Advancing Care Within an Adult Mental Health Day Hospital: Program Re-Design and Evaluation

Marlene Taube-Schiff, PhD, C. Psych.
Adrienne Mehak, BA
Sandy Marangos, RN, BSc., MSc.
Anastasia Kalim, MSW, RSW
Thomas Ungar, MD, MEd

Abstract

   Day hospital mental health programs provide alternate care to individuals of high acuity that do not require an inpatient psychiatric stay. Ensuring provision of best practice within these programs is essential for patient stabilization and recovery. However, there is scant literature to review when creating such a program. This paper provides an overview of the steps an acute care hospital took when designing and implementing new programming within a day hospital program. Qualitative data was collected following initial program rollout. This data helped to inform the ongoing modification of groups offered, group scheduling and content, as well as ensuring patient satisfaction and adequate skill delivery during the rollout period and beyond. The goal of this paper is to inform health service delivery for other programs when attempting to build or re-design a day hospital program.

   Address correspondence to Marlene Taube-Schiff, PhD, C. Psych., Sunnybrook Health Sciences Centre, Frederick W. Thompson Anxiety Disorders Centre – OCD Intensive Treatment Services, 175 Brentcliffe Rd., Toronto, ON M4G 0C5, Canada. Phone: 416-652-2010 x 101; Email: marlene.taubeschiff@sunnybrook.ca.
   Marlene Taube-Schiff, PhD, C. Psych., North York General Hospital, Mental Health Program, Toronto, ON, Canada.
   Adrienne Mehak, BA, North York General Hospital, Mental Health Program, Toronto, ON, Canada.
   Sandy Marangos, RN, BSc., MSc., North York General Hospital, Mental Health Program, Toronto, ON, Canada.
   Anastasia Kalim, MSW, RSW, North York General Hospital, Mental Health Program, Toronto, ON, Canada.
   Thomas Ungar, MD, MEd, North York General Hospital, Mental Health Program, Toronto, ON, Canada.
Current Address: Anastasia Kalim, Assessment and Reintegration Program, Ontario Shores Centre for Mental Health Sciences, Toronto, ON, Canada
Current Address: Thomas Ungar, St. Michael's Hospital, 30 Bond Street, Ste. 17-038, Toronto, ON M5B 1W8, Canada

Introduction

Day hospital (DH) and day treatment mental health programs, often referred to as partial hospitalization programs (PHPs), provide intensive treatment for individuals presenting with heterogeneous acute psychiatric illnesses. Treatment is often offered in a structured and routine format (i.e., daily or several times per week), and typically of a shorter duration. The goals of these programs often include optimization of medication regimen, provision of psychoeducation, fostering of coping strategies and relapse prevention techniques, as well as development of a discharge plan after DH treatment completion. DH programs are often contrasted with inpatient programs in terms of ensuring comparable treatment outcomes. For example, Kallert and colleagues performed a large multisite trial and reported no significant differences between DH versus inpatient services in terms of patient symptoms and satisfaction as well as quality of life upon discharge.[1] However, DH programs were found to have a greater impact on patients' social functioning at discharge, with these improvements maintained at 3- and 12-months.[1] This was attributed to the setting of a DH, in which individuals are able to remain within their home environment as opposed to the challenges that may arise when living within an inpatient milieu on a 24-hour basis.[1] Research by Priebe and colleagues revealed that patients attending a DH program reported superior symptom improvements compared to inpatient hospitalization at discharge.[2] However, at the 3- and 12-month follow-up, there were no continued improvements. A Cochrane Database Systematic Review evaluated DH treatment versus inpatient treatment for individuals presenting with acute psychiatric illness.[3] Results indicated the presence of "moderate quality evidence"[3] (p. 26) to support DH services reducing the duration of inpatient care. Furthermore, the authors commented that outcomes show improvement for individuals suitable for DH treatment, and therefore, it was questioned as to why there are not more widespread DH programs.[3] Overall, research does support the benefit of psychiatric DHs and appears to be suitable when an individual does not require an inpatient admission.[4–6]

