THE CHANGING ROLES OF PSYCHIATRIC DAY HOSPITALS IN HONG KONG

K.Y. MAK

SUMMARY

Psychiatric day hospitals have existed in Hong Kong for over thirty years and psychiatric day-time activity centres have also been established within the last decade. Though in theory these two services cater for different categories of psychiatric patients, there are in practice some duplication of services. As activity centres are more economical to run, day hospitals therefore have to consider new roles in order to function efficiently.

Keywords: psychiatric services, day hospitals, activity centres, history, roles

HISTORY OF PSYCHIATRIC DAY HOSPITAL

Psychiatric day hospitals have come into existence for over half a century. The first psychiatric day hospital (actually called 'half hospital') began in 1933 (Dzhafgarov, 1937) in Moscow, Russia due to bed shortage and inadequate funding in a large mental hospital for the severely mentally ill. The programme consisted mainly of work therapy, with some 80 patients treated for an average duration of two months.

In 1947, a real experimental 'day hospital' was set up at the Allen Memorial Institute of Psychiatry in Montreal, Canada with the purpose to stimulate community life by allowing the individual to attend treatment only during the day just as one might go to work (Cameron, 1947). Since then more and more day hospitals were set up throughout the world. The first one in the United States was set up in 1949 at the Menninger Clinic in Topeka, Kansas (Barnard, et al 1952). The deinstitutionalisation movement since the 1950s and the community care movement in the 1980s have all facilitated the development of day hospitals further.

In the United Kingdom, the first day hospital started in 1948 (Bierer, 1951) for psychiatric patients shortly discharged from hospitals. During the 1950s, more and more day hospitals were set up by the Health Authorities (Farndale, 1961), with different degrees of staff provision, therapeutic emphases and management. Later on, day hospitals were given a unique role in the process of run-down of large mental hospitals (DHSS, 1962).

From the above description, it can be seen that psychiatric day hospitals are developed as an alternative service to traditional service (hospital care, out-patient care or home care) of mental patients provided perhaps that they are not dangerous to themself or others. The scenario behind this development is that in the early stages, in-patient treatment in over-crowded mental asylums could be an awful experience, yet total home-care could be extremely stressful to family members. At one time, day hospital care was considered not only as good as but perhaps even better than inpatient care. In certain sense this is true, as day hospital care may prevent the regression and isolation characteristic of institutionalised patients. Bennett (1981) even called day hospital the 'corner-stone' of community care. Besides, day programmes can vary more easily to suit individual patient's needs than those at in-patient or outpatient settings. Using the milieu atmosphere, Guy and others (1969) found that day hospital care was more effective in reducing relapse rate compared with traditional out-patient care.

THE CHANGING WORLD SCENE

Since the 1960s, the scene has gradually changed. Firstly, many patients, especially acute cases, are now treated in inpatient psychiatric units within district general hospitals. The setting is less crowded. Secondly, even for mental institutions, the treatment is more humane and the care more decent. Furthermore, there is a trend for shorter term in-patient treatment, and more and more patients are now discharged back home and to the community. Day hospital has thus been regarded as part of the community psychiatric service (NIMH, 1967). Therefore, the functions of the day hospital have been evolving gradually. According to

Astrachan et al (1970), the objectives of a day hospital are:

1. to present an alternative to 24-hour hospitaization;
2. to provide previously hospitalized patients with a transitional care setting that facilitates reentry into the community;
3. to be a treatment and rehabilitative facility for chronically mentally ill persons; and
4. to deliver services which the community has defined as a public need.

However, these traditional noble purposes were not unchallenged with various development in psychiatric rehabilitation. In the United States, many day hospital units have closed down and many more programmes have been dropped (American Psychiatric Association, 1988) during the past decade. In a reassessment of `partial hospitalisation' (a term sometimes used synonymously with day hospital care), Hoge et al (1992) put up the following limiting factors:

1. there is disruptions in the continuity of care when one patient is transferred from one unit to another;
2. the typical length of stay is too long for symptom stabilization but too short for rehabilitation;
3. the potential regressive effects of a protective day hospital treatment environment; and
4. the majority of patients do not require this level of care and can be managed effectively by intensive outpatient assertive community care.

