A DESCRIPTIVE SURVEY OF ADULT PSYCHIATRIC
DAY TREATMENT CENTERS IN BRITISH COLUMBIA

by

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Date July 20, 1923
ABSTRACT

A DESCRIPTIVE SURVEY OF ADULT PSYCHIATRIC DAY TREATMENT CENTERS IN BRITISH COLUMBIA

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At the present time there is very little informational data available relating to the adult psychiatric day treatment centers in the province of British Columbia. In recent years the trend in psychiatric care has been to treat people within their family and community setting. Within the past five years, four new day care centers have been established at various hospitals throughout the province of British Columbia. The purpose of this descriptive survey was to provide a composite picture of the currently functioning adult psychiatric day care centers.

A total of five official and two unofficial day care programs were surveyed and 290 patient records were examined. The specific areas of interest in day care functioning centered around; the family and community involvement in the treatment program, the types of treatment that were used, the type of role the staff carried out, the total program evaluation and a profile of the patients who were treated by this modality. To collect the data, the researcher used; a questionnaire which was answered in a taped interview, observational visits to each center, and an examination of the patients' records.

The results of the questionnaire indicated that family involvement in the total day program was generally limited, group methods of treatment were used which gave the patients a sense of community, and patients were followed-up either by the day care center or by the referral source. Referral of patients to these centers were mainly from in-patient wards, other psychiatrists and psychiatric clinics. The criteria that was used to terminate a patient's treatment was on the basis of his actual performance in
the program and his level of functioning at home and in the community. This was also the prevalent method used to evaluate the effectiveness of the total treatment program. Staff in these day care centers were both permanent and rotating with their role function being both specific and generalized.

An examination of the patients' records revealed that the average patient was 33 years old, generally female, single, diagnosed as being depressed, above Grade 11 in education and presently unemployed. Seventy-seven per cent of the patients had previously received psychiatric treatment and the length of stay in the treatment program was 54 days.

Findings from this study indicated that a wide variety of patients were treated in day care, which, had these centers not been available, would have been admitted to an in-patient ward. Day care is not only an alternative to hospitalization, but it may be the choice method of treatment for many patients.
ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to the many people who have helped to make this study possible. To the directors and the staff working in each of the seven day care centers who so willingly gave their time, effort and full co-operation during the data collection period of this study. To the members of my committee, Dr. A. Crichton and Mrs. E. Warbinek for the continued help and support that they provided throughout this study. I would especially like to thank Miss M. Horrocks, the chairman of my committee for her continued interest and guidance in the progression of this study.
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CHAPTER I
INTRODUCTION

The concept of treating adult patients in a psychiatric day centre dates back to 1957 in British Columbia. Since that time, five day treatment centres have been established. Four of these are located in Greater Vancouver and one is located in the Northern section of the province. Several other treatment centres are in the early planning stages. The psychiatric day treatment programs have generally evolved by two different methods. One, being the formalized planning and implementing of a program prior to patients being admitted to it, and secondly, where former patients return to the psychiatric ward on an informal basis, and are incorporated into the ward program. It is when these "visiting" ex-patients become quite numerous that a formal day program is set up. At the present time there are several informal or unofficial programs operating in conjunction with an established psychiatric in-patient unit, within the general hospitals. Therefore, this present study was undertaken to provide a systematic body of knowledge relevant to the existing psychiatric day treatment centres in British Columbia.

The Choice of the Problem

At the present time there is very little informational data available relating to the adult psychiatric day treatment centres in the province of British Columbia. The design of this descriptive survey was to generate a body of systematic knowledge to provide some basis for general statements to be made. Hyman states:

Further the descriptive survey by providing data on the rarity or universality of some phenomenon and its distribution socially gives guidance as to what type of determinants might lead to the most fruitful hypotheses. 1

It was not feasible to formulate a hypothesis, as the modest aim of this study is to describe objectively the phenomena of day treatment centres.

I. THE PROBLEM

Statement of the Problem. The purpose of this study was to provide a composite picture of psychiatric day treatment centres in British Columbia as they relate to adult patient care. Increasingly, more people are seeking help and guidance for their problems in daily living and a large number of these people are being seen and treated in psychiatric day treatment centres. How are these treatment centres set up so that maximum patient benefit can be derived? What categories of people are receiving this type of care? How are the patients referred to the day treatment centre? What family and community involvement is there with the patient in his treatment program? These are some of the questions which this survey attempted to answer in providing a general description of the day treatment centres.

The empirical generalization is a summary statement about facts derived by systematic methods...In many areas of health care research, it is necessary first to assemble such ordered facts before it is possible to move to more refinement of meaning.2

Significance of the Problem. In recent years the trend in psychiatric care has been toward treating people within the family and the community setting. One reason for this trend may be cited as: "Community care extends the number of situations in which relatively normal social roles can be learned or resumed by the patient."3 Increasingly, more people are receiving out-patient treatment, day care treatment and follow-up treatment.


Specifically within the last 15 years, both official and unofficial treatment centres have been established at various hospitals throughout the province of British Columbia. Several advantages have been cited by Cumming, for the use of day treatment centres. These are: the "sick role" is usually not as prominently displayed by the patient; a value system is adopted through treatment which generalizes to the patients' home situation and there is also an economic factor involved, where less monies are required for treatment facilities. These basic advantages for day care have also been cited by Herz et al. With regard to the efficacy of a psychiatric day treatment centre, a study carried out by Wilder et al., they conclude that:

The findings of the applicability study and this two-year follow-up study indicate that the day hospital was a feasible treatment modality and was generally as effective as the in-patient service in the treatment of acutely disturbed patients for most or all phases of their hospitalization.

According to the literature, day treatment centres operate on the principle that the needs of the patient are being met so that treatment benefits are derived. How is this treatment modality evaluated? Unfortunately, there is a scarcity of literature pertaining to the evaluation of these treatment centres in terms of patient

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benefits. Thus, one pre-requisite before evaluation can take place is to be aware of the existing facilities and how they operate. The purpose of this study was to become familiar with these treatment centres as they relate to adult patient care.

II. DEFINITION OF TERMS USED

Adult. This term designates a female or a male who is 19 years of age or over.

Psychiatric Day Treatment Centre. This is defined as a formal, on-going program of activities and treatment which is attended by patients who have emotional problems. "The service is designated for patients with mental or emotional disorders who spend part of the twenty-four hours of any one day in the program." In this study, the patient population attended the program for three or more days per week on a regular basis until they were discharged.

Unofficial. This term is synonymous with informal, to designate a day care program which does not receive specific Governmental funding. The patients coming to these day care programs are incorporated into the total in-patient structure and activities.

III. LIMITATIONS OF THE STUDY

This study was limited by: a) the size of the sample, b) the type of questionnaire, c) the type of setting.

The size of the sample. The decision to examine a sample of 50 patient profiles from each of the five official treatment centres was an arbitrary one. This selected population may or may not have provided a representative picture of the type of patients and the centres under study. In the two informal day care programs that were

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studied, a total of 20 patient profiles were examined, as the total number of attending day patients was greatly reduced.

The type of questionnaire. The questionnaire that was used in this study covers many complex areas of the functional psychiatric day treatment centre. In order to get the required informational data, a broad generalized approach to each area was chosen instead of delving in-depth into only one or two areas.

The type of setting. The intent of this study was to deal exclusively with the formalized adult psychiatric day treatment centres. This excludes treatment provided once or twice a week, or weekly maintenance groups. The setting of this study took place in the five officially designated day treatment centres in the province. Two of the existing unofficial programs were examined to provide an indication of the type of activities engaged in, and the patient population using this treatment modality.
CHAPTER II
REVIEW OF THE LITERATURE

A. Historical Perspective

Historically, the first day treatment centre in Canada was established in Montreal, in 1947 by Cameron. This unit treated both convalescent in-patients and patients who would normally be admitted to the hospital wards. The diagnostic categories of the patients cared for in this day treatment centre ranged from "early schizophrenia," "depressed" and "hypomanics." Initially, there were twenty patients attending the program, six days a week. In 1954 the existing facilities were enlarged so that 40 patients could be accommodated. The writer was able to gain first hand knowledge and experience by working in this day care program in 1968. The successful results of this day centre may have helped to initiate the establishment of psychiatric treatment centres in other areas and to hasten its acceptance as a treatment modality.

In England, Bierer in 1951, is credited with describing the first day hospital, which was entirely independent of the existing mental hospitals. This Marlborough Day hospital functioned with a community orientation and the length of patient attendance varied. The types of treatments rendered to the patients included both physical and group care. By 1959 there were "...45 psychiatric day-hospitals and day centres of all types..." In 1958-9 the passage of the Mental Health Bill indicated a shifting of psychiatric care from mental

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institutions to the community. "One of the main principles... (was) the re-orientation of the mental health service away from institutional care towards care in the community." This Bill gave further impetus to the establishment of day centers within the community, whereby the patient received treatment but was not separated from his family and social setting.

In the United States, the Menninger Clinic established a day hospital in 1949. The patients who attended this day hospital came from a wide geographical area and foster homes were provided while they were under treatment. By 1959 there were approximately 25 day hospitals in full operation. Since that time, this form of treatment modality has increased very rapidly in all areas of the United States. Guy and Gross cite one reason for this rapid expansion as: "The awareness of, and the dissatisfaction with, the limitations of huge custodial hospitals makes us seek eagerly for alternatives." In the province of British Columbia, a day hospital was established in 1957 at the Mental Health Center in Burnaby. Treatment was afforded to a diverse group of patients who were categorized as acutely disturbed, schizophrenic and character disorders. A structured program was carried out which emphasized communication patterns, behavioural skills and patient responsibility.

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B. Day Treatment Centres

A recurring definition of a psychiatric day hospital is the one that is given by Craft:

...as one where full hospital treatment is given under medical supervision...It is suitable for those of the mentally ill who are well enough to travel and to spend the night with their families.7

This article reviewed the literature pertaining to day hospitals and it was found that "a wide variety" of mental disorders were being treated with similar treatment modalities as that on the in-patient wards. Craft also found that there were two limiting factors to day care. These being:

a) the patients' geographical location

b) the "quality" and receptiveness of the patient's family or relatives in the home.

In an attempt to overcome the first limitation of geographical distance, foster homes have been used to lodge the patients. An inherent draw-back to the use of foster homes is that the patient is removed from his family and community setting. "...after a prolonged absence, the patient cannot re-enter the community and start again exactly where he left off."8 The patient, his family and the community may become accustomed to a separation and they may adopt a satisfying life style which inhibits disruption. In this regard Gove and Lubach further state:

Thus, if the patient has an extended stay in the hospital, the skills he needs for performing effectively in the community will gradually atrophy and he will develop a new set of skills which are adapted to a setting...9

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7 Craft, loc. cit.


9 Ibid.
The attitudes and responses of the relatives of patients who were treated in a day hospital was the focus of a study by Odenheimer. The sample of the relatives that were studied was small—a total of seven. The results showed that all but one of the relatives voiced dissatisfaction when the patient was admitted to a day hospital and not to an inpatient ward. This treatment modality was experienced by the relatives as being "unwanted and anxiety-provoking." This would indicate that in order for the day hospital to be a successful community based service, guidance and support must also be given to the family members of the patient. In summing up this study Odenheimer stated:

A survey of relatives' statements about the admission procedure, their interaction with the day hospital staff and their family members in treatment at the time of admission and during the first week after admission, has shown that certain, albeit unstructured, supportive measures on the part of staff can materially minimize the relatives' resistance.