North York General Hospital (NYGH) Adult Outpatient Day Hospital Program in Toronto, Ontario, Canada, provides group treatment to patients presenting with mood disorders, anxiety disorders, personality disorders, schizophrenia as well as other severe and persistent mental illnesses. The team within this program is comprised of inter-professional staff, including occupational therapists, registered nurses, social workers, psychiatrists, and clinical psychologists. Patients enter this program in a rolling admission system; thus, the groups are comprised of both novice and experienced patients. This DH program had been operating smoothly with little change over 20 years, and staff were familiar and comfortable with the programming and groups offered. However, in keeping with principles of quality of care,[7] some of the clinical staff and the leadership expressed a desire to review groups and programming to ensure that it was in keeping with patient safety, best practice evidence-based care, treatment effectiveness, and was being delivered with a patient-centered focus. This review would ensure that patients attending groups were receiving similar material each time that the group was presented, and allow for a coherent curriculum design across the entire program. In addition, group sizes had grown very large, often resulting in over 25 patients within one group at any given time. Therefore, developing a system in which patients could be assigned to groups, based on appropriate clinical characteristics, was seen as beneficial. As with any change, some staff were eager to champion it, while others were more wary or resistant to any change in roles. As a result, several steps were taken to ensure that staff felt engaged with this process (i.e., working groups, staff training).

In order to create a program that adhered to best practice guidelines, various curriculum development strategies were carried out,[8] including a review of psychiatric DH program literature, an environmental scan conducted by surveying several Canadian DH programs, a needs assessment within the current program, the creation of a staff working group, the development of group modules with facilitator handbooks, as well as collecting data from patient focus groups. For the purposes of this paper, data will be described from patient

focus groups that occurred following program rollout. In these sessions, patients were asked about group curriculum, impact of programming on their functioning, as well as overall satisfaction with the program. This data shed light on the patient perspective during initial program delivery. Importantly, little literature was found that could specifically guide clinicians with respect to what the key elements within a day hospital program are, as well what specific curriculum is offered. Therefore, within this paper, the overall program development and implementation process will be reviewed in order to enable other programs to better understand the steps taken, and allow for improved facilitation of program development in mental health.

Methods

Program Development Approaches

Literature Review The first author (MTS) was aiming to redevelop the current DH program to be aligned with program offerings within similar mental health DH programs. However, a thorough review of the literature did not reveal any "how to" guides that would have made the process of program design transparent. However, for a general overview of program development, the interested reader is referred to Program Development in the Twenty-First Century.[9] Thus, it quickly became apparent that "best practice" was not to be guided by research evidence. However, a set of standards and guidelines was published by the Association for Ambulatory Behavioral Healthcare (AABH) in 2015.[10] This appeared to be an excellent starting point for learning more about the common elements recommended for DH programs. These guidelines included general criteria for a variety of elements, with the criteria for the therapeutic milieu of a PHP being the most relevant for the present discussion. For example, the guidelines state that "group therapy is a key building block"[10] (p. 19) and that psychoeducational services are also an integral ingredient. Psychoeducational services could consist of "worksheets, workbooks, videos, computer-based learning, trainers, role-playing, expressive therapy and activity-based tasks."[10] (p. 19) The types of groups suggested included theme-based groups, medically based disease or illness management groups, evidence-based groups (CBT, DBT etc.), positive psychology groups, recovery-based education, as well as subspecialty groups for targeted populations, such as individuals with trauma or obsessive-compulsive disorder.[10] In addition to the group treatment that is offered, other supplemental components might include individual therapy, family sessions, occupational therapy, and creative/expressive therapies.[10] Reviewing these guidelines provided broad strokes as to the types of services that should be considered when building a DH program. Given the dearth of literature available to guide the development of evidence-based best practice for DH programs, these guidelines were helpful in ensuring that "common practice" was being carried out in the redevelopment of this program.

Environmental Scan and Needs Assessment In order to design this program, the first author (MTS) of this paper conducted an environmental scan across Ontario, speaking with multiple hospitals within Canada that run DH programs. This was extremely helpful, given that the literature was not overly helpful for establishing best practice within DH programs. Four site visits were also conducted. This allowed for an understanding of the landscape of DH programming, as well as best practice that was being implemented. Individuals undergoing treatment within the DH program were also surveyed before and after program rollout. Prior to rollout, focus groups were run by two staff working in the program with the goal of obtaining feedback on the structure and format of the existing program. This was not part of a research project, and therefore, the narrative gathered

during those focus groups cannot be shared. However, following the rollout, a Research Ethics Board-approved research project was conducted, and eight focus groups were conducted (see below for the detailed methods). This ensured that program design was being modified based upon both staff and patient perspective, in keeping with principles of patient-centered care and co-production. Program structure and scheduling was not emphasized in these focus groups, as the rollout and new scheduling had already been implemented.

