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THE PSYCHIATRIC DAY HOSPITAL : AN EVALUATION OF 4 YEARS' EXPERIENCE

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The principles that the patient should spend the least possible time in hospital and that as much as possible should be done for him in a visiting, rather than a resident capacity, are well established in medicine and psychiatry. The logical extension of this is the concept of the day hospital for the treatment of mental illness. In practise this fills a gap between consultant and out-patient services, on the one side, and in-patient hospitalization on the other. By day hospital is meant an organization where the patient attends during the day only over a period of time, and where he receives whatever treatment may be necessary and returns to his home in the evening. The advantages of this are obvious. The cost is less; the patient is spared the inconvenience and emotional disturbance consequent on his being uprooted from home and family; there is a diminished risk of 'institutionalization' (always a danger to be avoided in psychiatry with its large proportion of chronic cases and persons unable to fend for themselves adequately in the outside world); and the transition on discharge from a sheltered hospital world, when the patient is still to some degree convalescent, is made easier because he was never really isolated from his normal surroundings in the first place. In addition, the principle of day hospitals is in keeping with advanced thinking in psychiatry as described in the 5th Report of the WHO Expert Committee on mental health.[1] In this report it is advised that the mentally ill are best treated in their own community as far as possible. The 3rd report[2] of the abovenamed body is based on the same premise and the Expert Committee record their opinion that day hospitals represent a distinct and important addition to the means of treating psychiatric patients. Every community hospital should consider the establishment of a day-patient section.

Day hospitals are a comparatively recent development; the first organized endeavours were made in Montreal in 1946 and they were described by Cameron[3] in 1947. As a result of this work centres have been established elsewhere, notably in England, where Bierer[4] and Aron and Smith[5] report good and encouraging results. Although day hospitals are particularly suited to the needs of psychiatric patients, they have an application in other fields of medicine as well, for instance, in geriatrics, and work in this sphere has already been commenced in Oxford.

In this article our experience gained in the day-hospital section of Tara Hospital in Johannesburg is reported. It covers a 4-year period since 1954, when it was first established, and an attempt is made to analyse certain practical and theoretical problems which concern a psychiatric day hospital. During this period a total of 432 patients have passed through this day hospital (with an average of 108 admissions per year). These 4 years have provided a varied and fairly extensive experience of the workings and management of such a hospital. As the day-hospital section of Tara has been a pioneer venture in this field in South Africa, in many ways experimental, it has been felt that the experience gained should be shared with others who are interested in the possibilities of day hospitals.

FUNCTIONS OF A PSYCHIATRIC DAY HOSPITAL

The functions of a psychiatric day hospital correspond fairly closely to those of an in-patient hospital. In addition, however, the following special features must be enumerated:

1. *Observation and Investigation of Mental Illness.* Very often patients presenting in routine practice need observation of their behaviour and psychic processes in a more continuous fashion, and more comprehensively, than can be achieved on an out-patient basis. The day hospital is an ideal venue for this purpose and it does not entail removing the patient from his home. Furthermore, because all facilities needed for such investigation are aggregated under one roof, and the patient is continuously present, psychologists, social workers, clinical pathological laboratory, etc., can speedily carry on their work.

2. The day hospital is an *active treatment centre* where the majority of the conventional and current psychiatric therapies can be administered. In psychiatry we are fortunate because the patient can often be treated without having to stay in hospital at night, for instance by means of psychotherapy, electro-convulsive therapy and various drug treatments. Electro-convulsive therapy is suitably given in the day-patient setting. The patients arrive at the hospital early in the morning before breakfast. They then have their treatment, and after a short recovery period spend the rest of the day engaged in the many therapeutic activities of the hospital, e.g. occupational therapy, relaxation therapy and recreational therapy. Tara Hospital is perhaps somewhat exceptional in this respect because extensive facilities for

therapeutic occupation exist. Therapeutic occupation fills the major part of the patient's day. It is quite feasible, however, that in institutions with less developed facilities of this nature, other arrangements, in which the patients can participate, can be made.

Another range of activities which are duly accentuated in this hospital, is group psychotherapy of different types, and most day patients attend these sessions daily. Those patients who need specialized forms of psychotherapy, either individually or in a group, are further dealt with by a special psychotherapy unit. Milieu therapy plays an important role in the day hospital. Its main aim is to encourage the patient to take an active part in his own treatment. This serves to discourage passive, regressive psychopathological trends which may result from too much care and control in hospital; it helps to counteract the isolation of the self from the environment (a constant feature of mental illness), and it tends to keep the patient in contact with those aspects of life which are external to the hospital and which demand activity, enterprise and initiative in the conduct of daily life. A bridge towards rehabilitation is thus built. The means by which this is accomplished are described elsewhere by Moross and Gillis,[6] and will not be dealt with here except to say that a significant part of this therapy rests upon the fact that patients are expected to assume some responsibility for the running of the day hospital through committees, representatives, and general discussion of communal affairs.

