

RESIDENTIAL AND DAY HOSPITAL
Alternatives in Psychiatric Treatment

by

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ABSTRACT

A survey of residential and day psychiatric hospital literature was undertaken to determine whether day hospitals are alternatives to residential hospitals. The literature was approached utilizing a functional frame of reference. The following four questions were asked:

1. Are the functions of the day hospital as described in the literature the same as those attributed to the residential hospital?
2. If the functions are the same for both hospital types, are they performed in the same manner?
3. Are the characteristics of the patient populations the same for both hospital types?
4. Is there a difference in the effectiveness of the two hospital types?

The conclusions were reached that the two types of hospitals had the same functions but that these functions were fulfilled differently and were of different degrees of importance; that the patient populations while overlapping were not the same; that, as a whole, the effectiveness of the two types of hospitals as measured by rates of patient improvement did not differ. In the instances that differences in effectiveness did appear, there were questions as to whether or not the patient populations had been controlled by the researchers. It was also concluded that

if the type of deviance (i.e., the characteristics of the patient population) was held constant, the two hospitals are not interchangeable or alternatives; but, if the types of deviance are placed under a more general category (e.g., mental illness), the two types of hospitals become two examples of a type of institution for the control of that general deviance (mental illness) in society.

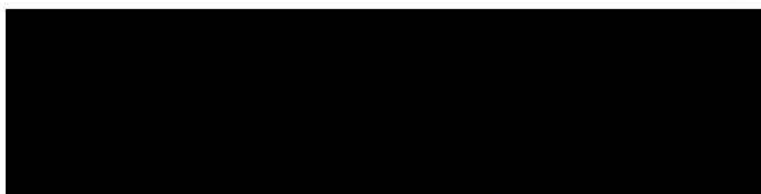


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INTRODUCTION

The residential mental hospital has traditionally been viewed as the central treatment agency for the mentally ill (Stanton and Schwartz 1954; Caudill 1958; Goffman 1962). However, in the last two decades, a new modality or type of treatment agency, the psychiatric day hospital, has been proposed as an alternative to the residential hospital. Initially the claim was made that the day hospital would completely replace the residential hospital (Glaser 1969:829).

A wide variety of claims stating the advantages of the day hospital over the residential hospital is made by various psychiatrists and mental health workers. The "great hope" of psychiatric treatment, the day hospital, is reported as avoiding evils of in-patient treatment such as dependency and regression, rejection of the returning patient (Kraft 1969:180) and the stigma of incarceration (Farndale 1963:177). Kris (1961) reported that day hospitals are more effective than residential hospitals since the day hospitals "produced" better adjusted patients. The claims which remain constant throughout the day hospital movement can be synthesized into one major claim: the day hospitals can provide not only an alternative to residential hospitals but also a more effec-

tive mode of treatment.¹

While there are not, to my knowledge, direct counterclaims against day hospitals (i.e., claims which state that the residential hospital is more effective, etc.), there are two interdependent factors acting against the day hospital movement: Day hospitals appear to be under-utilized (Glaser 1969:827), and one of the main reasons is that therapists are reluctant to use day hospitals (Herz, et al. 1971).

A survey of the literature is always a useful tool in trying to understand and analyze a conflict which is relevant to social control particularly in one's own society which seems to be having problems in defining what are appropriate controls for different problematic behaviour. From a sociological perspective, a survey of a body of literature is useful both in differentiating existing empirical data from what "one thinks" is in the literature and in preparing the essential background work for empirical research.

In this report, I will discuss a survey of literature on

¹Included in this claim is the ability of the day hospital to operate more economically than the residential hospital. However, I shall not deal with the economic aspect of psychiatric hospitals but will confine my research to aspects of treatment.

psychiatric residential and day hospitals. Anyone working with human subjects should be constantly aware that it is people as individuals and in groups who are the "subjects". This knowledge creates ethical and moral conflicts in respect to procedures and the ongoing application of any project. Some of the conflicts arise from the choice of terms and definitions. People are very complex identities, and any behavior or set of behaviors will involve varying aspects of individuals. Therefore, a danger exists of applying the wrong term or label, e.g. the labelling of a patient, by an emergency room staff, as drunk and suffering from D.T.'s when the patient may be a diabetic and suffering from a low blood sugar. A second danger derived from labelling is that the label may imply more than is stated in the definition, e.g. "neurotic" often implies a "worse" state of being than is stated in textbook's definition of the term. A third danger involved in applying a label is the very fact that using the label will have a long term effect upon the person to whom it is applied, e.g. to label someone as demonic or possessed by demons (as was once commonly done) certainly creates a lasting effect upon the labeled person.

Many labels tend to imply personal negative qualities, that are not in the denotation of the label. These terms may

be ascribed in particular cases and not in others, for example the term criminal, defined as a person who breaks the law, is always applied to the person who commits murder, never to the person who jay-walks, and may or may not be applied (depending upon the circumstances) to the person who misappropriates public funds.

The problems stemming from the choice of labels and definitions are more or less short term for the person who does the labelling. However, the moral and ethical responsibilities do not end there, nor do they end with the completion of a study. They are on-going processes from which one cannot walk away. These questions of responsibility and ethics have led to a wide variety of theories about "mental illness", for example the functional psychoses have been labelled quite differently as "problems in living" and "hereditary weakness" both referring to the same types of behaviors. More importantly on a concrete level these questions have led to a wide variety of attempts to help the labelled group, such as counselling services, lawyers, doctors, dispensers of such drugs as Vitamin E, mental hospitals, halfway houses and so on. Many of these attempts to assist people bearing the label of "mental illness" may have created more problems than they have solved, for example mental hospitals have led to deterioration and neglect and the phasing out of the hospitals has led to deter-

ioration and vagrancy in the community.

Aware of the ethical questions and moral responsibilities involved, I have chosen to examine the literature on two types of mental hospitals. The choice of these agencies is directly related to a concern expressed by the British Columbia government. In Canada, the provincial and federal governments are the main funding agencies for the treatment of those labelled "mentally ill". The governments are beginning to recognize that the focus of treatment is shifting. But where the shift will end and what the overall trend will be is far from predictable at this point. I am not attempting to justify or avoid an ethical stand on the basis of funding. By presenting a review of the literature, the negative as well as the positive aspects of the two hospitals were revealed.