Working Group

As described above, in order to encourage staff engagement and input in the program re-design, a working group was formed. This group was comprised of staff representing each professional group (i.e., nursing, social work, and occupational therapy) and was led by the first author (MTS), a psychologist. The purpose of this group was to meet on a monthly basis in order to share current materials that were in use (as curriculum was being developed), review new curriculum that was being developed, and afford staff the opportunity to provide feedback during the program rollout process. MTS asked staff to provide feedback on specific curricula relevant to their facilitation skill set, and this feedback was incorporated into the final group curriculum. Although psychiatrists were not in this working group, they were also invited to review the modules that were created for the program and provide feedback.

Curriculum Development

Curriculum developed for this program centered on evidence-based practice. Manuals were designed with an agenda, group outline, list of handouts to be provided, and detailed content. Content was written in a fairly scripted manner to provide staff with a detailed roadmap for delivery of group material. As familiarity developed, it was expected that inter-professional staff would adapt the groups to their own style in a more flexible manner. However, a standardized approach was applied by highlighting key points to be addressed by every facilitator in each group. An electronic library was created for group resource material, as were hard copies organized within binders and housed within the DH nursing station. As described, feedback on modules was sought from staff and physicians working within the DH program. Modules were also revised in an iterative process (i.e., as staff used these modules) over several months following the initial program rollout in April 2016.

Qualitative Analysis

Participant Sampling and Characteristics

Ninety-five participants were sampled from North York General Hospital's Adult Day Hospital Program. Eligibility criteria required that participants were (a) currently attending the Adult Mental Health DH Program, (b) over 18 years of age, and (c) fluent in English. Focus groups were conducted approximately once every three weeks to ensure that each cohort of patients had the opportunity to participate once over the course of their three week treatment. The sample was heterogeneous, with 45.7% female patients, 50% male patients, and 1.1% transgender patients (3.2% did not have the gender reported). Ages ranged from 18 to 78 ($M = 38.13$, SD = 17.48). Please see Table 1 for an overview of diagnoses upon admission, reported by frequency. Approval for this study was obtained from the Research Ethics Board at North York General Hospital in Toronto, Canada.

Data Collection

Eight patient focus groups were conducted over a 6-month period (May to October 2016). Focus groups were conducted to ensure a better understanding, following program rollout, of patients' general functioning, perspectives on programming being offered, as well as overall experiences. Focus groups were not targeting the specifics of program design, given that the rollout had already occurred. However, the information gathered from these groups was incorporated into modification of programming during the initial months of implementation. One focus group included only individuals that had recently begun the program, and as it was felt that this would not be representative of overall program experiences, data collected from this group is not included in the following results. Groups were facilitated by one to two research assistants. Participation in all focus groups was voluntary. Upon arrival, a research assistant provided participants with a verbal explanation of what their participation would entail and provided each individual with a written consent form. After consent was obtained, the research assistant(s) initiated the focus group and began audio recording the discussion.

A semi-structured interview guide was used to ensure an organized discussion addressing topics relevant to the study, while allowing flexibility for participants to guide the conversation and elaborate on the aspects of their treatment they believed most significant. The interview guide was developed in an iterative process. Preliminary thematic analysis by MTS began after the first focus group to review emerging themes and modify the interview guide accordingly, throughout data collection. Questions fell under four broad categories: (1) patient recovery/changes in symptoms and general functioning, (2) group programming, (3) other supports offered in program, and (4) personal experiences and engagement. Focus groups ranged in length from 36 to 75 min, and the number of participants within each group ranged from 6 to 16. Audio recordings of each focus group were transcribed, verbatim, in preparation for analysis.

Table 1
Patient diagnoses upon admission (frequencies)

Diagnostic category	Primary diagnosis	Secondary diagnosis	Additional diagnosis
Depressive disorders	40.4	13.8	1.1
Anxiety disorders	11.7	12.8	2.1
Bipolar and related disorders	13.8	0	0
Obsessive-compulsive and related disorders	0	2.1	0
Personality disorders/features	3.2	13.8	6.4
Substance-related and addictive disorders	3.2	2.1	1.1
Feeding and eating disorders		2.1	1.1
Trauma-related and stressor-related disorders	5.3	2.1	2.1
Neurodevelopmental disorders	5.3		2.1
Schizophrenia spectrum and other psychotic disorders	4.3	0	0
Neurocognitive disorders		1.1	0
Sleep-wake disorders		1.1	0
Unknown	12.8	0	0

Approach and Data Analysis

Two researchers (MTS, psychologist, and AM, psychology student/research assistant) independently reviewed and coded each focus group transcript, using the qualitative research software HyperResearch to organize the data. Following this independent coding process, the coded transcripts were merged, and themes were compared for consistency to ensure inter-rater reliability. The coders met throughout the coding process to discuss high-level observations of emergent themes. A third coder served as a "tie breaker" (MR, psychology student/research assistant) for any coding disputes. Analyses were conducted according to the literature for qualitative research, such as that described by Creswell,[11] as well as Braun and Clarke.[12] Data saturation was defined as occurring when no meaningful new themes were identified by either coder.[13] Following data saturation, emergent themes were synthesized and organized by both coders and then organized into the finalized framework of themes described in this study. The research team adhered to the COREQ guidelines throughout the qualitative research design and data collection.[14]

Descriptive statistics were analyzed with SPSS Software Version 24 to provide sample characteristics (i.e., age, gender, and diagnosis).