The attitude of the general public indicates that inpatient treatment is more acceptable for emotional illness, than is day care treatment. Suchman states: "The value system of a society helps to shape the public's attitudes, beliefs and behaviour in regard to health and illness."

C. Aims of Day Treatment Centers

In common with all other organizations, day treatment centers have been established to perform a primary task or objective. Set within a broad framework this task is to help the patient cope with

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11 Ibid.

his emotional problems. Astrachan et al. presented four objectives around which day hospitals may be designed. The day hospital may provide:

a) "an alternative to 24 hour inpatient hospitalization
b) a transitional care setting whose task is to facilitate the re-entry into the community of previously hospitalized patients
c) a treatment and rehabilitative facility for the chronically mentally disturbed
d) a structure which delivers those psychiatric services which a specified community defines as an over-riding public need."\(^{13}\)

Thus each day treatment center would be established on the basis of the specific task or objective which is deemed most appropriate to that specific environmental situation and community need. Since the day hospital operates in an open system, a working relationship with the community and the environment is essential for total day care functioning.

The length of time that a patient would spend in the day treatment center would depend on such factors as: the type and severity of his illness; his past coping patterns and his outside supportive resources. Meltzoff and Blumenthal in their description of a day treatment center state that:

If we are to have a significant impact on a patient, succeed in breaking up long established behaviour patterns, and give opportunities for learning a new repertory, sufficient interaction time with the patient is essential.\(^{14}\)

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D. Evaluation of the Program

Evaluation or the extent to which the program achieves the stated objectives is a difficult process. Craven approaches evaluation of a program in terms of goal achievement.

The basic and distinguishing characteristic of program evaluation is that program goals or objectives are stated and the evaluation is then designed to determine the degree to which the goals were reached.\(^{15}\)

Increasingly, the cost of health care is rising at a rapid rate. Thus the cost-benefit factor for all programs need to be evaluated to see if the objective of adequate patient care has been met.

Therefore, on a cost-benefit basis, day care is one of the most economical forms of psychiatric treatment. This economy extends to space requirements, efficient use of staff and retention of community ties which shorten the rehabilitation period.\(^{16}\)

In terms of evaluation of a day treatment program, Guy and Gross state that two types of assessment procedures are necessary. These being:

a) a terminal assessment which would measure the immediate treatment effects or results

b) a follow-up assessment to evaluate the permanency of the treatment effected.\(^{17}\)

This would indicate the necessity of stating a definite criteria for success of a treatment program. This criterion may deal with the amount or slope of observable patient improvement, length of hospital stay or the rate of remission.


\(^{17}\)Guy and Gross, op. cit., p. 117.
Service programs have progressed much more rapidly than evaluation and research on the programs and effectiveness of centers, but the latter are being planned.18

E. Disadvantages of Day Treatment Centers

The day treatment center, along with the many advantages as a treatment modality, also has some recognized disadvantages and inherent problems. Some of the negative aspects include the following:

a) the center can be under-utilized, this may be due to the selection procedure or that the referring agencies are not aware of this treatment facility

b) the patient and his family may not view the program as an acceptable treatment modality, since the concept of day care does not conform to the inpatient model. Thus the needed family support may be lacking.

c) there may be a higher risk with suicidal or homocidal patients

d) it may be more mentally fatiguing for the working staff in the center, because of the structure of the program, to help the patient cope with his problems

e) the drop out rate could be higher than it is for inpatient care. "...one possible explanation for the high, early drop out rate could be, of course, that the patient simply does not find anything in the program that seems useful and worthwhile to him."19

f) the geographical distance between the patient and the treatment center.


F. Future Trends

"During the last hundred years psychiatric care of patients has changed from almost complete institutionalization to a diversity of treatment forms." In the future, will the day treatment center replace the inpatient wards for psychiatric care? The shifting trend is such that the patient, the family and the community share a greater responsibility in the care and treatment of emotional illness. "More recently the emphasis has been on independent day-care centers existing separately from inpatient psychiatric facilities."  

The advantages and the disadvantages of day treatment centers which provide care to patients with emotional problems, have been the topic of many articles and books. As yet, no definitive conclusion has been reached. Cumming, in his summation stated:

It seems likely, at least in the field of the delivery of services, that we are seldom going to find new ways of delivering care which will entirely supersede a previous mode... For the present we will have to act on the basis of informed good sense.  

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20 Congdon, op. cit., p. 244.


22 Cumming, op. cit., p. 32-33.
CHAPTER III

DEVELOPMENT OF THE STUDY

A. Background of the Study

The literature relating specifically to the psychiatric day treatment centers in British Columbia was scanty. Two recent papers by Cumming were relevant to this study, but the objective of these papers was not to provide a descriptive summary of the available centers. One initial problem encountered by the writer, was to discover the location of each adult psychiatric day care center in this province. A contributing factor here may have been, that within the past year or two, there has been an increased interest in establishing this type of treatment modality. After the day care centers were located, they were then contacted by mail and in Greater Vancouver by a personal visit, as to their willingness to participate in this study.

Numerous psychiatric wards which are located within general hospitals had unofficial programs, where former patients came to the ward during the day and were incorporated into the ward structure and activities. One important assumption here is that, these former patients may be maintained outside of the hospital because the staff devotes time and attention to the people and their problems. A possible re-admission into the in-patient facility may therefore be prevented. This type of unofficial program does not receive Governmental funding.

B. Personal Background

The researcher has been actively involved in the delivery of psychiatric care for the past four years. During this time the trend toward day care, out-patient care, and the prevention of in-
patient admissions has been more and more evident. The initial contact with day care treatment for psychiatric patients was in 1968 at the Allan Memorial in Montreal. The basic assumption that many patients do not require the specialized services of an in-patient ward and that other resources were able to provide a continuity of patient care, stemmed from this personal experience. In 1971, this writer was fortunate to participate in the planning and implementing of a day care program in another province. The resultant interest in this method of delivering health care to psychiatric patients in British Columbia seemed to be a natural outcome.

C. The Patient Population

In this study, informational data was collected on 50 patients from each of the five official day treatment centers. In the two unofficial centers, a total of 20 patient records from each center, were examined. This reduction in number was due to a reduced patient intake who did not meet the criteria of attending for three days on a regular basis. The total number of patient records that were sampled was 290. The patients included those who were actively involved in the treatment program at the present time, and to make up the total compliment of 50 patients from each area, data were obtained on the most recently discharged patients. The criteria that was used for inclusion in this study for the patient population was:

a) female or male adult
b) attendance at the program for three or more days per week on a regular basis
c) a total attendance in day care for six or more consecutive treatment days
d) presently involved in the program and the most recently discharged patients.

D. Day Care Setting

There are four day care centers located in Greater Vancouver and one center is located in the northern interior section of British
Columbia. Two unofficial centers, which are located in central British Columbia were also examined. This survey is not a sampling of the available psychiatric day care centers, as all of the existing programs participated in this study.

The respondents for the taped interview varied with the centers, but all were in direct control and active participants in the total treatment program. These respondents included; a nurse, a psychologist, two psychiatrists, and an occupational therapist. In the two unofficial programs, the nurse in charge of the in-patient ward was interviewed. Initially the writer had planned to interview jointly the two people directly in charge of each program, for example, the psychiatrist and the nurse. But this plan was revised when the time factor was taken into consideration. Since each of the centers functioned with a limited number of staff, it was not deemed equitable to request the time of two staff members at the same time.
CHAPTER IV

THE RESEARCH DESIGN

The aim of this survey was to provide a composite picture of the current functioning of the existing adult psychiatric day care centers in British Columbia. Therefore, the use of a descriptive survey was deemed to be the most feasible method of focusing attention on the natural distribution and the relationship of the variables found within these day care centers. "Naturalistic methods attempt to extract the elements of a naturally occurring complex of variables without the intrusions of direct manipulation or constraining controls." The survey procedures used to collect data in these centers consisted of a questionnaire, observational visits and the patient records.

A. The Questionnaire

The construction of this questionnaire was based on the assumption that the existing psychiatric day care centers have many commonalities. One assumption here, is that family and community support is essential before a patient can attain and maintain a higher level of functioning. This formed the basis for the question relating to family involvement in the patient's total treatment program. Lamb, in an article on chronic patients states:

It was also found that the patients' level of functioning in the community had a much higher correlation with the expectations of the significant people of their environment rather than with symptomatic expression of their illness.²


Several other assumptions relevant to the construction of this questionnaire were:

a) that day care is an effective treatment modality
b) long term care is not essential, nor is it always desirable, in helping people cope with life situations or to learn new relationship patterns
c) an on-going evaluation of any type of health care delivery system or organization is imperative
d) each individual person has a responsibility for his own behaviour and actions

This questionnaire was designed to provide an indication of the current functioning of the day care center. Prior to the data collection each respondent was given a copy of this questionnaire for their perusal. The questionnaire was then answered via an hour long tape recorded interview with the writer. The use of a scheduled list of questions was deemed necessary to ensure that the relevant information was obtained during each interview. But these interviews were not so rigidly structured as to prevent elaboration on any topic related to the functional operation of the center. Unscheduled questions were also asked of the respondent, which added to the writer's understanding of that center. "Interviewing is both a direct source of information on belief and knowledge systems and a form of vicarious observation to increase case examples of various types of overt behavior."  

Some of the questions were more relevant to some centers than to others. For example; the question of who referred the

patient to the center, was more related to a large city center, than it was to a town where the hospital was the only medical facility. The questionnaire that was used in these interviews is included in Appendix A.

The use of a tape recorder in each interview was necessary so that the obtained information would be an accurate representation of the conversation. These taped interviews yielded an average of eleven pages for each center, which proved too lengthy to be included in their entirety. Therefore, each answer was selected and a shortened version of the transcript for each center has been included in Appendix B. Due to the limited number of adult psychiatric day care centers in the province, a pre-test of the questionnaire in one of the centers was not carried out.

B. Observational Visits

Two observational visits were made to six of the psychiatric day care centers, the other center received one visit of a six hour duration. These visits normally varied from one to four hours in length. The purpose of the visits were two-fold; one, to enable the writer to become familiar and to gain a certain degree of knowledge about these centers, and secondly, to obtain the informational data from the taped interview with the respondent.

It was not the intent to actively participate in all the patient activities that were carried out in each center. The writer directly observed some of the patient activities, but this varied with each center dependent upon the activity in progress, the time period and the staff that was involved. With regard to observational visits Blau and Scott state: "...the observer would do well to keep constantly in mind that he is playing a social role in a social situation and to adapt his role to his research objectives."  

C. Patient Records

To provide a patient profile of the patients who attended each day care center, certain variables were obtained from the charts that are kept on each person. The records of the patients presently engaged in treatment plus the most recently discharged were used to equal a total of 50. A structured form was used to ensure that the relevant information was obtained from each record. Throughout this study, all the statistical calculations were taken to the nearest decimal point. In the two unofficial day programs, a patient profile was obtained from examining the records of 20 of the patients who were presently coming up to the ward, and those who had attended in the first three months of 1973. Complete records were not always kept on these patients, therefore areas such as education or written objectives were not readily available.

In each center, the records that were kept on the individual patients varied a great deal in the format that was used. In one area the recorded focus was on past performance and behaviour, in another center the goals of the patient were emphasized and the progress he made to achieve those goals. This variance in record keeping gave credence to the question that is often cited in the literature regarding the reliability of the records that are kept on the patients, especially when they are later used for informational purposes.
CHAPTER V

METHOD OF ANALYSIS

A descriptive analysis will be given for each of the seven day centers that were examined in this survey. This will provide the essential background information and introduction to each of these areas before proceeding to make generalizations from this data. This survey generated informational data relevant to:

a) the patient population that attended the day care centers  
b) the type of treatments provided  
c) the involvement of family members  
d) the staffing pattern in the centers  
e) the present functioning of the centers  
f) the physical facilities of the centers

The time period for this data collection commenced on March 26, 1973 and it was completed on April 27, 1973.

