THE BRISTOL PSYCHIATRIC DAY HOSPITAL.

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In April, 1946, an experimental form of hospitalization for psychiatric patients was set up in Montreal.* This form of hospital, described by Ewen Cameron (1947), admitted any type of patient, the only criterion being that they should be well enough to stay at home over-night. To such an institution he gave the name of Day Hospital. At about the same time J. Bierer (1951) was experimenting in the same direction in this country, in connection with his attempt to extend the principles of "social psychiatry" to the everyday treatment of patients. Since then there have been several other short communications on the subject such as those of A. E. Moll (1951) and H. Gilmore (1952).

A review of the above work, and a visit by one of us (S. S.) to the Institute of Social Psychiatry in London through the kindness of Dr. Bierer, suggested a similar application to a particular problem which faced us in Bristol at that time. This was the perennial question of too many psychiatric patients waiting for too few beds. A Day Hospital seemed a logical answer to this pressing problem. This purely "utilitarian" approach was the main motivating factor in the formation of the present Centre.

Organization.

The Day Hospital was established in a three-storeyed mansion, well-kept and in excellent state of repair in Central Bristol. Geographically it is situated between the two main hospitals of the Bristol Mental Hospital Group.

Two fairly large rooms were set aside for occupational therapy, each capable of holding about fifteen people. An occupational therapist was obtained who found 25–30 patients, attending daily, a reasonable maximum. A small work-room was also formed for rather more heavy occupations, such as woodwork for men.

The administration of the whole is in the hands of a consultant psychiatrist, with a senior registrar in constant daily attendance. Other doctors who refer

* Dr. Helen Boyle admitted day patients to the Lady Chichester Hospital, Hove, many years ago.
patients there are also encouraged to visit them at any time. One nursing sister and three nursing orderlies constitute the nursing staff. We also have the services of a part-time social worker, and a psychologist attends once per week for various psychological evaluation procedures. A 6-Channel Ediswan E.E.G. apparatus has recently been installed, and is in much demand by clinicians who want an out-patient E.E.G. only, as well as for the use of the Day Hospital.

Patients arrive in the mornings at 9.30 a.m. and leave at 4.0 p.m. The late arrival is necessary because of the number of women who have to get their children to school before arriving. All are given lunch at the Hospital. The Hospital is open all week except Saturday and Sunday.

In the beginning it was found convenient to divide the patients into three groups. The first was a so-called Convalescent group, mainly of treated patients from our other Hospitals—post-electroplexy, post-insulin shock, etc., whose attendance here let us have their beds in hospital, whilst at the same time keeping them under further observation. The second group was a Treatment group who attended for some specific purpose, e.g., electroplexy or individual or group psychotherapy. The third group was an Observation group. Here again a patient whose illness was rather vague and unclear on first examination at an out-patient clinic could attend for further and more detailed observation without, as hitherto, using up a much-needed bed in an ordinary hospital.

The patient population was, therefore, drawn not only from the two parent mental hospitals and the Bristol Neurosis Unit, but also from the various psychiatric out-patient clinics at two general hospitals.

Although no attempt was made to apply generally any particular view of social psychiatry, nevertheless Bierer’s concepts were carefully studied, and we did institute from the beginning the idea of a Therapeutic Social Club as well as group methods of psychotherapy. The Club meets twice a week; to one of these meetings patients may bring their relatives. It has proved very popular and, although its precise value is impossible to gauge, there is no doubt that from a clinical point of view many asocial and poorly socially-integrated people have benefited considerably.

Both individual and group psychotherapy are thus available. In addition to this, electroplexy, abreactive techniques, relaxation and pharmacotherapy are all given and are often extensively used.

A close liaison has been established with the Ministry of Labour, and Disablement Resettlement Officers (male and female) come to the Hospital at least once a month.

Follow-up clinics for discharged in-patients and discharged Day Hospital patients are held every evening except Saturday and Sunday.

Results.

