and conducted, research provides a range of tools for the purpose of building knowledge, and it can do much to reduce the uncertainty with which every human service agency must deal. In other words, it is anticipated that this thesis will assist administrative persons by providing them with a clearer picture of the program's operation. For example, it may bring a new level of precision to the exploration of relationships between the program operations and goal attainment and contribute to administrative decision-making regarding the expansion, contraction and/or modification of the Riverview Day Hospital program. The more detailed and systematically derived information administrators and staff have at their command, the more effective they are likely to be in meeting their goals and objectives.

In brief, it is anticipated that the evaluability assessment and formative research (hereafter simply referred to as

"formative research") will address perceived needs for information and enable the decision-making system to move on to a comprehensive evaluation. Examples of follow-up studies which administrative persons may consider are included in the subsequent Chapters of this thesis.

THE ROLE OF THE PROGRAM DIRECTOR IN EVALUATION

There are various pressures on program directors for evaluation. Mandatory evaluation, for example, requested by funding groups or higher administrative authorities often take the form of progress reports; additionally, other reports that demonstrate the program management is responsible regarding its accounting procedures and its allocation of funds may be demanded.

The program director must comply with those requests, for they are from groups to which he or she is directly accountable. If the program director does not respond to such requests, he or she may either argue that an evaluation is not needed or risk the possibility of not receiving continued support for the program. (Tripodi, Fellin & Epstein, 1978, 14)

Should funds be available for the conduct of evaluation, the program director may be confronted with the dilemma of deciding what kind of evaluation, at what cost, is sufficient. Consequently, the program management should have some conception of different kinds of evaluation as well as the pow-

er inherent in such a highly political process. The power of research evaluation is derived from its impact both on particular decision-makers and on program/organizational dynamics.

In some instances, charges regarding alleged discriminatory practices, program inequities and/or mismanagement of funds, arise from social and political groups that may be directly or indirectly involved with the program. Such external pressures which result in an investigation of program practices may compel the program director to call for an internal evaluation. Regarding internal evaluation, Tripodi, Fellin and Epstein state:

The pressures for internal evaluation may arise from the program director and his or her staff, with the primary purpose of improving the program. For example, there may be a perceived lack of success of the program, or it may be felt that there should be some reallocation of program activities. On the other hand, the pressures may arise from the professions to which the program administration and staff belong; they may believe that they are obligated to provide a quantity and quality of services that are in keeping with current professional standards. (1978, 13-4)

In spite of difficulties they may be confronted with, program directors can play a key role in the planning of evaluations. In fact, according to the authors quoted above, they have "a primary responsibility to plan for evaluations" of their programs.

CHAPTER II
REVIEW OF THE LITERATURE

The literature indicates that the concept of day care dates back to the Middle Ages, but that the day hospital is a relatively new development.

HISTORY OF THE DAY HOSPITAL

According to Polner and others, the development of psychiatric day hospitals preceded that of geriatric ones. Day hospitals in the Soviet Union, "in the United States and in Europe have cared primarily for the psychiatric patient" (Polner, 1961, 89). Farndale not only supports Polner in making this point but also provides evidence regarding the origin of the day hospital.

Dr. Michael Craft . . . states that the first day hospital was started in Moscow in 1932 and refers to regulations governing day hospitals in the U.S.S.R. . . . It would seem, therefore, that day hospitals began in Russia where there has been an extensive system for many years, mainly as part of psychiatric out-patient services. (1961, 1-2)

Harris agrees that day hospitals originated in the Soviet Union, however, he differs in his estimate of the origin of

the psychiatric day hospital. As noted in "Day Hospitals and Night Hospitals in Psychiatry", The Lancet, by Harris (1957, 729):

Soviet Russia has had day centres as departments of its neuropsychiatric dispensaries at least since 1942. In the Russian centres the emphasis is on occupation and rehabilitation for work, although hospital facilities are also provided.

In The Day Hospital Movement In Great Britain, Farndale indicates that the first day hospital in England was started as an independent institution; namely, London's Marlborough Day Hospital which opened in 1946 (then known as the Social Psychotherapy Centre). However, "it was not until 1958 . . . that the first day hospital for elderly patients with physical disabilities was established in Oxford, England" (Farquhar & Earle, 1981, 16). Regarding the day hospital movement in Britain, Koval adds:

British emphasis on geriatric day hospitals began in 1962 when a dearth of beds nearly paralyzed the hospital system. To release much-needed beds, the Ministry of Health reviewed the cases of patients, particularly the elderly, to see whether they could be better treated, socially as well as medically, by returning them home but continuing regular treatments at a fully equipped geriatric outpatient hospital. (1971, 114)

Almost simultaneous to the opening of the Marlborough Day Hospital, the first day hospital in North America opened as

part of the Allen Memorial Institute in Montreal, a psychiatric teaching hospital; as a point of interest, Dr. D. Ewen Cameron of the Allen Memorial Institute is considered "the father of the present day hospital movement in Canada" (Polner, 1961, 89). According to Farndale (1961, 2), the first geriatric day hospital in the United States was started under the auspices of the Menninger Clinic in Topeka, Kansas; and, in 1949, a day and night hospital was opened under the auspices of the Yale Psychiatric Clinic. Another day hospital was established in 1950 in the Montreal General Hospital.

In elaborating on the development of day care services in North America, Rathbone-McCuan and Warfield-Elliott begin by acknowledging that "no single service delivery pattern can adequately meet the current and future long-term care needs of older Americans"; they add:

Over a decade ago, however, there was recognition that a pattern of 'overutilization' of institutional beds for the elderly had created serious social problems for the elderly and a tremendous financial burden to society. Professionals concerned with the human costs and policymakers with financial costs concluded that wholesale institutionalization was no longer the answer. Institutional settings were no longer considered to be the most desirable setting for those aged persons who could manage to function with less than 24-hour inpatient services. (1976/77, 153)

Many factors seem to influence policy. Some of these are as follows: (1) population density and its propinquity to the

hospital, (2) the personal views of the physician on what should be the functions of a day hospital, (3) the availability of other hospital services, staff and volunteers; and, (4) the quality and quantity of community services. (Pathy, 1969, 533)

Some significant advances have been made in developing non-institutional service patterns for the chronically ill and impaired in North America. There is great interest among policymakers and professionals in the public and private sector, however, "the interest and support are not predicated on a clear understanding of the service delivery modality" (Rathbone-McCuan & Warfield-Elliott, 1976/77, 154).

Day hospital services are still in their infancy, limited in their scope and not available everywhere in Ontario. In fact, it was not until the late 1970s that day hospitals opened in this province. According to Skelton (1980, 2), "the day hospital concept was introduced" at Kingston's St. Mary's of the Lake Hospital more than five years ago. Other day hospitals, in chronological order, are as follows.

(1) In January of 1978 the first purpose-planned geriatric day hospital was opened at Parkwood Hospital in London.

(2) A day hospital, named after James A. Thornton, a benefactor of the hospital, first opened for patients in February, 1978, at Oshawa General. (3) Toronto's Queen Elizabeth Hos-

pital opened a day hospital on the 10th of October 1978 at 130 Dunn Avenue, and (4)another at 550 University Avenue on the 8th of January 1979. (5)In Windsor, Riverview Day Hospital officially opened January 16, 1980. (6)The Dorothy A. Macham Day Hospital was formally opened on the 2nd of April 1980, under the auspices of West Park Hospital in Toronto. Finally, as of January of this year, according to Farquhar and Earle (1981, 16), nine day hospitals were located in different settings in Ontario; "three were sponsored by chronic care hospitals, one by an active treatment hospital, and the remainder by active treatment hospitals having chronic care beds".

THE BRITISH MODEL

The British experience, in particular, has served as an important model for the development of geriatric day care in North America.

In Britain, "day hospitals for old people may be defined as those which provide day care and treatment chiefly for elderly patients who are or have been physically infirm or disabled" as well as for the mentally infirm (Farndale, 1971, 67). Geriatric day hospitals provide a means of getting the patients (the majority of which have previously been in-patients) back into their own homes, whereas those

for psycho-geriatric day-patients provide a means of avoiding admission altogether. Thus, both types of day hospitals address the risk of institutionalization as well as the needs of the patients' family. In many instances, as stated by Morley (1974, 11), "day hospitals are supporting families who cannot take a disabled person back into their own homes, or where everybody is out at work all day". In continuing, Morley stresses that the day hospital is not a "social prop" and, therefore, that it should not be used as one.

It should be noted that transportation of day-patients by "ambulances" is identified as a problem area. In fact, according to Pathy (1969, 534), it is "the greatest weakness of any day hospital scheme"; apparently, transportation both to and from day hospitals is given a "relatively low priority" and the vehicles are often "unsuited to the task that they undertake".

In Britain, day hospitals are recognized as providing a preferable alternative to long-term hospitalization. This statement is supported by the fact that they are one of the most rapidly expanding parts of the British Health Service and are becoming "an indispensable adjunct of every British hospital" (Koval, 1971, 115).

THE NORTH AMERICAN MODEL

In Canada and the United States, day care programs range from geriatric day care centres to day hospitals. Although these facilities have many elements in common, they are nonetheless different from each other administratively (ie. auspices; funding) as well as in their purpose, primary service and target population.

"Geriatric defines the population served; day defines the temporal limits of the services; care places the service in the broad field of health and social welfare;" and, as further noted in "Geriatric Day Care in Theory and Practice" (Social Work In Health Care), hospital or "centre denotes a single location where a variety of specific services are clustered" (Rathbone-McCuan & Warfield-Elliott, 1976/77, 154).

In North America, day care centres are designed for senior adults who require supervised social programs. More specifically, a day care centre provides social intervention to improve the quality of life for elderly persons by giving them the means to continue living independently with varying degrees of assistance. Padula provides a clear definition of day care centres in Developing Day Care For Older People (1972, 6):

Day Care Centres. This is primarily a social program for the frail, moderately handicapped, or slightly confused older person who needs care during the day for some part of the week --- either because he lives alone and cannot manage altogether on his own or, by sharing some of the responsibility of his care, to relieve his family and thereby help them to keep him at home.

In day care centres, no time limit for duration of attendance is stipulated. Providing no health risk is involved, participants may continue in the program as long as they or their family wishes.

As a day hospital provides a program of services under health leadership, it may be thought of as a unit where patients are given sleeping-out passes. Padula provides the following definition of a geriatric day hospital, and of a psychiatric day hospital:

Day Hospital. This is primarily a health related program for the disabled or ill aged person who requires treatment either following hospitalization, or instead of admission to 24 hour in-patient care in a hospital or nursing home. . . .

Psychiatric Day Hospital. This primarily serves the mentally ill person suffering from depression, confusion, anxiety or outbursts of temper and usually does not accept those who also require treatment of physical ills. (1972, 6-7)

Although a day hospital provides some social intervention, the primary emphasis is on skilled nursing and medical care for brief and intensive treatment of patients discharged

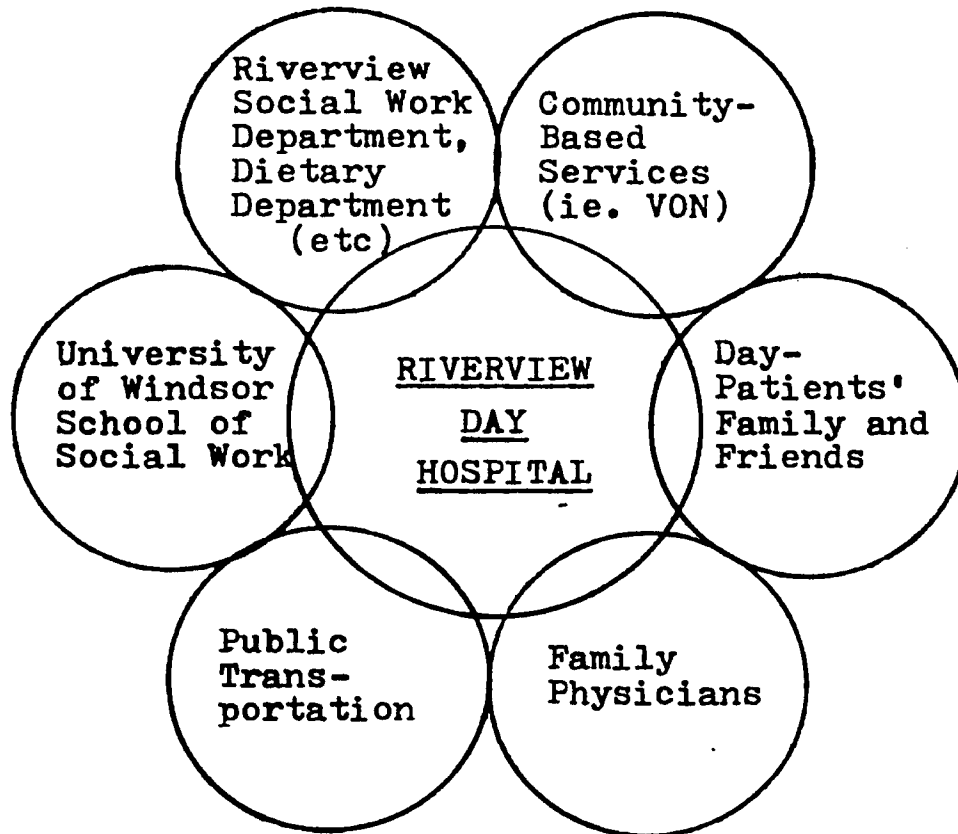
from active treatment hospitals, and for physical restoration/maintenance of function of, for example, patients who have been in rehabilitation or chronic care hospitals. Referrals to this facility are made by the participants' attending physician or by some other appropriate source such as an institutional discharge planning program or a social service agency. The most common diagnoses amongst day-patients are diseases of the circulatory system; other common diagnoses in order of frequency are: (1) mental disorders, (2) diseases of the nervous system and sense organs, (3) diseases of the musculoskeletal system, (4) endocrine, nutritional and metabolic diseases, and (5) accidents (Farquhar & Earle, 1981, 16).

The essential difference, therefore, between the facilities defined in the preceding paragraphs is that day care centres provide primarily social and recreational programs, whereas day hospitals provide clinical treatment and structured therapeutic programs. There are other day care medical services available through the diagnostic and treatment departments of any hospital (ie. Out-Patient Department), but these are not organized as programs or with the specific purpose of being an alternative to institutionalization.

It may be of value to consider day hospitals in terms of the systems theory which offers a conceptual framework that

"shifts attention from discrete units . . . and their characteristics to the interaction and interrelatedness of units" (Compton & Galaway, 1975, 61). Systems theory provides us with tools of analysis, a way of viewing and organizing data in ways that are useful to our profession. For example, a day hospital receives input from and produces output to its environment and, therefore, must be defined as an "open system" (as opposed to a "closed system" that does not interact with other systems). Open systems, by definition, have semipermeable boundaries; however, the relative "openedness" or "closedness" of those boundaries will vary with the system. In any case, exchanges or transactions between a day hospital and its environment are basic to its existence - to its very survival.

Following is a schematic representation illustrating elements of Windsor Western's Day Hospital, the sample selected for study in this thesis. In looking at this from a theoretical perspective, one may keep in mind the fact that the organizational environment in which the day hospital is imbedded continually changes, and so it is with the program --- technologies evolve, values change, needs of target population change, and so on. Essentially, then, an attempt has been made to depict the day hospital program as a dynamic process that can benefit from a continuing flow of information from its surrounding environment (and vice versa).



As exemplified by the above diagram, a system such as River-
view Day Hospital may be described as a set of interrelated
elements with a capacity for certain kinds of performance.
Compton and Galaway elaborate in Social Work Processes
(1975, 62):

Each component of the set is related to at least some others in a more or less stable way within a particular period of time and space. The assumption is that a system is a complex adaptive organization of parts which, by its very nature, continually generates, elaborates, and restructures patterns of meanings, actions, and interactions. Within a system something is continually going on, including a constant interchange with the environment across its boundary. Although a system is viewed as a constantly changing whole that is always in the process of move-

ment toward a selected purpose, its parts are assumed to interact within a more or less stable structure at any particular point in time.

Briefly, upon discovering that many families were having difficulty, in the home situation, caring for patients discharged from Windsor Western Hospital Centre's Riverview Unit, an outreach program was started in 1974 as a pilot project. This program, operating one day-per-week, was designed explicitly to assist patients in the transition from hospital to home and to alleviate some of the stress felt by their families. On the basis of the results of this pilot project, "Outreach" was not only continued but, as of July 1976, expanded to operate two days-per-week. In January of 1980, Windsor Western Hospital Centre changed the name of the outreach program to: Riverview Day Hospital. In the following sections of this thesis, the North American model will be studied and exemplified by the Riverview Day Hospital.

To recapitulate, the primary functions of a day hospital are physical restoration/rehabilitation and maintenance; a third function of nearly equal importance is social care. In a geriatric day hospital, program activities are designed for their therapeutic value and the socialization elements in the program are considered vital for the purpose of fostering and maintaining the maximum possible state of health and

well-being. Table I on the following page presents the minimum service requirements of day care centres and day hospitals. This Table is a modified version of one printed in Developing Day Care For Older People (Padula, 1972, 17-9). Note that day hospitals should have all the social and health components listed under "Day Care Centres"; additionally, day hospitals should provide these health services with special emphasis on restoration/rehabilitation and maintenance.

IDENTIFICATION OF TARGET GROUP IN ONTARIO

The population projections in Table II were presented in "Brief to the Ontario Cabinet Committee on Social Development" by the Ontario Campaign for Community-Based Services, Chairman of the Social Development Committee of Cabinet (1980, 32); for purposes of specificity, participants in the Ontario Campaign are listed in Appendix A. It should be noted that their "actual" statistics are contained in Ontario Statistics 1980, "Table 2.2: Population by Age Group, Ontario, 1954-1979" (1980, 44), and that these figures are also supported by Statistics Canada in Canada Year Book 1978-79 (1978, 159). The Ontario Campaign's "projection" statistics, which look ahead ten years from the Census of 1976, are based on fairly conservative population projections published by the Ontario Statistical Centre in January of 1979.

TABLE I. --Minimum Services of Day Care Facilities:
Day Care Centres and Day Hospitals

DAY CARE CENTRES	DAY HOSPITALS
<u>Social Components:</u>	
*a pleasant, comfortable and safe environment	*professional skilled nursing services to give medications, change dressings, administer eye drops, and to supervise personal care services like cutting toe nails and bathing for disabled persons as well as oral hygiene and foot care
*leisure-time activities	
*self-care training	
*one meal containing the equivalent of one-third the nutritional requirement per day	
*rest	*physician availability for diagnostic and treatment procedures, in addition to emergency medical care (which would include podiatry)
<u>Health Components:</u>	
*prior physical examination of participants to ensure absence of communicable disease and to include recommendations regarding limitations on activities, special diet, medication (kind, dosage, and whether individual is capable of taking it himself), and other considerations to determine if appropriate services are available	*physical therapy
*a written agreement for medical emergency care which should include a physician and substitute physician on call, the availability of hospitalization and/or emergency room care and assurance of transportation to the appropriate facility	*occupational therapy (as an adjunct to treatment, not simply as activity)
*staff with First Aid training and the capability of recognizing symptoms of distress	*professional psychiatric services to handle emotional and behavioral problems beyond the scope of ordinary disturbances
	*special diets
	*environmental aid equipment to use in the day hospital and to lend for home use - such as crutches, commodes, walkers, and the likes

TABLE II. --Ontario's Elderly Population: Showing Distribution by Age Group in 1976, with Projections for 1981 and 1986

AGE GROUP	A C T U A L		P R O J E C T I O N			
	1976		1981		1986	
	<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>
65 - 69	260,955	35.3%	300,949	34.8%	325,460	33.0%
70 - 74	197,325	26.7	228,720	26.4	264,019	26.7
75 - 79	137,030	18.5	160,966	18.6	187,262	19.0
80 - 84	82,985	11.2	100,948	11.7	118,893	12.0
85 and over	60,755	8.5	73,748	8.5	91,004	9.2
	<u>739,050</u>	<u>99.9%</u>	<u>865,331</u>	<u>100.0%</u>	<u>986,638</u>	<u>99.9%</u>

Source: Ontario Statistical Centre, 1979, as reported in "Brief to the Ontario Cabinet Committee on Social Development"

The aforementioned projections are based on the assumption that (1) current low fertility rates will continue, and (2) net immigration to Ontario will remain low at about 30,000 a year (Ontario Campaign, 1980, 31). Regarding the latter assumption, it may be added that "the largest groups of immigrants still come from Britain and the United States"; however, as reported in a publication of The Canadian Council on Social Development, significant numbers come from Italy, Germany, Poland, and other parts of mainland Europe (Hepworth, 1975, 1).