METHODS

This survey of the literature relating to residential and day hospitals attempts to discover the empirical bases for the claim that the day hospital is an alternative to the residential hospital. A functional frame of reference was utilized. There were four basic questions to which answers were sought:

1. Are the functions of the day hospital as described in the literature the same as those attributed to the residential hospital?
2. If the functions are the same for both hospital types, are these functions fulfilled in the same ways?
3. Are the characteristics of the patient populations the same for both residential and day hospitals?
4. Is there a difference in the effectiveness of the two hospital types?

The literature relating to or describing the residential hospital is extensive, of adequate quality and multi-disciplined. After an initial survey of this literature, I decided to select for detailed examination only those studies which included a full statement of methods, which were generally accepted as reliable studies by other researchers in the field and which were most often cited in the overall literature. An effort was made to balance the impressionistic studies such as Goffman's (1962) with those using systematic data such as Hollingshead and Redlich (1959).

The literature on day hospitals is limited, is often of doubtful quality, and tends to be written by persons directly involved in the particular day hospital that they are describing. There is no thoroughly good account of day hospital structure. Because of these limitations, it was decided to include all articles relating to day hospitals which were listed in the Index Medicus (1950-1971), the Social Science and Humanities Index (1960-1971), and the Comprehensive Community Mental Health Center: An Annotated Bibliography (Lacher 1969). Altogether over 200 articles were reviewed. A list of criteria was developed to determine which articles would be used as primary sources and which articles would be used as secondary sources. To be included in the primary sources the article had to state:

1. Name, affiliation, size and location of the day hospital.
2. The hospital's criteria for patient admissions and the referral agencies used by the hospital.
3. A statement of the goals and orientation of the hospital.
4. The characteristics of the patient population (i.e., the sex ratio, age groups, socio-economic class and ratio of patients in each diagnostic category).

Among the 200 articles examined, an insufficient number were found to meet all of the above criteria; however, many of the articles overlapped since they referred to the same hospital. Therefore a great deal of time was spent in sorting and com-

binning the information given in these articles. This process resulted in providing adequate information to meet the required criteria for 40 day hospitals. This paper may be criticized in that the method for selecting the material on the two hospital types was not the same. However, it is felt that the day hospital does not permit the desired strictness of method.

The literature on day hospitals presented a further problem relating to definition. The term day hospital is used loosely to refer to a number of different types of treatment. Adding to the confusion is the use of several different terms--day center, day unit and day program---which may or may not refer to the same kind of facility (Cumming and Bass 1972:3). The definition most often used in the literature and adopted for the purpose of this paper is that of the U. S. National Institute of Mental Health:

A therapeutic facility for patients with mental or emotional illness or retardation who spend a part of the day in a planned treatment program in this facility in which a psychiatrist is present (as quoted in Zwerling, 1966).

HISTORICAL BACKGROUND

The romantic, often told legend of St. Dymphna of Gheel is of interest and may relate to the "first" day hospital. Around 600 A.D. a widowed Irish king who was possessed by the devil decided to marry his daughter. However, the daughter, who had been under holy teaching and had taken a vow of purity, fled from her father and crossed the English Channel to Belgium. She was overtaken and decapitated by her father near the village of Gheel. Some years later, five lunatics chained together on the site of the girl's murder were cured of their insanity when the girl, reincarnated as St. Dymphna, appeared to them in a vision. Thus St. Dymphna became the patron saint of the mentally ill and the village of Gheel became a place of holy pilgrimage for the mentally ill. By the fifteenth century regular pilgrimages were made to Gheel. The pilgrims were housed in the near-by village and spent their days seeking cures at the site of St. Dymphna's appearance. Today there is a mental hospital at Gheel and the sick still visit the shrine of their patron saint.

However, the day hospital as defined in this paper, is a fairly new psychiatric institution. To describe its history we need to go back only as far as 1933. At that time, there

was a drastic over-crowding in the Moscow residential hospital. As funds were lacking to build and staff new hospitals, a plan was devised to treat a number of patients on a day basis (Dzaghagarora, 1936). The term day hospital was not coined until 1947 when Cameron created a new unit of the Allen Memorial Institute in Montreal. The establishment of this unit was, according to Cameron (1947), an answer to a shortage of beds for predominantly psychotic patients. The second use of the term day hospital was in England in 1951 (Bierer 1951).

By 1933, the provincial and state asylums or residential mental hospitals in the country with landscaped gardens and planned farms, high fences and fortress-like buildings, were an established part of North American culture. In 1938 electroconvulsive therapy was introduced. By 1947 the more progressive residential hospitals were trying such programs as the un-locked door policy, and staff involvement in therapy sessions. However, the overwhelming majority of residential hospitals were continuing to employ a custodial approach and retained locked doors with staff as keepers.

Meanwhile the spread of day hospitals was rapid; in 1963, there were approximately 200 day hospitals in North America.²

²The 1963 N.I.M.H. survey showed 168 day hospitals in the U.S. The Canadian estimate is based on known day hospitals and not on a survey.

Owing to increased health funding in Canada, and the requirement that day hospitals be a part of the Comprehensive Community Health Centers in the United States, the increase in day hospitals was even more rapid after 1963.

The residential hospitals reacted to the growth of day hospitals almost as a biological entity reacts to an adaptive mutation which threatens its survival. Residential hospitals began integrating some of the day hospital traits and giving themselves something which (in my view) amounted to a face-lift (i.e., an external or superficial change which was helpful but not adequately pervasive). Glaser (1969:827) has theorized that the spread of day hospitals and the changes in residential hospitals corresponded to the establishment of the community mental health movement which was in turn a response to the extension of the benefits of American society similar to that of the Roosevelt New Deal. Others have theorized that the "gospel of mental health was spread over the land...(by) radio, television, magazines, newspapers, sermons, and lectures" (Mereness and Karnosh 1966:270).

FUNCTIONS

In this section, the literature on the functions of the two modalities, residential and day hospitals, is examined to determine whether they are the same or different. Each function is examined for its effect on the hospital structure and on the patients.