In Britain, problems with the day hospital movement also arose. The Local Authorities did set up a number of `day centres' for psychiatric patients, with emphasis on the `support' of the long-term social needs (Shepherd, 1991). This had caused considerable overlap between the services provided by day hospitals and day centres (Edwards & Carter, 1979), but it was obvious that day centres were more economical to run. Fortunately, there was a recent resurgence of interest in the management of severe psychiatric illness in the day hospital (Creed et al, 1989). It had been found that "day and in-patients differed little in terms of psychiatric symptoms and social disability, especially if compulsory admissions were excluded". Day hospitals were also found to be valuable for acute psychiatric illness, according to Creed's study (Creed 1989) which showed that it was possible "to treat about half of all new admissions in a psychiatric day hospital, but only if there are adequate staff".

In certain sense, different day hospital settings can serve different functions, e.g. some will be short-term and crisis oriented, while others are for extended period of intensive treatment. There is still the traditional setting for prolonged maintenance treatment for chronic patients, and this is this latter role that is being challenged in Hong Kong.

THE SCENE IN HONG KONG

DAY HOSPITALS

The first psychiatric day hospital in Hong Kong was started in 1961 (Ng, 1981) and more were established in recent years. According to the Government's idea on day hospitals (Hong Kong Government, 1991), this method of treatment "conforms with the modern view that where possible patients should be treated outside psychiatric hospitals ... and are more economical to build and to operate".

Currently, there are over ten such day hospitals, distributed fairly evenly throughout the Hong Kong Island, the Kowloon Peninsula and the New Territories. Most psychiatric out-patient clinics have an adjunct day hospital, and there are a few day hospitals attached to district general hospitals. Each day hospital has 40 to 60 places. In some, the occupancy rates are quite high, partly because of a significant proportion of chronic patients (including those cases with learning disabilities or mental retardation) who have stayed for prolonged periods. In others, there are some reserved day hospital places for crisis or urgent admissions.

ACTIVITY CENTRES FOR PSYCHIATRIC PATIENTS

Since 1985, the Baptist Oi Kwan Social Services pioneered the first day-time activity centre on the Hong Kong Island (Wanchai district) for mental patients, supported financially by the Community Chest of Hong Kong (Chiu, 1988). By 1988, this novel service evolved into a standard government supported form of community rehabilitation service, similar to that of sheltered workshops. Three more activity centres had since been established, one in the New Territories (the Tuen Mun district) and two on the Kowloon Peninsula (the Yaumatei district and the Kwun Tong district), all managed by non-government organisations. Each centre looks after 30 to 50 clients.

Originally, the Hong Kong Government viewed this service as a cheaper means (compared with psychiatric day hospitals) of engaging those very chronic yet mentally stable patients in activities. However, it was found out by the frontline workers that quite a number of such mentally stable patients could be successfully rehabilitated in these centres, to the degree that they could find open employment and live independent lives in the society.

DAY HOSPITAL AND ACTIVITY CENTRE

Soon it is apparent that there are overlaps of service between the activity centre and the day hospital, and there is a possibility of competition for `patients' (day hospital) or `clients' (for activity centre) between these two services. This is consistent with the findings in the United Kingdom (Edwards & Carter, 1979) which demonsrated striking similarities between day hospitals and day centres. The only substantial difference was the staffing ratio and day centres quality, with more qualified staff in the former setting.

Table 1: Cases indicated for day hospital rehabilitation.