3. The day hospital may serve as *a diagnostic device* for the screening of patients. The patient can then, if not suitable for day hospitalization, and according to his condition, be transferred to the in-patient section of the hospital or referred to a special clinic; or arrangements can be made for his admission to a mental hospital if he is grossly psychotic.

4. *Rehabilitation* of the psychiatrically ill is an important function of the day hospital, and right from the beginning efforts are made to facilitate the patient's rehabilitation to his family, his work and the community in which he lives. On discharge, therefore, he may, without further loss of time, and without psychological or material obstacles, take up his ordinary life again.

5. Another function of the day hospital which operates in conjunction with an in-patient unit, is its use as *a stepping-stone* towards full participation of the patient in his community. For example, in-patients at Tara Hospital are often transferred to the day hospital before discharge so that they can gradually become adjusted to a fuller participation in their ordinary activities.

ORGANIZATION OF THE DAY HOSPITAL

Patients attend daily from Mondays to Fridays from 8.30 a.m. to 4.30 p.m. They report to the sister-in-charge on arrival and then disperse to their various treatments and hospital activities. Great emphasis is placed on regular attendance, and on arriving and leaving on time. It has been found very necessary to insist on this in view of the nature of many psychiatric illnesses. For instance, depressed patients may, and usually do, feel particularly bad in the mornings and 'not up to coming out'. They stay away, therefore, when they are most in need of treatment. With other patients fear of therapy may have the same effect, or the state of inertia, induced by the illness, may operate. Still others, driven by a morbid desire for isolation and withdrawal, will stay away to avoid the socializing influence of the hospital. Much supervision is necessary and all late or non-attendances must be discussed with the patient. Should a patient suddenly cease to attend, either he or his relatives are contacted by the nurse working in the community service. She may go out to visit him, investigate his difficulties and induce him to return.

In order to afford a picture of what the patient is doing whilst in hospital, the following account of the time spent weekly in various activities is given. It is only a general estimate for it varies from patient to patient:

Occupational therapy: about 20 hours per week.
Special treatments:
Interviews with psychiatrists: } 4-5 hours per week.
Group therapy:
Relaxation therapy: about 1-1½ hours per week.
Physical education and sporting activities: 8-9 hours per week.
Rest and meal periods: 6-7 hours per week.
Group meetings, excluding group psychotherapy: 2-3 hours per week.

In a day hospital run in conjunction with in-patient facilities as at Tara Hospital, constant endeavour is required to keep a close coordination of day patients with the rest of the hospital so that they do not become a split-off group among themselves. There are several reasons why this is necessary, the most important being that this particular hospital is conceived, and operates, as a single, coherent, therapeutic structure. Much of the benefit of hospitalization is a result of the processes of group interaction, socialization procedures, and the interdependence and teamwork of the hospital population. These processes are vitiated or minimized by the splitting-off of any particular section within the hospital. How this is achieved is described elsewhere.[6]

In order to facilitate group interaction day patients and in-patients mix and work together freely in all hospital activities, e.g. they mix in the occupational therapy department, they attend the same group therapies, participate in sporting and recreational activities together, and they use the same dining room. It has been found, however, that a separate focus for day patients is necessary without encouraging them to form a separate group. What is required is something that corresponds to the ward duty room for in-patients, where they can be given their medicines, where administrative matters can be attended to, and where they can raise immediate problems and requests. In addition we have found that they tend to feel themselves 'loose bodies' in a highly organized hospital structure unless some central gathering point is available. The arrangements described above are the result of the experience at Tara Hospital, and some of them arise only because of the mixed population of in-patients and day patients. In other hospitals where only day patients are admitted the problem does not occur, although the experience in general will probably correspond with our experience.

Staffing Arrangements

We have found that one senior psychiatric nurse with some experience of this kind of work is usually able to deal with 40 patients—except under circumstances of stress. She has a special and difficult role to fill because much of the control normally exercised for in-patients is lacking in the day hospital as the patients are not under expert supervision at night; the diet is difficult to supervise, and day patients absent themselves more easily from hospital than in-patients. It is a problem of greater dispersion of day patients in contrast to closer agglomeration of in-patients, who are more easily kept under observation and control. For this reason we have

found it necessary to train nurses specially for the day hospital.