1. Custody

In the mind of many people the custodial functions is a defining characteristic of psychiatric hospitals. This follows, no doubt, from the mental hospitals having traditionally performed a custodial function in society. Grob argues that the function of protection at Worcester State Hospital resulted from a variety of inherited reasons.

First, the existence of a mental hospital meant that jails and almshouses were not the only places for the confinement of insane persons. Families that had once been reluctant to send loved ones to substandard institutions were now more willing to consider the possibility of institutionalization. Second, the growing urbanization made it more and more difficult to care for the mentally ill in the community. Deviant behavior in densely populated areas not only posed greater problems than in rural areas, but it was also less likely to be tolerated. Third, the establishment of a mental hospital increased societal awareness of mental disease, and undoubtedly some who had been considered quaint or odd were now looked upon as insane (Grob 1970:303).

He claims further that the custodial function served as a

"survival technique" for many mental hospitals in that, at a time when mental hospitals could not justify their existence by curing the patient, their raison d'être had to be rationalized in custodial terms.

Indeed, much of the support that the hospital received was predicated on the assumption that it would provide protection against groups that menaced the safety and security of society (Grob 1970:303).

In Human Problems of a State Mental Hospital, Belknap (1956) describes the function of custody in a residential hospital. Implicit in Belknap's account is the importance of custody as a survival technique as well as the most basic internal function of the hospital. To show the legal basis of the custodial function he quotes the constitution of "South State" (Texas): "It shall be the duty of the Legislature to provide for the custody and maintenance of indigent lunatics, at the expense of the State...."(Article Ten, Section Six of the Constitution of Texas as quoted by Belknap 1956:33). As late as 1956, the first legal and administrative responsibility of the hospital was custodial (p. 67). From the reports of other researchers working in the late 1950's and early 1960's (Caudill 1958; Brown and Wing 1962; Goffman 1962), it appears that the importance of custody as a function in residential hospitals was not confined to one particular type of residential hospital or to one particular geographical section

of North America.

Dunham and Weinberg (1960), in The Culture of the State Mental Hospital, discuss the function of custody in the residential hospital and point out in vivid terms the primacy of custody in the form of removal, isolation, surveillance and the preventing of escape. Their findings were based on a study of residential hospitals in Michigan.

Grob (1970), in an historical review of Worcester State Hospital, gives a detailed account of the functions of the residential hospital. In this study he explicitly identifies custody as the main function of this New England Hospital from the year 1846 forward.

In England the County Asylum Act of 1808 made provision for the founding of asylums as custodial agencies. Kathleen Jones (1963), in a review of the functions of residential mental hospitals in England, comments that custody is the principal function of these institutions. Brown and Wing (1962) found in comparative clinical and social surveys that the custody function in England is still primary but has lost some of its importance. A general reading of both the American and English literature gives the impression that overt custody (i.e., the use of chains, strict surveillance, etc.) has not been as important in English hospitals as in North American hospitals, at least since the 1850's (Jones 1959).

The most intensive impressionistic data on custody as a function of the residential mental hospital is found in Goffman's Asylums (1962). The book gives a comprehensive overview, in both an implicit and explicit manner, of the function of custody. In terms of systematically collected data, Gilbert and Levinson(1957) furnish the most impressive single study on custody and the residential hospital. Three hospitals were studied; all were found to be in a state of change.

The large state hospital, C, was assessed as the most custodial in view of its structural emphasis on detention, protection, and custodial care of patients in a highly controlled setting. The pressures it exerted on personnel, and the kind of experiences it offered them, seemed most conducive to custodial orientation. The large VA hospital, T, was considered intermediate or transitional in that it was in a process of fairly rapid change away from custodialism. The third hospital, H, was the most humanistic of the three in its program of ward care, patient government, and general staff-patient re-³lationships (Gilbert and Levinson 1971: 582-583).

Whether custody is a function of day hospitals could not be adequately determined from the explicit information given

³ Gilbert and Levinson use the term, custodial hospital, to denote a hospital which has the main function of custody, and the term, humanistic hospital, to refer to a hospital which has the main function of treatment in the form of "rehabilitation" or "therapy".

in the literature. There are two reports of custody as a function of day hospitals, in terms of so-called baby-sitter services (Kramer 1969: 15; Cumming and Bass 1972: 8). Kramer states that the use of a day hospital as a baby-sitter service especially for the chronically ill, senile, and the mentally handicapped is a valid use of day hospitals and is of great social value. The literature on English, and Australian day hospitals indicates that the baby-sitter service is the primary purpose of these day hospitals (Ferguson and Carney 1968). However, an analysis of the patient populations in those particular day hospitals which have been referred to as fulfilling the baby-sitter service leads one to conclude that such a service is part of the function of protection and not a part of custody. This question will be discussed to a greater extent in the section of this paper which deals with protection.

Custody is very obviously a central function of residential hospitals but only marginal in day hospitals. Total or 24 hour custody brings with it the necessity for a series of services known as hotel services.⁴ Rosengren and Lefton (1970) discuss the effect of hotel services on the custodial structure of

⁴Hotel services refers to food service, provision of beds, etc. and is used throughout the literature in connection with residential hospitals.

residential hospitals. Goffman (1962) introduced the term social hybrids to describe total institutions such as the residential hospital which is part formal organization and part residential community. He states that these social hybrids will, by necessity, contain conflict and he deals at length with the characteristics of these institutions. He appears to be saying that the residential hospital must be able to remain a community in which the patient is forced (by the presence of the custodial function) to stay and be labelled as not responsible, while at the same time the hospital must be a place of work for a responsible staff. This situation leads to structural stress, because the patients and staff will be asked to express common sentiments for the good of the institution (Parsons 1957: 41-42).

When a patient is judged clinically as not being capable of carrying on daily activities and is placed under 24 hour custody (i.e., in a residential hospital), he is then perceived as being different from other people in that he has been judged as not responsible. Perrow (1961, 1963), Rosengren and Lefton (1970), and Friedson and Rhea (1963) argue that this perceived difference in the nature of the patient leads to differences in the structure of the hospital. Perrow, and Rosengren and Lefton state that the organization that deals with patients who are not responsible will tend to be bureaucratic and will be concerned with power, authority and division of work groups.