1. ***Intensive drug supervision is indicated when:***
   a. *patient has poor compliance to oral medications;*
   b. *patient needs frequent drug adjustment (e.g. every two weeks or less, those on drug trial, etc.);*
   c. *frequent fluctuation in symptomatology (e.g. anxiety symptoms, psychotic symptoms);*
   d. *acute stage of the disorder, requiring close observation for assessment and treatment;*
   e. *significant co-existing physical disorders requiring medical supervision (excluding those life-threatening illnesses) such as - poorly controlled illnesses, e.g. epilepsy, diabetes, etc. - serious or critical illnesses, e.g. severe hypertension, heart disease, etc.*
2. ***Other significant psychiatric problems within the last three months:***
   a. *drug or alcohol abuse;*
   b. *features of anti-social personality disorder;*
   c. *occasional aggressive behaviour or temper tantrums, requiring restraint or sedation;*
   d. *impulsive or inappropriate behaviour affecting participation in ordinary activities.*

N.B.

1. *Frequent aggression, suicidal patients or patients with life threatening conditions should be treated in in-patient hospital setting.*
2. *Exception to the criteria above are allowed for those over the age of 60, as this is the age limit for acceptance into the activity centre.*

Conceptwise, there should be a clear difference between the day hospital and the activity centre. According to paragraph 8.56 of the 'Hong Kong 1990 Review of Rehabilitation Programme Plan' (Hong Kong Government, 1991): "The dividing line between the need for a day hospital and an activity centre service lies in the patient's level of recovery. It is expected that patients with less serious residual psychiatric symptoms as diagnosed by the psychiatrist would use the activity centre service. Activity centres will not take in adults with personality disorders or behaviour problems, or those who require intensive drug supervision and treatment. These persons should remain the target group of the day hospital."

Even with this distinctive statement, there are still some ambiguities in application. Some terms, e.g. serious residual symptoms, behaviour problems, etc. are rather vague and subjected to different interpretations. There are also borderline cases who are difficult to classify in terms of 'level of recovery'.

In practice, if not for the hostility of the local residents of the Laguna City (in the Kwun Tong district) against the setting up of a new activity centre nearby their residence, many patients and their relatives do prefer to go to the activity centre for further rehabilitation. This is because of the lesser degree of stigma attached to social facilities than psychiatric clinics, and because they do not have to pay for attendance, in contrast to the day hospital fees. On the other hand, because of the distance of these few activity centres from their homes, some patients still prefer to go to day hospitals for rehabilitation. Besides, there are patients who enjoy the security feeling and the more structured environment of the day hospitals. Last but not the least, a few patients are fairly attached to the medical staff of the day hospitals and are reluctant to be transferred to a new environment. Unfortunately, activity centres may occasionally be quite choosy in accepting clients, especially those chronic, intellectually subnormal psychotic patients. In certain sense, this selective preference is a waste of health resources, as day hospitals are much more expensive to run than activity centres. To avoid overlap or duplication of services, a clearer set of criteria is urgently needed (see Table 1) for patient selection purpose.

'NEW' ROLES FOR PSYCHIATRIC DAY HOSPITALS

With such criteria, it is envisaged that quite a significant number of day patients could be transferred to the activity centres. As a result, the patient load in the day hospitals may be decreased. This has not yet happened because there are so far not enough places in the activity centres, some of which are situated far away from the place of residence of the potential clients. Therefore, there is a need to set up new roles for psychiatric day hospitals. The followings are some of the possibilities, viz.:

1. ***Traditional care***: for those who require intensive psychiatric or medical care (e.g. those with persistent disturbing symptoms, those with severe medical conditions such as epilepsy); those who need frequent drug monitoring or constant supervision, the traditional role of 'maintenance' rehabilitation should be maintained unless the patients have become clinically stable.

2. ***Management of acute cases***: Creed (1989) has demonstrated that the day hospitals are suitable even for acute cases, whether they are new or relapsed cases. This is also the trend in the United States (Hoge et al, 1992). However, the staffing situation in Hong Kong medical setting may not be adequate at present; for the safety of the patients and the public, it is not yet advisable to include those patients who are suicidal or dangerous to others.