Results

Environmental Scan and Needs Assessment

Prior to the redevelopment, programming in the DH consisted of skills and discussion-based groups that often did not adhere to a standardized format or consistent curriculum. As described, groups were often large and unbalanced in number when two groups were being conducted simultaneously. Therefore, the goals of program redevelopment were to introduce more explicit structure, ensure evidence-based practice, and formalize the content delivered during group interventions. Given the skill and dedication of staff within the program, it was important to honor their expertise while also formalizing group practice.

Highlights from the environmental scan are shown in Table 2. Given that this environmental scan was not part of a formal research project, the identities of the hospitals remain anonymous. During this process, the following topics were reviewed with each program: (1) type of group programming offered, (2) structured nature of groups/modular nature of groups, (3) staffing available, (4) program structure and schedule (e.g., program hours, group divisions, daily breaks), and (5) delivery of material (e.g., open groups, closed groups, modules, etc.). From this scan, it was felt that the development of standardized facilitator manuals would be an excellent modification to current programming. In addition, a modular-based group system appeared to be a common practice in many of the group programs that were surveyed and was thus implemented for almost all groups running within the program. It was also decided that groups would be streamed based on patient insight into their disease presentation, mood, and ability to engage with the group programming. Group 1 is typically composed of patients with a greater ability to engage with group processes, whereas patients in group 2 are functioning at a lower level of psychological mindedness. Table 3 provides an overview of the groups that were designed.

Behavioral Activation   Another significant change to the curriculum was the introduction of primary nursing behavioral activation (BA) groups. BA is an evidence-based treatment intervention designed to improve functional outcomes by reducing patient avoidance, which often results from depressive symptoms.[15, 16] It is a multifaceted psychological treatment that encompasses elements of goal setting, activity monitoring, activity scheduling, as well as problem solving skills.[17] It has been employed in outpatient populations, often targeting depressed individuals.[17–20] However, it has been modified successfully to treat individuals presenting with a variety of psychiatric issues in

general psychiatric inpatient units.[21, 22] The BA protocol that was used within the current program was modified, with permission, from the treatment manual designed by Gollan and colleagues.[23]

Working Group Members of the DH staff working group were consulted regarding various modules and provided helpful feedback on specific content. These individuals, as well as other staff, expressed a need for more formal training regarding group facilitation skills and BA following program rollout. The training was developed and administered by MTS in July 2016, and staff indicated that this was extremely useful. In addition, MTS and the Director of Mental Health and Emergency Services at NYGH (SM) met with staff on a regular basis for the first few months of programming to allow for peer consultation and troubleshooting of program challenges.

Qualitative Results of Focus Groups

Focus Group Themes—Patients

Analysis of emergent themes from the patient focus groups revealed three major categories: (1) what the program offers me, (2) what the groups provide, and (3) always room for improvement. Several more specific subthemes are subsumed under the main categories.

Theme 1: What the Program Offers Me

Improved Quality of Life Participants spoke about how their participation in the program allowed them to improve their quality of life. This encompassed improvements in energy levels, self-

Table 2
Highlights from the environmental scan

Program	Length of time	Group format	Groups offered	Special notes
Hospital A	4 weeks	Open groups; modules	CBT; DBT; recreation therapy groups; life skills	Facilitator manuals
Hospital B	12 weeks	Open groups; modules	Psychoeducational; skill-based; CBT; relaxation; activity-based groups	Streams
Hospital C	8 weeks (stream B) and 12 weeks (stream A)	Open groups; looser modules	Psychoeducational groups; life skills; stream B: depression groups; relaxation skills; psychodynamic groups	Streams
Hospital D	8 weeks	Open groups; not as modularized	CBT; activity groups; wellness; social skills; yoga; medication; mindfulness	Menu of groups for patients provided each day

