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THE DAY HOSPITAL: AN EXPERIMENTAL FORM OF HOSPITALIZATION

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A new form of hospitalization has been set up on an experimental basis in the Allan Memorial Institute of Psychiatry and has been in operation since April 1946. It has been evolved out of an arrangement of psycho-sociological and economic factors which differs in certain important respects from that found in the customary types of hospitalization.

Those who have had the job of organizing departments of psychiatry in general hospitals have commonly planned them in a way which as closely as possible resembles that in which the other departments of the hospital are organized. This is in part an expression of the policy of breaking down in the minds of the hospital staff, of the patients and of their relatives the concept that psychiatric illness is different from all other forms of illness. In part it arises from the vaguely thought out conviction that the ways of administering hospital care which have been successful in the general hospital will serve to raise the standards of efficiency when transferred to the department of psychiatry.

A number of the methods and ideas which psychiatric departments have taken over from other departments of the general hospital have most assuredly proved themselves useful and productive. But we have also taken over some methods and ideas which, while they have validity in many of the divisions of the general hospital, have none in the psychiatric department. Indeed, in many instances they constitute an actual handicap to us. Among those which clearly are useful throughout all departments of the hospital are the interne system and the consultation service. Among those which are well entrenched in the other departments - such as surgery, internal medicine and gynaecology - but which have little or no validity when transferred to the psychiatric department, are the concepts that: (i) hospital is a place where the patient goes to bed; (ii) hospital is a place where a patient stays until he is well, or as well as the

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doctor can make him; and (iii) hospital is a place where only the patient is treated.

Having recognized this, we have begun to experiment with new kinds of hospital settings in which to furnish psychiatric treatment more effectively. The particular form which I wish to describe is the Day Hospital. This is a unit which gives expression to the fact that psychiatric patients do not require to stay in bed; that they do not have to remain in hospital until they are well, and indeed often do not get well if you try to make them stay; and that it is not only the patient, but his family unit and his general social setting which require to be treated.

Patients come to the Day Hospital at 9:00 a.m. and remain throughout the daylight hours, receiving the appropriate forms of treatment. At 4:30 p.m. they begin to go home, and the ward is closed at 5:30 p.m.

All types of patients are admitted, the only criterion being that they should be well enough to stay home overnight. Some idea of the range of such patients is afforded by considering the number of people who, in these days of overcrowded hospitals, have to remain on the waiting list - and therefore at home - for many months.

An appreciable proportion of our patients suffer from early forms, or relatively mild advanced types, of schizophrenia. Both hypomanic and depressive patients have been successfully treated in the Day Hospital. We carry in the Day Hospital, as does everyone who has an office practice, patients who are hallucinating and patients who have been expressing suicidal ideas. In deciding whether or not to admit such patients to the Day Hospital or to the rest of the Hospital, we have to weigh their assets - how well they are socialized, how well they are integrated into their family group, and the reliability of that group. We have to assess, of course, our psychoneurotic patients in

precisely the same way. We have had at least as much difficulty in managing severe psychoneurotic reactions in the Day Hospital as we have had in dealing with psychotic individuals.

On occasion, patients originally admitted to the Day Hospital have had to be transferred to the day-and-night division of the Institute. Typical situations which have led to transfer are illustrated in the following four consecutive instances:

The first patient's condition deteriorated rapidly during the first three or four days after admission. She became so anti-social and disorganized that she no longer fitted into the setting. The second said that she felt that the difficulties which she had with her husband when she went home quite offset the gains which she had made during the day, and she requested 24-hour hospitalization. The third, who was suffering from a degree of mucous colitis, found it hard to remain on a strict diet at home. The fourth woman, suffering from anxiety and severe repressed hostility, became during the course of psychotherapy so aware of her hostility towards her mother, with whom she was living, that it was felt wiser that she should remain in hospital while this aspect of her therapy was going forward.

From this it will be understood that the Day Hospital should be thought of as extending and supplementing the work of the day-and-night hospital. It may be that, for certain categories of patients at least, it will eventually take its place, but at present the Day Hospital should be operated in association with a day-and-night hospital.

In practice, we have found that those patients who were first admitted to the ordinary day-and-night division of the Institute and then transferred to the Day Hospital make a somewhat better adjustment than those who were admitted directly to the Day Hospital. The first group tend to feel that their transfer

to the Day Hospital indicates progress; moreover, by this time they have established relations with the Institute staff and are accustomed to the technical procedures. Some of those who were admitted directly from their homes to the Day Hospital encountered some difficulties in terms of their stereotypes of what hospitals should be like. One or two of them felt that because they did not go to bed, and because they went home at night, this was not really hospital care. This, however, can be offset in a large measure by careful planning of the patient's first day in Hospital, ensuring that the nature of his experience in Hospital is explained to him, and ensuring also that the patient has an opportunity within the first few hours to obtain some of the things which he had anticipated he would receive, among these being an opportunity to state his problem in as great detail as possible to a member of the psychiatric staff.

At first, all patients admitted to the unit were women, but later, after we had established the Day Hospital principle on the men's ward, we brought men and women patients together for certain therapies, such as group psychotherapy and occupational therapy. Two hundred and nineteen (219) patients were treated during the first twelve months' period. The duration of stay was about five weeks.