3. ***Special sub-units***: a trend is for the day hospital to develop psycho-geriatrics day care (Plotkin & Wells, 1993), as many such patients do have co-existing medical illnesses requiring intensive clinical attention (e.g. uncontrolled diabetes or heart disease). Of course, those with life-threatening diseases should be hospitalised. Likewise, it may be useful for the Day Hospital to cater for those psychiatric patients with co-morbidities such as alcohol abuse, personality disorders, etc. These patients at present need more intensive psychiatric care, and a study in Holland had found that the day hospital had efficacy in treating patients with neurosis and character disorders who would otherwise be treated in in-patient settings (Schene, 1990).

4. ***Special service***: with the well trained multi-disciplinary staff team at the day hospital, it may be very fruitful to admit patients for short-term observation and comprehensive assessment of their disabilities, from the medical, social and vocational perspectives. It is most suitable for those who at present require a psychiatrist's opinion for disability allowance or for compensation purposes.

5. ***Co-ordination with community services***: there are always some borderline cases whose mental conditions fluctuate in intensity and may need both day hospital and activity centre services at different periods of time. In order to have smooth transition between these two services, there should be better co-ordination with mutual referral and support. One significant role of the day hospital staff is to act as a backup service for the occasional medical crisis that may arise in community facilities.

6. ***?Respite care***: for those patients whose relatives are unable to look after them at day time due to special circumstances (e.g. work or sickness of the carer), the day hospital may try admitting them for temporary stay to tide over the period.

7. ***?Night hospital***: for those patients who are able to work at day time, but who need more medical attention than that provided in half way houses or hostels, the day hospital may use its facilities for some night care. This may incur quite a lot of staff support and even structural change.

8. ***?Private day patients***: currently, there is no private day patients in the day hospitals which are all public funded. But in the United States, private day hospitals are still useful to enable the private sector to respond to demands from managed care companies (Budson, 1990). In Hong Kong, there is also quite an extensive private psychiatric service, and it may be worth trying to let in a few private patients for day hospital care while continue their clinical treatment under the private psychiatrists.

PROBLEMS FOR THE CHANGES AND THEIR SOLUTIONS

In a way, some of the 'new' roles mentioned are not really novel, as some day hospitals have already experimented with these roles, albeit on a small scale. With every new adventure, there are bound to be difficulties, the more obvious ones come from the staff. Firstly, there could be resistance from the staff to change. Understandably, the medical staff of the day hospitals may feel anxious about new services, especially for the relapsing or acutely ill patients. Secondly, for those who are willing to change, there is a danger of staff burn-out. With the new roles imposed, the demand on the staff energy will be magnified.

Furthermore, the low tolerance of some sectors of the public towards mental patients in the community can make the implementation of these roles (especially for those acute patients) difficult. On the other hand, if the present day hospitals do not change their roles, probably their importance may dwindle away. One way out is to close down some units, or to shrink its capacity, resulting in even more disenchantment of the staff. Another solution is to convert part of the day hospital into an 'activity-centre-like' setting to maintain and to rehabilitate the patients. In this aspect, there is a need for staff restructuring, and this 'day hospital cum activity centre' model may come into direct competition with other activity centres for resources and patient quota.

CONCLUSION

As Hong Kong is changing fast, both economically and socially, psychiatric rehabilitative service need similar changes in order to maintain their efficacy. With limited health resources available, the service must also be used efficiently. Those which are less cost-effective should be abandoned.

Day hospitals in Hong Kong have served their functions extremely well in the past few decades, but with better development in social rehabilitation services, it is now the right time to review their traditional structure and roles, otherwise they may better be closed down for more efficient rehabilitation or treatment modalities, as had happened in some parts of the States (Hoge, 1992). Though day hospitals still have their continual importance in the medical treatment of acute psychiatric disorders and in the assessment of psychiatrically disabled persons on a holistic basis, there should also be new developments to meet the needs and demands of the patients and their relatives, not to mention a better working relationship between different medical and social rehabilitative facilities.

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K.Y. Mak MBBS, MRCPsych, DPM, MHA, FHKAM(Psych), MD *Head of Rehabilitation Team,Department of Psychiatry, The University of Hong Kong, Queen Mary Hospital, Pokfulam Road, Hong Kong.*