The following represent the figures for one year’s experience (November, 1951, to November, 1952). A total number of 307 patients were dealt with by the Day Hospital. (This figure excludes the 40–50 patients seen every week in the follow-up clinics).
Out of this figure the following tables can be compiled:

**Table I.** — *Analysis of Total Number of Patients into Three Groups.*

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
<td>59</td>
</tr>
<tr>
<td>Treatment</td>
<td>200</td>
</tr>
<tr>
<td>Convalescent</td>
<td>48</td>
</tr>
</tbody>
</table>

A further subdivision of these cases into those of standard psychiatric nomenclature gave the following results:

**Table II.** — *Results of Analysis of Cases into Disease Entities.*

<table>
<thead>
<tr>
<th>Type of illness</th>
<th>Diagnostic code No.</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurotic depression</td>
<td>314</td>
<td>95</td>
</tr>
<tr>
<td>Anxiety reactions</td>
<td>310</td>
<td>29</td>
</tr>
<tr>
<td>Manic-depressive group</td>
<td>301</td>
<td>25</td>
</tr>
<tr>
<td>Involutional melancholia</td>
<td>302</td>
<td>19</td>
</tr>
</tbody>
</table>

The diagnostic code number refers to that used in the *International Nomenclature* (1948).

Other diagnostic categories were epileptics for observation or treatment, post-insulin schizophrenics, immature and pathological personalities.

The whole gamut of psychiatric nosology was represented, but psychopathic personalities, organic states with intellectual impairment and deteriorated schizophrenics were considered specifically unsuitable.

Fifteen cases or 25.4 per cent. of the observation cases were subsequently admitted to one of the parent hospitals for more intensive treatment, e.g., insulin coma therapy. The remainder were treated in the Day Hospital.

The average number of attendances for discharged cases was 21.1; i.e., each patient on an average attended about 3 weeks, although many were attending for much longer periods.

These results are, of necessity, tentative and provisional in view of the short time which has elapsed since the establishment was opened.

At first sight they appear reasonably satisfactory, and seemingly could be equated with the results achieved in our in-patient units, both psychotic and neurotic. Dividing the results into categories after elimination of cases who discharged themselves against medical advice, we found the following results:

**Table III.** — *Results of Treatment after 1 year in the Day Hospital.*

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>State on discharge</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>Recovered</td>
<td>21.3</td>
</tr>
<tr>
<td>92</td>
<td>Relieved</td>
<td>52.9</td>
</tr>
<tr>
<td>44</td>
<td>Not improved</td>
<td>25.3</td>
</tr>
<tr>
<td>1</td>
<td>Death</td>
<td>0.5</td>
</tr>
</tbody>
</table>
Sixty-nine out of a total of 307, a higher proportion than in our in-patient units, had discharged themselves against medical advice. We felt that the novelty of the situation and the actual physical effort to get to the Day Hospital played a big part in this group. No particular disease played a bigger part in this figure than any other. With further experience we confidently hope to be able to reduce this figure even further, by more adequate explanation to the patient on arrival, of the purpose of the establishment, although we are certainly in agreement with Ewen Cameron that there is a definite group, containing neurotic and psychotic material, “who only too willingly . . . want to give up and be told,” and whose admission to hospital represents the retreat into the private room that they so much desire.

Contrary to our anticipation we have had few troubles with the electroplexy patients, and very few failed to turn up for further treatments.

Twenty men and women have been referred to the Disablement Resettlement Officer, and of these, twelve were satisfactorily placed either immediately or after a period in an industrial rehabilitation unit. The monthly conferences between the social worker, the disablement resettlement officer, the occupational therapist and the doctor, now a commonly accepted method of job placement, are found to be of great value, and certainly have laid a reasonable foundation for further placings. The services of our Psychological Department are also found to be of valuable help in vocational aptitude assessments.

Ewen Cameron and his associates evolved a method for dealing with the confusional episodes after electroplexy, but in several hundreds of such treatments we have not been unduly perturbed by this. All electroplexy is administered in the mornings and patients can remain subsequently as long as they like until they feel fit enough to go home, invariably with a relative.