A definite upward progression in life expectancy (or the average duration of life) has been evident throughout history, and the trend is for the pace of this acceleration to increase as we progress in time. In other words, the lifetimes of a substantial proportion of the population in this affluent society have been extended beyond the economically productive years. We have reached a plateau at age 70 or just above, which is the age we have been programmed for, and the trend continues to be survival to a much later age than ever before. According to the Ontario Campaign (1980, 14), the very old -85 years of age and over- are growing faster than the total population and "will double their numbers in less than 20 years"; they add: "As a percentage of the population, the elderly will grow from 9.9 percent in 1981 to 13.6 percent in 2001." This growth in our population, par-

ticularly the shift to the old-old within the aging community, means that there will be more people in poorer health and, as may be expected, less able to look after themselves.

To further explicate and again draw the reader's attention to Table II, the projections reported within lead to two important observations. As noted in "Brief to the Ontario Cabinet Committee on Social Development":

1. The over 65 population will grow much faster than Ontario's population as a whole. Over the ten-year period, the over 65 group will increase 33 percent while the whole population grows only 11 percent.
2. The 'old-old' group, people over 85 years, will increase even faster than the rest of the elderly population. The ten year growth rate for this group will be 50 percent.
(Ontario Campaign, 1980, 31)

The first implication drawn from the above statements is that services to the elderly are a growth industry. Consequently, "programs for the over 65 population, growing at three percent a year, cannot be subject to the same restraint as programs aimed at the general population" which is growing at a rate of one percent per year (Ontario Campaign, 1980, 31). The second implication is that there will be a great demand for more institutional beds. The seeking of institutional care, as pointed out by Cohen (1975, 57), occurs as the results of functional losses, either gradual or abrupt, "interacting with the unavailability of protective

supports for the maintenance of community living".

Approximately eight percent of Ontario's aged populace are presently institutionalized. Apparently, if we continue to institutionalize the elderly at the current rate, we would have to build facilities for nearly 1,900 new beds a year.

To add 1900 beds a year to the 60,000 already existing would require an annual capital investment of over \$50 million, not considering the replacement of existing obsolete stock. The additional operating cost for this kind of care would exceed \$10,000 per bed, reaching \$90 million a year in excess of current spending by 1986, excluding the impact of inflation. (Ontario Campaign, 1980, 33)

The significance of the projections may therefore be viewed in terms of social problems, the terminal phase and institutionalization of those who have survived - to succumb to the degenerative conditions. Problems related to increased anxiety and loneliness, alcoholism and suicides for example, are rising readily. However, it is not aging per se which precipitates these social problems but rather "a variety of factors which often intensify with age such as isolation, poverty, dependency, status loss, poor health, and depression" (Berdes, 1978, 32). Furthermore, unlike in the past, the aged no longer have an assured place in the household of children and grandchildren. Some of our elderly members do feel that they are a "burden" to their family.

Historically, our society relied on the family as the source of care for the chronically ill and disabled elderly. As the caregiver functions of the family changed, society adapted to this kinship and family function changed by increasing the availability and accessibility of institutional settings for the provision of long-term care to the aged. Institutional care became the alternative to home care for more and more elderly persons. (Rathbone-McCuan & Warfield-Elliott, 1976/77, 153)

Fears of dependency and financial insecurity cause much anxiety amongst some of the aged and understandably so with today's mandatory retirement policies, time-lags between rise in cost-of-living and the consequent raising of the pension scale. Even if in good health, few opportunities for employment exist for persons 65 years of age and over.

Briefly, we may divide Ontario's elderly population in the traditional way; that is: white-collar middle class, blue-collar working class, poverty population. The lifestyles of these strata depend upon or are associated with income, health, wealth, occupation and occupational prestige, housing, ethnic origin, educational attainment, and so on. Conversely, lifestyles correlate with the health level and mortality experience of each stratum. Of particular relevance to the aged in each of the three major lifestyles is not only the level of living (ie. food; housing) but also factors such as the degree of access to medical care and other public facilities as well as the homes of friends. Given

this, candidates for day care programs should be looked for amongst the "at risk" population - people teetering on the edge of long-term institutional care, getting along at home but not very well.

Specific to the City of Windsor, the population distribution of elderly persons here is higher than it is in other parts of Ontario. A statistical statement pertaining to this population characteristic follows:

Slightly less than eleven percent (11%) of Windsor's population is sixty-five years of age and over compared with 8.9% of Ontario's population as a whole, as reported in the January 1979 Bulletin published by the provincial government.
(United Way of Windsor-Essex County, 1979, 21)

According to a Table presented in "Demographic and Social Data for Human Services Planning - Windsor and Essex County" showing Windsor's population by age groups, the 21,550 persons of retirement age constitute 10.95 percent of the city's population. With reference to distribution by sex, the United Way further states:

Male-Female ratios of population are on the whole equal throughout all the age categories until age fifty-five. There is a noticeable difference in the greater number of females here. This difference becomes very pronounced after age sixty-five.
(1979, 21)

Finally, in considering the preceding statements plus the population projections for Ontario as a whole, the need for preparing to cope with the changes becomes apparent as does the need for revising priorities in the field of health and social services. In fact, "with the striking increase in the number of people over age 65 expected in the coming years, there is no time to waste" in changing the situation. If policymakers and professionals focus their efforts on reducing institutional access and simultaneously foster an increasing variety of non-institutional alternatives, the situation involving the elderly could be ameliorated. The balance that should be striven for might be described in the rewording of an old Canadian aphorism - "institutionalization if necessary, but not necessarily institutionalization".

DAY HOSPITAL GOALS and PHILOSOPHY OF OPERATION

The goal of any human service program should be to help people help themselves. Simply stated, as by Morgan (1978, 39), the overall objective of day care services is "to maximize individual potential irrespective of disease of infirmity" through forms of health support offering viable alternatives to institutionalization.

The major goal of day hospitals is to provide an integrated professional service to people living in the community and,

thereby, to help preserve the ability of its patients to continue living in their own homes. Stated more specifically, the primary goal of this day care facility is to prevent or postpone/reduce periods of institutionalization by:

- (1) providing aftercare of patients discharged from active treatment and chronic care hospitals, and helping them make the transition from institution to community living;
- (2) preventing or retarding physical and/or mental deterioration; and,
- (3) providing the disabled or ill persons' family with relief of some of the care and supervision required.

Table III contains a statement of objectives for each of the day care facilities defined in the preceding pages of this Chapter. This Table is a modified version of one presented in "Geriatric Day Care in Theory and Practice", Social Work In Health Care, by Rathbone-McCuan and Warfield-Elliott (1976/77, 157).

The day hospital's philosophy of operation is based on three principles. Morgan specifies these in "Gaining Independence at a Geriatric Day Hospital" in Dimensions In Health Service (1979, 25):

1. That health represents a dynamic balance between the individual and his or her environment. . . .

TABLE III. --Day Care Facilities: Major Service Objective and Type of Client

CATEGORY	MAJOR SERVICE OBJECTIVE	TYPE OF CLIENT
Day Care Centre	*to provide appropriate socialization services	*individual whose social functioning is regressed to the point where, without formal organized social stimuli, overall capacity for independent functioning would not be possible
Day Hospital	*to provide daily medical care and supervision to help the individual to regain an optimal level of health following an acute illness	*individual who is recovering from an acute illness, no longer requiring hospitalization but still requiring medical intervention on a regular basis
	*to provide health care resources when required to chronically impaired individuals	*individual who has chronic physical illness or disabilities; condition does not require daily medical intervention but does require nursing and other health supports
Psychiatric Day Hospital	*to provide a protective environment that assists individuals in dealing with multiple problems of daily coping	*individual who has a history of psychiatric disorder; could reactivate and/or suffer from mental deterioration (organic or functional) that places client in danger if not under close supervision

2. There are significant inherent disadvantages in institutional care which may damage a person's health (for example, the development of excessive dependency). . . .
3. A day hospital, as defined,
 - (a) Permits comprehensive assessment both of the health state and needs of an individual.
 - (b) Provides a means of delaying or preventing institutionalization through the therapeutic orientation of its programs which improve a person's ability to cope with the environment.
 - (c) Enables patients in hospital to return home more quickly by providing a continuing support during the awkward period of readjustment to independent living after an illness.

ADVANTAGES and PROBLEMS OF THE DAY HOSPITAL

In addition to the physical and psychological advantages suggested in the preceding discussion of goals and philosophy of operation, the advantages of day hospital treatment are also economic and social. Itemized, these are as follows:

- (1) existing buildings can be adapted to meet the increasing demand for day hospitals, unlike in the case of other hospitals which must be purpose-planned;
- (2) more patients per floor space, and no sleeping space required;
- (3) less equipment and supplies required (ie. no electrocardiography equipment or bed linen necessitated);
- (4) only one shift to staff, rather than three;

- (5) less skilled and semiskilled nursing personnel called for;
- (6) kitchen and domestic staff necessitated for shorter periods of time as only one meal must be prepared each day;
- (7) pecuniary benefits to the hospital, and to the day hospital clientele.

The principal advantage of the day hospital is that the patients keep their place in the family and, thus, there is a minimum disruption of both family life and community life. However, as pointed out by Polner (1961, 91), "the home or work environment must be such that it will not destroy the medical or therapeutic work done at the day hospital". In addressing the disadvantages of day hospitals, Polner expresses the following concern:

It must also be recognized that there are some aged persons who will impose a great strain on the family if they remain at home. Although it may be good practice to have such persons remain in the family and in the community, they should not be allowed to do so at the expense of other members of the family. (1961, 91-2)

Consistent with the British experience, the major difficulty identified in Canadian day hospitals is transportation of patients. The most reliable, least costly, and preferred methods "often appeared to be family and friends rather than special buses, vans or volunteer services" (Farquhar & Earle,

1981, 17). Other problems noted are as follows:

- inadequate knowledge by hospital staff of the role of the day hospital and types of client to refer;
- failure of referring doctors to follow-up their patients once admitted to the program;
- referral of clients to day hospital at a stage when institutional admission could no longer be prevented;
- a lack of suitable community placements such as day care centers, once clients were ready for discharge;
- delay in referrals to the program by hospital physicians, thereby reducing the day hospital's potential for facilitating early discharge from acute care. (Farquhar & Earle, 1981, 17-8)

THE ROLE OF THE SOCIAL WORKER IN A DAY HOSPITAL

In addition to establishing goals relating to problems emerging in the program environment and emotional problems involving the family, for example, the goal of casework with day-patients is enhancement of their social functioning so that they may lead as full and creative a life as possible. To achieve this goal, the social worker must understand the patients' strengths (and weaknesses); in striving to do so, he/she focuses on understanding forces affecting present life experience, as opposed to focusing on or exploring in-depth childhood and early life experiences. Concisely stated, the roles of the social worker may therefore include outreach worker, broker, consultant and, as specified by Cohen (1975, 58) in Social Services And The Aged, "advocate,

enabler, educator, innovator, social parent, and therapist".

Social work tasks may include responsibility for intake and admission procedures, casework and group work with participants and their families, referrals to and liaison with community resources as well as participation in discharge planning/implementation. Various authors indicate that service to families is emphasized since many patients in day hospital programs live with a family member(s). Ideally, family involvement would therefore begin with the decision to seek professional care/supervision and continue until the termination of that service.

For purposes of brevity, areas to be explored in the intake interviews include: (1)present living arrangements, (2)levels of physical care and attention required, (3)financial resources as well as (4)family history/relationships.

Rathbone-McCuan and Warfield-Elliott provide examples of questions to which answers should be sought in the initial contacts with the program applicant; they are as follows:

Does the applicant live with a family member?
How long? Who initiated this arrangement? What
would be the optimal situation? . . . What can
the applicant do for himself? Who is available
to share in responsibilities for care? Are re-
sponsibilities equally shared? What are the at-
titudes? What relief to the family is antici-
pated through the services of day care? . . .

Can the day care per diem be paid? What funds will be used? Does this cost seem justified in light of the possibility of having eventually to cover the cost of institutional care? Is the aged person a financial burden? What is the feeling about the need to keep cash reserves intact for future use? (1976/77, 163)

Central to all of social work practice -casework, group work and community organization- is the concept of relationship. Biestek (1957, 4), for one, sees the relationship between the social worker and client/patient as the medium through which the knowledge of human nature and the individual is used and, thus, it is also "the channel of the entire casework process". The identifying mark of a professional relationship, as pointed out by Harris-Perlman (1957, 64), "is in its conscious purposiveness growing out of the knowledge of what must go into achieving its goal". Furthermore, all growth-producing relationships contain elements of acceptance and expectation, support and stimulation.

In summary, the fact that the relationship between the social worker and the patient develops out of purposive work means that it has motion and direction and emergent characteristics. The professional relationship is a dynamic one - it grows, develops, and changes; and, when the purpose has been achieved, the relationship is terminated.

CHAPTER III

RESEARCH DESIGN

The term "research design" simply refers to the specification of an approach to answering the questions posed for study. In other words, as stated by Suchman (1977, 40), the design is "the plan of study".

CLASSIFICATION OF RESEARCH DESIGN

By definition, evaluation research is a process of applying scientific procedures "to accumulate reliable and valid evidence on the manner and extent to which specified activities produce particular effects or outcomes". Some of the constraints which may necessitate compromises in the "ideal" design and data collection procedures include cost, administrative factors, legal requirements and ethical considerations. "Emphasis is nevertheless placed on approaching the highest practical degree of scientific adequacy" in dealing with basic methodological issues such as research design and data analysis. (Rutman, 1977, 16)

A second definition of evaluation research relevant to this study is provided by Suchman (1967, 75): "Evaluation re-

search is a specific form of applied research whose primary goal is not the discovery of knowledge but rather a testing of the application of knowledge." Experts have deliberated upon the differences between applied and basic research, taken as opposite poles of a continuum ranging from "pure" research to "engineering" research, and the convergent point was - most research has both basic and applied elements. According to Andrew C. Fleck, who is quoted in Evaluative Research,

The distinguishing feature converting a search for knowledge into an evaluation project is the presence of a purpose that the knowledge sought is to be used as a guide for practical action. (Suchman, 1967, 75).

Given definitions such as the ones noted in the preceding paragraphs, this project was classified by the researcher as evaluation research; and, it was subtyped as formative research. Based on the types of information provided and how the information is used, various authors have further classified evaluations into two categories: formative and summative. Simply stated, the first of these terms denotes evaluation for development and improvement, whereas the latter one signifies evaluation to determine effectiveness or efficiency.

Michael Scriven, current Director of the University of San Francisco's Evaluation Institute, introduced these labels -formative and summative- in discussing evaluation of educational curriculum. Initially, the term "formative evaluation" referred to information gathered to improve curriculum products in education; however, the formative-summative distinction has since become a fundamental evaluation typology and the terms are applied more broadly than they were by Scriven (1967, 39-83). Although they are never "finished" in the sense that a curriculum is, the distinction can be applied to many other types of programs. As stated by Franklin and Thrasher (1976, 101):

These distinctions, developed primarily to apply to evaluation of an educational curriculum, are not so easily made in evaluations of ongoing social programs. First, social programs seldom emerge completely processed entities; rather, they continuously change or develop. In addition, rarely are unfavorable judgments of worth or merit made without an attempt to improve the program.

Formative and summative evaluations involve significantly different research foci. Summative evaluations are aimed at determining the essential effectiveness of programs. Consequently, funding bodies are most interested in the results of such studies which are frequently used in making basic decisions about a program. For example, decisions may be arrived at regarding continuation or termination, particu-

larly in the case of an experimental program or demonstration project. Formative evaluations, on the other hand, focus on identifying and elucidating both the strengths and weaknesses of a program in a search for improvements in its strategies and techniques, practices and procedures. Given this, the results of such studies are especially useful to program administrators and staff. Formative evaluations, as noted in Utilization-Focused Evaluation, "focus on ways of improving and enhancing programs not only in their initial development, but at any point in the life of a program" (Patton, 1978, 81; underlining added).

Since formative research is aimed at improving program quality, it follows that such evaluations may focus on gathering descriptive information about the quality of program activities and outcomes, not just levels or amounts of attainment. Therefore, as in the case of this study, formative evaluations can make use of both quantitative and qualitative data. Qualitative data, which provide depth and detail, emerge from responses to open-ended questions, whereas standardized questionnaire items produce quantitative data. Patton differentiates between these two types of data in Qualitative Evaluation Methods (1980, 22):

Qualitative data consists of detailed descriptions of situations, events, people, interactions, and observed behaviors; direct quotations from people

about their experiences, attitudes, beliefs, and thoughts; and excerpts or entire passages from documents, correspondence, records, and case histories. The detailed descriptions, direct quotations, and case documentation of qualitative measurement are raw data from the empirical world. . . .

Quantitative measurement relies upon the use of instruments that provide a standardized framework in order to limit data collection to certain predetermined response or analysis categories.

To apply the above quotation to this evaluative study, a quantitative approach was used in an attempt to fit the experiences of the patients in the program and the important variables that describe the program setting into standardized categories to which numerical values could then be attached. Additionally, the researcher used a qualitative approach to measurement in seeking to capture what the members of the patient sample had to say in their own words.

To capsulize, summative evaluations are intended to provide a final assessment of a program's value "to aid the administrator in deciding whether or not to use the program, but not in deciding how to improve it"; whereas,

Formative evaluations . . . are designed to provide feedback to program developers to aid in improving the usefulness of the program. . . .
Formative evaluations are much more challenging to design and conduct as they require understanding of the internal operation of the program.
(Poister, 1978, 16)

Table IV presents the methodological characteristics of formative research, in comparison to those of summative research, as outlined by Rutman in Evaluation Research Methods (1977, 69-70). For purposes of clarification, following is a statement regarding the use of the terms "effectiveness" and "efficiency" in relation to summative evaluations. Evaluation of program effectiveness is "concerned with whether intended outcomes, and beneficial unintended consequences, have been attained as a result of program efforts"; and, evaluation of program efficiency is "devoted to determining the relative cost of achieving these outcomes" (Tri-podi, Fellin & Epstein, 1978, 9). It is important to note that while efficiency and effectiveness tend to go hand-in-hand, they not always do.

Herzog identifies three types of evaluative studies which further provide a frame of reference in which to consider the classification of this research project. The types of research discussed in Some Guide Lines For Evaluative Research are: (1)ultimate evaluation, (2)pre-evaluative research, and (3)short-term evaluation. Ultimate evaluations are concerned with the determination of the final success of a program in eliminating or reducing the social problem at which it is aimed. Hence, subsumed under this type of research are those studies designed to determine effectiveness or efficiency.