As regards medical attention, we have found that 1 experienced psychiatrist can handle 30-40 patients. It must be remembered that at Tara Hospital some, at least, of the patients are treated concurrently by other agencies, e.g., in the physical treatment units and in the psychotherapy unit. Conceivably, were these facilities not available 1 psychiatrist might find himself unduly taxed and more might have to be employed. In addition there is a full staff of social workers, occupational therapists, relaxation therapists, a psychologist and other ancillary personnel, who attend to both day patients and in-patients. A day hospital operating autonomously will need similar staff of its own, although it may be possible that some of them need only be employed part-time.

CASES SUITABLE FOR TREATMENT IN A DAY HOSPITAL

Only a proportion of the psychiatric cases presenting in doctors' consulting rooms or in out-patient departments are suitable for treatment in a day hospital of the type described above. Suitability depends on two general groups of factors which are dealt with separately a follows:

A. *Limitation of Suitability imposed by Factors External to the Patients' Psychiatric Condition*

1. Patients who are domiciled in areas distant from the hospital, or where they are not able to avail themselves of regular hospital transport (which runs from the centre of Johannesburg), are unable to attend the day hospital. It is surprising, however, to note how many patients come from as far afield as Springs, Pretoria and Krugersdorp.

2. Physical disability or infirmity of age sometimes makes it difficult for patients to attend; e.g., concurrent heart disease or hemiplegia.

3. Financial or domestic considerations, as with the destitute man with a family to support, or the housewife and mother who cannot leave the family all day, also play a part. These obstacles to daily attendance can usually be dealt with by the social worker but on occasion they constitute an absolute bar to day-hospital treatment, and other arrangements for treatment must then be considered.

B. *Limitations of Suitability imposed by the Patient's Psychiatric Condition*

An analysis of the diagnosis of 357 cases treated in the day hospital during the 3 years 1955-57 reveals the following composition. For comparison the composition of in-patients by diagnosis is also given.

Diagnosis	*Percentage Incidence of Total*	
	Day patient	*In-patient*
Anxiety reactions	21·8	33·9
Hysteria	5·3	7·5
Obsessional compulsive states	2·5	1·2
Occupational neuroses	0·1	0·7
Hypochondriasis	3·1	2·4
Neurosis—other and unspecified	5·6	3·4
Neurotic or reactive depression	9·5	10·6
Severe depression, including manic depressive psychosis	17·9	15·3
Schizophrenic illness	6·2	8·7
Paranoid states	3·1	0·7
Behaviour disorder	0·8	1·3
Adjustment reaction of adolescence	3·4	—
Personality disorders	11·5	9·3
Addiction and chronic alcoholism	1·4	5·0
Not diagnosed	4·0	—
Other conditions	3·8	—

These figures demonstrate that classification by diagnosis for in-patients and day patients are highly comparable and that, generally speaking, a day hospital can deal with the same type of case as an in-patient hospital like Tara Hospital. There are, however, certain differences of practical importance irrespective of diagnosis. The day patient must not be so severely disturbed as to constitute a nuisance or a danger which his family or his normal community cannot control while he is not at the hospital. If he tends to wander off and get lost, or has strong and irresistible suicidal inclinations, or shows irresponsibility and lack of control of his behaviour, e.g. failure to attend hospital regularly; or, if by virtue of his symptoms he causes an undue disturbance at his home at night;—if for these and other similar considerations the patient cannot be managed in a day hospital, he should be treated elsewhere. For the same reasons, chronic alcoholics and drug addicts are particularly difficult to handle in a day hospital because they can obtain their drug with ease from outside and thereby negate the effect of treatment.

The limiting factor to admission is therefore not the diagnosis, but the nature and the degree of the disorder. If the patient will and can attend regularly, and if his behaviour is satisfactory at home during the rest of the time, he will be suitable for the day hospital. In practice, a large proportion of psychiatric cases do conform to these requirements, and our opinion, which has gathered weight with increasing experience, is that many cases previously only considered suitable for in-patient hospitalization can now be equally well treated as day patients. In fact, at Tara the in-patient waiting lists are scanned periodically to detect likely cases for the day hospital, and in this way many patients are treated earlier, less expensively, and as effectively as they would have been treated as in patients. In addition, the in-patient waiting list has been shortened considerably.

