THE DAY HOSPITAL APPROACH IN CHILD PSYCHIATRY*

By

P. H. CONNELL

Historical Background

THE Day Hospital approach in adult psychiatry appears to have begun with the original conception of Cameron in Montreal. He stated (Cameron, 1958) that both the original concept and its further development sprang from growing appreciation of the possibilities of new methods of treatment and diagnosis: at this time the rapid rise of the cost of in-patient treatment took place and there was increasing realization of the importance of the treatment milieu. At the same time as Cameron was setting up his Day Hospital in Montreal, Bierer was setting up the Marlborough Day Hospital in London (Bierer, 1951) and he discussed the theory and practice of Psychiatric Day Hospitals later (Bierer, 1959). Harris (1957) also discussed the implications of Day Hospitals and Night Hospitals in psychiatry with regard to the adult patient.

The most extensive developments of this method of approach in adult psychiatry have taken place in Great Britain where over thirty units are in existence at the present time. These day hospital developments have been reviewed by Freeman (1960) who quotes Moll (1958) as dividing Day Hospitals into five classes:

1. An integral component of a general hospital.
2. Affiliated with a hospital, but in a separate building.
3. Part of a community service or out-patient department.
4. Within the grounds of a mental hospital.
5. A completely separate treatment centre.

These developments of the Day Hospital approach in adult psychiatry are reviewed in detail by Farndale (1961).

This approach had not been applied in a continuous and structured manner as an integral part of a child psychiatry service (so far as the writer is aware) until the Day Hospital at "Tiverlands" was started some three years ago. The interest this method of approach aroused at various meetings, including the Child Psychiatry Section Meeting of the Royal Medico-Psychological Association in Newcastle of 1959, and the World Health Organization Seminar on Child Guidance and Child Psychiatry held in Brussels in August, 1960 (when the writer presented a brief outline of this approach) has suggested that a general presentation of its development, principles of practice, aims, and three years' experience may be of interest and value in future planning. Apparently a Day Hospital for child psychiatric problems is soon to be opened in Paris, and this approach has been operating in Aarhus, Denmark, for the past year in conjunction with an in-patient Child Psychiatric Unit.

This paper is not intended to be more than a general presentation of the work. Detailed presentation of the type of cases admitted, methods of treatment and results obtained will be submitted in a further communication.

* Based upon a paper read to the Child Psychiatry Section of the Royal Medico-Psychological Association on 7 May, 1959.

Theoretical Considerations

It is possible to formulate several clearly defined theoretical advantages of the Day Hospital approach in child and family psychiatry. These can be summarized as follows:

1. *Attendance*

It avoids the dilemma facing most child psychiatry out-patient units, involving the choice of a maximum of one therapeutic interview or group session a week or admission to residential units if the weekly session is not sufficient. The Day Hospital can provide a *flexible* situation, in which attendance can range from one morning or afternoon a week through one day, two days . . . up to five days a week.

2. *Treatment*

(*a*) Avoidance of the need to remove a child to a residential establishment eliminates the separation trauma and the difficulties of re-establishment in the home, following a residential placement (which nearly always means placement in a unit far away from home under a different set of psychiatrists, psychologists and psychiatric social workers, who have the greatest difficulty in maintaining close contacts with the home).

(*b*) It avoids placement of the child in a residential establishment not really suited to his needs, owing to the lack of adequate in-patient units. In particular, many children may not need to be sent to special schools for maladjusted children, where adequate psychiatric, psychological and social work facilities are often lacking.

(*c*) The Day Hospital provides a therapeutic environment which can be adjusted under psychiatric direction, to meet the individual and group needs of the patients attending. A therapeutic environment of great *flexibility* is thus provided.

(*d*) Continuity of handling and of contact with parents, schools, local authorities, probation officers, child care officers, etc., can be maintained, and therapeutic manipulation of the home and school environments can be effected on a sound basis.

(*e*) There is the possibility of providing for children who are not suitable for individual psychotherapy and individual play therapy treatment which can be based upon the manipulation of the environment, in terms of the particular history of faulty handling and training received at home or elsewhere. In this situation, treatment of character disorders may be attempted by such a manipulation of the Day Hospital environment and of group dynamics.