Description of Day Care "A"

A. General Description

This day care program began operating two years ago in the hospital psychiatric ward, with limited physical facilities. In February, 1973, the day care program moved into a separate house, which is located about two blocks from the hospital. This building presently provides spacious areas for the various activities that take place. At the time of this survey, the day care program was still in the process of "settling in" with regard to activities and remodeling the facilities. Operational costs are covered by Governmental funding. Patients attend either a full time program or a part time one (Monday to Wednesday) dependent upon their specific needs.
The average age of the patients attending this program was 33.0 years, with males being slightly older. The average number of treatment days per patient was 29.2. The largest marital category for both female and male was; single, being 46 per cent of the population. The category of unemployed comprised a total of 45 per cent of the patients. About one-third of the day patients had been hospitalized previously within the past five years, a similar number had previously seen a psychiatrist and the remaining one-third had not received previous psychiatric treatment. Transportation to this area is fairly adequate.

The present day care facility provides several large rooms and also smaller areas in which program activities can take place. This writer attributed the more relaxed atmosphere and group activities to the fact that this program did not occur in the medically orientated hospital setting. Some recreational activities take place within the total community. The hours of operation are from 9:00 a.m. to 4:00 p.m., on a Monday to Friday basis. The staff consists of three registered nurses, a part-time social worker, occupational therapist and a psychiatrist. The average number of patients in this program was twelve, when this survey was conducted there were nine patients.

B. Objectives

The theoretical aims which govern the operation of this day care program were taken from a 1972 Report. These were stated as:

a) To provide the patient with simultaneous exposure to a rather intensive therapeutic artificial and natural environment.

b) To provide a non-medical therapeutic setting.

c) To provide a therapeutic community which stresses the general characteristics of individuality, trustworthiness, positive reinforcement, responsibility, the provision of activity and a proper working day structure.
d) To provide a multiple interlocking group therapy, which provides the potential for learning and interaction.

C. Patient Profile

A descriptive patient profile of day care "A" which was gleaned from 50 patient records can be shown by:

a) Average number of patients in treatment - twelve.
For the first three months of 1973, there were a total of 50 patients or 16.7 patients per month. In 1972, the average number of patients was 7 per month.

b) Mean age of patients - 33.0 years.
Female - 30.7 years, with the range being 19 to 58 years.
Male - 35.4 years, with the range being 20 to 59 years.

c) Sex - Female, 72 per cent
Male, 28 per cent

d) Marital status can be shown by:

<table>
<thead>
<tr>
<th></th>
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<th>Married</th>
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<td>Female</td>
<td>32%</td>
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<td>6%</td>
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<tr>
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<td>8%</td>
<td>4%</td>
<td>2%</td>
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</tr>
</tbody>
</table>

e) The mean days of treatment was - 29.2 days.
Female - 29.1 days, with the range being 9 to 48 days.
Male - 29.3 days, with the range being 6 to 44 days.
The 9 patients presently engaged in treatment were not included in these statistics.

f) The educational categories can be shown by:

<table>
<thead>
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g) The occupational categories can be shown by:
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<thead>
<tr>
<th>Professional</th>
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<td>Male</td>
<td>4%</td>
<td>8%</td>
<td>12%</td>
<td>0</td>
</tr>
</tbody>
</table>

h) Diagnostic category:
- Depression - 48%
- Personality Disorder - 36%
- Others - 16%

Description of Day Care "B"

A. General Description

Day Care "B" was the first one to be established in this province, and has been in operation for the past 16 years. A unique aspect of this program is that the physical facilities were especially constructed to house a day care hospital. The physical layout is quite spacious with sufficient areas for meetings and relevant activities. This day care is not attached to, or located in close proximity to either a psychiatric or a general hospital. Initially, this day hospital provided largely somatic types of treatment. Funding for this program is provided through the Mental Health Branch of Government. Transportation to this facility presents a problem and a car is a definite asset, if not a necessity.

The average patient stay at this day care program was 73.0 days with males staying predominantly longer. The female to male ratio was fairly equal in number. The mean age of the patients was 29 years. The educational level was usually above Grade 11, (66%) and 50% of the patients were unemployed prior to coming for treatment. Once again, the single status was the highest for both female and male at 56%.

This day care operates from 8:45 a.m. to 3:45 p.m., on a Monday to Friday basis. Each day is fully structured with group
activities, occupational or recreational therapy. One period a week is spent in a community activity. The permanent staff consists of one registered nurse, four psychiatric nurses, a psychiatric aide, three occupational therapists and a psychiatrist-director.

B. Objectives

The written aims as outlined in the information sheet which is given to the patients for this day hospital, can be shown in the following four functions.

a) We believe that human beings are responsible for their behaviour, that is, they must accept the consequences of that behaviour.

b) We concentrate on problems in the here and now, rather than trying to deal with the past since we believe that people can change their present behaviour and thus alter their future.

c) We encourage direct honest communication between all members both of ideas and feelings as they arise.

d) We encourage the development of skills and interests as this increases the capacity to gain competence and satisfaction and use time effectively.

C. Patient Profile

A descriptive patient profile of day care "B" which was gleaned from 50 patient records can be shown by:

a) Average number of patients in treatment - 30. For the first three months of 1973, the average number of patients was 32.6 per month. In 1972, the average number of patients was 33.0 per month.

b) Mean age of patients - 29 years. Females - 29.5 years, with the range being 19 to 48 years. Males - 28.5 years, with the range being 20 to 59 years.
c) Sex - Female, 56 per cent  
Male, 44 per cent  
This female to male ratio was also observed by those patients presently involved in the treatment program.  
d) The marital status can be shown by:  
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 e) The mean days of treatment was - 73.0 days.  
Female - 55.0 days, with a range of 7 to 146 days.  
Male - 91.0 days, with a range of 6 to 162 days.  
The 21 patients presently engaged in treatment were not included in these statistics.  
f) The educational categories can be shown by:  
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g) The occupational categories can be shown by:  
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</tr>
<tr>
<td>Male</td>
<td>6%</td>
<td>8%</td>
<td>24%</td>
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</tr>
</tbody>
</table>

 h) Diagnostic category:  
Personality Disorder - 32%  
Schizophrenic - 36%  
Depression - 24%  
Others - 8%  

Description of Day Care "C"  
A. General Description  
Day care "C" is located in a semi-isolated, basically a line industry supported, interior community. This semi-isolation
may provide fertile ground for emotional problems that are not encountered in a large populated city. The psychiatric in-patient service and the day care program at the hospital, serves people from the surrounding geographical areas. The only additional service for patients with emotional problems is provided by the Mental Health Center located in this community. Transportation to these two facilities does present a problem, not only to people living in the outlying areas of the town, but also for people from the smaller surrounding towns.

This day care was initially started in 1969. The program presently operates from about 9:00 a.m. to 4:00 p.m., on a Monday to Friday basis. Governmental funding provides for the daily operational costs. This day care program is closely aligned with the in-patient services, as there is a sharing of the staff and the available physical space. This program is loosely structured as staffing, and the physical facilities are limiting factors. There is one practicing psychiatrist in this community. Some recreational activities take place within the community setting. When this survey was conducted there were 17 patients in the program, which was more than the average number. Most of the patients in this program are referred from the in-patient ward, as a transitional phase before the patient returns fully to community living.

B. Objectives

The objectives of this day care program were expressed verbally as being:

a) To help people cope with their emotional problems and to return to family and community living.

b) To treat people without admission to the hospital wards.

c) To help alleviate the acute bed shortage.
C. Patient Profile

A descriptive patient profile of day care "C" which was gleaned from the 50 patient records can be shown by:

a) Average number of patients in treatment - 10.
For the first three months of 1973, there were a total of 10 patients per month. In 1972, the average number of patients was 7 per month.

b) Mean age of patients - 38.4 years.
Female - 37.7 years, with the range being 19 to 64 years.
Male - 39.2 years, with the range being 19 to 53 years.

c) Sex - Female, 74 per cent
Male, 26 per cent

d) The marital status can be shown by:

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e) The mean days of treatment was - 28.5 days.
Female - 23.0 days, with the range being from 7 to 94 days.
Male - 34.0 days, with the range being from 6 to 103 days.
The 17 patients presently engaged in treatment were not included in these statistics.

f) The educational categories can be shown by:

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<td>Female</td>
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<td>36%</td>
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<tr>
<td>Male</td>
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g) The occupational categories can be shown by:

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<tr>
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<td>12%</td>
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<tr>
<td>Male</td>
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<td>14%</td>
<td>10%</td>
<td>0</td>
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</table>

h) Diagnostic category:
Depression - 62%
Schizophrenic - 16%
Anxiety Reaction - 8%
Others - 14%
Description of Day Care "D"

A. General Description

Day care "D" was one of the resultant programs which occurred in 1971, when a re-organization of the day care services took place at one of the hospitals. Initially, a day care follow-up program had been established on each of the three in-patient wards. From this, day care "D" and "E" were set up. Day care "D" operated within the hospital setting for one and a half years, prior to moving into its separate present facility two months ago. This facility consists of a large house, located about one block from the hospital. Governmental funding provides for daily operational costs of this program.

The mean age of the patients attending day care "D" was 27.8 years, with females being slightly older. The educational level of the patients was 90% in the Grade 11 and above category. The largest occupational bracket was the unemployed, which totaled 42% of the female - male population. Females out-numbered males 2 to 1 in this program. The average length of stay for each patient was 6 weeks. The marital status of 50% was in the single category, with married patients totaling 36%. Transportation, at selected times, is better in this area than it is to some other areas of the city, but a car is still a definite asset to reach this facility.

Patient activities take place in a spacious house, which has several large rooms and several smaller areas. The patients are responsible for the daily maintenance of the house and of the surrounding grounds. Recreational activities take place in the community setting. The hours of operation are from 9:00 a.m. to 4:00 p.m., on a Monday to Friday basis. The staff consists of a psychiatrist, a psychologist, a nurse, an occupational technician and two rotating Medical Residents. The average number of patients in this program was 20. When this survey was conducted there were 17 patients engaged in the program.
B. Objectives

The written objectives for this day program are six in number. These are:

a) To assess neurotic patients who demonstrate good motivation for treatment, by intensive group psychotherapy, in the day care program.

b) To form a therapeutic community comprised of clinical staff and patients which is a model of real life.

c) To involve the patients' marital partners, family members and friends in family and "significant others" therapy.

d) To offer discharged day care patients out-patient psychotherapy when appropriate.

e) To study objectively the results of the treatment in day care, aiming towards a steady increase in the efficiency and (time) economy of treatment, by developing and testing new treatment methods.

f) To share our knowledge with mental health professionals as well as community agencies and those who contribute towards enhancing the standards of mental health care in the community.

C. Patient Profile

A descriptive patient profile of day care "D" which was gleaned from 50 patient records can be shown by:

a) Average number of patients in treatment - 20.

For the first three months of 1973, there were a total of 24.0 patients per month. In 1972, according to the Hospital Statistical Report, the average number of patients was 20.2 per month.

b) Mean age of patients - 27.8 years.

Female - 30.4 years, with range being 20 to 49 years.