They also state that the perceived difference in the patient affects the technology used to achieve the goals of the hospital.

The literature reports other effects of custody that directly involve the patient. One phenomenon of residential hospitalization is long term: the patient may be forgotten by the outside world. Kramer (1970:455) states that the most distinctive feature of the day hospital is the ability to help the patient avoid becoming isolated from the community in that the patient returns each day to the continuity of outside roles. Another latent function of custodialism is termed institutional neurosis which Barton defines as:

... a separate disease entity, characterized by apathy, submissiveness and inability to make decisions, and caused by custodial systems of care. He lists seven main factors in causation: loss of contact with the outside world, enforced idleness, authoritarian staff attitudes, loss of personal possessions, over-sedation, depressing surroundings and loss of prospects for the future (Barton as quoted in Jones 1963: 61).

Kramer (1970: 453) uses the word dependency to describe a state in which the patient becomes dependent on the hospital environment. He quotes a staff member of one hospital as saying "This hospital is like one big breast: if you don't watch out, the patients would be here forever". He also uses dependency to define an orientation of one school of mental health worker. This orientation views the hospital as a refuge and a place to

which the patient should turn (p. 453-454).

Apart from the previously mentioned latent functions of full time hospitalization, there is a serious charge made in the literature that a correlation exists between custodial care and increased symptoms. This charge was first made by Myerson in 1939 when he stated that total hospitalization made schizophrenia more pronounced (Perrow 1963: 1197). Since that time, several studies have been made to determine whether a correlation exists between full time hospitalization and increased symptoms of different diseases (Hunter, et al. 1962; Klein and Spohn 1962, 1964; Wing 1968). Wing (1968) specifically reports a correlation between institutional restrictiveness and such symptoms as regression and depression.

In summary, the literature reveals that custody is an important function of residential hospitals and reports certain effects that custody has on hospital structure and on the patients. Custody is not reported explicitly as a function of day hospitals. However, there are articles which refer to the day hospital as fulfilling a baby-sitter service, which is, in part, a custodial function.

2. Protection

The second function of mental hospitals identified in the literature is that of protection. Protection is for the patient, whereas custody protects society from the patient. The word asylum, meaning an inviolably safe place, is a good indication of the protection function (Jones 1963). Jones, in explaining protection as a function of mental hospitals, quotes Tuke's speech of 1813:

... to convey the idea of what such an institution should be namely a quiet haven in which the shattered bark might find a means of reparation or of safety (Tuke as quoted by Jones 1963: 62).

There are at least two current sociological indications in the literature for the use of protection as a function of mental hospitals. Parsons (1957: 285) defines the sick role as a "passive-alienative deviant behavior" with "an element of dependency ... illness is predominantly asking to be taken care of".⁵ Goode (1960) used the concept of protection in relation to the inept, both deviants and incompetents. It is implicit in his meaning that protection is for both the

⁵ Parsons (1957: 458-447) includes mental illness in this definition of the sick role.

group and the individual.⁶

Protection in the form of meeting the physical needs of the patient, such as food and shelter, is obvious in residential hospitals just as it is obvious in other total institutions. However, the residential hospital ideally furnishes protection in the sense that the patient does not experience stressful and overpowering situations and does not have active responsibilities. Devereaux (1944) and Jones (1963) discuss tensions and stress in society, such as rate of social change and cultural lag, that may contribute to mental illness and from which mental hospitals protect the patient. White, Miller, and Polansky, in an address to the American Psychiatric Association (1955), summarize the views of Tuke, Jones, and Devereaux in a statement which described protection as a basic function of mental hospitals.

Kramer (1970) reports that there are two schools of thought on whether protection should be a function of mental hospitals. One viewpoint discussed earlier in this paper sees protection as a primary function, while the other viewpoint does not consider it a valid function. However, according to Kramer the critical issue concerns the correct

⁶The Cummings have found that patients will label themselves as inept rather than mentally ill as a way of reducing stigma (Cumming and Cumming 1957).

amount of protection which the patient should be given. The Cummings (1962: 108) state that both custody (control) and protection (support) must be included in psychiatric treatment.

Protection as a function of day hospitals is referred to throughout the literature but often in either general or vague terms. [Frequently it is reported that day hospitals remove the patient for part of the day from specific stress and provide him with an alternative environment] (Glaser 1969; Kraft 1969; Farndale 1963). Trends in the Mental Health Services edited by Freeman and Farndale (1963) discussed protection in English day hospitals. In this collection of writings, day hospitals are called sheltered workshops, half-way centers, and general help sessions. As I pointed out earlier, day hospitals are referred to as providing a baby-sitter service. In some day hospitals, particularly those in blighted urban areas of North America, this baby-sitter service appears to be custodial. However, in other day hospitals, particularly geriatric day hospitals, the baby-sitter service appears to be primarily part of the protection function (see Chasin (1967) on problems in an urban day hospital; and Fine (1963) on geriatric day hospitals).

The importance of reducing the overall length of stress time by the use of day hospitalization has not been reported,

even though the importance of such a stress-relieving function was recorded by Appel in his study of front-line soldiers (Appel and Beebe 1946).

Protection as a removal of stress is not without its cost to both the patient and the hospital.

The concept of a hospital as a refuge too often means, however, that patients are robbed of their status as responsible human beings (Main as quoted in Perrow 1965: 932).

Protection, at the best of times, may result in withdrawal and at the worst of times, in an increase of symptoms (Main 1963; Perrow 1963; Goffman 1962). For the hospital, a strong emphasis on protection can limit the effectiveness of certain therapeutic programs and can result in longer average stays. In the residential hospital, patient protection may be equated with good physical care but not with treatment. As Belknap says:

Improvement in physical care of patients in the hospitals has occurred, but it has not resulted in reduction of patient population through cure, but in greater average duration of hospital life for some schizophrenics, the mentally deficient with psychosis, and patients with mental diseases of the senium (Belknap 1956: 13).

To summarize, protection is reported throughout the literature as a function of both day and residential hospitals. The type of protection provided by the two institutions is essen-

tially different, in that one provides total protection and the other provides partial protection. The cost of protection to the hospital can be long patient stays. The cost to the patient can be a deeper withdrawal from society.