In order to define our experience regarding the suitability of cases more accurately, and also to throw light on selection procedures, it has been helpful to analyse a series of 128 consecutive cases treated during 1957 in respect of length of stay, reasons for leaving hospital, patterns of attendance, and the improvement obtained. The results of this analysis are as follows:

1. The average length of stay of day patients was 32 days, as compared with 45 days for in-patients. The difference is probably accounted for by the fact that, in general, in-patients were more seriously ill than the day patients.

2. A significant finding was that nearly 50% of the day patients stayed less than 2 weeks in hospital. This is not a satisfactory state of affairs because it is unlikely that such a large proportion of psychiatric cases will improve sufficiently for discharge within such a short period. Investigation of these cases revealed the following reasons for their short stay:

(*a*) 32 cases had been previously treated as in-patients for varying periods and were transferred to the day hospital pending arrangements for discharge. In these cases the day hospital was legitimately used as a stepping-stone before discharge.

(*b*) 20 cases (30% of those who left within 2 weeks) discharged themselves, usually without notifying the doctor, or against his advice. Many of these cases were unsuitable for treatment in the first place, or came to hospital only under the pressure of family or friends and against their own wishes. Some felt they were not psychiatrically ill, and others had gross neurotic fears and urges which prevented them from

accepting the recommended treatment. This, however, is not a problem which is confined to the day hospital only; it is spread through the whole field of psychiatry, and a very similar proportion of cases fail to take advantage of either out- or in-patient treatment in this and other hospitals. This fall-out becomes of more importance in institutions such as the day hospital, where the patient is free to dictate his own actions regarding treatment.

(*c*) The remaining cases were found to be so grossly disturbed on admission that they were unsuitable for treatment in a day hospital—they needed to be confined or have custodial care—or their physical and material circumstances were such that daily attendance was impossible, e.g. they suffered from disabling heart disease, lived too far away, etc.

This high initial fall-out rate emphasizes the great need for careful selection before admission, and in practice it has been found necessary to screen all cases at an initial interview. This initial interview has been made a *sine qua non* at this hospital and seems to have resulted in a lower fall-out rate, although no actual figures are available as yet.

3. The remaining cases stayed in hospital for periods ranging from 2 to 10 weeks. In only 8 cases was it necessary for the patient to remain longer than 10 weeks.

4. Regarding improvement on treatment, results were found to be comparable with those of in-patients; that is, about 70% of cases improved to different degrees. This is a general assessment and it includes such criteria of improvement as removal of symptoms, occupational adjustment, insight, interpersonal relationships, personality reorientation, and better adjustment in general. A more detailed report on these results will be published later. In general it was found that the more regularly a patient attended the day hospital, the better was the ultimate result.

5. The cost of day hospitalization is substantially less than that of in-patient hospitalization. No wards or ward equipment are necessary, and the patients get only the midday meal in hospital. An estimate of the running costs per patient-day made at Tara Hospital, alloting to day patients a 'pro rata' share of all relevant expenses, including salaries, medical services and equipment, meals, linen, the services of ancillaries such as occupational therapy, physiotherapy, and other amenities, shows that day hospitalization in this hospital costs at least one-third less than full in-patient hospitalization.

SUMMARY

1. There is an ever-growing need for psychiatric facilities, and day hospitals should be regarded as an effective and relatively inexpensive way of providing for a considerable segment of the psychiatric needs of the community. The operation of day hospitals is in line with the present-day psychiatric thinking that the psychiatric treatment centre should be as open and accessible to the community as possible, and that the patient should be removed from his community as little as is feasible whilst he receives treatment.

2. A selected group of psychiatric patients can be treated in a day hospital but many patients previously thought suitable only for in-patient treatment can be dealt with quite adequately on a day-patient basis.

3. The day hospital should be an active treatment centre where all current therapies can be carried out on a short-term basis and one of its main functions should be the rehabilitation of the patient to his community. The day hospital will function best in conjunction with other psychiatric facilities such as out-patient departments, long-stay units, neurosis centres, etc. Nevertheless, even in areas where these are limited or do not exist, the day hospital will provide, relative to its cost, a considerable service.

4. The establishment and maintenance of a day hospital are likely to cost considerably less than other institutional treatment because it is a non-residential organization. Purpose-designed buildings are not essential, neither is lavish equipment, and two of the most effective institutions known to me (the Marlborough day hospital and the Maudsley day hospital, both in London) operate quite modestly in converted old houses. It is essential, however, to have premises which are large enough, a fully equipped occupational-therapy unit, and the services of experienced psychiatric nurses, occupational therapists and social workers, etc. Some of these can function on a part-time basis.

5. A survey is given of the organization and experience of the day-patient section of Tara Hospital, embracing a period of 4 years.

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