Male - 25.3 years, with the range being 21 to 41 years.

c) Sex - Female, 66 per cent

Male, 34 per cent

This female to male ratio was also observed by those patients presently involved in the treatment program.
d) The marital status can be shown by:

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<th>Married</th>
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<tr>
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<td>8%</td>
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<tr>
<td>Male</td>
<td>28%</td>
<td>4%</td>
<td>2%</td>
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</tbody>
</table>

e) The mean days of day care treatment was - 34.6 days. Female - 34.3 days, with the range being 7 to 46 days. Male - 35.0 days, with the range being 23 to 49 days. The 17 patients presently engaged in treatment were not included in these statistics.

f) The educational categories can be shown by:

<table>
<thead>
<tr>
<th></th>
<th>University</th>
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<tr>
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g) The occupational categories can be shown by:

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<tr>
<td>Male</td>
<td>0%</td>
<td>12%</td>
<td>20%</td>
<td>0%</td>
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</tr>
</tbody>
</table>

h) Diagnostic category:

- Depression - 58%
- Personality Disorder - 30%
- Others - 12%

Description of Day Care "E"

A. General Description

The history of day care "E" and "D" are unique in their origin. Initially, in 1968, separate day care programs were established for patient follow-up on each of the three in-patient wards. These programs were partially incorporated into the total ward structure and partially they were maintained as a separate program of activities. Numerous changes in the programs and the staff structure took place over the ensuing three years. In 1971, two separate day care programs
were established within this hospital setting. Day care "E" was one of these programs. Originally this program served as a transitional phase for patients who came from the in-patient wards, prior to their complete return to their family and the community. Governmental funding provides for daily operational costs of this present program.

Day care "E" serves a relatively selected patient population, where the majority (72%) are in an educational level of Grade 11 and above. The largest marital category for both female and male was; single, yielding 54%. Unemployed is the largest single occupational category, also 54%. The average stay in the program was about 10 weeks per patient. Transportation, at selected times, is better in this area, than it is to some other areas of the city, but a car is still a definite asset to reach this facility.

Day care program "E" is located within the hospital setting. Patient activities take place within one large comfortable room, a large occupational area and several smaller areas within the hospital. Many recreational activities take place within the total community setting. The hours of operation are from 9:00 a.m. to 4:00 p.m., on a Monday to Friday basis. The staff includes two registered nurses, one occupational therapist, a medical supervisor, a part-time Resident and access to a social worker. The average number of patients in this program is 12. When this survey was conducted there were also 12 patients in the program. This day care program serves almost exclusively patients who are categorized as schizophrenic and post-psychotic.

B. Objectives

The written objectives for this day care program are six in number. These being:

a) To assess and treat mainly post-psychotic and borderline patients who demonstrate some degree of motivation for change in their behaviour and interpersonal relationships.
b) To continue to maintain a structured, daily program which is supervised by a multi-disciplinary team.

c) To achieve re-integration into the community by various means, in addition to pharmacotherapy.

d) To involve relatives and friends in bi-monthly therapeutic group sessions and when indicated, to engage individual families in brief conjoint family therapy.

e) To provide a more adequate follow-up program for patients and their families upon discharge from the day care program.

f) To teach students from various disciplines, the means of recognizing and utilizing an individual patient's human potential as implemented in this day care setting.

C. Patient Profile

A descriptive patient profile of day care "E" which was gleaned from 50 patient records can be shown by:

a) Average number of patients in treatment - 12.

For the first three months of 1973, there were a total of 12 patients per month. In 1972, according to the Hospital Statistical Report, the average number of patients per month was 20.2.

b) Mean age of patients - 29.5 years.

Female - 31.4 years, with the range being 19 to 64 years.

Male - 27.6 years, with the range being 19 to 54 years.

c) Sex - Female, 54 per cent

Male, 46 per cent

This female to male ratio was also observed by those patients presently involved in the treatment program.

d) The marital status can be shown by:

<table>
<thead>
<tr>
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<td>Male</td>
<td>30%</td>
<td>10%</td>
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</table>
e) The mean days of day care treatment was - 52.7 days.
Female - 28.8 days, with the range being 6 to 63 days.
Male - 76.6 days, with the range being 7 to 68 days.
The 12 patients presently engaged in treatment were not included in these statistics.

f) The educational categories can be shown by:

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g) The occupational categories can be shown by:

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<td>Male</td>
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<td>2%</td>
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</tr>
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</table>

h) Diagnostic category:
Schizophrenia - 54%
Depression - 32%
Others - 14%

Description of Program "F"

A. General Description

Program "F" was one of the unofficial areas that was surveyed regarding day patient visits. This survey took place about two months after the psychiatric ward moved from a separate house into the hospital setting. The present ward provides a fairly large lounge area and several smaller rooms which could be used for patient activities or interview rooms. In 1972, the day patients visited the ward on the average of 227 visits per month. In the first three months of 1973, the monthly patient visits averaged 264. When this survey was conducted there were a total of 12 in-patients on the ward, this below capacity number was due to an inadequate number of staff to care for 23 patients. Both patients and staff were still
engaged in a "settling in" process in this new area.

The average age of the patient on day care was 33.5 years, with females being in an older age bracket. All patients had previously been hospitalized, with a diagnosis of schizophrenia being slightly higher at 35% than the remaining diagnostic categories. The average number of visits per patient was 17.0, with females making predominantly more visits. The day patients are incorporated into the structure and activities of the ward patients. At the present time the ward staff consists of nine nurses and a part-time occupational therapist.

B. Patient Profile

A descriptive patient profile of the people visiting the psychiatric ward which was gleaned from 20 patient records can be shown by:

a) Mean age of the patients - 33.5 years.
Female - 36.1 years, with the range being 21 to 63 years.
Male - 31.0 years, with the range being 19 to 64 years.

b) Sex - Female, 70 per cent
Male, 30 per cent

c) Marital status:

<table>
<thead>
<tr>
<th>Single</th>
<th>Married</th>
<th>Separated</th>
<th>Divorced</th>
<th>Widowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>20%</td>
<td>45%</td>
<td>5%</td>
<td>0</td>
</tr>
<tr>
<td>Male</td>
<td>5%</td>
<td>10%</td>
<td>5%</td>
<td>10%</td>
</tr>
</tbody>
</table>

d) The mean visits to day care was - 17.0 per patient.
Female - 25.6 visits, with a range of 3 to 66 visits.
Male - 8.5 visits, with a range of 4 to 17 visits.

e) The educational level was unknown.

f) The occupational categories can be shown by:

<table>
<thead>
<tr>
<th>Professional</th>
<th>Working</th>
<th>Unemployed</th>
<th>Homemaker</th>
<th>Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>5%</td>
<td>15%</td>
<td>15%</td>
<td>35%</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>20%</td>
<td>10%</td>
<td>0</td>
</tr>
</tbody>
</table>
g) Diagnostic category:
   Schizophrenia - 35%
   Anxiety Reaction - 20%
   Depression - 30%
   Others - 15%

h) Previous hospitalization of patients - 100%.

Description of Program "G"

A. General Description

Program "G" was one of the two unofficial programs that was studied in this survey. The eight bed psychiatric in-patient unit was opened in March 1971, and overcrowding of this facility has been a common problem. In 1972 there were 366 patients admitted to the ward, an unknown number of day care patients came to the ward and 123 home visits were made. In the first 3 months of 1973, a conservative estimate of day care visits was 80 patients per month.

The ward is located at the end of a corridor, off one of the medical wards. One fairly large comfortable looking room serves as a dining area, lounge, meeting area, and a limited recreational area. Several small windowless rooms are located off the ward, which also serve as multi-purpose rooms, besides being used as interview rooms. A large physiotherapy and occupational area is located near the psychiatric ward, which contains a ping pong table and a punching bag, that the psychiatric patients can use in the evening.

The average age of the patient attending this unofficial day care was 37.6 years, with females being in a younger age bracket. This figure is slightly higher than the average would be; as there was one female aged 79 years and one male aged 69 years attending. All patients had previously been hospitalized, with depression (70%) being the most common diagnostic category. The average number of visits was 10.9 per patient, with females making predominantly more
visits. Unless the day patient had a specific problem which he dis­
cussed with a staff member, he was incorporated into the total treatment
program and activities which were planned for the in-patients. A
nursing staff of six, manages both the in-patient activities and
the day care visits.

B. Patient Profile

A descriptive patient profile of the people visiting the
psychiatric ward which was gleaned from 20 patient records can
be shown by:

a) Mean age of patients - 37.6 years.
Female - 35.8 years, with the range being 19 to 79 years.
Male - 40.3 years, with the range being 19 to 69 years.

b) Sex - Female, 60 per cent
      Male, 40 per cent

c) Marital status:

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Separated</th>
<th>Divorced</th>
<th>Widowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>35%</td>
<td>10%</td>
<td>5%</td>
<td>10%</td>
<td>0</td>
</tr>
<tr>
<td>Male</td>
<td>30%</td>
<td>0</td>
<td>5%</td>
<td>5%</td>
<td>0</td>
</tr>
</tbody>
</table>

d) The mean visits to day care was 10.9 per patient.
Female - 13 visits, with a range of 3 to 31 visits.
Male - 8.9 visits, with a range of 1 to 29 visits.

e) The educational level was unknown.

f) The occupational categories can be shown by:

<table>
<thead>
<tr>
<th>Professional</th>
<th>Working</th>
<th>Unemployed</th>
<th>Homemaker</th>
<th>Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>0</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Male</td>
<td>5%</td>
<td>25%</td>
<td>10%</td>
<td>0</td>
</tr>
</tbody>
</table>

g) Diagnostic category:
   Depression: 75%
   Adolescent Reaction: 25%

h) Previous hospitalization of patients - 100%.
VIII. Diagnostic Categories

Throughout this survey the significance attached to the diagnostic categories into which the patients have been placed, was viewed to be of little importance. The validity of placing a diagnostic label on a patient has been questioned by many medical professionals. Scheff, in one of his statements on labeling, comments that; "...the physician and others inadvertently cause the patient to display symptoms of the illness the physician thinks the patient has."¹ Several of the centers surveyed also reported that often an accurate diagnosis could not be made until the patient had completed a course of treatment, but that a diagnostic label was required for statistical purposes. Not all diagnostic labels were acceptable for these statistics, for example; the term alcoholic, even though this may have been the major presenting symptom of the patient. This may help to explain why the diagnostic label of "Depression" was used for 47% of the total patients surveyed.

CHAPTER VI

INTERPRETATION OF FINDINGS

In this descriptive survey of the day care centers the aim was to obtain complete and accurate information in several specific areas of day care functioning. A summary of the basic commonalities and divergencies of each center can be seen in Table 1. These answers have been selected and shortened for easier reference. This table deals only with the five official, Government funded centers, as many of the questions were not directly applicable to the two informal programs. Only one of the day treatment centers was not directly affiliated with a psychiatric ward of a hospital.

A. Premise of Day Care

The premise that was used to establish each center varied, thus providing a diverse range of areas for patient care. The basic premises that were given included:

a) to provide an out-patient program
b) providing a center to treat all types of patients
c) to relieve the bed shortage
d) to provide a therapeutic community
e) to increase effective relationships and skills

The basic difference between in-patient care and day care was that more responsibility was allotted to the patient while he was still in a semi-protected environment.