TABLE IV. --Methodological Characteristics of Formative Research & Summative Research

FORMATIVE RESEARCH	SUMMATIVE RESEARCH
*procedure for determining program evaluability and, ideally, for increasing the evaluability of a program	*procedure for testing program effectiveness and efficiency
*purpose pursued through the use of different types of commonly accepted research methods and data procedures	*purpose pursued through research designs which provide the greatest possible assurance that the program, not other factors, produced the measured results; attempts are therefore made to approximate experimental designs, involving randomization to experimental and control groups with "before" and "after" measures
*inductive approach taken which searches for causal relationships and prepares programs for subsequent effectiveness/efficiency evaluations; research is used as a tool for collecting data to assist in the conceptualization and operationalization of a program, its goals and effects, and the assumed causal relationships	*hypotheses-testing approach taken which attempts to verify through measurement the relationship between the independent variable (program) and the dependent variable (goals; outcomes)
*demands of reliability and validity of the measures relaxed to some extent; heavier reliance placed on "soft" approaches for data collection and the measures used	*rigid demands of reliability and validity of the measures; highest practical degree of reliability and validity required since conclusions are drawn about the programs and their effects

(TABLE IV - continued)

FORMATIVE RESEARCH	SUMMATIVE RESEARCH
*data provided to the program on an on-going basis so as to clarify, develop, and operationalize it and its goals	*data withheld and program held constant during experimental period (otherwise it would be impossible to know what was evaluated)
*internal evaluator not problematic, but rather desirable because formative research is an important part of program development	*internal evaluator may be problematic due to concern about the "objectivity" of the researchers
*data equivocal and suggestive	*data definitive

The second type of evaluative study identified by Herzog is comparable to formative research. Pre-evaluative research deals with the intermediate problems that need to be solved before one can attempt ultimate evaluation. Examples of specific tasks involved in conducting such a study are the development of reliable and valid classifications of the problem, the definition of program goals, and the perfection of tools and techniques.

'Pre-evaluative research' refers to the kind of studies that will be necessary to answer the questions that must be met before fully satisfactory evaluative studies can be made. . . . Such research will contribute to practice as well as to ultimate evaluation. It will contribute also to reformulating our ideas about what is desired from ultimate evaluation (Herzog, 1959, 79-80)

Thirdly, short-term evaluation is limited to seeking specific answers to concrete procedures in terms of immediate utility. Such studies aim only at filling immediate needs concerning the effectiveness of particular acts and attempts to make no generalization beyond the limits of the data. As stated by Herzog (1959, 80):

Short-term evaluation can often be done in a way that meets research requirements, fills immediate need, and at the same time contributes to pre-evaluative research. It cannot, however, give the answers that people want most. These require ultimate evaluation, which in turn demands many pre-evaluative studies.

RESEARCH QUESTIONS

The first of the two basic research questions posed in this study was specific to the conduct of an evaluability assessment; that is, does the Riverview Day Hospital program meet the preconditions of an evaluable program? This question was divided into three sub-questions: (1) is it a clearly articulated program, (2) are its goals and/or effects clearly specified, and (3) are the causal assumptions (the rationale linking the program to the goals and/or effects) plausible?

The second research question, framed in formative terms, was: does the data collected in monitoring the Riverview Day Hospital program verify the decision-making system's understanding of this program - its goals, outcomes and/or effects, and causal assumptions?

The reasons for establishing the preconditions for summative or ultimate evaluation also constitute the rationale for the research questions posed in the above paragraphs. Itemized, they are as follows:

- (1) the articulation of a program can reveal the nature of the service; furthermore, an articulated program can be conceptualized in measurable terms and relevant data then collected on the program's operation;
- (2) since goals serve as the criteria of program success,

they must be clearly specified for the purpose of developing reliable and valid measures; and,

- (3) it is necessary to determine whether the rationale linking the program to the goals and/or expected outcomes is sufficiently sound to merit a follow-up evaluation.

Briefly, in those instances where the preconditions have been inadequately developed "effectiveness evaluation are premature and, if conducted, these studies are likely to be irrelevant and relatively useless for drawing inferences about program effectiveness" (Rutman, 1977, 59).

POPULATION SELECTION

"In everyday language the term population is used to refer to groups or aggregates of people." Ferguson (1976, 6) further indicates that the term population, as used in statistics, does not necessarily refer to people. It may be used in reference to defined groups or aggregates of animals, inanimate objectives, "things" or "happenings" of any kind (ie. programs; activities).

For purposes of this study, the population of interest was operationally defined as day hospital programs currently operating in the province of Ontario.

SAMPLING STRATEGY

A sample is a smaller representation of a larger whole. The study of a subgroup or subaggregate, in lieu of a whole population, has several advantages. Since a sample is smaller, the time and expense involved in data collection often can be greatly reduced, thus, making possible investigations that could not otherwise be carried out. Additionally, if the population is large, changing rapidly or, as in the case of day hospitals, widely scattered, the study of a sample may produce more accurate information because of fewer errors in data collection.

The object of most sampling procedures is to produce a sample which is representative of the population. However,

The sampling requirements of a particular research undertaking are heavily influenced, if not predetermined, by such factors as the nature of the problems being investigated, the aim of the study, and the level at which research is to be conducted. These factors influence the decision on whether to use probability or nonprobability sampling, and on the particular subtype to be used. (Wechsler, Reinherz & Dobbin, 1976, 71-2)

Concisely stated, probabilistic sampling refers to a process in which the laws of probability determine which elements of the population to include in the sample; whereas, in non-probabilistic sampling some criterion other than the laws of

probability are used to select the items of the sample (ie. accessibility of the elements; opinions of experts; convenience to the researcher). Regardless of the sampling strategy used, there is always some risk in generalizing research results. If the procedures of probability or random sampling are followed in selecting a sample, one can determine how representative a sample can be expected to be, however, this is not feasible with many other types of sampling procedures; consequently, inferential statistics are generally based on the assumptions of random sampling.

Wechsler, Reinherz and Dobbin explain that the power of probability sampling lies in the fact that it represents, "within specifiable limits", the population from which it is drawn and, therefore, one can generalize from the sample to the population; these authors add:

Nonprobability sampling does not allow for this. Representation of the population in the sample drawn, as required by probability theory, is not provided for in nonprobability sampling; it is used where this is not an overriding issue.
(1976, 71)

Convenience sampling is most commonly used in preliminary or exploratory studies or, as indicated above, where representativeness is not a crucial factor. With reference to this study, nonrandom sampling procedures were used in selecting

the sample: Windsor Western's Riverview Day Hospital. Stated otherwise, as by Eckhardt and Ermann (1977, 159), if a researcher selects those units or "cases which are convenient, he is using accessibility sampling procedures".

To monitor the program's operation, it was necessary to select patients from the day hospital program as members of the sample; in so doing, accessibility sampling procedures were again utilized. More specifically, included in this study were all patients participating in the program during the six week period that the questionnaire was administered. As all program participants were scheduled to attend at least once a week, it was anticipated that the total number of day-patients would in fact be accessible for inclusion in this study; nonetheless, it was realized that some members could be excluded by virtue of their absence (or nonreturn of the questionnaire).

Also appropriate to this classification of research are purposive or judgment sampling procedures. In "Some Principles and Methods of Sampling", Social Work Research: Methods For The Helping Professions, Yeakel and Ganter support this choice of sampling strategy in stating:

In early stages of knowledge development, when insights that lead to the discovery of variables or to hypothesis formulation are the intent, purposive

sampling may be employed. Cases are selected on the basis of their likelihood of stimulating insights within the investigator. . . . The selection made is a selection of 'insight-stimulating' cases, situations, or individuals. (1975, 105)

Although not explicitly stated thus far, "formative research is aimed mainly at discovery" (Rutman, 1977, 60). And, the "insight-stimulating" individuals selected as participants in this study were: (1) Director of Day Hospital, and (2) Director of Social Services at Windsor Western's Riverview Unit.

Briefly, each of the aforementioned sampling procedures involves a researcher's decision and, consequently, permits human bias in the selection process. In accessibility sampling, for example, (units or) "cases which are convenient may differ in relevant ways from cases which are not" (Eckhardt & Ermann, 1977, 159).

INSTRUMENTATION

Instrumentation, the science of developing and utilizing instruments is discussed under two headings. Firstly, data collection methods specific to this evaluative study are discussed and, secondly, data collection techniques.

DATA COLLECTION METHODS

Methods refers to the means of gathering data. The data collection methods used in this study include both questionnaires and interviews.

In program evaluation, "questionnaires can be used to ask administrators . . . and clientele about their subjective evaluations of social programs" (Epstein & Tripodi, 1977, 10). The questionnaires designed for purposes of data collection were: (1)"Questionnaire: Director of Riverview Day Hospital", and (2)"Questionnaire: Riverview Day Hospital Patients". The questionnaires, plus their accompanying covering letters, are included in Appendix B and C, respectively.

Interviewing is a data collection method involving verbal communication via telephone or in a face-to-face situation. Both of these methods were employed in this study; that is, (3)a joint interview with the Director of the day hospital program and the Director of Social Services at Riverview Unit, and (4)a telephone interview with the Director of Social Services. According to Eckhardt and Ermann (1977, 332), the quality of information obtained by telephone does not differ markedly from that obtained by face-to-face interviews.

Following is a discussion of two well-known scales, the Guttman Health Scale and the Srole Anomie Scale. These scales were incorporated into the patient questionnaire for purposes of obtaining a measurement of the patients' functional health and psycho-social health status.

Guttman Health Scale

In 1941, Louis Guttman proposed a scaling procedure "which yielded a single scale score and simultaneously reflected the pattern of responses responsible for the score" (Eckhardt & Ermann, 1977, 106). Prior to World War II quantitative analysis had been applied to qualitative data with reservations; therefore, the distinguishing mark of Guttman's technique is that it was "created especially for qualitative data" (Lundy, 1971, 29).

The procedures involved in Guttman scaling differ from other procedures of scaling. "First, Guttman scaling requires and assumes unidimensionality for the property being scaled"; consequently, the items used in the scale must tap one and only one property (Eckhardt & Ermann, 1977, 106). For example, in scaling reported functional health, Guttman requires that the items relate only to health, not to attitudes upon which health may impinge or any other phenomena.

Second, Guttman scaling decrees that items be ordinal. This requirement differs from Likert scaling, for example, where the responses, rather than the items, are ordinal. Third, the Guttman method permits researchers to change a respondent's score if the data indicate that he or she was misclassified. (Eckhardt & Ermann, 1977, 107)

Guttman scales have been used widely in social research; the variables studied are usually opinions or attitudes - however, the technique is not limited as such. One example used to demonstrate this fact is a scale of insight. This scale is discussed by Polansky in "Techniques for Ordering Cases" in Social Work Research (1960, 155-65), and again in "Children's Verbal Accessibility as a Function of Content and Personality" in American Journal Of Orthopsychiatry (Polansky, Weiss & Blum, 1961, 153-69). Another example is the scale of functional health reported by Rosow and Breslau in "A Guttman Health Scale for the Aged", Journal Of Gerontology (1966, 556-9).

The scale of functional health mentioned above was originally part of a 25 item questionnaire "developed in a study of 1200 persons in Cleveland over the age of 62". Of particular relevance is the fact that three questions produced six response categories from which the researchers were able to construct "an excellent Guttman scale of reported functional health". (Rosow & Breslau, 1966, 556-7)

The three questions mentioned in the preceding paragraph, in their complete original form and order, are provided by Rosow and Breslau in "A Guttman Health Scale for the Aged" (1966, 557); the responses used in the scale are indicated by the symbol +:

- H-4. Is there any physical condition, illness, or health problem that bothers you now?
 - + A. No
 - B. Yes
- H-6. Which of these things are you still healthy enough to do without help?
 - + A. Heavy work around the house, like shoveling snow or washing walls?
 - B. (Men) Work at a full-time job.
(Women) Do the ordinary work around the house yourself.
 - + C. Walk half a mile (about eight ordinary blocks).
 - + D. Go out to a movie, to church or a meeting, or to visit friends.
 - + E. Walk up and down stairs to the second floor.
- H-10. Which of these statements fits you best?
 - A. I cannot work (keep house) at all now because of my health.
 - B. I have to limit some of the work or other things that I do.
 - + C. I am not limited in any of my activities.

The above Guttman scale, incorporated into "Questionnaire: Riverview Day Hospital Patients", can be employed in studies of ambulatory patients without any modifications. However, for purposes of this study, a couple of the items had to be adapted to accommodate participants who were wheelchair-bound or who used a wheelchair in the course of a day al-

though not so confined. As shown in the patient questionnaire, the revisions made were as follows: (H-6.C)"Travel half a mile (about eight ordinary blocks) either by walking or via wheelchair." and (H-6.E)"Walk up and down stairs to the second floor, or transfer from my wheelchair into a car seat."

Although responses to items in a Guttman scale necessarily follow a cumulative pattern, the respondents must not realize it. The cumulative property of Guttman scales "should arise from the relationship of the questions or items to the underlying variable, and not from the response set or expectations of the respondents" (Lundy, 1971, 33). Simply stated, it was expected that the way in which the patients answered one question would relate to the way they responded to other items in the set.

Srole's Anomie Scale

An anomie scale was employed by Srole in a study in Springfield, Massachusetts, in 1950. Although the study was originally conceived as applied rather than pure research, "the attitude-type scale devised afforded an operational formulation of the anomie concept" (Srole, 1956, 709). In 1952, Srole applied his version of the anomie concept to research in New York City in connection with a large scale study of

mental health and its social corollaries. For purposes of reference, the primary resource utilized in researching this psycho-social concept was "Social Integration and Certain Corollaries: An Exploratory Study" in American Sociological Review. This article, written by Srole, benefits from the findings of the New York research but is substantively based on his earlier study of 1950.

Although the state of normlessness has resisted a universal definition, the Srole Anomie Scale makes it possible for researchers to place individuals on a eunomia-anomia continuum. This variable is conceived as referring to the individual's generalized pervasive sense of "self-to-others belongingness" at one extreme compared with "self-to-others distance" and "self-to-others alienation" at the other pole of the continuum. As stated by Srole, "for semantic neatness the terms eunomia-anomia are here used to refer specifically to this socio-psychological continuum"; he adds:

Accordingly, individual eunomia-anomia is viewed as a variable contemporary condition having its origin in the complex interaction of social and personality factors, present and past. In short, the condition is regarded as a variable dependent on both sociological and psychological processes. (1956, 711)

It should be pointed out that Srole's definition of anomie "as a psychological state departs from the more traditional

meaning of the phenomenon as a property of a social system", a theoretical meaning originally contributed by Emile Durkheim. (Eckhardt & Ermann, 1977, 220)

The Srole Anomie Scale consists of five items designed so that agreement with the statement indicates anomie while disagreement indicates its absence. Technically speaking, it is an ordinal scale structured to locate respondents with respect to their relative state of anomie. This scale was incorporated into the patient questionnaire exactly as it appears in Handbook Of Research Design And Social Measurement (Miller, 1977, 376).

Following are brief explanatory comments regarding the scale items as noted by Srole (1956, 712-3); for purposes of convenience, each of the five items in the questionnaire are recited in conjunction with Srole's comments.

- (1) In spite of what some people say, the lot of the average man is getting worse, not better. The first of the postulated components was the individual's view, "beyond abdication of future life goals, that he and people like him are retrogressing from the goals they have already reached.
- (2) It's hardly fair to bring children into the world with the way things look for the future. This second component postulated, the one perhaps most closely approximat-

ing Durkheim's particular definition of anomie, was the decline or loss of internalized social norms and values "reflected in extreme form in the individual's sense of the meaninglessness of life itself",

- (3) Nowadays a person has to live pretty much for today and let tomorrow take care of itself. This hypothesized element of anomie was the individual's perception of the social order as "essentially fickle and unpredictable, i.e., orderless, inducing the sense that under such conditions he can accomplish little toward realizing future life goals".
- (4) These days a person doesn't really know whom he can count on. This anomie component was hypothesized as the individual's perception that "his framework of immediate personal relationships, the very rock of his social existence was no longer predictive or supportive".
- (5) There's little use writing to public officials because often they aren't really interested in the problems of the average man. The last of the postulated components was the individual's sense that community leaders are detached from and indifferent to his needs, "reflecting severance of the inter-dependent bond with the social system between leaders and those they should represent and serve".

In concluding the discussion of Srole's Anomie Scale, it has been noted that some researchers express concern regarding the problem of response set; that is, the tendency of some respondents to consistently agree or disagree with a set of attitude or opinion statements. Since agreement with the Srole items reflect anomie, as previously defined, persons with an agreement response set tendency will score high on the scale.

Carr, for one, studied the above mentioned problem. To investigate the impact of the Srole Anomie Scale as a measurement instrument, he reworded the five item scale so that disagreement, rather than agreement, with the items would signify anomie. Carr's findings (ie. that the scale scores may reflect the characteristics of the instrument, the respondents, and the norms of the research situation) are reported in "The Srole Items and Acquiescence" in American Sociological Review (1971, 287-93).

Reported in "Anomia and Eunomia: A Methodological Evaluation of Srole's Anomie Scale", American Sociological Review, are the results of Miller and Bulter's analysis. Their study focused on Srole's suggestion that the items were scalable in the Guttman sense (ie. forming a hierarchy), and that they formed a unidimensional latent continuum; for the sake of brevity, these researchers concluded as follows:

Whatever may account for the results, the lesson and implications are clear: it cannot be assumed that an item, or a set of items, will foster the same results in different universes or at different times, even under somewhat similar modes of analysis. (1966, 405-6)

DATA COLLECTION TECHNIQUES

Techniques refers to specific procedures that are used in a given method. The techniques utilized in this study include (1)administering the questionnaire designed for the Director of the day hospital program by mail. Upon the researcher's receipt of this completed document, (2)a questionnaire was developed for the day-patients, distributed in the hospital setting, self-administered at home, and returned to the Director in a sealed envelope. Next, (3)a joint interview was conducted with the Director of the Day Hospital and of the Social Services Department at the Riverview Unit of Windsor Western Hospital Centre. Finally, (4)a telephone interview was carried out with the Director of Social Services.

The major advantages of mailing the questionnaire to the Director of Riverview Day Hospital were: (1)it provided the informant with more time for completing the instrument and, therefore, permitted for more considered answers, and (2)mailed questionnaires are more adequate in situations in which the informant may have to search files for information. On the other hand, the disadvantage of mailing the

document was the possibility of misinterpretation of questions within. However, this possibility was reduced, if not eliminated, as a follow-up interview was conducted in which the researcher could immediately clarify questions and/or answers as necessary, probe for additional information, and collect supplementary material.

With reference to the document which was self-administered by the patients, the major advantages were identified as follows. (1)It was less time consuming than personal interviews, and (2)it provided the respondents with more time for completing the instrument. It was anticipated that many participants in the day hospital program would require as much as two hours to complete the questionnaire; therefore, considering the therapeutic nature of the program and the fact that most patients attended the program only one or two days-per-week, it was not practical to conduct interviews or to administer the questionnaire in a group setting. (3)It eliminated the researcher-respondent interaction, thereby curbing any influence the researcher may personally exercise on the sample members. Finally, (4)it provided the respondents with a greater sense of privacy and anonymity than personal interviews warrant.

Regarding the disadvantages of the patient questionnaire being self-administered, (1)the possibility of a lowered re-

response rate was considered, but not expected to be problematic. (2) The completion rate was expected to be high, however, it was anticipated that specific questions (ie. of income) would be answered less frequently than in an interview. And, (3) self-administered questionnaires often pose difficulties for illiterate respondents as well as for those with physical limitations (ie. arthritis of finger joints; poor eyesight). Furthermore, it was assumed that patients would tend to respond favorably to questions if the researcher or a staff person assisted them, as opposed to a family member or friend. Not only was it thought that a friend or relative would solicit more candid responses, but it was also hoped that in conferring the patients would be more likely to recall (or be reminded of) specific events which would stimulate them to provide accurate information and additional comments.

ASSUMPTIONS and LIMITATIONS

It is not feasible for researchers to study all variables, therefore, assumptions are frequently stated on the basis of theory or previous research. By definition, assumptions are "propositions which have not been verified, but which are taken as givens for purposes of investigation" (Tripodi, Fellin & Meyer, 1969, 74). Assumptions may be classified into two types: value assumptions and validity assumptions.