3. Therapy or Clinical Treatment

A third function of mental hospitals described in the literature is therapy. The original functions of mental hospitals or asylums were custody and protection; therapy having little effect on the hospitals or patients. Hospital reforms previous to those of the early 1900's were concerned with humane care or the protective function, not with therapy per se. Belknap (1956: 67) states that the medical or clinical function "ranked only third in the concrete responsibilities of the institutions" and that the "medical functions..may be discharged after the first two requirements are met".⁷ Most of the literature on psychiatric hospitals, including that by sociologists, reflects an interest in either custody or humane care, not in therapy or clinical treatment (note Goffman's Asylums).

However, there is a body of literature that deals with therapy not only as a function of psychiatric institutions but also as the technology of those institutions. Technology, as defined by Perrow (1961: 854-866), is a technique or complex of techniques employed to alter "materials" (human or

⁷Belknap, as stated earlier in this paper, sees the first function as custody. He refers to what he calls "institutional maintenance" as the second responsibility of the hospital.

nonhuman, mental or physical) in an anticipated manner. Perrow discusses the operative conflicts that result when a hospital changes its primary functions from custody and protection to therapy. He argues that organizations are influenced by the technology they use to reach their goals.

However,

Mental hospitals can exorcize devils, apply shock treatments, develop conducive milieus, apply learning-theory techniques or use psychotherapy. Note that the systems-level goals do not necessarily change in the process. For example, hospitals still try to cure; only the 'operative' goals --means to the system level goals--- change (Perrow 1961: 854-866).

The effect of a particular technology or fulfillment of the therapy function is discussed by Moll (1963), and Strauss, et al. (1970). Moll is convinced that:

The selection of personnel is largely dependent on the therapeutic programme, which in turn is dependent on:

- (i) the selection of patients;
- (ii) the number of patients;
- (iii) the expectations of stay; and
- (iv) general therapeutic orientation (Moll 1963: 196).

Following this line of reasoning, residential and day programs, owing to differences in size, length of stay, and (as will be discussed later) selection of patients, will have different orientations to the therapy function. There are overlaps, however; namely, the milieu orientation. The Cummings (1962)

have stated that "In the past few years the term 'milieu therapy' has become so popular that few hospitals will admit to not supporting a therapeutic milieu".⁸ In residential hospitals the stability of therapy, particularly milieu therapy, is threatened by the function of custody as perceived by the patients and staff. Caudill, as well as others, have made clear the difficulty in convincing a patient of the desirability of free expression when he must seek permission to perform even routine activities. It is equally difficult for the staff to conform to a milieu program if they are held responsible for the custody of the patient (see in particular Caudill 1970: 315-388). On the other hand, Caudill describes patients who considered all rules and structured activities or the lack of structured activities in a residential hospital as being part of an overall "24-hour-a-day-therapy".

The patients believed that therapy was 'somehow psychoanalytical'; that one had 'to go back into childhood'; and that therapy went on '24 hours a day'. One evening a group of 11 patients were discussing the lack of activities in the hospital, and they came to the conclusion

⁸ Milieu therapy is defined as "a scientific manipulation of the environment aimed at producing changes in the personality of the patient (Cumming and Cumming 1962).

that it was part of a conscious plan by the staff to increase the intensity of '24-hour-a-day' therapy (Caudill 1970:357).

The residential hospital, if it wishes, is able to cope with a wide variety of therapeutic programs owing to its size and potential high division of labor, whereas the day hospital has a very limited choice of therapeutic programs because of its smallness and the limited time in which it has to make clinical evaluations of the patient (Chasin 1967: 780). The literature indicates that there are two major modern therapeutic programs used in both types of hospitals: milieu therapy and drug therapy. Secondary programs mentioned in the literature are group psychotherapy and shock treatment. However, it is drug therapy alone that is credited with reducing the importance of the functions of custody and protection (Wechsler, et al. 1970).

From the literature, it can be seen that therapy is now considered a valid function in every accredited residential and day hospital. In the United States, therapy is legally mandated as "the right to treatment" and a recent Alabama decision has spelled out in detail what therapy means. Therapy in general means different treatment and to different extents. The choice of a particular therapeutic program will affect the structure of the hospital and, of course, will affect the patients.

4. Socialization

The fourth function to be discussed is socialization. By socialization is meant the process by which the patient is incorporated into the world of the hospital. However, the term socialization has been used by Jones (1963) and others to mean a form of re-socialization. A clear distinction must be made between these concepts in order to differentiate the function of socialization from the function of therapy.

Re-socialization is the end goal of the function of therapy.

Since the nineteen-thirties, as the dangers of "institutional neurosis" have become more clearly recognized, policies of social integration have formed a major part of the mental hospital's work. The theory of the "therapeutic community", as developed in a number of hospitals, means more than the recognition that the mental hospital has a healing purpose. It implies an attempt to use the whole social group, staff and patients, as a means of integrating and healing individuals (Jones 1963: 64).

In relation to the function of protection, re-socialization produces a therapeutic dilemma in which sanctuary (protection) is opposed to social demands (re-socialization) (White, et al. 1955). Jones interprets White's arguments as meaning "Just as undue prolongation of 'sanctuary' can lead to a condition of permanent dependence, so 'social demand' can lead to relapse..." (Jones 1963: 63-64).

The function of socialization concerns the inter-personal relations between patients and staff as well as between patients, and also the induction into the patient role and

adoption of hospital norms. (See Fromm-Reichman 1950; Caudill, et al. 1970; and Bateman and Dunham 1948). One of the most quoted statements in mental hospital literature is from Rowland (1939) "... it (the mental hospital) is a community of interacting individuals who are participating in a living drama". Rowland's early studies dealt with certain aspects of socialization as a function of the mental hospital; namely, the establishment of friendship groups and pecking orders among the patients.

Goffman (1970) describes the function of socialization and its importance to the status quo of the hospital. In a post-script he says... "patients develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it" (Goffman 1970: 349). Caudill, as a participant observer who had been admitted in the guise of a patient, studied the socialization function in a residential hospital. He reports that he was pressured on his first day to adhere to certain attitudes in four areas of ward life--"self, other patients, therapy and therapist, nurses and other personnel" (Caudill 1970: 353). Solomon and Maher (1966) summarize the body of research on the function of socialization in residential mental hospitals. In this literature it is repeatedly asserted that the social system of mental hospitals is oriented toward manageability rather than toward mutual social relationships.