B. Family Involvement

In one center, "D", it was mandatory for family members or significant others to be involved with the patient's treatment program. In this center the patient group also interviewed the prospective patient before he was admitted into that program. Two other centers provided family therapy in select cases when the patient's
<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>DAY CASE A</th>
<th>DAY CASE B</th>
<th>DAY CASE C</th>
<th>DAY CASE D</th>
<th>DAY CASE E</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Precise on which day treatment center was established.</td>
<td>To provide some type of out-patient program.</td>
<td>Most severely ill psychiatric patients could be treated in a day hospital</td>
<td>To find an answer to the bed shortage and to keep some people from being</td>
<td>To provide the concept of a therapeutic community.</td>
<td>Our program is for patients who have difficulty with interpersonal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>in their community.</td>
<td>being admitted.</td>
<td></td>
<td>relationships and social skills.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. What is the level of education and significance?</td>
<td>Day care gets away from the old structure.</td>
<td>Depends on the nature of the problem.</td>
<td>They are not really involved very much.</td>
<td>A family group runs every week and patients work on their problems</td>
<td>Patients have more experience in taking responsibility and for the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical treatment at mostly open house when indicated family therapy is</td>
<td></td>
<td>together.</td>
<td>decision making process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>carried out.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How do the patients differ from in-patient care?</td>
<td>Day care gets away from the old structure.</td>
<td>Day care gets away from the old structure.</td>
<td>Day care gets away from the old structure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical treatment at mostly open house when indicated family therapy is</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>carried out.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is staff permanent or are they rotating?</td>
<td>Full time, occupational therapist and social worker are permanent.</td>
<td>Staff is permanent.</td>
<td>Staff is permanent.</td>
<td>Staff is permanent.</td>
<td>We have a rotating group, and some family therapy with selected families.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Specific or general role function for staff?</td>
<td>Specific function, not much blurring of roles at all.</td>
<td>Very little differentiation made in role functioning.</td>
<td>Each staff has a specific function as well as a generalized one.</td>
<td>Each staff has a specific function as well as a generalized one.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Decision on which patient to discharge.</td>
<td>We know what the patient’s problems are, and we stick to what he has</td>
<td>Patients are conferenced regularly, and it is decided on the basis of the</td>
<td>All patients’ progress is discussed in weekly rounds, stay 6 to 8 weeks,</td>
<td>To expect patients will stay 6 to 8 weeks, and it is the change in</td>
<td>Patients have a problem list which they work on. Constructs are made</td>
</tr>
<tr>
<td></td>
<td>done against the problem. If we can see the making headway to all areas,</td>
<td>basis of reports when he terminates.</td>
<td>if they can cope at home or to the community, then they are discharged.</td>
<td>behaviour during this time.</td>
<td>weekly on these problems and we observe changes in behaviour.</td>
</tr>
<tr>
<td></td>
<td>we support him and he is discharged.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Follow-up care</td>
<td>A discharge summary goes to the referring doctor and the patient is</td>
<td>The psychiatrist or Mental Health Clinic.</td>
<td>A chart which measures the somatic progress of the patient’s problem and</td>
<td>A chart which measures the somatic progress of the patient’s problem and</td>
<td>Patient returns at 3, 6, 9, and 12 month intervals. Also referring source.</td>
</tr>
<tr>
<td></td>
<td>encouraged to make a follow-up appointment.</td>
<td></td>
<td>a weekly questionnaire that measures happiness, neurotic symptoms and</td>
<td>a weekly questionnaire that measures happiness, neurotic symptoms and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>harmful traits.</td>
<td>harmful traits.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>from other hospitals.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Exclusion of patients?</td>
<td>It works out that there is very little exclusion. Do exclude organic</td>
<td>No, we do not exclude patients on the basis of that kind of symptom.</td>
<td>Exclude alcoholics, drug addicts, and psycho-pathic patients.</td>
<td>Exclude alcoholics, drug addicts, and psycho-pathic patients.</td>
<td></td>
</tr>
<tr>
<td>Specifying alcoholics or alcoholics.</td>
<td>brain syndrome and chronic alcoholics. Each case is considered on its own</td>
<td></td>
<td>Addicts, alcoholics, severe personality disorders, suicidal or homicidal</td>
<td>Addicts, alcoholics, severe personality disorders, suicidal or homicidal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>merits.</td>
<td></td>
<td>patients are excluded.</td>
<td>patients are excluded.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Types of treatment used.</td>
<td>Group meetings, role playing, psychotherapy, individual sessions,</td>
<td>Focus is on providing a milieu therapy type atmosphere.</td>
<td>Group discussions, occupational therapy, and recreational activities.</td>
<td>Interactive group therapy, role playing, discussion, entertainment,</td>
<td>Healthy orientation, group therapy, discussion, entertainment,</td>
</tr>
<tr>
<td></td>
<td>patient evaluation of the program, recreational therapy, individual</td>
<td></td>
<td></td>
<td>theatre techniques, work projects, occupational and recreational therapy.</td>
<td>theatre techniques, work projects, occupational and recreational therapy.</td>
</tr>
<tr>
<td></td>
<td>sessions, role playing, psychotherapy, creative games, relaxation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Methods used to evaluate the program</td>
<td>Rely on feedback regarding how the patient is doing, yearly effort to</td>
<td>Do what the patient is able to do when they get out. Give time to the</td>
<td>To see if people are resocialized and to see how they rate in the</td>
<td>We have not yet structured our criteria of how to research the effectiveness.</td>
<td>We believe there is improvement of people who come here.</td>
</tr>
<tr>
<td></td>
<td>judge progress of program.</td>
<td>progress in the community, ability to work, circle of associates.</td>
<td>community, and in the community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Supplementary questions.</td>
<td>No, not a standard procedure.</td>
<td>No.</td>
<td>Yes, for about 25% of the patients.</td>
<td>No.</td>
<td>Yes.</td>
</tr>
<tr>
<td>13. Is this a day care and used primarily as a transitional phase?</td>
<td>No.</td>
<td>No.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TABLE I**

A SUMMARY OF THE TAPE RECORDINGS ANSWERS RECEIVED FROM THE FIVE OFFICIAL DAY CARE CENTERS IN RESPONSE TO THE QUESTIONNAIRE.
problem indicated this. Family involvement in these two centers was also obtained through a regularly scheduled Open House and a Relatives Group. The other two centers provided little, if any, family involvement. This degree of involvement of family members may reflect the treatment philosophy, the availability of staff and the type of patients selected in each specific center.

C. Staffing

In three of the centers the staff were permanent, and in the other two, there was a combination of permanent and rotating staff. It was difficult to obtain an accurate staff to patient ratio, as many of the centers engaged staff on a partial or irregular basis. An approximation of this ratio could be 1 staff to every 4 patients. This included all levels of staff involved in that program, also in some centers there were more staff members employed than in others. The range of the role functioning of the staff included:

a) specific functions
b) specific and generalized functions
c) generalized functions

The type of staff role functioning did not form a pattern which was dependent upon the category of staff found within that center.

All but one of the centers used volunteers in some aspect of the functioning program. Drama volunteers were used in two centers and volunteers were generally involved with escorting patients, and in one center, with clerical activities. From this study it cannot be concluded whether the volunteers were used because staff was not available for these activities or whether these volunteers were more adept at the specific duties they carried out.

D. Basis for Patient Discharge

One general criteria that was used by all of the five centers to discharge a patient was on the basis of that patient's actual performance in the daily program and his level of functioning at
home and in the community. Two of the centers stated that regular staff conferences were held and the decision to discharge the patient was made at that time. One center included the patient in these conferences whenever this was feasible. A chart was used in one center which weekly measured the severity of the patient's problem, but this was not specifically used as the criteria for discharge. Two of the centers stated that the treatment program is terminated when progress has been made by that patient to cope with the problems that he had initially voiced.

E. Patient Follow-Up

In each center the patients were generally followed-up by the referral source. Two of the centers required the patient to return to the day care center for a varied time period after discharge. The five respondants in these centers were in agreement that some type of follow-up care was essential for continued patient functioning and patient maintenance. One of the inherent difficulties with follow-up care, is that often the patient feels in excellent health on leaving the treatment program, and therefore does not feel any need for follow-up care. This is one problem that confronted all of the centers. Dependent upon the patient situation, perhaps it may not be required or even desirable to have follow-up care.

F. Referrals

The referral of the prospective patients to day care centers came from several sources, most of which included other medical resources. These were, in-patient wards, other psychiatrists and psychiatric clinics. Three of the respondants in three centers stated that they were working out the difficulties that were encountered when patients were referred from community agencies or from psychiatrists who were not affiliated with that specific center. Two of the centers were being used as a transitional phase for patients
coming from an in-patient ward and back into full family life. This was one of their stated objectives.

G. Patient Admission

The present limited treatment facilities in British Columbia for drug addicts and alcoholics prompted the question of whether this category of patient was excluded from day care treatment. Three of the centers stated that they did not admit these two categories of patients, while the other two centers stated that the admission policy was determined by each individual situation. The latter two centers also mentioned that they had had very few drug addicts in their treatment programs, while alcoholics were more numerous and were treated in these programs. A frequent secondary diagnosis that was found on the 290 patient records that were examined was both alcoholism and a drug problem. But these accounted for only 3% and 2% respectively of the officially reported diagnostic categories.

Each of the centers stated that they did adhere to some form of admission policy, which ranged from a selected patient population to one which was less selective. For example; one center selected a neurotic patient population and another center admitted schizophrenic and post-psychotic patients.

H. Treatment

In the five official centers that were surveyed, group methods of treatment were used with individual sessions being infrequent. Occupational and recreational therapy played an important part in the total treatment program of each center. This group method of treatment was in keeping with:

...in the hospital setting, task groups with patient leadership and group cohesion have a more beneficial influence
on social behaviour and performance than do individual tasks and workshop activity directed by staff.¹

The importance that was placed on the use of prescribed medications varied from the expectation that every patient is required to take the medication, to one, where medications were prohibited, except for medical purposes such as diabetes or similar physical ailments. Four of the centers did use or prescribe medications. One factor in the use or the non-use of medications is that this may reflect the category of the patients that were admitted into each specific program or the selected method of treatment. For example; a schizophrenic person may need to be maintained with the use of medications.

I. Program Evaluation

The methods that were used to evaluate the effectiveness of the total program ranged from:

a) feed-back
b) patient performance
c) re-admission rate

The most prevalent method being used was based on the patient's actual performance both in the program and his ability to cope in his family and the community setting. Often it may be difficult to evaluate or measure the quality of the patient's functioning or coping ability, since the patient spends two-thirds of his time with family members and significant others. Here the patient's own assessment of his particular life style is used to gauge his progress. One of the problems that plagues all the present methods of the delivery of health care is the lack of concrete objective evaluative procedures.

¹Susser, op. cit., p. 145.
J. General Patient Profile

A patient profile that was obtained from the 290 patient records that were examined would include:

**Average Age:** 33 years. This included the seven centers.

**Sex:** Generally female, (ratio of 2:1). This included the seven centers.

**Marital Status:** 45% being single, with 34% being married.

**Treatment Days:** 54. The average days for females were 34 days, and males 73 days. This included the five official centers only.

**Education:** 60% above Grade 11, with 38% being unemployed.

**Previous Psychiatric Treatment:** 77%, females 50% and males 27%.

**Largest Diagnostic Category:** Depression and Schizophrenia.

This profile may be likened to the profile expressed by Susser when he described patients in mental hospitals. He stated: "Because single patients lack social support and mental hospitals provide social support, these rates could be more an index of response to a social rather than a psychological strain." In this descriptive survey the ratio of single females to single males was equal and it was found to be the largest marital category. In the married category the female patients out-numbered the male by a ratio of 5 to 1. Whether these latter patients lacked the "social support" or if family involvement in the treatment program was lacking, cannot be fully determined by this study, since only one day care center stipulated family involvement as a condition of treatment. But it may indicate that the male who is married received more family and social support than the female who was married. Loeb wrote:

...these intimates must be involved in the treatment process from the beginning, or else they probably will not be there when the person, now an ex-patient, is ready

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2Susser, op. cit., p. 88.
to return...and if they (intimates) do not understand
the nature of his disability they cannot help him.  