Table 3

Overview of group curriculum

Group name	Content and facilitation
Primary nurse: behavioral activation group	Patients' primary nurses led this daily group. These are smaller groups in which patients learn about avoidance and how to begin to engage in helpful activities. Topics covered include *increasing activities, reducing avoidance, tracking and rating mastery and enjoyable activities, creating change in small steps, scheduling activities, and goal setting*
Building balance groups	A series of 12 group modules typically led by the team psychologist. Topics covered include *cognitive behavioral principles, dialectical behavior therapy skills, mindfulness skills, problem solving, exposure,* and *behavioral experiments.*
Wellness toolbox groups	This is a series of six different group modules led by the team occupational therapist and the registered nurses. Within each group, patients receive education regarding a specific topic and then discuss this theme in the group environment. Topics covered in these groups include *anger management, assertiveness, stress management, coping skills, self-esteem,* and *self-care.*
Managing relationship group	This group is typically led by the team social worker. In this group, patients focus on examining themselves and how they behave in relationships with other people. There is self-exploration involved for every participant. They learn from what they share, as well as from the feedback received from others.
Managing self group	In this group, people use the medium of art to express their thoughts and feelings. A facilitator-guided activity will be announced at the beginning of each session, focusing on topics such as comfort, gratitude, emotions, activities, and strengths. Participants are encouraged to share their creation towards the end of the session, and a facilitated discussion will also take place in this group. This is the offset to the managing relationship group for those individuals that have more difficulty expressing their emotions through a verbal narrative.
Body and mind awareness group	This group, led by the team occupational therapist, allows individuals to become more aware of muscle tension and perform calming stretching exercises. This group often offsets the mindfulness group for individuals unable to meditate due to intrusive/traumatic thoughts.
Wellness and recovery groups	The three sessions within the *Wellness and Recovery* series focus on topics related to enhanced physical and mental well-being. Specific topics will include *sleep hygiene, emotional behaviors,* and *relapse prevention.* The team occupational therapist often runs these groups.
Relaxation skill groups	Patients learn several methods to help increase body awareness, know when body is feeling stress, and ways in which they can calm the body and mind. The skills learned include *diaphragmatic breathing, progressive muscle relaxation,* as well as *imagery and grounding techniques.* Occupational

Table 3
(continued)

Group name	Content and facilitation
	therapy and registered nurses often run these groups.
Women's and men's issues	These are open discussion groups that focus on issues specific to men and women and the types of challenges they face. Registered nurses run these groups.
Weekly community meeting	Every Friday, there is a 30-minute community meeting. Individuals receiving treatment within the day hospital program run these groups with staff present as well.. Within these meetings, people will discuss any new business that they might like to raise as well as a review of any old business that was previously discussed. In addition, members decide on who will be in charge of certain "roles" within the community of the day hospital (e.g., bringing up newspapers, tidying up the kitchen).
Peer-led weekly activity	Every week, one member of the day hospital program (not staff) will lead the programming. Activities have included a group trip to a nearby restaurant for breakfast, a walk in the neighborhood, or playing games or puzzles in one of the group rooms.

esteem, mood, anxiety, attention, and concentration. For example, one participant noted, "I laugh. It's been a long, a long, long time since I heard my laugh" (focus group 4). Another participant indicated, "I'm more active, in small ways maybe, but in—more active than I have been in so long" (focus group 2). One participant also responded, "More relaxed, more focused. More calm, I don't have that anxiety where I was very, very, very nervous" (focus group 4).

Skills   Individuals within all focus groups commented on different skills they had learned since entering the program. These skills included increased self-awareness; anger management; sleep hygiene; connections between thoughts, feelings, and behaviors; labeling and challenging negative thoughts; tracking events; exposure exercises; becoming activated (i.e., behavioral activation skills); decreasing avoidance; mindfulness; relaxation exercises; decision making; and relationship skills. One participant said:

> I really started to realize that number one my brain is always jumping to different thoughts, and number two a lot of them, a lot of the thoughts are quite negative. So uh just being aware of that, I think is really uh impacted me. So, I'm starting to try to put it to practice to sort of label them and categorize them and what not, but just, just being aware of it has been a real eye opener. (Focus group 3)

Some patients also spoke about the challenges in making the changes, and being able to apply the skills:

> Even with the strategies and structure and whatnot, it's hard to sort of go home and, and change things, if you're just so used to doing, doing one thing. So, uh it is, with the structure and the evidence and the group discussion about how other people are doing, it is making it easier to break the habit, but still breaking the habit is very difficult. (Focus group 3)

As described, participants learned a great deal about *behavioral activation* during their time in the program. A comment from one participant reveals the impact that this treatment can have:

> I see behaviour activation as an appointment with myself. If I said that I was going to go swimming, if I said it to a friend, not by myself I would just go but if I said it to myself that I would go swimming, I want to go, because I'm as

important as the other person and I felt that's like what I did this two weeks, almost three weeks, I've been swimming every day except two days where I had to go for other commitments and it changed, it changed my mood and it changed my perception how I can better look at myself. (Focus group 5)

Another individual also said, "The other word that I learned a lot these three weeks was "activate", activate, activate, activate. And that's a hard—that was hard for me to do, but I think I've done, been able to do it" (focus group 4). Group members also learned to track their avoidance and approach behaviors, using the Checklist of Unit Behaviors,[24] on a daily basis and would bring it to their primary nurse groups. One participant noted:

I hate filling out the CUB, however it does help. I hate it, but it kind of does help because like you get to see—if you're honest, if, only if you're honest about it, if you fill it out you can be like okay I'm more you know avoidant or more approachable this time or whatever, and you get to see why and you can analyze it and say hey you know what, it's because you know I had a bad day or whatever, or I had this, or I didn't really listen so much—stuff like that. (Focus group 2)

Relatedly, individuals spoke about the challenges with, but also the necessity of, *applying all the different skills* that they learn in the program:

It's hard to apply when you need them and when I first started the program I thought why do we keep doing the same things, uh some things were doing it through the three weeks but I get it it's to get us to practice so that it's easier to do it at home when we are alone, so I do appreciate that part of the… the program. (Focus group 5)

Power of the Group   In every focus group, participants remarked on the benefits of being a member of a group treatment program. Comments focused on elements of group process, such as learning from others, feeling validated by hearing other people share similar stories, and feeling a general sense of being *connected*. One individual indicated, "Everybody has their own issues, but you're in the same position. And sometimes talking even to a friend sometimes will help you because he has a suggestion. So all this feedback and stuff is very positive" (focus group 3). Another person shared, "So you know that you're not alone and… this thing that I think is so crazy about myself that person experiences as well so that's good" (focus group 6). One individual remarked:

When I'm here with the groups and uh a lot of people, and a lot of people here are in the same situation as me and everything, and the staff is incredible, helpful and it's, I know it's such a short time, it's only been two days but I noticed a difference. (Focus group 4)

A subtheme that often arose, related to the *power of the group*, was the idea of *learning from others*. As one participant indicated, "Hearing what other people have to say, this is actually helping me" (focus group 6), and another person also indicated, "It's pretty easy to relate so you could go through the three weeks without saying a word and still take something from it" (focus group 6).

Theme 2: What the Program Gives to Me

Having a Place to Go Every Day   Many participants spoke about the benefit of having structure in their day, every day Monday-Friday . Prior to entering the program, they often had few activities to organize their day, and having "*a place to go every day*" was described as very beneficial. One patient spoke about how the structure helped with the transition after being discharged from the inpatient ward:

For about a week or so I was just on my own and uh outside the hospital, and then I got right into here and it was good in that it gave me structure, like I had to be up and out of bed, um I had to get on the, the public transit, come into the hospital. (Focus group 2)

Another participant indicated, "I have structure and I know where I'm going to be for the next three weeks and that has helped lessen my, my anxiety" (focus group 4). Similarly, another individual noted, "Coming every day, same time, leaving every day, same time and going home and then coming back the next day—that routine is something that I don't have in my life so it's very nice for me" (focus group 1). Participants spoke about the program providing them with a *safe space*. One individual said:

It's just sort of it's in a safer environment and you can say whatever you want, you're not going to be judged, and you know—I know it's not the outside world, but it gives you a little safe haven even if it's for a while." (Focus group 4)

Support   Individuals commented on the support they received in the program,often focusing on staff helpfulness, as well as the support received from other group members in the program. One individual described it in this way:

I think um having the support from North York General has been very helpful and having [been here] four times this year for different reasons and um and um it has been a life saver and um I think um um I can't thank enough North York General because it's been, it's-it's just um it's so um protected um um it's incredible service uh and um I thank the doctors and the nurses and that it's an incredible program that they have here and I'm, I feel very blessed. (Focus group 3)

Related to feeling this support was also *gratitude* expressed by participants towards the program. One participant said:

For me having this program was extremely helpful and I felt that I was given exactly what I needed to, to um build myself up a little bit, so um I was very determined to, to, to be here in classes, or do all the programs and um it was very helpful so I—I'm happy that uh I—I was here. (Focus group 4)

Theme 3: Always Room for Improvement

In order to ensure a balanced view of the program, participants were encouraged to comment on aspects of the program that they felt could be improved. Two common themes expressed were wanting smaller group sizes and wanting more individual support. One individual remarked, "[I] think the most important thing we'll come back to is the size of the groups. Because the bigger it is, the less comfortable…" (focus group 1).