3. *Investigations and Diagnosis*

The Day Hospital situation avoids the necessity of basing diagnosis upon the somewhat artificial individual interview with the child or upon short-term group observation. More continuous, longer term observations of the child can be made in an environment which can be manipulated by the production of stresses, useful in assessing the child's adjustment potentialities.

If the Day Hospital is part of a General Hospital out-patient service, special departments needed in investigation are readily available. In particular,

departments of child health, pathology, radiology, neurology, neurosurgery and electro-encephalography may be contacted.

The effects of drug therapies (particularly tranquillizers and anti-convulsants) can be easily assessed, as can the effects of other methods of physical treatment.

4. *Planning of Services*

Should the Day Hospital approach be found successful in treating some severely disturbed children, the call on in-patient child psychiatric beds would be diminished (there is a gross deficiency in such facilities at the moment and there are waiting lists of over a year in many units); the calls for placement in residential special schools for maladjusted children would be diminished. These facts would have far-reaching implications upon the future national planning of child psychiatry facilities and special educational facilities.

5. *Training*

A *flexible* training situation for psychiatrists, psychiatric social workers, psychologists, nurses, teachers, etc., would be available.

6. *Research*

A *flexible* research situation would be present in which, in particular, the effect of methods of treatment, other than individual therapy from a psychiatrist or play therapist, could be studied and assessed.

Development of the Day Hospital

It must be admitted that the foregoing considerations were *post hoc* so far as the Day Hospital at Tiverlands was concerned. There were no special facilities in the field of child psychiatry in Tyneside, which has a population of about 1,250,000, when towns within a radius of twenty-five miles are included (excluding Sunderland, which has run a Local Authority Child Guidance Service for more than twenty years). This tragic lack of facilities in the North-East was due not so much to the disinclination of the Regional Board and Local Authorities to set up such services, but to abortive attempts to do so, on account of lack of trained psychiatrists, psychologists and psychiatric social workers.

There are, of course, no residential facilities for psychiatrically disturbed children, either in terms of in-patient beds or of special schools or hostels for maladjusted children in the North-East.

In order to cut across this situation, the Regional Board, in association with the Department of Psychological Medicine, King's College, University of Durham, set up an Out-patient Unit in a converted private house as part of the services provided by the Newcastle General Hospital, which also contains out-patient and in-patient departments of psychological medicine for adults, the latter comprising some fifty-four beds. The aims of this new unit for children were to establish a limited clinical service, to provide teaching for under-graduate and post-graduate (University of Durham D.P.M.) students, for psychiatric social workers and others, and to carry out research, which is an indispensable part of the work of a teaching unit.

Tiverlands was opened in late June, 1957, when the writer came to Newcastle to take charge of this section of the Joint Department of Psychological Medicine (which also includes the out-patient, in-patient and adult day hospital

facilities at the Royal Victoria Infirmary) under the overall charge of Professor Martin Roth.

The staffing of Tiverlands, at that time, consisted of the medical director, a senior psychologist, a secretary, a nurse and staff for cleaning who attended until 11.30 a.m. The building itself contained a kitchen, three large playrooms (one of which has a one-way screen), a small garden, a self-contained garage and a brick coal shed.

Soon after the clinic opened, a child was referred who was very disturbed: his symptoms included spitting because he was afraid his saliva might do him harm if he swallowed it; fear of electricity coming from the electric light switches, fear of gas coming from the gas fire, etc. Out-patient individual therapy was ineffective, and did not begin to meet his needs. Placement in an in-patient unit elsewhere was impossible because of long waiting lists. Rather than continue ineffective treatment as an ordinary out-patient, we took him on as a day patient. Soon after this, a child with gross disturbance of behaviour, involving neurotic and aggressive behaviour, was also taken on as a day patient after weekly psychiatric interviews proved ineffectual.

Both these children improved to such an extent with Day Hospital attendance that they were re-established in their normal school environments and were much more settled at home. It seemed, therefore, that the Day Hospital approach might be well worth using as a permanent method in the unit.

During the past three years the staffing of the Unit has been built up to the level shown in the appendix. This staffing is still deficient in some areas. All members of staff are employed by the hospital authorities except the teacher, who is employed by the local department of education.