The day-hospital socialization process must co-exist with

the more permanent aspects of the patient's social reality (e.g., his family, friends, and the community). The overt effects of this dual environment appear to be situational. Freeman (1962) reports that "unfavorable" home environment may result in increased feelings of anger and confusion on the part of the day patient and members of his family (p.259). Cumming (1964) has speculated that the day hospital environment is adapted to deal with value problems. He considers that, with the patient remaining in his role as a family member, a situation is produced where there may be a value change in the whole patient social system which will make it less likely that new value systems will build up that are specific only to the treatment situation. Cumming concludes that, to maximize the usefulness of the day hospital, the family should be directly involved in the therapeutic process.

Parsons has defined the mental hospital as a social organization with the goal of coping with the consequences of mental illness for the individual patient and also for the patients as a social group (Parsons 1957b). A considerable number of the contributions in the residential and day hospital literature discuss the socialization process as a function of mental hospitals. The term socialization is also referred to as an end goal of therapy. I have assigned the term resocialization to this process. The socialization function in the residential

hospital is more complete since the patient has only the one environment--that of the hospital. The socialization function of the day hospital must co-exist with the more permanent aspects of the patient's social life.

PATIENT CHARACTERISTICS

Patients in residential mental hospitals are persons who have been judged to be incapable of coping with the outside world even with the help of other available means of treatment. Public residential hospitals' criteria for admission usually consist in the person being judged as clinically in need of hospitalization and in being a resident of a particular geographical area. Among residential hospitals, patient population shows extreme variation in terms of diagnosis, age distributions and sex ratio. The socio-economic class distribution is less variable, with most patients being lower middle and lower class (Hollingshead and Redlich 1959).

As noted previously, day hospitals were started as overflow units for persons who otherwise would have been in residential hospitals.

As time went on, however, there seems to have been a tendency for more and more criteria of selection to be developed which had the effect of producing services with different populations (Cumming and Bass 1972: 3).

Two studies specifically compare the group characteristics

of patient populations of the residential and day hospitals.⁹ Kraft (1969) tabulated 300 patient factors. Fifty of these factors were checked to see if significant differences appeared between day patients and the residential patients at Fort Logan Mental Health Center. The total patient population of both hospitals was 235. A chi square analysis was performed to test the frequency with which the 50 factors or characteristics were found in both groups. Of the factors, 13 served to differentiate the two groups. These factors were; hallucinations, impairment of effectiveness, inappropriate behavior, delusional thought content, disturbed orientation, disturbed alertness, confusion, concept of illness, personality disorganization, admission diagnosis, in treatment just prior to admission, readmission to Fort Logan and previous psychiatric treatment.¹⁰ When

⁹Other studies done specifically for comparison of effectiveness rates in the two types of hospitals give data which pertain to patient characteristics. The information given in those studies on patients' characteristics will be discussed in the section of this paper which deals with the effectiveness of the two types of hospitals.

¹⁰Kraft states that two other factors are significant: ratio of broken homes to intact ones and voluntary to involuntary admissions. In explanation of the latter factor, he states that all involuntary admissions are residential admissions.

evaluating this study, one must note that Kramer does not list the 150 factors that were not chosen for the test of significance nor does he state how he chose the 50 factors that were tested.

A second study dealing with group characteristics of day and residential patient populations is a report of 500 patients at the San Diego Treatment Center with some comparison to the residential patients of San Diego General Hospital. This study by MacMillan and Aase (1969) deals primarily with the socio-economic characteristics of the two populations. The San Diego Center was at the time of the study atypical in that it served as a "gold fish bowl" for both visiting psychoanalysts and budget analysts. The modal patient of this day hospital was "white, married, Protestant female in her thirties, and was likely to have at least a high school education" (MacMillan and Aase (1969). There is not a description of the modal patients of the general hospital residential group, but it is implied that there would be a difference. The authors sum up by saying:

...the San Diego Day Center is meeting a need for the intensive treatment of mentally disordered middle class patients, who might find it stigmatizing to go to a public mental hospital.. (MacMillan and Aase 1969).¹¹

¹¹A third study that deals with group characteristics of the two patient populations was conducted by Hogarty, et al. in Baltimore (1968). This study reports that the two patient groups are different but does not report how this finding came about.

The characteristics of the patient of the San Diego Day Centre are similar to the patient characteristics of the patients admitted to the forty day hospitals used in this analysis. The data indicate that the modal patient is white, middle class, Protestant female in the late twenties or early thirties.

To test whether day and residential patient populations are the same, Zwerling (1966) conducted an experiment at Westchester Square Day Hospital in the Bronx, New York. Patients requiring admission were assigned randomly either to the in-patient service (residential hospital) or to the day program. If the random selection was for the day hospital, but the physician did not feel the patient could be treated there, he was required to set forth his reasons under one of three categories:

- a) Physical disability,
- b) Family objection,
- c) Nature of the symptoms such as overwhelming suicidal ideation, uncontrollable assaultive behavior, etc.

Seventy-two patients were included in the sample; of these 17 or 23.6 per cent were rejected on the basis of one of the above categories. Of the patients taken into the day hospital, a further 17 had to have some in-patient care and six of these were changed over to a general or state hospital to complete their treatment in the day hospital. Approximately half of those patients accepted for day hospital treatment successfully finished treatment in the day program. It would appear that a substantial portion of the patients who would ordinarily be

judged suitable for an active in-patient service could be treated as day patients.

As stated earlier, the criteria for admission have made the day population different from the residential population. The following criteria for admission were present in half, or 20, of the 40 day hospitals covered in the literature survey:

1. The patient must be able to spend nights at home.
2. The family must be willing to have the patient remain at home.
3. The patient must be able to provide transportation.
4. The patient cannot be suicidal, homicidal or destructive.
5. The patient cannot be alcoholic or a drug addict.
6. The patient should not be severely retarded.
7. The patient must not have severe physical handicaps.