There is mounting evidence that social and family support is necessary
for the ex-patient to maintain an appropriate level of inter-
personal functioning. It is noted that interactions outside of the
family milieu also have an important effect on the quality of patient
behaviour.

In this survey more than one-third of the people were unemployed
prior to entering treatment. It cannot be decided here whether the
patient's emotional difficulties prevented him from working, or
whether these difficulties prompted his discharge from employment.
An assumption here is that an activity or employment which the person
feels is worthwhile and he is capable of doing, will increase his own
confidence and self-worth. "Mental patients who obtain regular work
on leaving the hospital tend to settle successfully in the community."  
Places of employment are often more apt to keep a job open for a
professional person than they would for a person working in a lower
occupational level.

There were two findings that were common to the two unofficial
programs and the one official day care center located in the interior
of British Columbia. The first being, a greater percentage of females
gave their occupation as homemaker, 52% in the towns, than did the
ones in the city where homemaker was given as 18%. Secondly, in the
towns there were less patients classified as students than there were
in the centers located in Greater Vancouver. In the towns this may
reflect lessened job opportunities for females, training programs

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3 Leight M. Roberts, S.L. Halleck and M.B. Loeb (Edit.),
Community Psychiatry (London: The University of Wisconsin Press,

4 Susser, op, cit., p. 58.
may not be as readily available or emotional problems of people who would be classified as adult student may not become as evident or be as prevalent as they are in a larger city.

K. Age of the Patients

Table II indicated that there is a gradual decrease in the number of patients as their age increases. This inverse effect may reflect current societal values which place a great deal of emphasis on the younger population or it could reflect the attitude of the medical staff, where it may be more interesting and rewarding to modify the behaviour of a younger age group. Thirty-one per cent of the patients were in the 19 to 23 age bracket, which may also indicate that this is a difficult age period in which one seeks to discover a satisfactory life style. Jourard states: "...that one's attitude toward life and self are factors both in the onset of illness and in the recovery therefrom." This table also indicated that female patients out-numbered males in each of the age brackets. This gives rise to the unanswered question of whether a higher ratio of the female population succumbs to emotional illness than do males, or if females are more apt to seek treatment.

**TABLE II**

A SUMMARY OF THE AGE BRACKETS OF THE FEMALE AND MALE PATIENTS WHO ENGAGED IN THE DAY CARE PROGRAM IN THE FIVE OFFICIAL CENTERS

| Day Care Center | 19 - 23 (F) | 19 - 23 (M) | 24 - 28 (F) | 24 - 28 (M) | 29 - 33 (F) | 29 - 33 (M) | 34 - 38 (F) | 34 - 38 (M) | 39 - 43 (F) | 39 - 43 (M) | 44 - 50 (F) | 44 - 50 (M) | 51 - 60 (F) | 51 - 60 (M) | over 60 (F) | over 60 (M) |
|-----------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| A               | 13          | 3           | 6           | 3           | 5           | 2           | 4           | 1           | 4           | 0           | 1           | 2           | 3           | 3           | 0           | 0           |
| B               | 11          | 7           | 5           | 8           | 1           | 3           | 7           | 2           | 2           | 0           | 2           | 1           | 0           | 1           | 0           | 0           |
| C               | 6.1         | 2           | 1           | 6           | 2           | 4           | 3           | 5           | 2           | 6           | 2           | 6           | 3           | 1           | 0           |           |
| D               | 9           | 7           | 10          | 6           | 4           | 4           | 3           | 0           | 2           | 1           | 4           | 0           | 0           | 0           | 0           | 0           |
| E               | 8           | 11          | 7           | 5           | 6           | 3           | 0           | 0           | 1           | 2           | 2           | 1           | 2           | 1           | 1           | 0           |
| **Total**       | **47**      | **29**      | **30**      | **23**      | **22**      | **14**      | **18**      | **6**       | **14**      | **5**       | **15**      | **6**       | **11**      | **8**       | **2**       | **0**       |
### TABLE III

**THE NUMBER OF FEMALE AND MALE PATIENTS WHO HAD PREVIOUSLY RECEIVED PSYCHIATRIC TREATMENT WITHIN THE PAST FIVE YEARS**

<table>
<thead>
<tr>
<th>Day care center</th>
<th>Hospital or day care treatment</th>
<th>Visit to a psychiatrist</th>
<th>No previous treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>A</td>
<td>13</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>B</td>
<td>20</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>C</td>
<td>26</td>
<td>9</td>
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</tr>
<tr>
<td>D</td>
<td>27</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>E</td>
<td>24</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>110</td>
<td>55</td>
<td>16</td>
</tr>
</tbody>
</table>

**L. Previous Hospital Treatment**

One assumption that was not borne out in this study was that a higher percentage of males than females would find it more acceptable to visit a psychiatrist in his office than to be admitted to a hospital facility. Table III indicated that 5% of the male population had previously visited a psychiatrist versus 6% of the female population. This table indicated that 66% of the patients had been treated either in a hospital ward or in a day care center previous to this present admission to a day care center. A total of 23% had not received prior psychiatric treatment. The two unofficial day programs of "F" and "G" were not included in this table since all of the people who returned to the ward had been previously hospitalized.
M. Length of Time in Treatment

The length of time the patients spent in the day care treatment program ranged from 6 to 162 days. In three of the five centers male patients stayed in treatment predominantly longer than females, this was especially evident in day care "B" and "E". Two speculations concerning this may be made. One, is that it may require a longer time period for the male patient to learn different behavioural methods, and secondly, the male patient may be kept in the treatment program longer so as to balance the female to male ratio.

TABLE IV

THE NUMBER OF DAYS THAT FEMALE AND MALE PATIENTS SPENT IN DAY CARE TREATMENT IN THE FIVE CENTERS

<table>
<thead>
<tr>
<th>Average days of treatment+</th>
<th>Day Care Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
</tr>
<tr>
<td>Females</td>
<td>29.1</td>
</tr>
<tr>
<td>Males</td>
<td>29.3</td>
</tr>
</tbody>
</table>

+The patients who were presently engaged in treatment were not included in these figures.

N. Funding

The funding that the five official centers received varied from 14 to 23 dollars per patient per day, with the average being 18 dollars per day for each center. One center which received the highest amount of 23 dollars per day also provided all of the patients' medications. In four of the centers, this money was not paid directly to the day care center, but it was paid to the hospital which the
center was affiliated with. The hospital budget then bore the expenses of the day care center. The five official day care centers have a combined capacity to treat approximately 90 patients per day, and presently a total of one-third of these patients are being treated by one center. The average cost of 18 dollars per patient in the day care center could be contrasted with an average hospital cost per patient day of about 72 dollars. It is recognized that many other factors enter into this cost comparison which may make it invalid. But the entire cost-benefit factor is an important issue in the health care delivery system.
CHAPTER VII

SUMMARY, AREAS FOR FURTHER INVESTIGATION AND RECOMMENDATIONS

At the present time there is very little informational data available relating to the adult psychiatric day treatment centers in the province of British Columbia. In recent years the trend in psychiatric care has been to treat people within their family and community setting. Many people who require help and guidance for their emotional problems are being treated in psychiatric day care centers and they are not being admitted to a psychiatric ward. Within the past five years, four day care centers have been established at various hospitals throughout the province of British Columbia. The purpose of this descriptive survey was to provide a composite picture of the currently functioning adult psychiatric day care centers.

A total of five official and two unofficial day care programs were surveyed and 290 patient records were examined. The specific areas of interest in day care functioning centered around; the family and community involvement in the treatment program, the types of treatment that were used, the type of role the staff carried out, the total program evaluation and a profile of the patients who were treated by this modality. To collect the data, the researcher used; a questionnaire which was answered in a taped interview, observational visits to each center, and an examination of the patients' records.

The results of the questionnaire indicated that family involvement in the total day program was generally limited, group methods of treatment were used which gave the patients a sense of community, and patients were followed-up either by the day care center or by the referral source. Referral of patients to these centers were mainly from in-patient wards, other psychiatrists and psychiatric clinics. The criteria that was used to terminate a patient's treatment was on the basis of his actual performance in the program and his level of functioning at home and in the community. This was also the prevalent method used to evaluate the effectiveness of the total
treatment program. Staff in these day care centers were both permanent and rotating with their role function being both specific and generalized.

An examination of the patients' records revealed that the average patient was 33 years old, generally female, single, diagnosed as being depressed, above Grade 11 in education and presently unemployed. Seventy-seven per cent of the patients had previously received psychiatric treatment and the length of stay in the treatment program was 54 days.

Findings from this study indicated that a wide variety of patients were treated in day care, which, had these centers not been available, would have been admitted to an in-patient ward. In the two unofficial centers that were surveyed, the number of patient visits to the ward indicated that there was a need at these two centers for this type of treatment modality. Day care is not only an alternative to hospitalization, but it may be the choice method of treatment for many patients.

AREAS FOR FURTHER INVESTIGATION

As this study progressed there were several areas relevant to day care functioning which would warrant further investigation. These included:

a) The patients' perception of his emotional problem and what areas of day care treatment were most beneficial to him. Many times the same patient has been treated in both a hospital ward and in day care, thus his perceptions of what has helped him could be a guide for program initiation.

b) To study the attitudes and acceptance of the patient's family or significant others when the patient is treated in a day care center and then returns to his family setting in the evening.

c) To determine the effect of day care treatment on the patient regarding his short term and long term level of functioning and his social adjustment within the community. This would involve following the patient in his community setting at various time periods.
RECOMMENDATIONS

Descriptive surveys generate many unanswered questions as to why an event should occur, and this survey is no exception. The recommendations that could be drawn from this study include:

a) That greater family involvement be initiated in all of the programs so that there would be a greater sharing and understanding of goals and responsibilities between the family, the patients and the treatment team.

b) A liaison be established with various community agencies so that the day center can refer people for job placements or training and that these same agencies could refer people directly to the day treatment center.

c) The staff in the day care center should be permanent, so that they will have the responsibility of planning and implementing changes within the treatment program. In this way the staff member would also become more adept at carrying out their roles which would benefit the patient.

d) The present public relations campaign should be expanded so that day care as a treatment modality became more acceptable. This campaign would not only be aimed at the general public, but also at private and public agencies and the medical profession.

e) There should be a continued concern in each day care center in providing written literature pertaining to the objectives and philosophy of the program, the methods of delivering the treatment program, and to determine the program policies. This material could form a basis for an initial orientation of new staff members and to supply the community agencies with the information they would require to enable more co-operation between the agency and the day care center.

f) The cost of the program in each day care center should be determined with regard to what is the total cost to achieve the
stated objectives of the program and are there alternative methods of reaching these objectives.

g) Since each center has specific goals which guide its function, an in-depth study of each area should be made, as to the effects of treatment, quality of patient functioning after treatment and an evaluation in terms of fulfilling the stated objectives. This would include an on-going continuous evaluation.
APPENDIX A

QUESTIONNAIRE
A QUESTIONNAIRE TO PROVIDE INFORMATION REGARDING THE PSYCHIATRIC DAY TREATMENT CENTERS IN BRITISH COLUMBIA

1. Initially, on what premise or basis was the psychiatric day treatment center established?
   In what way does this differ from the premise used to provide inpatient care?