The origin and disposal of these patients will be seen from Table I. The kinds of treatment which can be furnished within this setting are shown in Table II. Some of these treatments required special modification in view of the fact that we do not observe these patients over a 24-hour period. In particular, insulin coma therapy was modified to the extent that the insulin was administered intravenously, and the onset of coma was hastened by the addition of sodium amytal. Efforts were made to limit the amount of confusion and memory disturbance arising in consequence of the electro-convulsive therapy by using the uni-directional type of apparatus and by work carried out, by Dr. J. Beaubien and Dr. J.S. Tyhurst,

upon the use of vaso-dilators. We may say that confusion in Day Hospital patients undergoing electro-convulsive therapy has disappeared as a problem.

One of the major advantages of this type of hospitalization is that the patients do not have the complete break with their homes which takes place when they enter a day-and-night hospital. Thus the therapist, the patient and the home remain much closer, and the patient and therapist can work in a setting much more akin to that to which he must finally be adjusted than is the case where the patient is removed entirely out of his everyday situation.

In consequence, we have found that the Day Hospital setting has been most suitable for the carrying out of our plans to develop more adequate psychodynamics and psychotherapeutic concepts. It is commonly agreed that many of those in current use, while therapeutically fruitful, do not lend themselves to experimental verification. It is also agreed that many of the ways of conceptualizing human behavior employed by the social sciences are readily adaptable to experimental validation, but do not so easily lend themselves to therapeutic use.

Accordingly, we have been actively engaged in exploring new ways of conceptualizing both directive and non-directive therapy, with respect alike to their therapeutic value and to their amenability to research methods.

In all this, our work has been rendered more vital, the issues more living, more vivid and pressing, by reason of the fact that the patient remains in daily, in realistic, relation with the problems of his home and his general social setting.

This new design has enabled us to obviate the "escape into hospital", the retreat into the private room, the regressive surrender to all-pervasive direction, that surrender which is only too willingly made by people who want to give up and be told.

At this point I should like to stress the fact that a great deal depends upon the ability of the supervisory nurse to create the most adequate psychological climate in the Day Hospital.

In regard to costs, it can be said that, at the outset, in view of the fact that we put twice as many patients in the same floor space, we undertook to cut by half the rates charged elsewhere in the Institute. Hence our public ward patients pay $3.00 per day, our semi-private patients $4.00 and our private patients $5.00. The City has agreed to recompense us for the care of indigent patients on the same basis as we are recompensed for patients elsewhere in the Institute, and we are at present negotiating with the Blue Cross to accept this plan of hospitalization as coming under the various hospitalization plans.

Figures for twelve months' operation indicate that we were able to operate at a per capita per diem cost of $2.16. During that year we supplied approximately 5,000 patient days, the Day Hospital being closed on Sundays.

It is our impression that this form of hospitalization can be extended not only within psychiatry, but also into other departments of medicine. There seems no reason, for instance, why it should not be applied to certain categories of patients within the departments of internal medicine and gynaecology. It could certainly be applied in the new convalescent, rehabilitation and resocialization units which are planned for addition to some of the leading hospital centres.

Finally, I may say that we consider that this is only one of many new kinds of setting which may be devised to supplement, and perhaps to replace, the older forms of isolation and immurement behind the walls of the general hospital.

Many factors are conspiring to increase the demand on the part of the public for hospitalization. Among these is the progressive loss on the part of the family of its former capacity to care for its sick members, due to the smaller size of the family unit and the fact that the women members are, to a greater

extent, becoming employed outside the home. Another general factor is the necessity for expensive equipment and highly trained staff, which can be most expeditiously centralized at the hospital. A third factor is that, to an increasing degree, medical care is now administered by a team rather than by an individual.

It is becoming clear that no building program, however ambitious, can hope to meet the very great demands which have already been made, and the still greater demands which will be made, for treatment in hospital. If, however, we take as our guiding principle that, as far as possible, treatment should be provided _at_ the hospital rather than _in_ the hospital, we can very reasonably expect to see coming out of this a series of adaptations and inventions such as the one outlined in this paper, which will permit all hospital centres to give intensive medical care to very considerable numbers of patients, without the necessity of providing the most expensive form of hospitalization, namely, "in bed" care.

TABLE I

ORIGIN AND DISPOSAL OF PATIENTS IN DAY HOSPITAL

ORIGIN			
Direct Admissions	105	Home	164
From rest of Institute	105	Institute (day-and-night)	34
From general wards, R.V.H.	5	Wards of R.V.H.	3
Re-admissions	4	Died	1
		Committed	1
		Remaining in Day Hospital	16
	219		219

Note: The number transferred from the Day Hospital to the rest of the Institute is high because of policy of admitting a certain number of patients to the Day Hospital for work-up prior to admission to the rest of the Institute.

TABLE II

FORMS OF THERAPY USED IN DAY HOSPITAL

Individual psychotherapy
Group psychotherapy
Occupational therapy
Weight-raising insulin
Somnolent insulin
Coma insulin
Adrenalin desensitization
E.C.T. (low voltage, uni-directional)
E.C.T. (alternating current)
Narco-analysis
Conditioned reflex treatment of alcoholism
Endocrine and vitamin therapies