Criteria four, six, and seven have a wide range of meaning so as to drastically limit the possible patient population of some day hospitals. The Baltimore Psychiatric Day Center's criteria included rejecting antisocial behavior, acting out behavior, suicidal risk, mental retardation (IQ under 70), severe brain damage, sociopathic illness, alcoholism and drug addiction (Hogarty 1968). Adelphi House, a day hospital in Blackpool, England, has a very simple admission criteria: no very young, old, disturbed, deteriorated, subnormal or physically infirm (Carney 1970).

Day hospitals in England have tended to be surprisingly conservative on admission criteria, particularly criteria pertaining to diagnostic categories. A study by Croft (1959) shows that they are treating depressive illness but very little psychosis with acute symptoms. After extensive study of English day hospitals, Farndale states "Day hospitals are in fact creating a new clientele and may well be increasing the demand for psychiatric treatment" (Farndale 1963: 180).

The literature as a whole offers little concrete data to establish if the day hospital's patients are the same as the residential hospital's patients. There would seem to be an overlap, with both hospitals treating the middle ranges in terms of severity of illness and in terms of the socio-economic class of patients. The admission criteria of day hospitals indicates that the day hospitals are not treating the severely ill and that they are not treating many who otherwise become residential patients.

In the following section of this paper there are reports of studies which try to measure the effectiveness of the two modalities. In these studies, controlling for patient population was very difficult, as randomly selecting patients for day care often proved clinically unfeasible. This is another indication that day hospital patients and residential hospital patients do not have the same characteristics.

EFFECTIVENESS OF THE TWO MODALITIES

Effectiveness is the ability of the modality to treat the patient in such a manner that he will show improvement in the shortest length of time possible and that the improvement is such that the patient is able to remain in the community without further hospitalization.

The earliest study attempting to measure the effectiveness of the two hospital types was that conducted by Kris (1961) at the Lower Manhattan Aftercare Clinic. The sample in this study consisted of persons who had previously been treated in a New York State residential hospital and had been judged as relapsing and in need of further hospital care. A second stipulation was that the patient's family had the resources to care for the patient at home during the night. Patients meeting these criteria were randomly assigned to the residential or day hospital. The total sample was small, but the report states that the follow-up time was adequate. The results of this study indicated only that the residential patients had longer periods of hospitalization than the day patients.

Wilder (1966) reported a follow-up study of the Zwerling experiment (mentioned earlier in this paper). After a period of two years both hospitals reported 85 per cent of the patients were not receiving psychiatric treatment. The length of the day

treatment had been longer, with a median of 37 days, than that of the residential treatment, with a median of 20 days. However, the length of time before re-hospitalization was longer for the day patients. There were no significant differences in clinical or social conditions of the two groups at follow-up.

It is also of interest that the total enthusiasm for day care shown in the earlier of these two related papers is considerably moderated in the second and there is the suggestion that a more specific role should be sought for the day hospital (Cumming and Bass 1972: 15).

Croft (1959) reported on a series of studies at the Maudsley and Bethlehem Hospitals. The reports were retrospective and based on a matching of records. One of these reports is on a study of matched groups of 43 day hospital and 43 residential hospital patients with depressive illnesses. The patients were matched in age, previous admissions, marital status, social class diagnosis and severity of illness. In this study the day patients were under treatment for a shorter period of time than the residential patients. There was no difference in the rate of those discharged as recovered or improved and there was no difference in their clinical or work status five months after discharge. Croft's report indicates that the two hospitals were almost equally effective.

The most thorough study on the effectiveness of the two modalities is by Herz, et al. (1971). This study was con-

ducted at the Washington Heights Community Services, a unit of Columbia Presbyterian Hospital. For over two years new residential patient admissions were screened for potential day admissions. The total screened population was 424. Of this number 31.6 per cent were judged too ill for day care and 20.1 per cent were judged as too healthy (i.e., they could not be considered in need of residential care). A further 27 per cent were rejected owing to factors such as uncooperative family or physical illness. Therefore 90 patients or 22 per cent were left who could be randomly assigned to either service. The patient follow-up was conducted at two and four weeks after admission and a final follow-up at two years after admission. The average length of stay was 48.5 days for day patients and 118 days for residential patients. Day patients were less often hospitalized and showed less pathology at the two and four week follow-ups but at two years looked much like the residential group. There are three factors which must be kept in mind concerning this study. First, 58.6 per cent of the patients¹² could not be admitted to day care owing to severity of illness or families' inability or uncooperativeness. Therefore the

¹²The total per cent rejected was 78; however, 20.1 per cent of these were judged as too healthy.

chance of having day patients who would not do well was eliminated. Secondly, the study was able to use complete random assignment. Third, the unusually long residential patient stay can in part be explained by the fact that Columbia Presbyterian is a teaching hospital.

From the studies considered in this paper, as well as more impressionistic studies not reviewed here, it appears that the day hospital is an effective alternative for residential treatment in almost half of a group of mentally ill patients. The available evidence seems to indicate that there is little difference in the effectiveness of the two types of care. The effectiveness of the two modalities has not been systematically tested. As the two patient populations cannot be equated, very little reliance can be placed on the indications of effectiveness provided in the present hospital literature.

CONCLUSION

In 1947 Cameron stated that an alternative to residential mental hospitals had been found. This proposed alternative was a psychiatric day hospital. In the period since 1947, various mental health workers have claimed that the day hospital is not only an alternative to the residential hospital but is also a more effective means of treatment. The proof of this claim is far from imminent, and the growth of the day hospital has failed to tip the balance of treatment for many severely ill patients away from in-patient treatment.

The present paper has dealt primarily with the most controversial questions about day hospitals: do they have the same functions of residential hospitals?; do they treat the same patient population as residential hospitals?; are they more effective than residential hospitals? Few would contend that there are data to support the answers to all of these questions. Therefore this paper surveyed the literature to find what and how much data exist. It was not proposed to resolve the controversy; rather it was attempted to define the limits of data about the two types of hospitals.

It was found that the functions of residential hospitals are clearly defined in the literature as custody, protection,

therapy and socialization. It was more difficult to find a clear picture of day hospital functions. Such documents as those reporting the work of Kramer and Farndale help, but on the whole they do not offer substantial information on the functions of day hospitals. This may, in part, be due to the fact that such information would be of little help to those involved in the actual process of running a day hospital. From the literature we can only pick out those main functions which are also defining characteristics of day hospitals: treatment and socialization.