2. In what way are the patient's family or significant others involved in the patient's total treatment program?

3. Who initiates this involvement?

4. In the day treatment center, is the staff permanent or are they rotated, for example, the doctors, nurse, social worker or the occupational therapist?
   Do you have any volunteers in the program?

5. Does each staff member have a distinct or specific role function or is there a generalized role function for all members?

6. On what basis is the decision made to discharge the patient, that is, how is it ascertained that the patient has achieved maximum benefit from the program?

7. On discharge of the patient, how is his follow-up care planned?

8. Where do you get your patient referrals from?

9. Do you exclude any category of patients from day care? Here I am thinking specifically of drug addicts or the alcoholic.

10. What methods of treatment are used in the day care centers?

11. What methods are used to evaluate the total effectiveness of the day treatment center?

12. What are the written goals or objectives of the day treatment center?
13. The following information was taken from the patient's chart:

<table>
<thead>
<tr>
<th>Age</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Occupation</td>
</tr>
<tr>
<td>Education</td>
<td>Days of Treatment</td>
</tr>
<tr>
<td>Previous admission</td>
<td>Diagnosis</td>
</tr>
</tbody>
</table>

Average number of patients per day, month, and year.
APPENDIX B

TAPED INTERVIEWS
Partial transcription of the taped interview with day care "A"

Code:  R - Respondant
       I - Interviewer

I: On what premise or basis was the psychiatric day center established?

R: The premise of day care generally is to provide some type of out-patient program for the patients. We wanted to get away from the old rigid ward setting and to get into something that's a bit looser and a bit less restricting for the patient.

I: How does this premise differ from that used for inpatient care?

R: Day care gets away from the old structure, it puts the patient in a unique position; halfway between a protected environment and reality. They come into day care, they hopefully learn things, they go home and they try them out and over a period of five to eight weeks, they seem to change their habit of dealing with people. You provide a protective shield for the patient, while they are in the program, it's less pronounced here than on the ward. Because of our treatment philosophy, but in addition, the patient goes home every night.

I: In what way are the patient's family or significant others involved in the patient's total treatment program?

R: We get some families involved, but not many. These families are involved mainly with the social worker and these are in select cases.

I: Who would initiate this involvement?

R: It would be by a decision made by the treatment team.

I: Is the staff here permanent or are they rotated?

R: The staff here is rotated. The psychiatrist stays for one year, the head nurse is permanent, and the other two nurses are rotated every six months. The social worker and occupational therapist are permanent and work part-time.

I: Do you have any volunteers in the program?

R: No, there are no volunteers in the program.
I: Does each staff member have a distinct role function or is there a generalized role function for all members?

R: No, I don't find much blurring at all. About the only place you could talk about blurring, is when we get together to talk about things. As far as roles are concerned, they are still pretty fixed and set. The thing that makes the difference, I think, is that everybody gets their say and people have a much more of an equal weight then, in most situations.

I: On what basis is the decision made to discharge the patient, how do you ascertain that he has received maximum benefit?

R: We don't usually have too much trouble agreeing on when a patient is ready to go. We know what the patient's problems are, and we stack up what he has done against the problem. If we can see him making headway in all those areas, we support him and he is discharged.

I: Is there a behavioural scale or questionnaire that you use as a helpful criterion for discharge?

R: No.

I: On discharge, how is the patient's follow-up planned?

R: On discharge, a discharge summary goes to the referring doctor and the patient is encouraged to make a follow-up appointment with that doctor.

I: Where do you get most of your referrals from?

R: A lot of the referrals are from psychiatrists, private doctors and from the ward at the hospital.

I: Would this day care be considered primarily as a transitional one, for patients from the ward to the community?

R: No, not as standard procedure. It couldn't be because of our program and the suitability of the people for this program.

I: Do you exclude any patients from day care? Here I'm thinking specifically of drug addicts or alcoholics.

R: Actually it works out that there isn't. Each case is considered on its own merits. We have had a couple of addicts and quite a few alcoholics. Somebody with a drug or alcohol problem we look at very carefully, but we certainly don't dispel them without
giving them a try. We do exclude organic brain syndrome and the chronic schizophrenics, as they would not benefit from this program. Our group is still basically a neurotic group with some personality disorders.

I: What types of treatment are used in the program?

R: They are all group methods, and all the variations of group methods. We do role playing, psychodrama, we tape one group a week, expressive groups, patients evaluate the program, occupational and recreational therapy. The methods are all group orientated, they are not only psychological, but also physical.

I: What methods are used to evaluate the total effectiveness of the day care program?

R: We haven't done any research into this at all. We rely on feedback that we get from other patients, staff and psychiatrists. Once a year we present our program to the other staff and at this time, we make an effort to judge the progress of the program. This gives us some indication as to what type of patient is doing well in the program.
I: Initially, on what premise was the psychiatric day treatment centre established?

R: The premise used was that most severely ill psychiatric patients could be treated in a day hospital in their own community, without having to be admitted to 24 hour care. The day hospital has moved from a position of providing largely somatic treatment and occupational therapy to inter-personally focused treatment milieu.

I: In what way is the patient's family or significant others involved in the patient's total treatment program?

R: This involvement depends on the nature of the problem presented. This is under the guidance of the patient's therapist; family group therapy sessions with the principal therapist, as an ongoing part of the patient's treatment, may be indicated while they are in the day hospital program.

We try to individualize this according to the demands of the situation. There is minimal involvement built into the program where we have open house once a month. All patients are expected to attend and are asked to invite interested friends or members of their family who wish to see what kind of treatment program they are involved in. And to meet the staff who are working with them.

I: In the day treatment centre, is the staff permanent or are the staff rotated?

R: The staff is permanent.

I: Do you have any volunteers in the program?

R: At the moment we have four ex-patient volunteers, they are engaged in various activities such as: helping people get to the program, in the occupational therapy area or in taking patients out into the community for brief periods.

I: Does each staff member have a specific role function or is there a generalized function for all?
R: There is really very little differentiated role functioning in the day hospital. All members of the team are expected to function in all parts of the program. However, the nurses dispense medications, physicians prescribe it and occupational therapy arranges the patient's occupational program. All members of the staff take part in group therapy, recreation periods, and the other items in the program.

I: On what basis is the decision made to discharge the patient, that is, how is it ascertained that he has achieved maximum benefit from the program?

R: Patients are conferenced regularly in the program, at 1 - 4 week intervals, depending on the rate of their progress. It is decided on the basis of the reports from week to week in these conferences when is the appropriate time to terminate.

I: There is no specific behavioural scale or questionnaire that you use?

R: No. Our evaluation of the patient, consists of their actual performance in the program and their performance in life in the community.

I: On discharge of the patient, how is his follow-up care planned?

R: I am very reluctant to take a patient unless we can arrange an adequate follow-up program. This is done by people such as: the patient's principal therapist, private psychiatrist, Mental Health Centers, private doctors or from the out-patient department here.

I: Where do you get most of your referrals from?

R: There are three major areas where we get referrals; one is from psychiatrists in the community, second, is from our own out-patient staff and third, is from in-patient resources from other hospitals.

I: Are there any types of patients that you do not admit? Here I'm thinking specifically of drug addicts and alcoholics.

R: No, we don't exclude patients on the basis of that kind of symptom. We have fairly rigidly enforced rules about the abuse of alcohol and drugs, and a patient cannot continue to attend here and continue that kind of behaviour. We've had a much larger number of alcoholics than addicts. I try not to have more than one-third of the people in the program psychotic at any given time.
I: What types of treatments are carried out here?

R: The focus is on providing a milieu therapy type of situation. The patient has an opportunity to engage in tasks related to working, playing and relating to others. We have group therapy, individual sessions, role playing, psychodrama, theatre games, relaxation and other techniques. Medications are also used. We use two kinds of theoretical backgrounds; one, provided by transactional analysis and the other provided by learning theory.

I: How do you evaluate the total effectiveness of the program?

R: Basically, on what the patient is able to do when they get out of it. If he is able to cope in the community, if he is able to work and has a reasonable circle of associates.
I: On what premise was the day care program established?

R: We were very short of beds, we only had about seven in-patient beds at that time. We had a lot of psychiatric patients who couldn't stay very long in the hospital, so they kept returning. We were trying to find an answer to the bed shortage. We thought we might be able to discharge patients sooner, and we might also be able to keep some people from being admitted.

I: In what way does this differ from the premise of in-patient care?

R: We've got a 14-bed capacity on the in-patient ward, but we usually have more patients.

I: In what way are the patient's family or significant others involved in the patient's total treatment program?

R: They are not really involved very much. We talk to members of the family and sometimes home visits are made, but not very many. About 75 per cent of our day care are the result of in-patients, and some family member may be called in. Our patients come from all over, so if it's far out or even 20 miles away it complicates the case of trying to get everyone together.

I: Is the staff here rotated or are they on a permanent basis?

R: The nursing staff from the ward go down to the activities, the nursing staff work rotating shifts so it's not the same staff all the time. The occupational therapist is permanent.

I: Do you use volunteers in the program?

R: We have one volunteer who comes in for activities and there is a volunteer occupational therapist.

I: Does each staff member have a specific or a generalized role function?

R: It's pretty well a generalized role. The groups are led by the social worker and usually a nurse, whenever she's free. People here don't have specific roles in which they don't dare step
outside of. Everybody seems to help everybody else and it's a very good atmosphere.

I: On what basis is the decision made to discharge the patient from the program?

R: When people say they're perhaps ready for the step to go on, whether it's to school or the home. We see if they are able to cope in the community or at home. All patients' progress is discussed in weekly rounds, and their own doctor says either they're doing fine or we should keep them longer.

I: On discharge of the patient how is his follow-up care planned?

R: Some see the psychiatrist and sometimes they go to the Mental Health Clinic. That's about all the follow-up care they have.

I: So a large number of patients use the day care as a transitional phase from in-patient care back to the community.

R: Yes.

I: Are there any types of patients that are excluded from day care? Here I'm thinking specifically of drug addicts or alcoholics.

R: We made a rule not to take the alcoholics and only special drug addicts that we felt we could do some work with. I feel the psychopaths destroy everything that's going on in the program. But perhaps we wouldn't have this rule if we had more than one room, where you could have more than one group, but when you have such small facilities, you can't have everything and you do what is best.

I: What methods of treatment are used in the program?

R: We have group discussions, occupational therapy and outside recreational activities. The time table seems to change every month.

I: What methods are used to evaluate the total effectiveness of the day program?

R: One way of evaluation is to see the re-admissions, and see if these people are able to cope, even for a couple of months. I could cite several cases where day care has seemed to help people cope and it has kept them from being in-patients. So it's more on how the person is able to cope.

I: In a town like this, where you pretty well know everyone, have you found this has hampered your treatment relationships?
R: Patients have mentioned this on occasion. I don't think it bothers us so much, it's just the fears that they have, but we tell them (patients) that this is confidential and that they probably need help.
Partial transcription of the taped interview with day care "D".

Code:  R - Respondant
       I - Interviewer

I:  On what premise or basis was this day treatment centre established?

R:  One of the major ideas behind this treatment program is the concept of therapeutic community. A group of people come together and establish their own rules, or follow a set of rules, that they speak openly, that they elect a committee among themselves to ensure the progress of all the patients. The progress of all the patients is the concern of every member of the community, and not only the staff. That the maintenance of the house and community and physical as well as the emotional needs are part of the patient's responsibility.