Value assumptions pertain to the system of beliefs concerning what is 'good' within a society or a subgroup of that society. Thus, we may have such almost universally accepted value assumptions as, 'Human life is worth saving'; 'Unnecessary suffering is bad'; 'Good health is to be desired'. (Suchman, 1967, 42)

In contrast to value assumptions, according to Suchman (1967, 42), "validity assumptions are much more specifically related to program objectives". All programs designed to produce change must make validity assumptions concerning the worthwhileness of their services. Attempts should be made, therefore, to clearly and objectively identify the assumptions underlying a program. Following are two validity assumptions relevant to the study of Windsor Western's Day Hospital program: (1)it was assumed that most people prefer to live at home and would do so if they could obtain appropriate help; and, (2)it was assumed that some elderly persons are isolated in hospitals and other institutional settings more often and longer than is necessary, and that the Day Hospital allowed for an amelioration of this condition. Finally, as stated by Wasserman (1971, 92):

One of the assumptions of the 'rational' system of organization is that knowledge, competence, authority, and important decision-making are at the top of the organizational pyramid.

As noted earlier, one of the three sub-questions posed for research pertained to the plausibility of the rationale

linking the program to the goals and/or effects. Given this, we may also note what is not assumed in this study: it is not assumed that there is a logical and empirical relationship between the goals which have been specified for the program and the procedures used in achieving them.

In The Limitations Of Social Research, Shipman (1972, 31) states: "Authors have a variety of motives for writing. They have in common only a desire to spread information, exert influence and gain material rewards or prestige." In response to this statement, it must be made explicit that this research project was, first and foremost, a Master's thesis which was undertaken to fulfill a degree requirement issued by the School of Social Work at the University of Windsor. Having said this, the initial motives of the author/researcher become apparent as does the audience for whom this report was written.

Even when there is no obvious source of bias, there is still a need to study the professional and social pressures on the author. As candidly stated by Myrdal in Objectivity In Social Research (1969, 43):

As social scientists we are deceiving ourselves if we naively believe that we are not as human as the people around us and that we do not bend to aim opportunistically for conclusions that fit prejudices markedly similar to those of other

people in our society. By keeping to higher valuations and by assigning prime importance to observed facts, we only partly purge these biases from our mind.

Each scientific discipline establishes a distinctive range of phenomena to be investigated by its members as well as ways in which their observations should be interpreted.

Shipman takes this thought a step further in stating:

A more important restraint comes through controls exercised over individuals by the discipline of their subject. Undergraduate and graduate education immerses the students in books, lectures, tutorials and research procedures that are chosen and controlled by teaching or supervisory staff. (1972, 39)

True though this may be, given the limited experience of most students in using concepts of research and statistics, this "restraint" seems not only justifiable but essential.

The researcher was cognizant of the fact that the confidence one can place in the adequacy of a sample varies (inversely with the distribution of the characteristics being measured and) directly with the numbers in the sample, and that the most significant limitation of this study would lie in the nature of the research. To elaborate on the limitations of this particular study, formative research is designed to examine an occurrence and formulate hypotheses or ideas from

the data collected; not unlike exploratory research, for example, this type of research is designed to raise more questions than it answers. Furthermore, due to time and monetary considerations, both the scope and depth of the research project undertaken were limited. The empirical generality or generalizability of the study must therefore be limited to day-patients with similar demographic characteristics in comparable treatment programs.

Formative evaluations do not generate knowledge that can easily be applied to other programs. They make possible inferences which are only suggestive of cause-effect relationships. . . . Knowledge about the relationship between program interventions and client outcomes is thus purely 'correlational'. (Epstein & Tripodi, 1977, 113)

One of the strengths of the study which may serve to counter balance the limitations lies in the fact that it was the first evaluative study carried out on the Riverview Day Hospital program. Stated more specifically, it provides the impetus for the conduct of continuing research such as would be useful to program description and as an aid to impact assessment, cost-benefit and/or cost-effectiveness analysis; and, it provides a fundamental basis for further research regarding medical and social aspects of similar day care programs.

RELIABILITY and VALIDITY

As noted in Table IV, the rigorous demands for reliability and validity of the measures in formative research are relaxed in comparison to those of summative research. Accordingly, heavier reliance is placed on "soft" approaches for data collection and the measures used. Unstructured interviews and observations are examples of "soft" approaches for data collection, whereas examples for the measures include felt needs, attitudes, subjective estimates, personal opinions and recollections. (Rutman, 1977, 70)

Concisely stated, as by Rossi, Freeman and Wright (1979, 160), a reliable measure is: "A measure on which scores are reproducible in repeated administrations, assuming all relevant factors are the same." Variation in the relevant factors relate to the major sources of unsystematic variation (inconsistencies due to random or chance factors) in evaluative research; these sources, discussed by Suchman (1967, 118-9), are as follows:

- (1) subject reliability - the subject's mood, motivation, fatigue, and so on, may affect their physical and mental health and, thus, their attitudes to the program being evaluated;
- (2) observer reliability - the same personal factors will also affect the way in which an observer makes his/her

measurements; these observer factors will not only tend to affect the subjects' reactions but also the observers' interpretation of their responses, particularly in an interview situation;

- (3) situational reliability - the conditions under which the measurement is made may influence the results obtained;
- (4) instrument reliability - specific aspects of the instrument itself may affect its reliability; poorly worded questions in an interview/questionnaire, for example, may lead to a random variation in responses; and,
- (5) processing reliability - simple coding or mechanical errors when they occur at random or in an unsystematic manner may also lead to a lack of reliability.

A valid measure, according to Rossi, Freeman and Wright (1979, 160), is: "A measure for which there is evidence or presumption that it reflects the concept it is intended to measure." Pragmatically, this means that the measurement device is directly related to the concept being measured.

Two types of evidence were used to infer the validity of the instrument used to monitor the Riverview Day Hospital program. They were (1) face validity, and (2) consensual validity. Regarding the first, Suchman (1967, 121) states: "This is the basic measure that the evaluator himself has decided upon. He justifies his choice in terms of the 'ob-

vious' significance of the measure." The second, consensual validity, is a type of face validity which involves the consensus of a panel of experts. In this case, the panel was composed of Professor Forrest C. Hansen of the University of Windsor (Research Coordinator); Ms. Janet C. Brosseau, Director of Riverview Day Hospital; and, Ms. Kathryn L. Meseck who acted as a consultant to the former outreach program and is the current Director of Riverview Unit's Social Services Department.

Given that validity refers specifically to the degree to which any measure or procedure succeeds in doing what it purports to do,

it is obvious that until the objectives of a program can be specified and some reliable criterion of measuring success or failure provided, it will not be possible to conduct a meaningful test of validity. (Suchman, 1967, 120)

In establishing the evaluability of a program, formative research provides the basis for further research in which the problem of validity, especially in the selection, definition, and application of criteria for success or failure, becomes a major methodological concern. Ultimately, the adequacy of a measurement technique must be judged according to its demonstrated utilities.

ANALYSIS OF THE DATA

At this point, it is evident that much of the groundwork had been set for the analytic process. The design has been developed from the formulation of the problem and the process of data collection bears, as it must, a direct relationship to the problem and the design.

Analysis in research includes the process of summarizing and making communicable the data collected to answer the questions posed in the initial phase of a study. In fact, one of the major goals of the analytic process is to condense information contained in a body of data into a form that can be easily comprehended and interpreted. Hence, in the following Chapter of this thesis, concise presentations of facts about the sample studied are provided in Table form.

Statistical analysis is the critical phase of the research process. Statistics are often characterized as being divided into two parts: descriptive and inferential. Descriptive statistics are used when the purpose of the research is to describe the data that has been collected, whereas inferential statistics are used when the purpose is not to describe such data but to generalize and make inferences based upon it.

The first type of statistics identified in the preceding paragraph describe data in terms of measures of central tendency, dispersion/variability and frequency. As noted in Research And Human Services by Twain, Harlow and Merwin (1970, 40):

Descriptive research can help to answer questions about the quantitative dimensions of components of the ongoing program, about the interactions among components, and to some extent about probable program results.

Furthermore, through careful scrutiny of data collected in formative research, tentative impressions may be drawn as partial guides to practical action. In any case, descriptive statistics are among the most useful analysis techniques in evaluative research because they are inherently meaningful and readily understood; and, they are the units for the statistical procedures commonly carried out in a comprehensive evaluation. Given these consideration and other factors such as the size of the sample, it was determined that emphasis should be placed on descriptive statistics rather than inferential ones which, as noted earlier, are based on the laws of probability.

Statements of findings regarding the Riverview Day Hospital program, presented in Chapter IV, are supported by statistics obtained through computer analytic procedures; stated

more specifically, the raw data were analyzed according to procedures available through Statistical Analysis System (SAS). Finally, it may be pointed out that the interpretation of any given set of data depends on who is interpreting the computer printouts and statistical tables and that it is the decision-makers who, in the end, must translate data into decision and action.

CHAPTER IV
DATA ANALYSIS

Windsor Western Hospital Centre's Riverview Day Hospital officially opened on the 16th of January, 1980. As of February 2nd, 1980, this program -formerly operated as an outreach program- functions four workdays-per-week, with the fifth one reserved for administrative planning.

Riverview Unit is classified as a chronic care institution but operates under the Public Hospital Act of Ontario and, therefore, the day hospital is subject to the same legislation. Funding for this program is provided through the hospital's budget, however, Ontario Health Insurance benefits are available for some professional services such as medical examinations. Day-patients utilizing the nutritional service are charged \$3.00 per day to cover food costs, other participants in the program are exempt for any personal fee.

Responsibility for the program is assigned to the Director of the Riverview Day Hospital. The staff consists of one Registered Nurse and a Nursing Assistant plus a Bus Driver - Porter. All volunteers are referred, prior to the assignment of any duties, to the Director of Volunteers who is re-

sponsible for orienting them to the hospital in general. Volunteers assigned to the day hospital program assist staff in craft and leisure activities; additionally, they provide assistance with meals and patients' personal care, for example, as well as performing other tasks delegated by the Director of the program.

Prior to the presentation of data provided by the participants in the research project, it is appropriate to note the following excerpt taken out of Research Reporting In Social Sciences:

While to the fellow researcher, methodology and data are important, to the administrator and the layman, and even to the researcher himself the more interesting part of the effort is the findings. In fact, to the administrator in particular, the findings are all-important and the method is only of incidental interest. (Gopal, 1965, 11)

RESEARCH QUESTION I

For purposes of this study, "the term program . . . refers to an interrelated set of activities designed to accomplish a common goal"; it does not, therefore, refer to any particular level of activity (Franklin & Thrasher, 1976, 25).

The schedule of program activities is presented in Table V, wherein the frequency of staff attending the day-patients is

also indicated. According to data provided by the Director of Riverview Day Hospital, a maximum of two volunteers are assigned to any given program activity.

TABLE V. --Riverview Day Hospital Program: Schedule of Activities and Frequency of Staff Involved

TIME	SCHEDULE OF ACTIVITIES	STAFF
8:30-	*staff conference (Mondays only)	4
10:30	*boarding & transportation of patients via Sunshine Bus	2
10:30-	*arrival of patients;	4 ^a
11:30	craft & leisure activities	1
	*physiotherapy (Wednesdays only)	
11:30-	*lunch & group socialization	2
12:30-		
12:30-	*craft & leisure activities	1 ^b
1:30	*provision of nursing care (activity not scheduled Thursdays)	1
	*physiotherapy	1
	*occupational therapy (Wednesdays only)	1
1:30-	*physiotherapy	1
2:30	*group exercise class	1
	*occupational therapy (Wednesdays & Thursdays only)	1
2:30-	*afternoon nourishment	3 ^c
(2:45)	*boarding of patients	4
4:30	& transportation via Sunshine Bus	2

^aWednesdays, three staff on duty

^bWednesdays, two staff on duty

^cWednesdays & Thursdays, two staff on duty

The first of the two basic research questions was: does the Riverview Day Hospital program meet the preconditions of an evaluable program? As indicated in Chapter III, this question was divided into three specific questions; these sub-questions are recited in the following paragraphs along with a discussion of the findings relevant to each.

SUB-QUESTION A

The first sub-question posed for research was: is it a clearly articulated program? Program labels such as "Operation Headstart" or "Multiservice Centre", for example, are so vague and/or include such a wide variety of approaches that there is no common or uniform meaning to these terms. In such cases, it is difficult to be certain that everyone refers to the same thing when applying a label to a program. Conversely, as stated by Rutman (1977, 19), "the articulation of a program can reveal the nature of the service, at least in terms of an 'ideal' description".

The label "Riverview Day Hospital" clearly defines the program investigated. An articulated program, such as this one, can therefore be conceptualized in measurable terms and ultimately data collected on the program's operation. Rutman elaborates on this thought in stating:

The articulation and monitoring of a program's operation also provide a basis for attributing the measured results to attributes of the program. . . . If this was effectively pursued, then there would be some direction provided for future research in which program attributes are purposefully varied or manipulated to determine outcomes. Moreover, the likelihood of using the findings is greater when data are available on specific program components rather than on complex global programs. (1977, 19-20; underlining added)

SUB-QUESTION B

Experts in evaluation research caution the novice not to assume a program is implemented in the prescribed manner; they point out that although a program is clearly defined, there is no assurance that it is implemented in the prescribed manner. Therefore, the second sub-question posed in evaluating the day hospital program was: are its goals and/or effects clearly specified?

The goals of London's Parkwood Day Hospital -which are the same as those included in "Questionnaire: Director of Riverview Day Hospital"- are lucidly stated in "Hospital without Beds", Highlights (1978, 4).

-To provide clinical treatment in a number of disciplines to people, usually the elderly, who have significant limitation of their physical functions, with associated social and psychological disadvantages.

- To provide to these people opportunity for socialization and recreation.
- To provide a variety of activity programs designed to have a broad therapeutic impact on the health of the individual.
- To ensure that each patient receives a continuum of care by closely coordinated arrangements with other agencies, hospitals and home support programs.
- To provide social relief for those who have responsibility at home for the care of people who have significant limitation of their physical functioning.

It should be noted that Parkwood Day Hospital has yet another goal; that is, as stated in "Hospitals without Beds" (1978, 4): "To establish a data system designed to monitor the progress of individual patients, to measure the efficiency of the day hospital over a period of time and to determine future needs." In the next Chapter of this thesis, wherein recommendations are made regarding further research, it is suggested that the Director of Riverview Day Hospital and hospital administration consider formally adopting this objective and the five previously stated ones (or objectives similar to these).

The effects of the program, implicitly stated in the data regarding program goals, are elucidated upon in the presentation of the data provided by the Director in addressing the third sub-question.

SUB-QUESTION C

As specified in the preceding Chapter, the final sub-question posed in evaluating the program was: are the causal assumptions (the rationale linking the program to the goals and/or effects) plausible? Following are the program activities and related causal assumptions which were explicated in the questionnaire designed for the Director of Riverview Day Hospital. Each of these items relates, in turn, to the respective program goals quoted.

The first statement of (a)program activities and (b)causal assumptions was specified as follows:

- (1.a) Assessment and review by Day Hospital physician, nursing care, physiotherapy, occupational therapy, nutritional counselling, social work counselling, and health monitoring such as lab tests and x-rays.
- (1.b) Provision of therapeutic hospital services allows a patient to attain and be maintained at an optimal level of functioning, thereby reducing the necessity for in-patient care and allowing the patient to remain in the community.

The second statement of activities and causal assumptions, which relate to the second program goal, was noted as follows:

- (2.a) This would include the physio and occupational therapy programs in addition to group exercise classes, craft activities, and recreational programs.
- (2.b) These activities also assist the patient in attaining an optimal level of functioning, thereby bringing about a feeling of personal satisfaction and success through accomplishment in personal endeavour. These programs also assist the patient in developing initiatives, self-reliance and orderly thinking. They help in bringing about a feeling of individual personal worth and self-respect that is extremely valuable in personality development and satisfying living.

The next two activities and the rationale linking them to their respective program goals were stated as follows:

- (3.a) Craft and leisure time activities. A common lunch time with the provision of a nutritional meal, an occasional day trip via the wheelchair bus for sightseeing, picnics and other activities.
- (3.b) These activities aid in reducing the isolation of homebound individuals. Sociological, psychological, and physiological needs are met as well as the development of interests to fill the potentially greater number of leisure hours experienced by these patients. These activities encourage social involvement and the provision of meaningful roles. Activity in general, and interpersonal, meaningful, satisfying activity in particular, is consistently important to increasing life satisfaction and an individual sense of well-being.
- (4.a) Contact is maintained with the patient's referring physician whereby he is contacted as necessary as to the condition of the patient in the program with minimum contact being every three months. If other agencies such as V.O.N. or Public Health agency

is involved with the patient then the Day Hospital will continue liaison with these services.

- (4.a) On-going contact with the patient's family, physician, and other social agencies involved in community care is of importance in providing a continuity of care to the patients attending the program.

Finally, the activities relating to the fifth goal were not specified because "this goal is in itself self explanatory"; however, the rationale linking the activities to the program goal was noted thus:

- (5.) Providing a brief rest to those persons responsible for the in-home care of the patient is an important aspect of the program. These persons often have many responsibilities in the home including up to 24 hour patient care, housework, and some hold down regular jobs as well. Providing these people with a much needed 'break' gives them a period of brief freedom from their responsibilities.

The causal assumptions underlying the Riverview Day Hospital program are well articulated and, therefore, do not require further elucidation. Without negating this statement, it should be noted that inquiry as to these assumptions was an essential aspect of the evaluability assessment for, as pointed out by Rutman (1977, 60), programs are often evaluated "when prior analysis would have revealed that the causal assumptions are not plausible and that there is little likelihood of the program producing the expected outcomes".

RESEARCH QUESTION II

FINDINGS BASED ON MEMBERS OF THE PATIENT SAMPLE

Of the 50 questionnaires distributed, 33 were returned (return rate = 66%). One questionnaire was returned with the first page removed, thus, demographic data is presented for 32 patients unless otherwise specified. Several other copies of the document, "Questionnaire: Riverview Day Hospital Patients", were returned with questions unanswered; missing values occurred most frequently for items regarding: (a) major program components, and (b) services offered through the day hospital program.

Socio-Demographic Characteristics

A. Age. The most common measure of central tendency is the mean (\bar{X}). The value which was most representative of values obtained for the patient sample was 66.9 and, thus, the average year of birth was 1914. The mode or most frequently occurring value in the distribution was 60 (year of birth: 1921). The median, defined as the middle value in a set of numbers arranged according to magnitude, was 66.5. This latter statistic, the value corresponding with the 50th percentile, represents "that point in a distribution which divides an ordered set of scores into two equal parts, so that

one half of the scores fall above and one half below it" (Malec, 1977, 24).

The most commonly used indicator of dispersion is the standard deviation (SD) which, basically, is a context for a \bar{X} . According to Philip, McCulloch and Smith (1975, 78), Social Work Research And The Analysis Of Social Data, it is "a kind of average of all deviations about the mean of a sample"; the higher the SD, the greater the dispersion from the \bar{X} . The SD for all members of the patient sample providing their date of birth was 11 or, more precisely, 10.96. The simplest measure of variability of a group of score values is the range which is defined to be the absolute difference between the highest and lowest value (range = 51). However, to describe a set of values fully one needs both a representative score and a measure of the extent to which they vary. Thus, the interquartile and semi-interquartile ranges were also calculated; they were found to be 13.5 and 6.75, respectively. The interquartile range describes the range of 50 percent of the sample in terms of their distance from the mean, whereas the semi-interquartile range describes the range of approximately 25 percent of the distribution in terms of their distance from the mean.

The following histogram illustrates the ages of 97 percent of the sample members. Note that 15 patients fell into the

60 - 69 age group, as demonstrated in Figure 1, and that another six were between the ages of 70 and 79 (64% cumulatively).