Patients' suggestions were also incorporated into the daily programming. For example, initially, patients were being given the CUB without being asked to track their outcomes, and in addition, copies of the CUB were being collected at the end of each day. In one of the focus groups, patients expressed a desire to keep the CUBs so that they could understand their changes over time. After this feedback was provided, patients were then given tracking graphs, and the feedback with regards to this change was quite positive.

Despite the constructive criticism that was offered, patients still, for the most part, provided a balanced view of what the program offered them. For example, one individual indicated:

I agree, nothing's perfect in anything, but it's a blessing to actually have programs like this and it would be nice if there was more of them—then we'd probably have smaller groups, because there'd be more of these programs, but it's important to have them. (Focus group 1) Furthermore, this participant also expressed, "there are some issues that could be ironed out, but even with the issues, coming here is better than not. Like I don't know—I don't even know, I don't want to think about what it would be like to not be here." (Focus group 1)

A meaningful exchange between a participant and facilitator was also noted in terms of rating the program overall: participant: "On a scale of 10, 10"; facilitator: "10?"; participant: "Only because I can't go higher." (Focus group 6)

Discussion

The purpose of this paper was to provide the reader with an overview of the steps taken to re-design a psychiatric day hospital program with a heterogeneous patient population. The approach taken was based on best practice from program development literature.[9] This involved conducting a review of DH literature, conducting a thorough environmental scan of DH programs within Canada, reviewing partial hospitalization guidelines from the USA, as well as speaking with service users about the current DH structure. Following this, a new curriculum and schedule was designed for the program at NYGH. Significant changes to this program included the development of standardized group modules and scheduling that included more skill-based groups, as well as the incorporation of behavioral activation. In order to ensure that the new programming was meeting patient needs, frequent patient focus groups were conducted. These groups revealed that many of the goals of the program re-design had been accomplished. Patients were able to identify skills that they were learning and practicing, such as CBT and mindfulness skills, as well as relaxation strategies. Individuals also indicated that they were benefitting from the new model of behavioral activation that had been implemented. They spoke about the importance of scheduling in activities and ensuring that these plans were carried out. Patients noticed changes in themselves, such as increased energy levels and enhanced mood. By capturing these themes, the team was confident that the programming was effective and enjoyable for patients. Focus groups also enabled modifications to be created according to important feedback (e.g., providing tracking sheets for individuals to see change over time). Furthermore, patients reported that they felt supported by staff in the DH program. Notably, individuals spoke to the group process that was developing within the treatment program; they felt supported and validated by each other within the program milieu. Patients also enjoyed the structure and routine of the DH program. Staff were also supported during this program re-design through staff training and regular peer consultation meetings.

Some of the findings with respect to patient satisfaction have been noted elsewhere. For example, Lariviere and colleagues conducted a phenomenological perspective of patients' experiences within a day hospital program.[25] Responses were derived from self-report questionnaires filled out during the last week of treatment. Within that study, patients spoke about the expertise and kindness of the professionals, as well as having enhanced routines while attending the program.[25] Individuals also commented on the size of the group being too large, similar to the feedback obtained in the current study.[25] These researchers also conducted a separate qualitative study, in which they found that patients, 6 months after discharge, spoke about how the experience of being in the DH treatment had improved their level of functioning.[26] Given the short duration of the current program being investigated, it would be interesting to reconnect with patients 3 to 6 months post discharge in order to better understand whether the changes that were reported persisted.

The data gathered from patients also revealed areas for improvement. Despite the creation of a more balanced group structure during the program re-design, individuals still indicated wanting increased individual support and smaller group sizes. Individuals also spoke about the challenges in implementing all the skills learned. Given the length of the current DH program at NYGH (i.e., 3 weeks), one could argue that it is not affording individuals enough time to truly implement the constellation of strategies that they are learning. Other programs sampled were slightly longer in length. However, additional issues arise in longer programs, such as increased wait times to enter into the program. It will be important for staff to encourage individuals to practice the skills learned as much as possible during their time within the program. For example, building in homework can serve the purpose of encouraging individuals to practice skills when they are not attending the group treatment. This is an effective skill often used within CBT treatments.[27]

The current paper also has some limitations. Although the environmental scan conducted was comprehensive, programs sampled were only within Canada. It is possible that traveling further

afoot might have highlighted other important elements to build into the current program. Furthermore, the structure of the program could only be modified to a certain extent. Resources were limited, and the new structure that was implemented needed to fit the current staffing roles. For example, prior to program rollout, patients expressed a desire for a longer treatment day. As a result, groups were extended into the afternoon 2 days per week. No further programming could be offered given the other duties of staff already engaged in the program. If more significant changes were to be made, it would likely require increase in human resources and modifying the staffing compilation within the program.