I:  In what way does this differ from the premise used to provide in-patient care?

R:  What we are trying to do here that is different than a hospital based program is that the self regulation and the responsibility can be taken upon the patient. It is not necessary for them to be in a hospital to be regulated by the hospital requirements and regulations. That patients can be more responsible for themselves than they are in a hospital setting.

I:  In what way is the patient's family or significant others involved in his treatment program?

R:  We run a family group every week and all the patients bring family members or significant others to the group and work on their problems together. Also they would bring family members during group meetings at other times during the week. So that we very much emphasize improving and working out relationships with other members.

I:  Who initiates this involvement?

R:  The individual has to be self motivated but the patient initiates his family's own involvement. All patients are initially interviewed by a Resident and also by the patient group. One of the questions the patients always ask new patients is, are they willing to bring their family members to the group. If there is resistance, they may not get into the program.

I:  Is the staff here permanent or are they rotated?

R:  Staff is permanent.
I: Do you use any volunteers in the program?

R: We have one volunteer who helps us with clerical work and we use drama volunteers who run a theatre workshop once a week.

I: Does each staff member have a specific role function or is there a generalized role function for all members?

R: It is both. Each staff member has a specific function as well as a generalized one. The occupational therapist is responsible for co-ordinating all the work in the program. The nurse is responsible for running an after care group, and I co-ordinate the program administratively. Weekly groups are conducted by the doctors.

I: On what basis is the decision made to discharge a patient, how do you ascertain that he has achieved maximum benefit from the program?

R: The expectation is that patients will stay 6 to 8 weeks and it's usually by the end of that time that we decide on discharge. So in point, it's a time factor, we feel that it's an intensive group therapy experience and after 8 weeks often not much more can be accomplished at the moment.

There is very much an emphasis on the change in behaviour. One of the criteria on discharge is change in behaviour, probably much more so than resolving internal conflicts.

I: Do you use a behavioural scale or a questionnaire in evaluating their progress?

R: Yes, we have a chart which we have just started using, where patients when they first enter measure the severity of their problem in the group. Each week they measure the change in the problem. We also have a questionnaire that the patients do weekly, which measures happiness, neurotic symptoms and harmful traits - what people see as their harmful traits.

I: On discharge, how is the patient's follow-up care planned?

R: One of the commitments when a patient leaves the program is that they are expected to attend for 3 weeks one of the regular group meetings back here. Following those 3 weeks, if they are sufficiently motivated, they may be invited to join one of the weekly after care groups.

I: Where do you get most of your patient referrals from?
R: Most of our patients seem to come from the Out-Patient Clinic at the hospital. We also have a considerable number who come from the in-patient unit, from Emergency at another hospital and from psychiatrists in the community.

I: Are there any types of patients that you exclude from the program, and here I'm thinking specifically of drug addicts or alcoholics.

R: We exclude both categories. Nor do we take clearly psychotic patients. The patients are very carefully screened. No one is permitted into the program who is taking drugs of any nature.

I: There are no prescribed medications then?

R: No, there are no prescribed medications, except for physical ailments. The expectation is no drugs, and taking drugs can mean expulsion from the program.

I: What methods of treatment are used in the day program?

R: It is intensive group therapy. We use many techniques; role playing, encounter, Gestalt, it's quite an eclectic approach and it is extremely confronting and a very demanding therapy program. We experiment with new techniques all the time.

I: What methods are used to evaluate the total effectiveness of the program?

R: We have not yet structured our criteria of how to research exactly the effectiveness. We believe that there is improvement of most people that come here, it's been a successful program. Most people who come, almost everyone who comes, does make changes in a very short period of time.
I: On what premise was this day care program established?

R: Our program was established for patients who have difficulty with interpersonal relationships and social skills. Our patients would be admitted from the in-patient services and this would largely be a transition period for them. It would be a supportive and rehabilitative kind of program that would help patients with problem solving and developing better skills. We focus on the here and now, along with reality orientation. We try to provide a program that will give the patient positive and helpful experiences in changing their unacceptable behaviour.

I: How does this differ from the premise of in-patient care?

R: In our program, patients have more experience in taking responsibility for themselves and the decision making process. On the wards, the program is planned for them. The patients really do not have much decision about what they do, or how their problems are solved, or in actual fact, what their problems are.

I: In what way are the patient's family or significant others involved in the patient's total treatment program?

R: Every other Wednesday we have a Relatives Group in the evening, which enables the family to find out about the total treatment program. We have some family therapy with certain selected families. These are about one hour in length for four to five weeks. We do not engage in intensive family therapy, but merely to point out to the family, that there is some pattern of behaviour that is prompting and promoting illness in the family member.

I: Who initiates this involvement?

R: Staff in the day care team initiates family involvement.

I: Is the staff here rotated or are they on a permanent basis?

R: Staff here is permanently assigned to day care.

I: Do you use any volunteers in the program?

R: We have five volunteers working with us in specific areas in the program.
I: Are any of the volunteers ex-patients?

R: No, they are not.

I: Does each staff member have a specific or generalized role function?

R: I believe that our roles blur very much in that we participate in all parts of the program. I administrate and co-ordinate the program, besides working in it, in various areas. But in the program our work is shared.

I: On what basis is the decision made to discharge the patient from the program?

R: The patients have their problem list, they are aware of what it is they want to work on, they tell us through commitments that they make about these problems and working on them each week. Most of our assessment is probably done on an objective and subjective basis; how does the patient feel, how does he feel about himself and his progress, and what have we observed as changes in his behaviour.

I: You don't use some scale or questionnaire that they fill in on admission and then again on discharge?

R: No. It is through the problem list rating and their future plans.

I: On discharge of the patient, how is his follow-up care planned?

R: In January of this year we initiated the plan of having each patient come back at 3, 6, 9, and 12 month intervals, to see us at the hospital here. Follow-up may also be done by the referral source, the private doctor or the clinic here.

I: Where do you get most of your referrals from?

R: We get referrals from the in-patient wards, from psychiatrists and different agencies in the community. People can be referred directly to us.

I: Are there any types of patients that are excluded from day care? Here I am thinking specifically of drug addicts or alcoholics.

R: The addicts, alcoholics, severe personality disorders, suicidal or homocidal patients would not be considered for this program.

I: What methods of treatment are used in this program?
R: We try to make the program as reality orientated and as every day as possible. We use group therapy, discussions and non-verbal techniques to develop self-awareness. Theater techniques, occupational therapy, medications, work projects and recreational activities are also used.

I: What methods are used to evaluate the total effectiveness of the day care program?

R: Basically, it relates to the patient's problem list, that is our major source of evaluation. Each patient writes a self-evaluation and a progress note on himself at the end of each week. He answers five questions pertaining to his progress. It really relates to the individual, how does he see himself and how does he see his progress. Our follow-up program will also be another method of evaluation.
I: What would be the objective of starting an official day care program here?

R: People need more than just a 15 minute interview for after-care. It is our belief that the more someone can stay in the community and be involved with their families, or be on the job, the better off they are. We feel that the further someone gets into a hospital set-up, the more difficult it is for them to re-adjust to being back in the world again.

I: The people that come in for day care visits, what do they do?

R: They are incorporated into the daily routine. I think that probably, because they are more able to assume more responsibility for themselves, this certainly is stressed and often they are quite helpful with the other patients who aren't as far along as they are.

I: What types of treatment are carried out on the ward?

R: The main thing we try to focus on, so far we don't have a really large number of patients, so we are able to spend a lot of time individually with people and helping them to relate to others in more healthy kinds of ways. We also stress group therapy, along the line of what's happening to you in the here and now, and how can we help you get more out of living. With the idea that you have the same types of problems in the hospital that you have outside, in that you react in similar kinds of ways and you can learn more about yourself and each other.

We do have occupational therapy, recreational therapy, medications, individual therapy and electro-therapy. It seems to me, that sometimes if you really just provide a climate that is secure and giving, that people will really come around. Sometimes we get so caught up in what we are going to do for so and so, that we often leave the patient out of the planning process.

I: Are there any types of patients that you exclude from day care? Here I'm thinking specifically of drug addicts or alcoholics.

R: Yes, we have had alcoholics and drug addicts on the day care program. Our dilemma is that, not for the alcoholic because we really do stress AA with them, and they start in AA when
they are here. But the drug addict, particularly the younger ones. There is nothing available in town and there's no place for them to go.

I: Is there any family or community involvement in the program?

R: We are fairly closely involved with the staff of the Mental Health Clinic here. There is some family involvement, but there needs to be a lot more work in this area. There is also a volunteer club here where people who need to be with other people, and can't really do this on their own, can congregate, and they have different activities. But direct family involvement in the program, there is very little of that.

I: How are patients referred to this unit?

R: The Public Health nurse can refer, and the private doctors are now admitting and the psychiatrists, the patients themselves or relatives.
Partial transcription of the taped interview with day care "G".

Code: R - Respondant

I - Interviewer

I: Would you tell me about the unit here and specifically about the day patients coming up to the ward?

R: Right from the very beginning, we realized that we really couldn't function as a psychiatric unit without some follow-up of the patient. Now we have; because of no funds, because of a lack of space and because of all kinds of things, we have not been able to set up any very high geared specific program. It has been more on the basis of saying to patients, "come on back if you really feel you need to see somebody" in terms of educating them not to slip back too far.

Now we have to be careful not to make people dependent too. By and large we have not set up specific times; it is more when they feel the need to come. Some have definitely been referred to be here for certain hours of the day and to get involved in whatever program we have set up. Here again, due to staff shortage, space, and facilities, we haven't had all that much activity for them to do when they do come. Depending on what the situation is they may stay for 15 minutes or up to 8 hours, or even longer sometimes.

We have three or four people coming in regularly and we have set up specific outlines of what we expect of them while they are here. The rest of the people that come are on more of an emergency basis. Today, one of the patients we've had since the ward opened, phoned and said she felt she was slipping. So she came in and I spent an hour talking with her. By the end of our conversation, her own self-confidence had returned. This is the sort of thing that we do a lot of, in fact, this is the majority of what I would call day care right now.

I: Where do you get most of your referral of patients from, besides the ones who come on their own?

R: Mostly our referrals come through the psychiatrists and the general practitioners. We usually decide after a patient gets here, just how much follow-up they need. Or it may involve us going out to visit them in their home.

I: What types of treatments are carried out here?
R: There is some group therapy, recreational activities, crafts, we use a lot of medications, some electro-therapy, and we try to give people as much individual therapy as possible.

I: Are there any plans for expanding the in-patient unit?

R: There is space that is going to be utilized, but I don't know if it will be by psychiatry. If we did expand, day care would also have to expand and we would need more staff. We've really tried to assess the type of patients that we are dealing with and what does this community or area really need. I'm beginning to feel that if we can run a flexible unit, if we had more space, then maybe a specific day care program with day care beds for people to stay overnight and that type of thing.

I: Do you have any volunteers in the program?

R: We have one who comes up to the ward for about four hours a day and she does various errands. We really do need volunteers. I would prefer to try and use ex-patients if that's possible. It has been my experience that these people do very well and you can get some very good volunteers.

I: Is there any community involvement with the program here?

R: We're presently working on a liaison with several community agencies. There has been some progress. It is obvious that everyone has been working in their own sphere and not really realizing what others are doing and there is a lot of duplication. We've got to get that sorted out first and get working as a team. This is a right sized community where we could do some really good things. Any program that is set up has to be unique to the area it is serving.
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