One of our more difficult problems was that of the elderly patient who found in such a centre the very activity and the company he or she required and who was apt to become lonely and depressed at home. We tried deliberately to set aside five long-stay places for such people but, of course, the actual numbers were much higher. However, our social worker has made a start in trying to settle some of the elderly women patients into clubs when they cease to need treatment in the ordinary sense but still require company and occupation. The Women’s Voluntary Service have co-operated with us in this.

Some difficulties were experienced by impecunious patients in travelling by bus daily to and from the Hospital. Of these some were very unexpected, e.g., although the National Assistance Board agreed to pay the fares, many patients objected very strongly to waiting for the money “in the company of unwashed tramps.” This apparently frivolous reasoning was at one time very prevalent and seemingly very real. We also found the inevitable and optimistic drawer of National Assistance Board funds who, instead of catching the bus, invariably walked!

Other more domestic matters included the difficulties in getting patients to attend at the proper hours. The new situation seemed to represent to a lot of patients a temptation to arrive at a very late hour, and an even bigger one to leave much earlier than was permitted. This sometimes proved very difficult to handle, but at all times an effort was made to strike a balance
between oppressive rules and regulations and a completely care-free and rule-free environment; both were considered sterile and unmanageable.

**Discussion.**

This Centre was formed to be a place where an attempt is made to make available, as far as possible, every type of treatment provided by a modern intra-mural department together with all the advantages and privileges enjoyed by patients in an extra-mural department (1947). In other words, an attempt was made to get the best out of both in- and out-patient methods.

It is of some interest to note that Cameron and Bierer appear to have evolved the idea of the day hospital independently of each other. The reasons for this may become clearer if a number of trends are considered which are becoming of increasing importance in present-day psychiatry, and to which the day hospital conception appears to owe its origin. The first is the practical need to overcome the shortage of beds available in mental hospitals. This has been one of the strongest of the motivating factors of our own experiment in Bristol. As a subsidiary and allied factor, as far as conditions in this country are concerned, the financial position of the Health Services during the past few years may be noted, in so far as it has imposed on us the necessity of searching for methods which, whilst still providing adequate treatment, might achieve some saving of public expenditure by reducing the average maintenance cost per patient.

One of Cameron's (1947) principles is that, as far as is possible, treatment should be provided at the hospital rather than in the hospital. We can reasonably expect a series of adaptations and inventions which will permit all hospital centres to give intensive medical care to considerable numbers of patients without the necessity of providing the most expensive form of hospitalization namely 'in bed' care. The day hospital, in Cameron's conception, is essentially an adaptation of this sort.

Another trend which has contributed to the development of the day hospital conception has been a certain degree of dissatisfaction among psychiatrists with the in-patient treatment of the neuroses and a growing realization of its limitations. Thus Blacker (1946) is of the opinion that in-patient treatment facilities are liable to be abused for a variety of reasons, among them being the opportunities which they afford for the disposal of awkward cases. He is of the opinion that the best solution is not to admit psychoneurotics at all.

Neustatter (1951) is of a similar opinion, believing that if neurotics have to be treated as in-patients six weeks should be the maximum length of stay, and even here he felt that the necessity for admitting these was partly due to lack of any other therapeutic facilities. Neustatter also drew attention to the considerable number of patients who discharge themselves prematurely (20 per cent. in his series), and to the corresponding waste of time that this entails for the medical staff, social workers, etc., who could otherwise be more usefully employed. Our own experience shows that this phenomenon of discharge against medical advice is as common, if indeed not more so, in day hospital practice, but even so, the total expenditure in the day hospital cases would most probably be less.
Other workers, Bierer (1951) and Moll (1951), are in essential agreement over other factors which they think are advantageous to the day hospital idea. They point out the excessive dependence on hospital care which is liable to develop in patients admitted to a psychiatric ward, and they both note the far greater degree of anxiety engendered in a patient by admission to a psychiatric ward—with all its connotations in the popular mind—than by his attendance at a day hospital. Bierer is at pains to point out the importance of not confusing the day hospital with the ordinary out-patient department of the traditional type. In the day hospital various forms of treatment of an experimental, situational or occupational character not available in an out-patient department are available and essential.