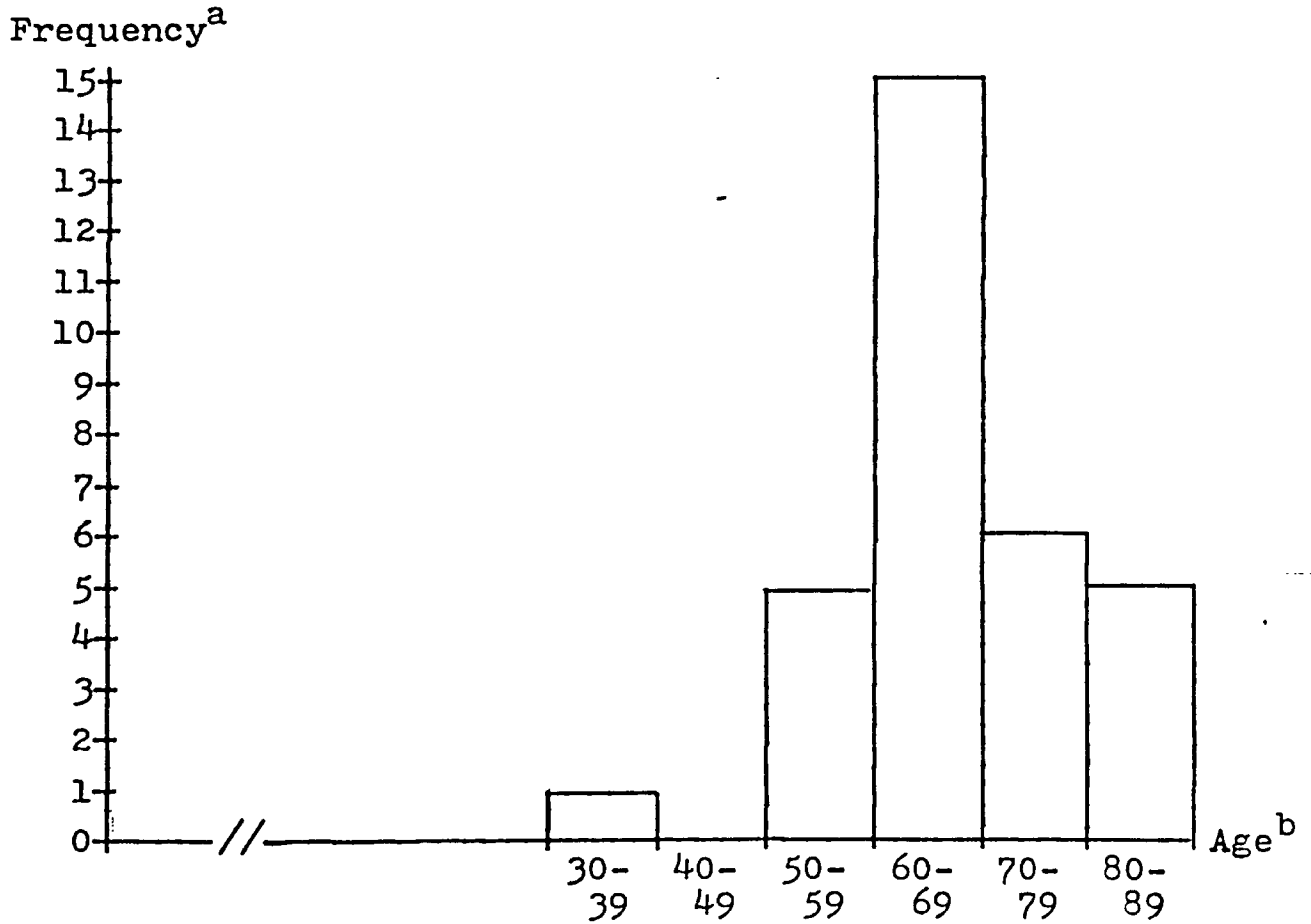


FIGURE 1. --Histogram illustrating Ages of Day-Patients

^aN = 32

^bClass Interval = 10

B. Ethnic Origin. The nationality of the majority of respondents (27, or 84%) was Canadian; of these, 20 patients indicated that they were born in Ontario, and eight in the City of Windsor. Regarding the other 16 percent of the pa-

tients who responded to the item pertaining to ethnicity, one was born in the United States and four were born overseas (Austria; England; Poland; Switzerland).

This variable, ethnicity, is a nominal one as are the following: sex, marital status, living arrangement, and employment. In the nominal level of measurement, classes are only named or enumerated, not compared. As noted by Malec in Essential Statistics For Social Research (1977, 7):

The nominal level of measurement is sometimes called the qualitative level. This term emphasizes the fact that at this level we are simply concerned with determining whether objects are equal in the sense that they possess the same quality. Nothing is implied about the relationships that might exist among different qualities.

C. Sex and Marital Status. Table VI pertains to the distribution of the variables sex and marital status. This bivariate Table shows that there was an equal number of males and females in the patient sample, with the exception of the one respondent who chose to withhold this datum. With reference to the variable marital status, a significant proportion of the male respondents (14) were married, whereas seven of the females were widowed and five were married. Thus, the majority of day-patients (19, or 59%), males and females inclusive, were married or living in a common-law-relationship.

TABLE VI. --Marital Status of Day-Patients related to Sex: Showing Frequency and Percentage

MARITAL STATUS	SEX					
	Males		Females		TOTAL	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Single	1	3.13%	3	9.38%	4	12.50%
Married*	14	43.75	5	15.63	19	59.38
Separated	-	-	1	3.13	1	3.13
Divorced	1	3.13	-	-	1	3.13
Widowed	-	-	7	21.88	7	21.88
TOTAL**	16	50.01%	16	50.02%	32	100.02%

* Includes Common-Law-Relationships

** Total of Percentages do not equal 100% due to rounding procedures

D. Living Arrangement. Of the 32 respondents who provided demographic data, seven (25%) lived alone. The remaining 25 (78%) were living with another person(s); most of the patients specified the relationship to the other person lived with as "spouse", whereas the remaining members of this group lived with another relative(s) such as their father or mother and/or offspring.

E. Employment. One hundred percent of the respondents providing demographic data indicated that they fit into the unemployed (or retired) category. The majority of these day-patients (19, or 56%) were 65 years old or over and, thus, of retirement age.

F. Income and Education. If numbers can be assigned in such a way that equal numerical differences correspond to equal increments in the property, it is called an interval level of measurement. When an interval scale of measurement has an absolute zero point as an additional property, it is referred to as a ratio level of measurement. As stated by Ferguson (1976, 12):

The essential difference between a ratio and an interval variable is that for the former the measurements are made from a true zero point, whereas for the latter measurements are made from an arbitrarily defined zero point or origin.

Table VII presents the frequency distribution for the 28 sample members who responded to the questionnaire item regarding income. It should be pointed out that 13 (46%) of the respondents indicated that they fit into the modal income bracket: under \$5,000; and, 10 (36%) fell into the \$5,000 - \$9,000 income range (cumulative percentage = 82%).

Regarding the variable education, 12 (38%) of the respondents indicated that they had solely attended primary school, and 18 (56%) attained a formal education at the secondary level; that is, 30 totaled or 94 percent inclusive.

In the Table mentioned above -which presents data regarding 28 patients' annual income, in relation to (a) education and (b) marital status- it is interesting to note that 13 of the 23 respondents with an annual income of less than \$10,000 had a post-secondary education, and that 14 of these respondents were married (or living in a common-law-relationship). However, most interesting are the observations that not one of the respondents claimed an income of \$20,000+ per annum (therefore, these categories are not included in the Table), and that only two members of the patient sample had pursued a tertiary level of education.

TABLE VII. --Frequency Distribution of Respondents' Annual Income related to
(a) Education and (b) Marital Status

	ANNUAL INCOME				TOTAL
	<u>-\$5000</u>	<u>\$5-9000</u>	<u>\$10-14000</u>	<u>\$15-19000</u>	
<u>(a) Level of Education</u>					
Primary School	6	3	1	-	10
Secondary School	7	6	1	2	16
Community College	-	-	-	-	0
University	-	1	1	-	2
					28
<u>(b) Marital Status</u>					
Single	4	-	-	-	4
Married*	5	9	3	1	18
Separated	-	-	-	-	0
Divorced	1	-	-	-	1
Widowed	3	1	-	1	5
					28
TOTAL	13	10	3	2	28

* Includes Common-Law-Relationships

Patients' Schedule of Activities

Exactly four patients noted that they attended the program Mondays only; two patients attended Tuesdays only, 11 - Wednesdays only, eight - Thursdays only. Of the remaining sample members, two indicated that they attended the program every Monday and Thursday and another two attended both Tuesdays and Thursdays, whereas one respondent indicated that he/she attended the program every Monday, Wednesday, and Thursday. Concise statements regarding this data are included in the section: "Program Activities and Scheduling of Activities". On the basis of the data provided by the 30 respondents mentioned above, the daily attendance in the program (per data collected in May/June) was as follows:

<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	
7	4	12	13	(N = 30)

Less than 50 percent of the patients, 14 members to be precise, complied with the request to "indicate all Day Hospital Program activities" they were scheduled to attend and, for the most part, data provided was consistent with that presented in Table V. A couple of the patients included all-encompassing comments in one column: (1)"any stimulating type activity available - exercise most important", and (2)"mostly PT" (physiotherapy). Another 14 respondents did not specify any of the activities they were scheduled to at-

tend in the day hospital program, rather they circled or otherwise indicated the day(s) they were present at River-view Day Hospital. The remaining three members of the patient sample left this page in the questionnaire blank.

Referrals to Program

A. Referral Source. Of the 33 members in the patient sample, 17 (52%) indicated that they were referred through a social service agency such as Victorian Order of Nurses (VON), Stroke Recovery Association (SRA), or a Public Health Unit. A total of seven respondents were referred either through Windsor Western Hospital Centre's Riverview Unit or I.O.D.E., and another seven were referred by a friend or relative; that is, 42 percent of the participants in this research project. The remaining two respondents, or six percent of the respondents, indicated that they were self-referrals. It should be noted that all patients admitted to the day hospital, regardless of the initial source of referral, had obtained a written referral - signed by a physician; furthermore, notification in writing was sent to the respective physician regarding approval or non-approval of each application. (N = 33)

B. Reason for Referral. The majority of the patients, -31- or 94 percent, indicated that they were referred to River-

view Day Hospital because of a chronic condition. The remaining two respondents were referred for treatment of a temporary health condition. (N = 33)

Patients' Health Status

A. Reported Functional Health. Presented on the following page are (a) the single Guttman Health Scale scores as well as their corresponding scale type response patterns, as noted in "Three Scales for Social Workers: Advanced Research Methods" (Lundy, 1971, 32). Additionally, (b) the Guttman Health Scale Items, extracted from "Questionnaire: River-view Day Hospital Patients", are shown for purposes of informing the reader as to the process used in coding the data for SAS; to be more explicit, the single scale scores (representing ones' functional level of health) and the codes used in SAS procedures were the same.

The majority of the 33 day-patients participating in this study (18, or 55%) obtained a single scale score of one; 11 obtained a score of two (cumulative percentage = 88%). Table VIII presents the discrete Guttman Health Scale scores of the respondents.

(A)	Single Scale Scores	Scale Type Response Patterns					
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>
	6 Healthiest	Y	Y	Y	Y	N	Y
	5	Y	Y	Y	Y	N	(N)
	4	Y	Y	Y	Y	(Y)	(N)
	3	Y	Y	Y	(N)	(Y)	(N)
	2	Y	Y	(N)	(N)	(Y)	(N)
	1	Y	(N)	(N)	(N)	(Y)	(N)
	0 Unhealthiest	(N)	(N)	(N)	(N)	(Y)	(N)

(B)	Data Code	Scale Items in Patient Questionnaire
	<u>6</u>	Still healthy enough to do without help - heavy work around the house
	<u>5</u>	No physical condition, illness or health problem?
		Which statement fits you best?
	<u>4</u>	- not limited in any activities
		Still healthy enough to do without help?
	<u>3</u>	- travel half a mile, walking or via wheelchair
	<u>2</u>	- walk up and down stairs, or transfer from wheelchair
	<u>1</u>	- go to a movie, church, meeting, or visit friends

TABLE VIII. --Day-Patients' Guttman Health Scale Scores:
Showing Frequency and Percentage

Scale Score	Frequency	Percentage	Cumulative Percentage
4	1	3.0%	100.0%
3	3	9.1	97.0
2	11	33.3	97.9
1	18	54.5	54.5
TOTAL	33	99.9% ^a	

^aTotal does not equal 100% due to rounding procedures

B. Psycho-Social Health. As indicated in the preceding Chapter, agreement with statements in the Srole Anomie Scale indicates anomie, whereas disagreement indicates its absence. Given this, respondents received a score of one for each statement they agreed with, and these were summed to obtain a single scale score which was used in coding the data for SAS. Presented in Table IX are the scores representing the respondents' psycho-social health status. Note that over 60 percent of the sample members scored two or less and that they, on the whole, did not have a strong agreement response set tendency as evident by the fact that only six percent scored five.

TABLE IX. --Day-Patients' Srole Anomie Scale Scores: Showing Frequency and Percentage

Score	Frequency	Percentage	Cumulative Percentage
5 ^a	2	6.3%	100.0%
4	4	12.5	93.8
3	6	18.8	31.3
2	13	40.6	62.5
1	2	6.3	21.9
0 ^b	5	15.6	15.6
TOTAL	32	100.1% ^c	

^aHigh Anomie

^bLow Anomie

^cTotal does not equal 100% due to rounding procedures

To summarize the findings thus far, a typical Riverview Day Hospital patient profile follows:

Date of Birth: September, 1914

Place of Birth: Ontario, Canada

Marital Status: married

Present Living Arrangement: living with spouse

Employment: retired

Annual Income: under \$5,000

Level of Education: secondary school

Referral Source: social service agency

Reason for Referral: chronic health condition

Level of Functional Health: one
(per Guttman Health Scale)

Level of Psycho-Social Health: two
(per Srole's Anomie Scale)

Need Satisfaction in Program

In an effort to discover the extent to which the patients felt their needs were being met in the Riverview Day Hospital program, one statement was included in the questionnaire regarding each of the major program components. Following is the scale used to measure this variable as well as its refined complimentary scale which was utilized in interpreting the findings.

<u>Scale Score</u>	<u>Scale Used In Questionnaire</u>	<u>Complimentary Scale</u>
6	strongly agree	very satisfied
5	agree	satisfied
4	agree with reservations	somewhat satisfied
3	disagree with reservations	somewhat dissatisfied
2	disagree	dissatisfied
1	strongly disagree	very dissatisfied

Ordered observations characterize the level of measurement applied to the variables discussed in this section; that is, of course, the ordinal level of measurement. An ordinal variable is a property defined by an operation which permits the rank ordering of objects or events. In ordinal measurement there is a concern not only with whether two objects or events are similar or dissimilar, as in the case of nominal variables, but also with the differences in possession of the certain quality being measured. According to the mathematical property of transitivity, if we know that "A" (or 6 in the case of this study) is greater than "B" (5) and "B" is greater than "C" (4), it must also be true that "A" is greater than "C", and so on.

Consequently, we know that there is a 'distance' between categories, but we do not know what the distance is. We cannot add these categories to each other or perform other mathematical operations on them. But having our categories rank ordered gives us a higher level of measurement than simply naming the categories. (Malec, 1977, 8)

A. Health Needs. A total of 29 patients responded to the statement regarding their health needs being met in the Riverview Day Hospital program. Of these, 10 indicated that they were "very satisfied" and 14 that they were "satisfied" with this component of the program (83% cumulatively). Table X provides the rating scores given this program component by the respondents.

TABLE X. --Patients' Level of Satisfaction with Health Component of the Day Hospital Program: Showing Frequency and Percentage

Score	Frequency	Percentage	Cumulative Percentage
6	10	34.5%	100.0%
5	14	48.3	65.5
4	4	13.8	17.2
2	1	3.4	3.4
TOTAL	29	100.0%	

B. Psychological Needs. Of the respondents who indicated their level of satisfaction with the psychological component of the program, 10 indicated that they were "very satisfied" and 14 that they were "satisfied" (89% cumulatively). Table XI presents the scores given this program component by the 27 day-patients who responded to the respective item in the questionnaire.

TABLE XI. --Patients' Level of Satisfaction with Psychological Component of the Day Hospital Program: Showing Frequency and Percentage

Score	Frequency	Percentage	Cumulative Percentage
6	10	37.0%	100.0%
5	14	51.9	63.0
4	2	7.4	11.1
3	1	3.7	3.7
TOTAL	27	100.0%	

C. Socialization Needs. In response to the item regarding the socialization component of the Riverview Day Hospital program - nine or 31 percent of the patients indicated that they were "very satisfied", and 19 (66%) were "satisfied"; that is, 97 percent of the respondents. Only one day-patient agreed with reservations that his/her socialization needs were met in the program and, thus, indicated that he/she was only "somewhat satisfied". (N = 29)

D. Nutritional Needs. In response to the item regarding the nutritional component of the program, 12 day-patients indicated that they were "very satisfied" and 14 that they were "satisfied" (cumulative percentage = 93). With reference to the remaining two respondents, one checked "agree with reservations" and the other checked "disagree"; thus, both of these respondents indicated that they were not as satisfied as could be expected. (N = 28)

E. Transportation Needs. The overwhelming majority of the respondents indicated that they were satisfied with the transportation component of the program. To particularize, 13 respondents indicated that they were "very satisfied" and 15 were "satisfied" (95% inclusive); of the 30 patients responding to this item, one checked "agree with reservations" and another checked "disagree with reservations". Further analysis of the data resulted in the following finding: of the 22 respondents whose means of transportation was Riverview's Sunshine Bus, 10 noted that they were "very satisfied" and 11 were "satisfied" (95% inclusive); one of this group of respondents checked "Sunshine Bus" in the questionnaire but failed to indicate his/her level of satisfaction.

To recapitulate, the majority of patients participating in this study evidently agreed that their needs were met in the Riverview Day Hospital program. Worded otherwise, a significant proportion of the patient sample was satisfied with all the major program components. Table XII presents a summary of the respondents' level of agreement with each of the five statements regarding the program components discussed in the preceding pages; as no one checked "strongly disagree", this category is not included in the Table. For the sake of specificity, a modal score of five resulted for each one of the five statements.

TABLE XII. --Patients' Need Satisfaction in the Day Hospital Program: Showing Frequency Distribution

DAY-PATIENTS' NEEDS	LEVEL OF AGREEMENT REGARDING NEED SATISFACTION					TOTAL
	Disagree (2)	Disagree with Reservations (3)	Agree with Reservations (4)	Agree (5)	Strongly Agree (6)	
Health	1	-	4	14	10	29
Psychological	-	1	2	14	10	27
Socialization	-	-	1	19	9	29
Nutritional	1	-	1	14	12	28
Transportation	-	1	1	15	13	30

Program Activities and Scheduling of Activities

A total of 26 patients responded to the item regarding level of satisfaction with the program activities they attended. Of these, 11 indicated that they were "very satisfied" with this aspect of the program and another 11 were "satisfied"; that is, 85 percent of the patients responding to the respective item in the questionnaire.

Of the 25 patients that indicated their level of satisfaction regarding the scheduling of activities they attended, 11 were "very satisfied" and 10 were "satisfied" (84% inclusive).

The modal score for these aspects of the program -activities and scheduling of activities- was five and six, respectively. Table XIII presents the frequency distribution as well as the ratio or relative frequency of scores provided by the respondents.

Furthermore, in specifying how they thought the activities they attended might be improved, seven respondents checked "provide for more staff and/or volunteers", and 10 checked "provide for greater variety of activities". Regarding the scheduling of activities, five of the day-patients indicated that this aspect of the program might be improved by in-

creasing the number of program hours-per-day, and 10 checked "increase number of program days-per-week".