Implications of the Above Staffing

The provision of the above staff tells its own story in terms of our experience at Tiverlands. It must be stressed, however, that the staff are not solely engaged with Day Hospital patients. Far from it. The Day Hospital is a somewhat theoretical concept so far as Tiverlands is concerned, in that it is not physically separated from the out-patient clinics, offices, etc. The staff are involved in assessing and treating some 270 new cases a year and deal with some 6,600 out-patient attendances, if the day patients are included, excluding school visits made by the psychologist (150 a year) and home visits made by the psychiatric social workers (300 or more a year).

In the first instance, so far as the day patients were concerned, a good deal of individual attention was available from psychiatrists, but as the work of the clinic and the case-load built up, less and less of this time was available. The Day Hospital patients increased in number, and Day Hospital "treatment" began to be prescribed for those patients who were thought to be suitable, but very little time was given to the nursing and other staff by the psychiatrist in charge, to discuss the handling of these patients. This situation arose "by default" due to pressures on the clinic rather than by deliberate planning, and it therefore became necessary to make formal provision for meetings with staff to discuss the day patients. An hour to one and a half hours a week are now given for this purpose.

With the appointment of a senior registrar in May, 1960, it also became possible to provide more satisfactory day-to-day contact between the medical and nursing staff. Thus, after three years, we are beginning to be in a position to manipulate the investigatory and therapeutic environment in terms of the real needs of the children and staff.

The provision of a full-time teacher (who will be a teacher in the widest sense of the word, not necessarily engaged in full-time formal teaching) is an indication of the need we have found to arrange a more structured environment within the Day Hospital setting, and the need to establish subgroups of the sixteen Day Hospital patients.

The need for staff of suitable personality and interests has also been made quite clear, and this has been solved by making the appointments to Tiverlands direct to the Unit instead of appointing the nurses as part of the joint department of psychological medicine on a rotating basis.

It will be clear from the foregoing that in the first instance the Day Hospital included an individual therapeutic situation with patients attending for the day. As the Unit developed, it became a therapeutic environment with little, if any, individual therapy from the medical staff and at first, with little contact between the medical and nursing staff; then came the present phase, which provides a more co-ordinated and medically supervised *flexible* environmental, therapeutic and observational situation which can also include some individual psychiatric treatment.

The Therapeutic Environment

It is difficult to describe in clear terms the therapeutic environment of a Day Hospital. Both physical factors, the building, play-rooms, and so on, and personal factors come into play. The latter are the vital attributes of the therapeutic environment, particularly with regard to the personality of the nurses, domestic staff and other staff in the Unit.

The physical aspects include the three play-rooms, the garage (shortly to be equipped as a construction workshop), the coal-shed (now converted into a room with lighting, heating, sink unit, and a drained floor, which will be used for clay pottery work and messy play) and the front and back gardens.

All children meet for lunch in the downstairs playroom, which is near the kitchen. Meals are brought down in heated containers from the main hospital some three hundred yards away, and dished up in the kitchen at Tiverlands. Tea is provided on the spot and all children meet for tea at 3.15 p.m. These meals provide two definite meetings of all children during the day.

The environment can, in general terms, be described as the result of an attempt to provide a warm accepting climate to which children, whatever their behaviour or disability, will respond. In fact, we do not see anything like as many severe outbursts of temper, violence, or destructive behaviour as would be expected from the history of the children's behaviour before attending the Day Hospital. This finding may well be a measure of our success in providing the optimal emotional climate, and testifies to the understanding and tolerance of the staff, at all levels.

The requirements of the Unit as an out-patient clinic have to be borne in mind, and a certain amount of restriction of noise and activity has to take place. The presence of a school on each side also constitutes a limiting factor.

The nursing staff meet a member of the medical staff once a week for discussions on individual cases or general topics concerning the handling of children, or for more formal instruction concerning orientation and basic facts of child psychiatry.

Each nurse is allocated about three or four children who are to be under her special care. She is required to observe these children and to write weekly notes about such observations of the child's progress. Subgroupings under the charge of individual nurses can be provided.

Sister is in day-to-day contact with the senior registrar, and weekly staff meetings are held on Friday afternoons to discuss the progress of some of the day patients.