Yet another factor, important in the new orientation in these matters, has been the ever-increasing emphasis on resettling the patient in the community both occupationally and socially. This need, important as it is in medical and surgical treatment, presents not only a greater but frequently more difficult problem in psychiatric work.

Rehabilitation of the psychiatric patient has been well summarized by Main (1948). Bierer (1951), Cameron (1947) and Moll (1951) have all, in one way or another, stressed the difficulties which patients who are suddenly discharged from an in-patient unit may experience in re-adapting themselves to outside life, and they frequently shrink from taking this step and remain hospitalized for long periods. Every psychiatrist is familiar with cases where the prospect of discharge is experienced by the patient as a threat to his security and brings about a recurrence of symptoms, especially in those cases where the newly-acquired stability is a precarious one, and still rests largely on a marked dependence on the hospital environment as well as the physician. In such cases the day hospital serves as a "half-way house," in close contact with both home and hospital, and we have found undoubted ease in rehabilitation of the patient in this less artificial environment. It is not intended to suggest that our Day Hospital is a sort of substitute for an industrial rehabilitation unit, but through our own Department of Psychology and the disablement resettlement officers of the Ministry of Labour we have been able to carry out various procedures such as vocational guidance testing, job visits and trials, job introductions, admission to an industrial rehabilitation unit or remploy factory, as generally practised in in-patient units nowadays.

Finally we must note among the contemporary trends which have contributed to the development of the day hospital, the emergence of what, for want of a better name, is sometimes called "social psychiatry." A fuller statement of the principles underlying social psychiatry is to be found in Bierer's (1951) monograph on the subject. Adler was the pioneer of this approach to the patient's total personality in terms of socially-determined goal-directed behaviour. The approach lays emphasis on "universal setting" and a multiplicity of factors considered to be aetiologically significant. Social psychiatry has hitherto made its distinctive form of contribution to modern psychiatric treatment through the development of two methods—group psychotherapy and the therapeutic social club. The principles of the latter and their application to different types of patients have been discussed in a monograph by Bierer.
Bierer, after first experimenting with both these methods, eventually evolved the day hospital as the most suitable medium for his type of approach. Sutherland (1951), in a review of Bierer's monograph, approves of the day hospital as an experiment designed to solve certain practical problems such as that of avoiding hospitalization, but tends to the view that his discussion of the basic principles of social psychiatry is irrelevant in this context. In this connection, however, it is only fair to note that Cameron (1947), who, as mentioned above, established his day hospital somewhat earlier than and independently of Bierer, was also influenced by the consideration that it was not only the patient but his general social setting that required treatment.

The above factors in varying degrees of importance have been the conceptions and consideration and the reasons which have contributed to the development of the day hospital. After a year's trial, much of which was in the nature of a pilot survey and experiment, we are convinced of the value of such an institution, and feel that when the novelty and growing-pains have worn off, many of our difficulties experienced in the "weaning stage" will have resolved to a large extent.

In our Bristol experiment we have used a diversity of therapeutic tools, including Bierer's social psychotherapy methods, as well as individual psychotherapy, electroplexy, endocrine treatment, etc. We have not been restricted in our approach by any academic theory or sectional viewpoint, and have concentrated on our primary aim in forming the Day Centre in Bristol, namely, to try and reduce the long waiting list of patients for the in-patient psychiatric units in this area.

**SUMMARY.**

1. A year's experience in the Bristol Psychiatric Day Hospital is noted.
2. The main results of the year's treatment are given.
3. The genesis of the Day Hospital concept has been discussed.

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**REFERENCES.**

Cameron, D. Ewen, "The Day Hospital: An Experimental Form of Hospitalisation for Psychiatric Patients," The Modern Hospital, 1947, 69, No. 3 (September).