TABLE XIII. --Day-Patients' Level of Satisfaction with Program Activities and Scheduling of Activities: Showing Frequency and Percentage

<u>Score</u>	<u>PROGRAM ACTIVITIES</u>		<u>PROGRAM SCHEDULING</u>	
	<u>Frequency</u>	<u>Percentage</u>	<u>Frequency</u>	<u>Percentage</u>
6	11	42.3%	11	44.0%
5	11	42.3	10	40.0
4	1	3.8	1	4.0
3	2	7.7	1	4.0
1	1	3.8	2	8.0
TOTAL	26	99.9%^a	25	100.0%

^aTotal does not equal 100% due to rounding procedures

Improvement of Overall Health

A total of 21 sample members responded to the statement regarding improvement of their health condition. Of this number, 43 percent (9) of the respondents indicated that they were "very satisfied" and, thus, that they believed the program did contribute to the improvement of their overall health; another nine indicated that they were satisfied with the extent to which the program contributed to the improvement of their health (86% inclusive). Table XIV presents the rating scores provided by the day-patients in response to this item (modal score = 5).

TABLE XIV. --Patients' Level of Satisfaction regarding Day Hospital Program contributing to Improvement of Overall Health

Score	Frequency	Percentage	Cummulative Percentage
6	9	42.9%	100.0%
5	9	42.9	57.1
4	2	9.5	14.3
2	1	4.8	4.8
TOTAL	21	100.1% ^a	

^aTotal does not equal 100% due to rounding procedures

Following are statements regarding the results of further analysis. A total of six respondents indicated that the program contributed to the improvement of their health in that they had become less limited in the number of things they could do for themselves. The majority of the respondents (19) indicated that they, as a result of their participation in the program, felt better about life in general. Other benefits were reported as resulting from having "companionship", "encouragement" and "something to do"; other patients said they benefited from being provided with the opportunity for "change in daily routine" and "diversion".

Services Offered through Program

For purposes of brevity, the scores given in response to the items regarding services offered through the day hospital

are presented in aggregate. As there was little variation in these scores, for the most part, and since many of the respondents indicated "don't know, never used service", only one Table was prepared to present this data. With reference to the service listed as social work counseling, it should be noted that day-patients must be referred to the Social Services Department as are patients from other areas of the hospital. According to the Director of Social Services at Riverview Unit, social workers are involved with day-patients in both casework activities, and group work (ie. groups of stroke recovery patients; special interest groups). As stated by Cohen (1975, 58), "the stigma of institutionalizing an elderly or disabled family member is too threatening for many persons to bear"; thus, emotional problems involving the family do result in purposive relationships with family members. Social work intervention may also be required in admission assessments or discharge planning.

As evident in Table XV, which presents the frequency distribution and \bar{X} rank for each of the services listed in the patient questionnaire, (1)one to five patients agreed with reservations that the various services offered were adequate and, therefore, only somewhat satisfactory from their perspective, (2)six to 13 agreed that the services listed were adequate and to their satisfaction, whereas (3)four to nine strongly agreed that these same services were adequate and

TABLE XV. --Patients' Level of Satisfaction regarding Day Hospital Services: Showing Frequency Distribution and Mean Rank

DAY HOSPITAL SERVICES	LEVEL OF AGREEMENT REGARDING SATISFACTION						\bar{X} Rank	TOTAL
	Don't Know (0)	Strongly Disagree* or Dis-agree** (1) (2)	Disagree with Reservations (3)	Agree with Reservations (4)	Agree (5)	Strongly Agree (6)		
Nursing Care	5	-	-	1	8	9	5.44	23
Liaison with Family	4	1**	-	-	12	6	5.44	23
Self-Care Training	8	-	-	2	6	6	5.29	22
Socialization Activities	4	-	-	2	12	7	5.24	25
Liaison with Referring Physician	1	-	1	-	13	7	5.24	22
Nutritional Counseling	-	-	1	2	12	9	5.21	24
Leisure Activities	4	-	-	3	9	7	5.21	23
Physiotherapy	1	-	1	5	12	6	5.17	24
Liaison with Community Services	5	-	1	1	11	6	5.16	24
Exercise Classes	2	1*	-	3	11	9	5.08	26
Social Work Counseling	6	-	-	3	9	4	5.06	22
Health Monitoring	2	-	-	3	13	4	5.05	22
Occupational Therapy	5	-	1	3	10	6	5.05	25
Craft Activities	2	-	1	3	13	6	5.04	25

that they were as satisfied as could be expected. Finally, computer analysis of the data showed that the modal score for each of these items was five --- with the exception of nursing care for which this score was six, and self-care training (ie. feeding; dressing; personal hygiene) for which the modal score was zero. (N = 22 to 26)

Referrals through Program

In answering the question "Have you been referred to any other agency through the Day Hospital Program", 82 percent of the patients checked "no" and 18 percent responded in the affirmative. Each of the five individuals in the latter group specified the agency or agencies to which they were referred; however, only one also specified the service he required, as noted: "YMCA - swim classes". Of the four remaining respondents, one stated he was referred to (a)YMCA and (b)Handi-Transit Bus Lines; the other three day-patients indicated that they were referred to VON, SRA and Meals-on-Wheels, respectively. (N = 27)

Attendance in Program

A. Days-Per-Week Attended. As suggested by the data presented regarding their schedule of activities, the majority of patients (25, or 83%) indicated that they were scheduled

to attend the program one day-per-week. Regarding the remaining five of the 30 day-patients responding to this question, four indicated that they were scheduled to attend two days-per-week, and one attended three days-per-week. (According to the Director of the program, no patients were scheduled to attend the program more than two days-per-week between January and May; and, the number of patients participating in the program remained relatively stable over these months.)

B. Days-Per-Month Absent. A total of nine patients (37.5%) indicated that they were consistently present as scheduled at the day hospital. Furthermore, five respondents estimated that they missed only one day-per-month, and another five - two days-per-month; that is, 11 (41.6%) of the 24 patients responding to the respective item in the questionnaire. Accordingly, almost 80 percent of the respondents estimated that they missed no more than a couple of days "in the last two or three months". (According to the Director of River-view Day Hospital, some patients could not attend the program because transportation via the Sunshine Bus was not available as expected; transportation problems were related to insufficient funds for maintenance and repair costs of the vehicle.)

A total of nine patients failed to indicate the number of days-per-month that they missed in the program, if any; nonetheless, four of these nine patients did provide reasons for their absence. Table XVI presents the number of days-per-month patients were not present at the day hospital as well as the reason they specified for their absence. Since none of the patients checked "worsening of chronic condition" or "dissatisfied with program" as a reason for their absence, these categories are not included in the Table. Also not represented in the Table below are the nine respondents who were present without exception (days-per-month absent = 0).

TABLE XVI. --Table of Frequencies showing Number of Days-Per-Month Respondents were Not Present at the Day Hospital and Reasons for Absence

DAYS-PER-MONTH ABSENT	REASONS FOR ABSENCE			TOTAL
	<u>Transportation Not Available</u>	<u>Minor Health Problem</u>	<u>Other*</u>	
7	-	1	-	1
6	1	1	-	1
5	1	1	-	2
4	-	1	-	1
2	5	-	1	5**
1	1	4	1	5
not specified	3	2	-	4
				24

* "weather"

**as a second reason, one respondent checked "do not need to attend as frequently as scheduled"

Personal Reasons for seeking Admission to Program

In response to the question regarding reasons for initially seeking admission to the day hospital program, 25 respondents explicitly or implicitly stated: (a)personal health reasons, (b)personal psycho-social reasons, and/or (c)reasons related to family needs or concerns. Note that these reasons are congruent with the objectives of day hospitals, as discussed earlier in this thesis.

Personal health-related reasons were explicitly stated by two respondents. And, listed by one respondent was "physiotherapy", "nutritional counseling" and "craft activities"; these may be considered exclusively as health reasons, however, particularly in light of other data provided in the questionnaire, psycho-social reasons may well be implied in his/her noting craft activities.

Another three respondents stated the following reasons, which fit into the psycho-social category and clearly relate to family needs or concerns: (1)"for company; give my wife some free time", (2)"because it meant going out among people with problems like mine - also gives my family a free day", and (3) relief for spouse from "constant supervision and care" as well as "to spend time away from each other for a change of atmosphere".

Due to their ambiguity, the following statements may be classified as personal health and/or family-related reasons and, perhaps, psycho-social reasons: (1)"I was in the Outreach Program and stayed on", and (2)family and doctor suggested "more contact with people, especially since I fell frequently".

The remaining 17 of these 25 respondents provided data which was interpreted primarily as psycho-social and/or health-related reasons. Their comments are presented (verbatim) in Table XVII.

Personal Reasons for Continuation in Program

Of the total sample members, 25 responded to this question: "What are your personal reasons for continuing in the Day Hospital Program". With direct reference to health, three stated that they did so because the program was "helpful". Three other respondents wrote: (1)"general well-being has improved markedly - I feel this will continue", (2)"to continue physical and occupational therapy", and (3)"mostly for therapy, builds morale as a handicapped person needs".

According to one patient, he continued in the program for health, psycho-social, and family-related reasons. This patient wrote: "it provides my wife and I an opportunity to

TABLE XVII. --Rationale provided by Respondents for seeking Admission to the Day Hospital Program

PERSONAL PSYCHO-SOCIAL and/or HEALTH-RELATED REASONS

Psycho-Social and Health-Related Reasons:

- (1)"for the company and exercise"
- (2)"need therapy, need activities with others"
- (3)"need more therapy, need activities with others"
- (4)"to get out of the house for awhile and meet other people"; "therapy"
- (5)"need more socializing and more physiotherapy"
- (6)"for the therapy and to meet the nurses"
- (7)"for a change - to relieve boredom"; "for therapy provided"
- (8)"to improve my condition mentally and physically - to meet and socialize with other people"; "to get back into the mainstream of life again, maybe get a part-time job to occupy my leisure time"

Psycho-Social Reasons:

- (1)"felt the need to meet other people maybe worse off than I"
 - (2)"to get out and meet people"
 - (3)"to get away for the day from home" and improve "outlook on my life"; "to learn to live and accept my limitation"
 - (4)"so I can get out of the house"
 - (5)"to get out with people and do things"
 - (6)"to see former patients and nurses"
 - (7)"to meet other people in same situation or even worse"
 - (8)"meet people with similar disabilities & enjoy the friendship and hospitality shown by staff"; "participate in activities"
 - (9)"need for recreation, motivation - lonely"
-

spend a few hours doing something on our own" and "it provides me with exercise, therapy and people contact I have not been able to get until now".

A couple of the respondents indicated that they continued to attend the program for the "enjoyment" they derived therein; and, two others simply included remarks indicating their satisfaction with the program in general (ie. "like it very much"). Comments provided by the remaining 14 of these 25 respondents, which are presented (verbatim) in Table XVIII, indicate that they continued in the program for reasons that again fit into the first two categories specified in the preceding paragraphs - health and/or psycho-social reasons.

Additional Comments Provided by Patients

Patients' responses to the request for additional comments regarding their experience in the Riverview Day Hospital program were as follows. Comments of a complimentary nature about staff and/or volunteers were provided by five respondents; for example, one patient stated: "I had reservations about the program but find it something to look forward to now. . . . These people are dedicated, kind and helpful." Another four respondents included positive statements pertaining to the program in general (ie. "find the program stimulating . . . would like to go for another day if pos-

TABLE XVIII. --Rationale provided by Respondents for Continuation in the Day Hospital Program

PERSONAL PSYCHO-SOCIAL and HEALTH-RELATED REASONS

Psycho-Social and Health-Related Reasons:

- (1) "for the company and exercises"
- (2) "enjoy it - change of scenery"; "therapy very helpful"; "I like the staff & the patients"; "meets my needs"
- (3) "the heat treatments seem to ease the pain, the exercises and the pleasant staff are what the doctor ordered"
- (4) "for the therapy, and to be with people"
- (5) "meeting human beings like myself and knowing I'm not alone"; "striving to learn more and understand my illness - I want to manage my particular health condition"
- (6) "need therapy, need activities with others"; "unable to go out of the house unassisted"
- (7) "meet different people"; "physio and occupational therapy and crafts"
- (8) "therapy, exercise, cards"
- (9) "day out with people"; "nice lunch"; "nice friendly people"; "crafts and games"; "need help with wheelchair"

Psycho-Social Reasons:

- (1) "gives me something to look forward to every week"
 - (2) "can be with people the same as I - disabled"
 - (3) "proud of what I can make, even though I just have one hand that is useful"
 - (4) "need to get out and talk to other people"
 - (5) "have a need for companionship - would be lost without it"; "fills a great need as I am not able to go out shopping, or for other activities"
-

sible"). Finally, health-related comments, congruent with the primary objective of the day hospital program, were as follows. (1)"I can do a lot better now than when I first started over two years ago. I can walk a lot better with a cane now." (2)"My daughter, who also has a few health problems, has been able to attend and it has been very good for her too." (3)"It has been wonderful - program helping me regain the use of my paralyzed left side, and I would like to continue." (N = 12)

Alternate Living Arrangements

Since one of the major objectives of day hospitals in general is to prevent/postpone/reduce institutionalization, the following question was incorporated into the patient questionnaire: "If you were not a participant in the Day Hospital Program, would you have to make alternate living arrangements". It was expected that many of the day-patients would answer "yes"; however, only eight (29%) did so, while 20 (71%) indicated that they would not need to make alternate living arrangements. For those respondents that answered in the affirmative, a secondary question was asked: "what alternate living arrangements would you have to make"; listed as possible alternatives were institutions (ie. Rest Home; Nursing Home). In responding to this item, two patients indicated that they would have to make arrangements

with a Chronic Care Hospital, and another two with a Nursing Home; one respondent checked "Rest Home" and as other alternatives specified: "or Nursing Home or get married". Three patients checked "yes" in response to the initial question but failed to specify which alternative would best suit their needs. Table XIX presents the institution checked in the questionnaire by the patients plus the reason which could result in their having to change their present living arrangement. As evident in this Table, two respondents provided more than one reason in support of their answer to the primary question regarding alternate living arrangements.

TABLE XIX. --Institution specified as Alternate Living Arrangement and Rationale regarding Respondents' Perceived Need

INSTITUTION AS ALTERNATIVE	RATIONALE PROVIDED ^a
Rest Home	1
Nursing Home	1
(yes)	1
Nursing Home	2
Chronic Care Hospital	2, 3
(yes)	2, 3
Chronic Care Hospital	3
(yes)	3

^a1 = it would be difficult for me to continue living alone without one or more services provided by a hospital

2 = it would be difficult for the one(s) I live with to assist me without one or more services provided by a hospital

3 = it would be difficult for the one(s) I live with to assist me during the day without any free time

Having presented the data collected, it would be appropriate to focus on the empirical observations regarding the day-patients' perceived need for institutional accommodations if, as stated in the primary question, they were not participants in the day hospital program. The statistical finding raises some important questions since it would suggest on closer examination that many participants in the program may not require a health service of this nature. It is a well-known fact that statistics do not provide -in and of themselves- precise answers to social inquires; furthermore, research experts strongly recommend that caution be exercised in relying on a single statistic in isolation of other factors. In keeping with these thoughts, four questions are posed merely as examples of ones that need to be considered in discerning how the finding should be interpreted.

- (1) Did the patients participating in this study differ in relevant ways from the 34 percent who were not accessible; or, worded otherwise, is it possible that the non-participants' overall health condition -health being a broadly defined concept which encompasses reported functional health- was more severe and, thus, their need for alternate living arrangements greater?
- (2) Is the expectation of a higher rate of "yes" responses no longer appropriate given the fact that 44 percent of the respondents were less than 65 years old and, thus, not yet members of the population for which the need for al-

ternatives to institutionalization is most apparent?

(4) Should this study be replicated in another day hospital also admitting middle-aged and younger patients, would the percentage of affirmative responses be similar? With this possibility in mind, two opposing views are presented in the following paragraphs regarding the respondents' perception and interpretation of the questionnaire item.

Firstly, the term "institutionalization", for example, is often associated with such words as "loneliness", "dependency", "isolation" and, perhaps most frequently, "death"; thus, on the one hand, it may be said that unconscious avoidance-denial mechanisms influenced some of the patients' perception of their need for alternate living arrangements. Indeed, we live in a youth-worshipping and progress-oriented society wherein negative attitudes towards aging and death are both perpetuated and internalized. Furthermore, particularly in a society wherein rugged individualism is a dominant value, mandatory retirement represents a form of segregation. In the context of discussing the legislation of retirement and how "we make death unmentionable in polite society", Baum makes a valuable observation:

Far more than economic interests come into play in any discussion of attitudes and policies relating to older persons. There may well be a

deeper, more central concern in this society's non-action or negative action to the old. This concern may be our attitude toward death, our collective fear of recognizing the total life cycle. (1974, 41)

Fear and denial of death are also reflected in the very fact that we institutionalize and thus segregate those persons, to use the term coined by Kubler-Ross, who are in "the final stage of growth".

Secondly, the researcher feels impelled to present the opposing perspective beginning with the following statement: the victims of our attitudes -societal and personal- are elderly citizens for whom death is most salient. Baum elaborates on this poignant assertion in The Final Plateau: The Betrayal Of Our Older Citizens (1974, 41):

When given an opportunity, the old are not afraid to speak of death. Indeed, not infrequently, even the terminally ill want to share their feelings; but they are often not allowed to do so by the people closest to them. The primary fear that exists springs from those who are not so close to death.

Succinctly stated, "if death can be accepted, the life cycle can be accepted" (Baum, 1974, 38). Consequently, one may point out that elderly persons have an increased awareness of their proximity to death and that they -men and women alike- tend to measure time in terms of years left to live

as opposed to number of years lived. In comparison to any other age group, older individuals are least likely to fear death and are most cognizant of the realities expressed by Joseph L. Braga and Laurie D. Braga in the "Foreword" to Death: The Final Stage Of Growth by Kubler-Ross (1975, x):

Death is as much a part of human existence, of human growth and development, as being born. It is one of the few things in life we can count on, that we can be assured will occur. Death is not an enemy to be conquered or a prison to be escaped. It is an integral part of our lives that gives meaning to human existence.

Some of the day-patients no doubt espouse the message put forth by Kubler-Ross (1975, 2): "Death does not have to be a catastrophic, destructive thing; indeed, it can be viewed as one of the most constructive, positive, and creative elements of culture and life." Given that this postulation is accepted by some of the patients, one cannot assume that unconscious defense mechanisms influenced their perception of their need for alternate living arrangements (although other intervening variables may have). In support of this perspective, one may consider the day-patients' psycho-social health scores.

The statistic may also be approached from an intermediate position based on other findings presented in this study (ie. average age of the respondents) and the fact that a day

hospital is often the final step between community living and institutionalization. Concisely stated, the participants in the research project may be regarded as being in a dual transition, particularly in terms of their attitudes towards "old age" and "institutionalization", and what connotations these words carry for them personally.

Finally, it should be pointed out that the item regarding alternate living arrangements was included in the patient questionnaire on the basis of material presented in Chapter II of this thesis. To be more explicit, only two types of day hospitals are defined in the literature: geriatric day hospitals and psycho-geriatric day hospitals. Consequently, difficulties arise such as illustrated in Morgan's article about Parkwood Day Hospital entitled: "Gaining Independence at a Geriatric Day Hospital" --- yet, admission to this program is not restricted to applicants who are 65 years of age and over. Interestingly, the first paragraph in this article is exactly as follows:

Last year the first purpose-planned geriatric day hospital was opened at Parkwood Hospital in southwest Ontario. It has proved to be a successful alternative to institutionalization. (Morgan, 1979, 23; underlining added)

Subsequently, Morgan (1979, 25) states, "although the day hospital is for the care of elderly, no age limit is set".

Furthermore, Ms. Frances Clearly - Coordinator of the Parkwood Day Hospital, "says that the criterion for admission to the Parkwood program is, broadly speaking, 'anyone who will benefit from the program'" (Hospitals without Beds, 1978, 4). In this second article, in which day programs of three different hospitals are examined, the author states that each is different in focus,

but all have in common the goal of providing support for people who, if they did not receive this care, would either be occupying an in-patient bed somewhere or would find independent living far more difficult. (Hospitals without Beds, 1978, 2)

Particularly on the basis of statements such as the one noted in the above quote, it seemed appropriate to include the item regarding alternate living arrangements, which relates to the ultimate goal of day hospitals in general. Nonetheless, it should be stated that "to prevent/postpone/reduce institutionalization" is not explicitly stated in the objectives of Parkwood Day Hospital; and, as indicated earlier, the stated objectives of the Parkwood program were reiterated in "Questionnaire: Director of Riverview Day Hospital".