The medical director and the teacher meet once a week to discuss the groupings of children attending her, and to make sure that she is not asked to take children who are not ready for a more formally structured group situation. The teacher keeps weekly notes of each child's progress and attends the staff conferences, so that there is full liaison and feed-back of observational material.

Practical Conclusions

The general administrative and practical conclusions we have reached can be summarized as follows:

1. There is a need to provide a warm accepting environment, in which immediate problems of behaviour can be dealt with as they arise by the medical staff, either by individual interview or by advice to the non-medical staff involved.
2. The number of children who can be handled in the Day Hospital will depend upon the type of problem the child shows and upon the number and personalities of the staff available, as well as upon the physical structure of the Unit.
3. Regular staff meetings should be held at least weekly if the Day Hospital patients are not to become the "lost legion", and provision must be made for one member of the medical staff to be available to the sister in charge for emergency consultation as she requires.
4. Some structure is needed in the environment, which should not be regarded as a "free play" centre, since this is disturbing both to some of the timid, fearful patients and to the aggressive children, who may be adversely affected by a continuous discharge of aggression.
5. The importance of maintaining contact with the mother, and sometimes the father, of children attending the Day Hospital, so far as these parents can accept this contact, has been clearly demonstrated to us.
6. It is not possible to run a Day Hospital for children without making liberal use of the hospital car and ambulance services, since it is unreasonable to expect mothers with other family and domestic commitments to travel to and from the Unit twice a day, and since the children themselves cannot travel alone on public transport. To insist that children should be brought by the parent may lead to refusal of therapy or the building up of adverse attitudes in parents, which will vitiate the treatment being given to the child.
7. There is a need for an accurate and efficient Day Hospital attendance register, so that failures of attendance can be immediately followed up. Thus absence from clinic and from school without the knowledge of the clinic staff can be avoided, and the ensuing difficulties in relationships with the child, parents and Local Education Authority can be obviated.
8. There must be ample playroom accommodation and ample equipment, as well as out-door facilities.
9. There must be access to a meals service to provide lunches, and a kitchen in the Day Hospital to provide morning milk, afternoon tea, etc.
10. There is a need for a Day Hospital waiting list, and a special meeting once a week between the psychiatrist in charge and sister in charge, in order to

discuss whether a proposed new admission to the Day Hospital will fit in with the group already attending. Too many aggressive children will disrupt the group, particularly if delinquency is a feature of their symptomatology. On the other hand, too many shy and inhibited children may lead to inadequate group pressures, and group stagnation.

The Relationship Between the Day Hospital for Psychiatrically Disturbed Children and the Day School for Maladjusted Children

The question of the relationship between the Day Hospital and the Day School for maladjusted children is important and needs clarification and definition. The essential differences are as follows:

1. The Day Hospital provides observation and short-term treatment facilities for the psychiatrically disturbed child, with close supervision and manipulation of the "therapeutic environment" by the psychiatrist, who is always available. The Day School for maladjusted children provides a longer term, less flexible environment, with some psychiatric supervision and psychologist participation, usually on an infrequent part-time basis.
2. The accent in the Day Hospital is on "treatment of children's illness" in a flexible therapeutic environment, many of the children being too ill to attend even a special school, whereas the accent in the special school is on education for special needs, in which formal teaching plays a much more prominent part, and the environment may be much more rigid.
3. The aim of the Day Hospital is to get the children well enough to attend their ordinary schools, or to attend a special boarding or day-school for maladjusted children if necessary.
4. The "treatment" provided in the Day Hospital includes close contact with the parents, and with the ordinary schools in the case of some children who attend them on a part-time basis, or who are likely to return to them. Thus therapeutic efforts are brought to bear on the family and school, as part of the treatment programme, by the Day Hospital team. This is not usually provided for by the special school for maladjusted children, and never to the degree possible in the Day Hospital approach. (The writer also holds an evening clinic in the out-patient department, to help parents and adolescents who cannot attend the child psychiatry unit during the day.)
5. The Day Hospital requires ready, and sometimes emergency, access to special medical facilities. These are not so easily available in the Day School for maladjusted children.
6. The Day Hospital provides continuity of handling and treatment and is open during the school holidays.