There is little evidence on whether the two types of hospitals treat the same patient population, as measured by the group characteristics of patients and the ability of the hospitals to treat patients randomly assigned to them. The literature does generally indicate that the most seriously ill, in terms of overt behavior, are being treated in the residential hospitals and not in the day hospitals. The literature identifies the admission criteria of day hospitals as the major factor in this differential of case loads. Three studies were described which dealt with patient populations of the two modalities. From these studies it appears that half of the day hospital patients would otherwise be receiving treatment in a residential hospital. It can be speculated that, if more patients' families were agreeable, this number

could be increased. On the other hand, it can be speculated that day hospitals are "enjoying" the Hawthorne effect (i.e., some patients' families and patients themselves attach a certain importance in having been chosen for day hospital care). For this reason, it is possible to treat these patients in day hospitals rather than in residential hospitals.

As with the lack of data on the patient populations of the two hospitals, there is also a lack of data on the effectiveness of the two hospitals. The studies which were described in this paper indicate that the two types of treatment have approximately the same rate of effectiveness. However, effectiveness of psychiatric treatment appears to be situational as well as related to the patient population. The treatment agencies cannot hold constant the patient's environment once he is released from treatment. And as people do not live in equal states of bliss there will be differential stresses on ex-patients.

If the type of deviance (i.e., the characteristics of the patient population), is held constant, the two hospitals are not interchangeable or alternatives. On the other hand, the types of deviance are placed under a more general category (e.g., mental illness), then the two types of hospitals become sub-types or examples of a type of institution for the

control of that general deviance (mental illness) in society.

One possible explanation for the scarcity of controlled studies, which allow for complete random allocation of patients, is the danger involved for the patient (such as, suicide) and for the community (such as harm to others and destruction of property). Considering these changes, it may be impossible to undertake studies using random patient allocation in the near future.

There are other types of studies which could give some indication as to the effectiveness of the two modalities. One such approach is an examination of cost to the community or patient and their families. Using a cost X utilization modal, a base could be established for determining if one hospital is economically more effective than the other. -Cost-effectiveness could also be examined by measuring number of work days lost per patient of each type of hospital. While there is probably a difference in the overall economic effectiveness of the two hospitals, it is probably not as great as is rumored. However, if economic effectiveness is the main concern there are no doubt other agencies which are less expensive than either the residential or the day hospital.

In considering other agencies, another research approach is possible. If a smallest space analysis of all agencies that provide aid to the "mentally ill" were done I suspect that the

residential and day hospitals would be more closely spaced than either type hospital to any other agency.

Whatever the research technique required, it would seem to be worth the effort, as long as, a relatively large number of people are labelled as suffering from "mental illness" and are being treated in the residential and day hospital.

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APPENDIX I

Day Hospitals

<u>NAME</u>	<u>LOCATION</u>	<u>PRINCIPAL SOURCE</u>
1. Andrew Duncan Clinic	Edinburgh, Scotland	Thomson
2. Adelphi House	Blackpool, England	Ferguson, Carney
3. VA Day Center	San Francisco, USA	Glascote
4. Ft. Logan Center	Denver, USA	Kraft
5. San Diego Day Center	San Diego, USA	MacMillan and Aase
6. DuBois Day Treatment Center	Stanford Conn., USA	Healey and Sensy
7. Warsaw Day Center	Warsaw, Poland	Abramczuk
8. Mass. Mental Health Day Center	Boston, USA	Kramer
9. Day Care Center	London, England	Richards
10. Poughkeepsie Day Center	Poughkeepsie, USA	Kramer
11. Penn. Foundation	Sellerville, Penn. USA	Glascote
12. San Mateo Day Hospital	San Mateo, USA	Glascote
13. Kansas City Day Hospital	Kansas City, Missouri USA	Glascote
14. Dutchess County Day Center	Poughkeepsia, USA	Glascote

- | | | | |
|-----|-----------------------------------|--------------------------|--|
| 15. | Perici View Day Center | Newton, Kansas, USA | Glascote |
| 16. | Jacob B. Riess Day Center | New York State, USA | Clascote |
| 17. | Elmhurst Day Center | Elmhurst, N.Y., USA | A Hospital Report and Combined Sources |
| 18. | Marlborough Day Hospital | London, England | Bierer |
| 19. | Moscow Day Hospital | Moscow, USSR | Craft, Kramer |
| 20. | Westchester Square Day Hospital | Bronx, USA | Zwerling and Wilder |
| 21. | NAPA Day Hospital | Imola, Calif., USA | Kramer |
| 22. | Day Hospital Unit | Trenton, USA | Kramer |
| 23. | Bristol Day Hospital | Bristol, England | Kramer |
| 24. | Brooklyn Day Hospital | Brooklyn, USA | Kramer |
| 25. | Manhattan after Day Care Hospital | Manhattan, USA | Kramer |
| 26. | Brooklyn VA Day Center | Brooklyn, USA | Kramer |
| 27. | New York Regional VA Center | New York State | Kramer |
| 28. | Menniger Clinic | | Kramer |
| 29. | Shepperd-Enoch Platt Day Hospital | Baltimore | Hospital Publication |
| 30. | Better Health Center | Providence, USA | Kramer |
| 31. | St. Olave Day Hospital | London, England | Oldham |
| 32. | Allan Memorial Inst. Day Hospital | Montreal, Canada | Cameron |
| 33. | Day Hospital | St. Johns, Nfld., Canada | Moll |

- | | | | |
|-----|------------------------------|---------------------|---------------------------------|
| 34. | Maudesly Day Hospital | England | Craft |
| 35. | Washington Height Day Center | New York, USA | Herz |
| 36. | Baltimore Day Hospital | Baltimore, USA | Hogarty |
| 37. | Brisbane Day Hospital | Brisbane, Australia | Hamilton |
| 38. | Henry Phipps Day Clinic | Baltimore, USA | Kramer and
J. Hopkins Report |
| 39. | Mid-Houston Day Clinic | Houston, USA | Hospital Report |
| 40. | Lions Gate Hospital | Vancouver, Canada | Cumming |

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