Finally, it may be pointed out that the discussion regarding Parkwood Day Hospital in the article entitled "Hospitals without Beds" is included under the heading: "Parkwood: A

Day Hospital in the Chronic Hospital Setting". Given that only two types of day hospitals are defined in the literature, authors/researchers and professionals in these facilities are obviously limited in their attempts to accurately classify the existing day care programs. This problem could be alleviated if professionals endeavored to formally define other types of day hospitals; for example, a third type may be identified as: chronic care day hospitals.

FINDINGS RELATED TO EVALUATIVE RESEARCH QUESTION

The second of the two basic research questions was: does the data collected in monitoring the Riverview Day Hospital program verify the decision-making system's understanding of this program - its goals, outcomes and/or effects, and causal assumptions? Following is a discussion of the outstanding findings relevant to this question.

An important finding in this study was that the respondents, by-and-large, agreed with statements regarding each of the five major program components and, thus, indicated that their (health, psychological, socialization, nutritional and transportation) needs were met in the day hospital program. Furthermore, the fact that the majority estimated they were absent from the program no more than two days in the last few months may also serve as an index of their level of sat-

isfaction with the program as does the fact that not one patient checked "dissatisfied with program" as a reason for his/her absence. As pointed out earlier, however, the Director of the program identified transportation of patients via the Sunshine Bus as a problem area. Those patients whose means of transportation was the Sunshine Bus did not provide an unsatisfactory rating in response to the item regarding this program component; however, it should be pointed out that all but one of the patients who checked "transportation not always available" as a reason for absence also specified their means of transportation as "Sunshine Bus". Furthermore, one may also take into consideration the fact that the patients' response to the item regarding transportation as a program component may have been influenced by a "recency effect", whereas the Director necessarily views the program from an overall perspective (winter months not excluded, when problems with the vehicle were at their peak).

Consistent with the experience of other day hospitals in Great Britain and North America were the reasons for which the patients were referred to the program. Stated more specifically, the overwhelming majority of the respondents were referred for treatment of a chronic health condition; and, their Guttman Health Scale scores support the identified need for day care services.

An interesting finding in this study was the low Srole Anomie Scale scores. This scale and the Guttman Health Scale were incorporated into the patient questionnaire, as indicated earlier, for purposes of obtaining an index of the respondents' functional health and psycho-social health levels; furthermore, not unlike the socio-demographic data requested, they served the purpose of providing a fuller description of the day hospital clientele. In formative research, as also indicated in Chapter III, knowledge between intervention strategies and outcomes is purely "correlational". Nonetheless, it is interesting to note that many of respondents indicated that they, as a result of their participation in the program, felt better about life in general and that several others were less limited in the number of things they could do for themselves. These findings, resulting from analysis of data provided regarding the variable improvement of overall health, are relevant to the functional and psycho-social health objectives of the Riverview Day Hospital.

Finally, the researcher concluded that the data collected vis-à-vis the patient questionnaire did verify the primary intended users' (of the planned evaluation) understanding of the program. This conclusion was further supported by the findings regarding the various services offered through the program. For example, in positively responding to the items

in the questionnaire prefaced with the statement "I think the following services offered through the Day Hospital Program are adequate", the majority of the patients indicated that they were as satisfied with these aspects of the program as they were with the major program components.

CHAPTER V
RECOMMENDATIONS

Although change is not synonymous with improvement, program evaluation can generate workable proposals for improvement. However, as noted by Murphy (1980, 165):

If program evaluation is intended to make things better, it is ironic that recommendations are often treated like the proverbial visiting mother-in-law: Some space is provided, but not much attention. So much time and energy is expended looking at the past that few resources remain to look toward the future. The result is often a recommendations section in an evaluation report that makes few sensible or practical suggestions for improvement.

Sensible and practical recommendations must go beyond the common suggestions for better coordination and communication; and, a variety of alternatives as well as the feasibility of implementing tentative recommendations must be examined. Having said this, recommendations which evolved from the process of conducting the evaluation follow.

- (1) To meet the current needs of the population served and the growing demand for day care services, the researcher recommended that the decision-making system seriously consider expanding the Riverview Day Hospital program.

This recommendation is based on the findings presented in the preceding Chapter (ie. patients indicating program could be improved by increasing number of program hours-per-day and/or days-per-week; most of the patients were scheduled to attend the program only one day-per-week). Furthermore, it is supported by the fact that the need for viable alternatives to institutional care has become more apparent with the increase in the elderly population, cost and shortage of institutional beds and, last but not least, the expressed desire of many families of the aged and the aged themselves to remain in the mainstream of community life.

(2) It was recommended that the Director of the program and hospital administration consider formally adopting the six objectives stated in "Hospitals without Beds" in Highlights, or objectives similar to these; and, that the stated objectives be included in both the Riverview Day Hospital's manual and public information brochure (in lieu of those currently printed therein). In conjunction with this, two further suggestions were offered:

(2.a.) Although the objectives are lucidly stated, it was thought that the following one should be modified:
"To provide to these people opportunity for socialization and recreation." Subtle though the difference may be, it was suggested that the words "to these peo-

ple" be deleted or that they be substituted with the word "participants", for example, or "day-patients". Basically, the reason for having suggested this revision is to eliminate any patronizing connotations. Day hospitals provide a service to the public and, ideally, staff work "with" the consumers of the service as opposed to "doing for".

(2.b.) Furthermore, it was suggested that the words "and recreation" be deleted from this statement. The rationale behind this is simply that the focus of day hospitals is medical intervention whereas, at the other end of the continuum, the primary objective of day care centres is recreational in nature. Worded otherwise, activities in day hospitals are organized explicitly for their therapeutic purpose; and, recreation -in and of itself- is appropriate to other facilities which share many elements in common but, nonetheless, differ in their purpose and primary service(s). Concern regarding the recreational aspects of other day hospital programs has been expressed by several professionals. For example, in concluding her discussion of day hospitals, Morley (1974, 11) succinctly stated: "The day hospital is not a social prop, although sometimes used as one."

(3) In light of the fact that data collected in formative research projects are equivocal and suggestive rather than definitive, as indicated earlier in quoting Rutman, it was further recommended that a research component be incorporated into the day hospital program operating out of the chronic care facility in which this project was conducted. This recommendation and the following ones relate to the reason for which an evaluation of the River-view Day Hospital program was initiated; that is, the request stemmed from a concern with the quality of the program and a felt need to develop a basis for future research and funding proposals.

Several approaches relevant to the above noted recommendation are discussed in Evaluation: A Systematic Approach. In routinely assessing progress towards fulfillment of program goals, for example, emphasis may be placed on developing an accurate set of administrative records useful to program description and as an aid to impact assessment, cost-benefit and/or cost-effectiveness analysis. Regarding the recording of information and the use of records, Rossi, Freeman and Wright state:

Almost all programs are required to keep record information about units served. Such information is generally useful in determining the accountability of project staff and resources expended. There is a large variation in the quality and ex-

tensiveness of record information and in the sophistication involved in their storage and maintenance. Moreover, the feasibility of keeping complete, ongoing record systems for all program participants varies with the nature of the treatment and available resources. Sophisticated computerized management and client information systems, for example, have been developed for medical and mental health systems. (1979, 126)

With specific reference to evaluation of social work practice, a brief outline of categories for both objectifying data about casework and systematically recording those data is included in Appendix D. Additionally, a form on which all these data can be summarized (one 8½ by 14 inch recording sheet) is also included in the Appendix; the form is presented exactly as shown in Effective Casework Practice: An Eclectic Approach (Fischer, 1978, 128). Although it is designed for evaluation of social work practice, this form could readily be modified for the recording of data regarding participants in all phases of the day hospital program. Note too that the systematized recording model can be considered as a preliminary step to the use of other methods, and that it can serve as an aid to developing hypotheses for further testing regarding the effectiveness of services provided; as noted by Fischer (1978, 121), since they also form a way "of constantly orienting practitioners to outcome and of evaluating the effects of their interventions . . . such recording can produce significant gains in efficiency".

Other models of self-evaluation are presented in the literature. Another example, one specific to the hospital environment which may be most useful in designing a funding proposal to the Ministry of Health, is the developmental model used at Saint Vincent Health Centre (Erie, Pennsylvania). The model is divided into three sections: background, incremental economic analysis, and subjective evaluation. Briefly, the administrative person responsible for the area affected is also responsible for completing the model. In order to secure the most accurate and useful data that person must work closely with other administrative personnel and, when applicable, with physicians who are interested in the project or expenditure. The information required is generally self-explanatory and requires no special understanding of financial concepts except in the final summarization of the economic factors. The form used at Saint Vincent Health Centre is included in Appendix E exactly as shown in "Project Analyses and Capital Budgeting: A Developmental Model", Hospital Progress, by Cox (1975, 46-51). Additionally, in the Appendix, a score sheet is provided which attempts to quantify the results of the analysis in such a way that dissimilar expenditures can be ranked in order of priority; however, as many factors of the model, the score sheet is less important for the actual answers it provides than for the concept it brings to the analysis.

(4) In the role of researcher, ideally, one acts as a catalyst for future research. And, as stated by Rossi, Freeman and Wright (1979, 162): "In the largest context, the problem of discerning the effectiveness of a program is identical with the problem of establishing causality." Accordingly, the researcher's fourth recommendation was that further research be conducted to establish the cause-and-effect relationship between the day hospital program goals and outcomes. For example, day hospitals which have a long waiting list equal to the actual number of people in attendance, could carry out a comparative study between matched groups over a period of one or two years. The purpose of such a study would be to determine what happens to those patients not attending the day hospital as compared to those who do attend; more specifically, the purposes would be (a) to ascertain the extent to which day hospitals serve a useful purpose, medically and socially, and (b) to ascertain the extent to which they keep patients out of hospitals and residential homes. Or, as another example, any day hospital could initiate a before-and-after treatment study for the same purposes.

(5) With reference to the questions this thesis raises, one may well expect that the reasons patients provided for their continuation in the program, which were primarily psycho-social as opposed to medical ones, be the subject

of further investigation.

Some doctors have testified that the medical disability usually clears up more quickly than the social disability, and that therefore the patient continues to attend largely because of the social problem. . . . sometimes it is not possible to distinguish between the medical and social needs of a patient. (Farndale, 1961, 77-8)

Obviously, the patients at Windsor Western's Day Hospital are not unique as other professionals affiliated with such facilities have inquired into the same concern. This not only lends support to the previous recommendation(s) for further research but also leads to one pertaining to the process of referring patients to other community services. The fifth recommendation was that administrative persons conduct a review of the referral process. In stating this recommendation, the researcher is cognizant of the fact that verbal referrals may well have been made by staff members, that some patients would not have recalled these at the time of completing the questionnaire, and that other variables might have intervened such as resistance to change, wheelchair access as well as transportation to/from other facilities, and cost to the patients.

(6) Finally, continued research regarding medical and psychosocial aspects is both needed and desired as the advance-

ment of knowledge and practice in day care facilities depends upon the research performed and, subsequently, the utilization/dissemination of evaluation results. To put research to effective use, ultimately, social service agencies must translate findings into action. One of the lasting effects of evaluation research, for example, is the increased sophistication of the knowledge about how social programs operate. The general rise in such knowledge, according to Rossi, Freeman and Wright, has filtered "first into the administration of social programs, to some degree into legislative bodies, and possibly to a lesser degree to the general public"; these authors add:

It has made special inroads into the curricula in universities and may well serve as the knowledge base for the decision-makers of the future, whose training will be undertaken in those institutions. (1979, 307-8)

CHAPTER VI

SUMMARY

"The summary is a brief résumé of the major findings, conclusions and recommendations, and it should faithfully reflect phases of the investigation" (Gopal, 1965, 26).

The major findings in this research project were as follows.

- (1) Most typical of the Riverview Day Hospital patients were those that were of retirement age, Canadian by nationality, and living with their spouse; they had attained a secondary level of formal education and received an income of less than five thousand dollars per annum.
- (2) The majority of the respondents indicated that (a) their health, psychological, socialization, nutritional and transportation needs were met in the program to their satisfaction, and (b) they were satisfied with the services offered through the program. Identified as a problem area, from the Director's perspective, was transportation of day-patients via the Sunshine Bus; this problem was reflected in the reasons the respondents provided for their absence from program activities.
- (3) On the whole, participants in this study were satisfied with the program activities they attended as well as the

scheduling of the activities. Nonetheless, several patients indicated that the program could be improved by (a)expanding the program and (b)increasing the number of staff and/or volunteers. (The overwhelming majority of the patients in this study were in attendance at the day hospital no more than two days-per-week.)

- (4)The majority of the patients believed that the program did contribute to the improvement of their overall health in that they felt better about life in general.
- (5)Respondents reportedly sought admission to and continued in the day hospital program for personal (a)health reasons, (b)psycho-social reasons, and/or (c)reasons related to family needs or concerns.

The major conclusions reached by the researcher were:

- (1)Windsor Western's Riverview Day Hospital program did meet the preconditions of an evaluable program; and,
- (2)the decision-making system's understanding of the program was verified by data collected in monitoring the program's operation.

The major recommendations proposed in this evaluative study were:

- (1)that the decision-making system seriously consider expanding the Riverview Day Hospital program to meet the current needs of the population served and the growing

- demand for day care services;
- (2) that the Director of the program and hospital administration consider formally adopting the six objectives stated in "Hospitals without Beds" in Highlights, or objectives similar to these, and that their stated objectives be included in the Riverview Day Hospital's manual and public information brochure;
- (3) that a research component useful to program description and as an aid to impact assessment, cost-benefit and/or cost-effectiveness analysis, be incorporated into the program and, in considering the feasibility of this recommendation, that approaches such as presented and discussed in Evaluation: A Systematic Approach be reviewed;
- (4) that research be conducted to establish the cause-and-effect relationship between the day hospital goals and outcomes; and, that a report be developed which would serve as a basis for funding proposals and, subsequently, provide staff with the means to more effectively meet the needs of those requiring their services;
- (5) that continued research regarding medical and psychosocial aspects of day care services be conducted for the advancement of knowledge and practice.

APPENDICES

APPENDIX A

PARTICIPANTS IN THE ONTARIO CAMPAIGN
FOR COMMUNITY-BASED SERVICES

United Senior Citizens of Ontario
Pensioners Concerned - Ontario
Ontario Welfare Council
Social Planning Council of Metropolitan Toronto
Senior Centres Association of Ontario
Visiting Homemakers Association of Metropolitan Toronto
Canadian Red Cross - Ontario Homemaker Division
Ottawa Council on the Elderly
Community Care Services of Metropolitan Toronto
Anglican Diocese of Toronto
Council of Catholic Charities
Ontario Association of Homes for the Aged
Ontario Federation for the Physically Handicapped
Baycrest Centre for Geriatric Care - Toronto
Centre for Creative Living - Toronto
Association of Jewish Clubs - Toronto
Coordinated Services to Jewish Elderly - Toronto

APPENDIX B



UNIVERSITY OF WINDSOR

WINDSOR, ONTARIO N9B 3P4
TELEPHONE AREA CODE 519
253-4232

December 12, 1980

Ms. Janet C. Brosseau
Director, Riverview Day Hospital
Windsor Western Hospital Centre
Riverview Unit
3177 Riverside Drive East
Windsor, Ontario

Dear Ms. Brosseau

RE: Evaluation of Day Hospital Program

Enclosed is the questionnaire referred to in our recent telephone conversation. Please respond to the questions in terms of your role as Director of Windsor Western's Riverview Day Hospital.

Upon my receipt of the completed questionnaire, I would like to arrange a personal interview with you, perhaps in the last week of January. Since the questions posed will require some time and consideration on your part, please feel free to contact me if you are unable to complete it by the end of January or if you have any questions.

I sincerely appreciate your willingness to contribute to this research project, and assure you the follow-up interview will be less taxing.

Thanking you in advance,

Ms. Lynn T. Murphy
RN, MSW Candidate

Enclosure

WINDSOR WESTERN HOSPITAL CENTRE
RIVERVIEW UNIT

Questionnaire: Director of Riverview Day Hospital

1. A goal is a general and abstract statement of intent. Given this definition, please specify the goals of Windsor Western's Day Hospital program indicating their respective level of priority.

GOAL #	GOALS OF PROGRAM (IN ORDER OF PRIORITY)

COMMENTS

2. Given that an activity is a means of achieving a goal, please specify the program activities aimed at fulfilling each of the goals state in Question 1.

GOAL #	Program Act. #	PROGRAM ACTIVITIES

COMMENTS

3. What other mechanisms (ie. policies, guidelines) exist to achieve the stated goals?

A large, empty rectangular box with a black border, intended for the user to write their response to the question above. The box is vertically oriented and occupies most of the page's width and height.

COMMENTS

4. In the first column below, list by number only the program activities as recorded in Question 2 ("Program Act. #"). In the second column below, please state why each program activity is expected to lead to the fulfillment of the respective program goal. (Note that information is requested regarding the rationale linking program activities to program goals, not a detailed description of each activity.)

PROGRAM ACT. #	WHY ACTIVITY RESULTS IN GOAL FULFILLMENT

COMMENTS

5a. Please complete the following schedule of activities, indicating the number of patients (PT) participating in each activity and the number of staff/volunteers (S/V) attending the patients.

HOURS	DAY	#	#
	Monday	PT	S/V
8:30 - 9:30			/
9:30 - 10:30			/
10:30 - 11:30			/
11:30 - 12:30			/
12:30 - 1:30			/
1:30 - 2:30			/
2:30 - 3:30			/
3:30 - 4:30			/
<u>COMMENTS</u>			

5b. Please complete the following schedule of activities, indicating the number of patients (PT) participating in each activity and the number of staff/volunteers (S/V) attending the patients.

HOURS	DAY	#	#
	Tuesday	PT	S/V
8:30 - 9:30			/
9:30 - 10:30			/
10:30 - 11:30			/
11:30 - 12:30			/
12:30 - 1:30			/
1:30 - 2:30			/
2:30 - 3:30			/
3:30 - 4:30			/
<u>COMMENTS</u>			

5c. Please complete the following schedule of activities, indicating the number of patients (PT) participating in each activity and the number of staff/volunteers (S/V) attending the patients.

HOURS	DAY	#	#
	Wednesday	PT	S/V
8:30 - 9:30			/
9:30 - 10:30			/
10:30 - 11:30			/
11:30 - 12:30			/
12:30 - 1:30			/
1:30 - 2:30			/
2:30 - 3:30			/
3:30 - 4:30			/
COMMENTS			

5d. Please complete the following schedule of activities, indicating the number of patients (PT) participating in each activity and the number of staff/volunteers (S/V) attending the patients.

HOURS	DAY	#	#
	Thursday	PT	S/V
8:30 - 9:30			/
9:30 - 10:30			/
10:30 - 11:30			/
11:30 - 12:30			/
12:30 - 1:30			/
1:30 - 2:30			/
2:30 - 3:30			/
3:30 - 4:30			/
<u>COMMENTS</u>			

THANK YOU FOR YOUR TIME AND COOPERATION

APPENDIX C



UNIVERSITY OF WINDSOR

WINDSOR, ONTARIO N9B 3P4

TELEPHONE: AREA CODE 519
253-4232

May 19, 1981

Riverview Day Hospital
Windsor Western Hospital Centre
Riverview Unit
3177 Riverside Drive East
Windsor, Ontario

Dear Respondent

As a participant in Windsor Western's Riverview Day Hospital program, your cooperation is requested in completing the attached questionnaire.