Future Development at Tiverlands and in Newcastle

It is apparent to all of us working in Tiverlands, that the presence of day patients within the out-patient clinic is far from ideal, because of the need to limit the general noise and mobility of the day patients for the sake of the ordinary out-patient clinics. Optimally, the day hospital should be specially designed, and situated in a separate wing of the out-patient clinic, with physical separation of the two functions. Ideally, also, there is a need for a close attachment to an in-patient unit for children who fail to respond to the Day Hospital approach.

A Day Hospital, suitably designed as such and attached to an out-patient and in-patient unit, is part of a plan submitted to the Regional Hospital Board and is being considered as a high priority by the Board.

The therapeutic deficiencies in the present unit can be summarized as follows:

1. There is need for provision of more individual psychotherapy and play therapy for those patients attending the Day Hospital who would benefit from this combined approach.
2. The need for in-patient accommodation.
3. The need for a co-ordinated Local Authority service of hostels and schools for maladjusted children, so that a graded approach from hospital or clinic to special school or hostel and then back to ordinary school and family life can be effected for those children who need such a gradual and planned approach. These are likely to be the most seriously disturbed children, whose progress can be retarded or halted by placements which are too abrupt. It is hoped that in the course of time these deficiencies will be made up. Indeed, the first of these is likely to be partially met by a re-organization of the Unit's efforts in the next few months.

Wider Implications of the Day Hospital

The fact that seriously disturbed children have been shown to benefit from an environmental approach without individual specialist treatment is a challenge which may have far-reaching implications in the future planning of children's services and endorses the theoretical remarks made earlier. It is bound up with the general questions of natural remission of symptoms, the relationship of symptoms to personality development and the whole problem of character disorders.

It is, however, essential that well-planned research be carried out in suitably staffed pilot Day Hospital units, if any conclusions of definitive value in future planning are to be formulated.

The field of child psychiatry will be faced for many years to come with the problem of training and provision of professional staff. Any methods which can be shown to be of definitive value, involving the use of less highly-trained staff than the psychiatrist, psychotherapist and play-therapist, will be of national importance and the immense cost of providing specialist services in the field of childhood mental and emotional disturbance may well be diminished.

Summary

1. Theoretical aspects of a Day Hospital approach in child psychiatry are formulated.

2. The development of a Day Hospital for psychiatrically-disturbed children in Newcastle upon Tyne is described.

3. Practical implications and future developments in the light of the three years' experience of this Day Hospital are discussed.

4. A comparison is made between the Day Hospital for psychiatrically-disturbed children and the Special Day School for maladjusted children.

5. Some implications for future national planning and for research into methods of therapy other than individual treatment by a psychiatrist or psychotherapist are mentioned.

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Appendix

Present Staffing of Combined Out-patient and Day Hospital Child Psychiatry Unit—"Tiverlands"

Psychiatrists

The Medical Director (9 sessions a week). Consultant Psychotherapist (2 sessions a week). Consultant Psychiatrist (1 session a week). Assistant Psychiatrist—S.H.M.O. (whole-time). Senior Registrar (whole-time).

Psychologists

Senior Clinical Psychologist (whole-time). Clinical Psychologist (whole-time).

Psychiatric Social Workers

2 Psychiatric Social Workers (whole-time). 2 Psychiatric Social Workers (part-time)—7 sessions in all.

Nurses

1 Sister (whole-time). 2 Staff Nurses (whole-time). 1 Auxiliary Nurse (whole-time). 1 Nursery Nurse (whole-time).

Teachers

1 Teacher (full-time, provided by the Local Education Authority).

Clerical and Secretarial Staff

1 Clerical Worker (operates switchboard, makes appointments, organizes filing and indexes, etc.). 2 Shorthand Typists (for psychiatric social workers and psychologists). 1 Shorthand Typist (for medical staff).

Cleaners and Domestic Workers

2 Cleaners from 7 a.m. until 11.30 a.m. 1 Cleaner from 12 noon until 5 p.m.

P. H. CONNELL, M.D.(London), D.P.M., *Medical Director*
Child Psychiatry Unit ("Tiverlands"), Newcastle General Hospital In Association with King's College, University of Durham