An evaluative study of the day hospital program is being conducted. As a graduate student at the University of Windsor, I have undertaken this research project in partial fulfillment of the requirements for the Degree of Master of Social Work. The research is being directed by Professor Forrest C. Hansen at the School of Social Work; Professor Bernhard J. Kroeker, also of the School of Social Work, and Doctor Ann Henderson Diemer, Department of Sociology, are the other members of the Research Committee.

Please be assured that all information provided will be treated confidentially. Your name will not appear on the questionnaire or in the research report; all responses to the questionnaire will remain anonymous.

In anticipating your cooperation, I thank you in advance for your assistance in this project.

Sincerely,

Lynn T. Murphy
RN, MSW Candidate

Attached

WINDSOR WESTERN HOSPITAL CENTRE
RIVERVIEW UNIT

Questionnaire: Day Hospital Patients

PLEASE PRINT and ANSWER ALL QUESTIONS

Date of Birth: _____

Place of Birth: _____

Sex:

- _____ male
_____ female

Marital Status:

- _____ single
_____ married (or living in a common-law-marriage)
_____ separated
_____ divorced
_____ widowed

Living Arrangement:

- _____ living alone
_____ living with others; please state
relationship (ie. spouse; son; aunt; friend): _____

Employment:

- _____ unemployed (or retired)
_____ employed; please state occupation: _____

Income Bracket:

- _____ under \$5,000
_____ \$5,000 - 9,000
_____ \$10,000 - 14,000
_____ \$15,000 - 19,000
_____ \$20,000 - 24,000
_____ \$25,000 and over

Level of Education:

- _____ Primary School
_____ Secondary School
_____ Community College
_____ University

Please specify number of years completed: _____

In space below, please indicate all Day Hospital Program activities you are scheduled to attend.

TIME	DAY			
	Monday	Tuesday	Wednesday	Thursday
10:30 - 11:30				
11:30 - 12:30				
12:30 - 1:30				
1:30 - 2:30				
2:30 - 3:30				

Which of these statements express how you were referred to the Day Hospital Program (please circle your response to each statement):

- YES NO I was referred from Windsor Western Hospital Centre's Riverview Unit or I.O.D.E.
- YES NO I was referred through a social agency (ie. Victorian Order of Nurses; Stroke Recovery Association; Public Health Unit).
- YES NO I was referred by a relative or friend.
- YES NO I was self-referred.

Which of these statements best describes why you were referred to the Day Hospital Program:

- YES NO I was referred to the Day Hospital Program because of chronic ill-health or condition.
- YES NO I was referred to the Day Hospital Program because of temporary ill-health or condition.
- YES NO Is there any physical condition, illness or health problem that bothers you now?

Which of these things are you still healthy enough to do without help?

- YES NO Heavy work around the house like shoveling snow or washing walls.
- YES NO Travel half a mile (about eight ordinary blocks) either by walking or via wheelchair.
- YES NO Go out to a movie, to church or a meeting, or to visit friends.
- YES NO Walk up and down stairs to the second floor, or transfer from my wheelchair into a car seat.

Which of these statements fits you best:

- YES NO I cannot work or keep house at all now because of my health.
- YES NO I have to limit some of the work or other things that I do.
- YES NO I am not limited in any of my activities.

Using the following code, please circle your response to each of the statements below:

A = basically agree D = basically disagree

- A D In spite of what some people say, the lot of the average man is getting worse.
- A D It's hardly fair to bring children into the world with the way things look for the future.
- A D Nowadays a person has to live pretty much for today and let tomorrow take care of itself.
- A D These days a person doesn't really know who he can count on.
- A D There's little use writing to public officials because often they aren't really interested in the problems of the average man.

Please circle your response to each of the statements below using the following code:

- | | |
|--------------------------------|-----------------------------|
| 1 = strongly disagree | 4 = agree with reservations |
| 2 = disagree | 5 = agree |
| 3 = disagree with reservations | 6 = strongly agree |

	<u>S</u>	<u>D</u>	<u>D</u>	<u>R</u>	<u>A</u>	<u>S</u>
	<u>D</u>	<u>D</u>	<u>R</u>	<u>R</u>	<u>A</u>	<u>A</u>
My health needs are met to my satisfaction in the Day Hospital Program.	1	2	3	4	5	6
My psychological needs are met to my satisfaction in the Day Hospital Program.	1	2	3	4	5	6
My socialization needs are met to my satisfaction in the Day Hospital Program.	1	2	3	4	5	6
My nutritional needs are met to my satisfaction in the Day Hospital Program.	1	2	3	4	5	6
My transportation needs to and from the Day Hospital Program are met to my satisfaction.	1	2	3	4	5	6

Means of Transportation:

_____ Sunshine Bus
 _____ other; please specify:

The activities I attend in the Day Hospital Program are to my satisfaction.

1 2 3 4 5 6

In any case, please indicate how you think the activities you attend might be improved:

_____ provide for more staff and/or volunteers
 _____ provide for greater variety of activities
 _____ other; please specify:

The Day hospital Program activities I attend are scheduled to my satisfaction.

1 2 3 4 5 6

In any case, please indicate how you think the schedule of activities might be improved:

_____ increase number of program hours per day
 _____ increase number of program days per week
 _____ other; please specify:

The Day Hospital Program is contributing to the improvement of my overall health.

<u>S</u>		<u>D</u>	<u>A</u>		<u>S</u>
<u>D</u>	<u>D</u>	<u>R</u>	<u>R</u>	<u>A</u>	<u>A</u>
1	2	3	4	5	6

In any case, please indicate how you think you have changed as a result of your participation in the program:

_____ I am less limited in the number of things I can do for myself

_____ I feel better about life in general

_____ other; please specify:

Please circle your response to each of the statements below using the following code:

0 = don't know, never used service

1 = strongly disagree	4 = agree with reservations
2 = disagree	5 = agree
3 = disagree with reservations	6 = strongly agree

<u>D</u>	<u>S</u>		<u>D</u>	<u>A</u>		<u>S</u>
<u>K</u>	<u>D</u>	<u>D</u>	<u>R</u>	<u>R</u>	<u>A</u>	<u>A</u>

I think the following services offered through the Day Hospital Program are adequate:

-health monitoring (<u>ie.</u> x-rays; lab tests)	0	1	2	3	4	5	6
-nursing care (<u>ie.</u> medication; first aid treatment)	0	1	2	3	4	5	6
-self care training (<u>ie.</u> feeding; dressing; personal hygiene)	0	1	2	3	4	5	6
-physiotherapy	0	1	2	3	4	5	6
-occupational therapy	0	1	2	3	4	5	6
-exercise classes	0	1	2	3	4	5	6
-nutritional counselling	0	1	2	3	4	5	6
-craft activities	0	1	2	3	4	5	6
-leisure time activities	0	1	2	3	4	5	6
-socialization (<u>ie.</u> special outings; Christmas party)	0	1	2	3	4	5	6
-social work counselling	0	1	2	3	4	5	6
-liaison with family	0	1	2	3	4	5	6
-liaison with referring physician	0	1	2	3	4	5	6
-liaison with community services	0	1	2	3	4	5	6

Have you been referred to any other agency through the Day Hospital Program:

- no
- yes; please specify (a) what agencies you were referred to, and (b) what services you required:

If you were not a participant in the Day Hospital Program, would you have to make alternate living arrangements:

- no
- yes; what alternate living arrangements would you have to make:

- Chronic Care Hospital
- Rest Home
- Home for the Aged
- Nursing Home
- other; please specify: _____

Reason for having to make alternate living arrangements:

- it would be difficult for me to continue living alone without one or more services provided by a hospital
- it would be difficult for the one(s) I live with to assist me without one or more services provided by a hospital
- it would be difficult for the one(s) I live with to assist me during the day without any free time
- other; please specify: _____

Please circle the number of days per week that you are scheduled to attend in the Day Hospital Program:

1 2 3 4

In the last two or three months, approximately how many days per month were you unable to attend the Day Hospital Program:

_____ days

Reason for not attending all of my scheduled activities:

- transportation not always available
- worsening of condition for which I was referred to Day Hospital Program
- minor health problems unrelated to condition for which I was referred to Day Hospital Program
- do not need to attend as frequently as scheduled
- dissatisfied with program
- other; please specify: _____

APPENDIX D

OUTLINE OF CATEGORIES FOR SYSTEMATICALLY RECORDING DATA

1. Identifying data: Client characteristics (e.g., pertinent demographic and assessment data).
2. Target problem(s): (e.g., . . . depression).
3. Specific objectives and outcome indicators: (e.g., . . . find new friends for divorced depressed man; specific indicators of success identified).
4. Time limits: Amount of time for casework services, specified in advance.
5. Worker role(s): (e.g., clinical/behavior change; broker/advocate; educator/consultant).
6. Client tasks in relation to specific objectives: What client is to do in relation to the attainment of specified objectives. . . .
7. Worker activities: Specific techniques used to accomplish specific objectives. . . .
8. Review of client activities and accomplishments: This record is made at each interview and includes exactly what the client has done to accomplish tasks, 'homework'. . . .
9. Weekly evaluation of problem resolution and degree of attainment of objectives: This includes changes on whatever outcome measures are being used, the extent to which the client reports specific changes and to which the new behaviors are aiding the client in coping with problems. When data for Categories 7, 8 and 9 are collected at every interview, they allow a somewhat clearer establishment of the relationship among worker techniques, client activities, and goal-accomplishment.
10. Summary of worker activities: (includes specific techniques).
11. Summary of specific client activities.
12. Concluding evaluation of attainment of specific objectives: Each objective can be rated on a sliding scale from 1 meaning 'completely attained' to 5 meaning 'not attained at all'.
13. Overall evaluation of problem resolution: This could include a global rating on a sliding scale from 1 meaning 'completely resolved' to 5 meaning 'problem is worse'.
14. Amount of contact.
15. Follow-up plans.

FORM FOR SYSTEMATIZED RECORDING

1. Identifying data	2. Target problem(s)	3. Specific objectives and outcome indicators (a) - (b) (c)	4. Time limits	5. Workers role(s) (a) (b) (c)
6. Client tasks in relation to specific objectives (a) Objective Task (b) Objective Task (c) Objective Task	7. Worker activities in relation to specific objectives (a) Objective Techniques (a) (b) (c) (b) Objective Techniques (a) (b) (c) (c) Objective Techniques (a) (b)	8. Review of client activities and accomplishments Week 1 Objective (a) (b) (c) Week 2 (a) (b) (c) Week 3 (a) (b) (c) : (b) : (c) Week 8 (a) (b) (c)	9. Weekly evaluation of problem resolution and degree of attainment of objectives Week 1 Objective (a) (b) (c) Week 2 (a) (b) (c) Week 3 (a) (b) (c) : (b) : (c) Week 8 (a) (b) (c)	10. Summary of worker activities
11. Summary of client activities	12. Attainment of objectives (a) Objective (b) Objective (c) Objective	13. Extent of problem resolution	14. Amount of contact	15. Follow-up

APPENDIX E

THE DEVELOPMENTAL MODEL:

A STANDARD SUMMARY AND ANALYSIS OF DEVELOPMENT EXPENDITURE(S)

SECTION I: Background

- A. Describe the proposed development expenditure(s).
- B. Does this development expenditure duplicate a patient service provided by another hospital in the area? Yes ___ No ___
If yes, what hospital(s)?

- C. Does this proposed development expenditure require approval by comprehensive health planning? Yes ___ No ___
If no, explain why not.
- D. Is there evidence to believe that the development expenditure will favorably affect any hospital service or department other than that most directly affected? Yes ___ No ___
If yes, explain.

SECTION II: Incremental Economic Analysis

Purpose: To provide the information required to determine the economic benefits of the development expenditure in relation to other proposed expenditures.

A. Required Initial Investment

	Cost	Depreciable Life (years)	Annual Depreciation
Capital expenditures—attach support including installation cost		=====	=====
Special training cost	=====		
Initial expenditure	=====		

B. Expected Additional (Incremental) Revenue

Unit of Service	Projected Annual Volume		Suggested Patient Charge
	Inpatient	Outpatient	
a.			
b.			
c.			
d.			

Annual Incremental Revenue

Inpatient	Outpatient	Total

C. Expected Annual Incremental Operating Cost Increases (Decreases)—attach detail in support of each factor

	Incremental Annual Cost
Personnel	\$ _____
Employe benefits @12%	
Physician cost	
Materials and supplies	
Maintenance contracts	
Insurance	
Other	_____
Total incremental annual cost	\$ _____

D. Incremental Financial Analysis (to be completed by treasurer)

- Let X = Total annual revenue = _____ (B)
- X₁ = Annual inpatient revenue = _____ (B)
- X₂ = Annual outpatient revenue = _____ (B)
- Y = Total operating cost = _____ (C)
- Z = Allowable depreciation = _____ (A)
- $\frac{X_1}{X} \times (Y + Z) = Y_1$ = Inpatient operating cost* = _____
- $\frac{X_2}{X} \times (Y + Z) = Y_2$ = Outpatient operating cost** = _____
- E = Total initial expenditure = _____ (A)
- Present value = Present value of \$1 received each year for 5 years @ 6% interest** = 4.212
- 68.5 = % cost reimbursers inpatient
- .03 = % bad debts inpatient
- .20 = % contractual allowances & bad debts outpatient

Formulation:

Gross revenue	X
Less	
Contractual allowances inpatient	- .685 X ₁ + .685 Y ₁
Bad debts inpatient	- .03 X ₁
Contractual allowances and bad debts outpatient	- .20 X ₂
Net patient revenue	X - .715 X ₁ - .20 X ₂ + .685 Y ₁
Operating cost	- Y
Net incremental revenue (NIR) =	X - .715 X ₁ - .20 X ₂ + .685 Y ₁ - Y

Net present value of project:
4.212 (NIR) - E = net present value = \$ (attach calculations)

*If the project or expenditure does not result in new revenue but does affect operating cost, use 12 per cent as outpatient and 89 per cent as inpatient cost.

**In order to properly analyze the return from investment, it is important to realize that the hospital could invest its funds in other investments and make a return. Here six per cent is an acceptable return. That being the case, a dollar received one year from now is worth only 94¢ as compared to a dollar received now. An initial expenditure made now would be made in current dollars while the payback will be in dollars which, when compared to current dollars, are worth less. Five years is used as a standard payback period.

SECTION III: Subjective Evaluations

A. Physician Impact

1. Will this expenditure or project result in a change in physician attitude toward the hospital? Yes ___ No ___
If no, ignore the remainder of A and proceed to B.
2. What is the scope of the physician attitude change? (Check one.)
___ a. One or two physicians will be affected.
___ b. The majority of the physicians in a hospital service will be affected.
___ c. A substantial portion of the medical staff will be affected.
Explain your answer. (Attach memorandum.)
3. What is the intensity of the effect on physician attitude? (Check two answers—one for acceptance and one for non-acceptance.)

Not Accepted

- 4 The physicians affected will move their practices to other hospitals.
- 3 The physicians affected will tend to reduce their practices at the hospital.
- 2 The physicians affected, at the very least, will be disgruntled and will tend to discuss the lack of the expenditure or project in the community and with other physicians.
- 1 The physicians will be aware of the lack of support for the project and expenditure and will be less likely to believe that the hospital is maintaining a proper level of patient care.
- 0 No effect

Accepted

- 1 The physicians affected will be aware of the expenditure or project and will be satisfied that the hospital is maintaining a high level of patient care.
- 2 The physicians affected will be very impressed and will tend to discuss the expenditure or project favorably in the community and with other physicians.
- 3 The physicians affected will tend to moderately increase their practices at the hospital.
- 4 The physicians affected will move their practices to the hospital.

Explain these answers.

B. Community Impact

1. Will this expenditure or project have an effect on community attitude toward this hospital? Yes ___ No ___
If no, proceed to C.
2. If yes, check the answers below which best describe the expected community impact. (Check one for acceptance and one for nonacceptance.)

Not Accepted

- 4 Intense and widespread negative reaction in the community will result in a severe blow to the hospital's image.

- 3 A widespread negative effect on the hospital's general image and reputation will result.
- 2 The hospital's image will be damaged among certain groups in the community.
- 1 The attitudes of a relatively few people will be negatively affected.
- 0 No effect.

Accepted

- 1 Relatively few people will be positively affected.
- 2 Certain groups in the community will be favorably impressed.
- 3 A widespread positive effect on the hospital's image and reputation will result.
- 4 Significant and widespread positive community reaction will contribute significantly to the hospital's general image and reputation.

Explain these answers.

C. Employee Impact

1. Will this expenditure or project have an effect on the attitude of the hospital's personnel? Yes ___ No ___
2. If yes, check the answers which best describe the expected employee impact. (Check one for acceptance and one for non-acceptance.)

Not Accepted

- 4 Major and widespread negative impact on employee morale and attitude toward the hospital will result.
- 3 Widespread disappointment with the hospital and some general negative effect on the hospital's image among employees will result.
- 2 A limited group of employees (one or two departments) will react negatively.
- 1 Relatively few employees will be disturbed.
- 0 No effect.

Accepted

- 1 Relatively few employees will know about the decision, but they will be pleased.
- 2 A limited group (one or two departments) will be very pleased.
- 3 Nearly all employees will be pleased.
- 4 Major and widespread positive impact with long-term effect on employee attitude toward the hospital will result.

Explain these answers.

DEVELOPMENT ANALYSIS SCORE SHEET

	Item No.	Instructions	Value To Be Assigned	Raw Score	Priority Instructions	Priority Score	
Economic Evaluation	Section II						
	A3	If total initial expenditure is less than \$25,000	-	+1			
		If total initial expenditure is more than \$25,000		-1			
	C4	If total annual incremental cost increase is less than \$50,000		+1			
		If total annual incremental cost increase is greater than \$50,000		-1			
	D	If present value is equal to or greater than zero		+2			
		If present value is less than zero		-2			
		Total economic score				If total economic raw score is greater than zero, enter raw score in priority score column.	
	Subjective Evaluation	Section III					
		A2a			1	Not applicable	
A2b				2	If A3 is greater than 4, the priority score is 1.		
A2c				3	If A3 is greater than 4, the priority score is 3.		
A3		Add positive and negative answers		1-8	If raw score exceeds 4, the excess is priority score.		
B		Add positive and negative answers		1-8	If raw score exceeds 4, the excess is priority score.		
C		Add positive and negative answers		1-8	If raw score exceeds 4, the excess is priority score.		
		Total subjective score					
	Total Score						

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VITA AUCTORIS

Lynn T. Murphy was born in Montreal on the 23rd of September 1948. Following graduation from an American high school in 1967, she attended Patricia Stevens Career College in Chicago and, one year later, was granted a diploma in photographic modeling.

Ms. Murphy is a registered nurse with current Ontario Certificate of Competence, and a member of St. Joseph's School of Nursing Alumni Association since 1973. Following a one year period of employment at Toronto General Hospital, she worked at Addiction Research Foundation for two years in the capacity of staff nurse and group therapist.

In 1976 she enrolled in the social work degree program at Ryerson Polytechnical Institute. Her field placements included practice in intervention (Toronto General Hospital), community organization (Scadding Court Community Centre), and research at the Ministry of Community and Social Services - Queen's Park. During her fourth academic year she was contracted as a writer/researcher by the Ontario Secretariat for Social Development; this endeavor resulted in the publication of a discussion paper on behalf of the On-

tario Advisory Council on Senior Citizens.

Ms. Murphy was accepted in the graduate social work program at the University of Windsor in 1980. Her specialization was administration, and her practicum was with the Ministry of Community and Social Services. She was contracted by the University as Graduate Research Assistant to the Director and Assistant Director of the School of Social Work.

As of April 1981 she has been a member of the Ontario Association of Professional Social Workers (OAPSW). In August she was a panelist for Sociologists for Women in Society (SWS) at the 1981 American Sociological Association (ASA) meetings. In the session "Older Women in Canadian and American Society" conducted at the University of Toronto, she presented a paper regarding strategies to non-institutionalization, social assistance programs and community-based services operating in Canada.

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