Implications for Behavioral Health

The aim of this paper was to share experiences regarding program development and evaluation within a DH setting from the setting of a large acute care hospital with specialized acute psychiatric services. Although programs often undergo re-design, the best approach to take is not always clear. Furthermore, the curriculum offered within psychiatric DHs is rarely published. Therefore, when designing treatment programming, the types of interventions offered within other programs are often unknown. This paper aimed to make those aspects of DH programming more transparent for other clinicians and health planners working in this area. Furthermore, qualitative data regarding patients' perspectives on DH programs are fairly scant within the literature. Therefore, the current paper provides further insight into elements that are reported as helpful for patients, as well as negative aspects of the DH experience.

This is important for other programs to consider when carrying out current programming. For example, in the current study, patients voiced a desire for smaller groups and more individual treatment. This would certainly be ideal, although resources often dictate availability of programming. The current DH program offers two simultaneous groups, staffed by one group facilitator each. As such, groups tended to be fairly large given that the program can house up to approximately 40 patients. Another program surveyed had specific groups of patients attending on different days. If the DH program at NYGH offered 3 days of programming for two groups of patients (i.e., group 1 attends Monday through Wednesday and group 2 attends Wednesday through Friday), then smaller groups could be run on at least two of those days (i.e., when half the patients are present), even with the same staffing modeling. However, one could then argue that 5 days of programming might better than only 3, despite the offering of smaller groups. These are questions that should be further investigated (i.e., what is the "right" amount of programming to offer within this type of a DH setting). Furthermore, being creative with current resources is an important issue and perhaps restructuring of this sort could be trialed based on patient feedback.

This paper also illustrated the importance of gathering narrative from patients regarding their areas of improvement and overall satisfaction with the program. If other DH programs were to elicit feedback from patients attending their programs and then disseminate this knowledge, it may enable a discussion regarding increased provision of DH services. Given the value of DH services, further research in this area would likely be welcome by many. Overall, this paper can serve as a replicable and generalizable example of program design, implementation, and evaluation for others.

Acknowledgements

Compliance with Ethical Standards

Conflict of Interest   The authors declare that they have no conflict of interest.

References

1. Kallert TW, Priebe S, McCabe R, et al. Are day hospitals effective for acutely ill psychiatric patients? A European multicenter randomized controlled trial. *The Journal of Clinical Psychiatry.* 2007;68(2):278–287.
2. Priebe S, Jones G, McCabe R, et al. Effectiveness and costs of acute day hospital treatment compared with conventional in-patient care: randomised controlled trial. *The British Journal of Psychiatry.* 2006;188:243–249.
3. Marshall M, Crowther R, Almaraz-Serrano A, et al. Systematic reviews of the effectiveness of day care for people with severe mental disorders: (1) acute day hospital versus admission; (2) vocational rehabilitation; (3) day hospital versus outpatient care. *Health Technology Assessment.* 2001;5(21):1–75.
4. Rosie JS, Azim HF, Piper WE, et al. Effective psychiatric day treatment: historical lessons. *Psychiatric Services.* 1995;46(10):1019–1026.
5. Yanos PT, Vreeland B, Minsky S, et al. Partial hospitalization: compatible with evidence-based and recovery-oriented treatment? *Journal of Psychosocial Nursing and Mental Health Services.* 2009;47(2):41–47.
6. Horvitz-Lennon M, Normand SL, Gaccione P, et al. Partial versus full hospitalization for adults in psychiatric distress: a systematic review of the published literature (1957-1997). *Americal Journal of Psychiatry.* 2001;158(5):676–685.
7. Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press; 2001.
8. Kern D, Thomas PA, Hughes MT. Curriculum developmeny for medical education: a six-step approach. Baltimore, MD: The John Hopkins University Press; 2009.
9. Calley NG. Program development in the 21st century: an evidence-based approach to design, implementation, and evaluation. Los Angeles, CA: Sage Publications; 2011.
10. Association for Ambulatory Behavioral Healthcare. (2015). Standards and guidelines: partial hospitalization programs and intensive outpatient programs. Portsmouth, VA: Association for Ambulatory Behavioral Healthcare.
11. Creswell JW. Research design: qualitative, quantitative and mixed methods approaches. 4th ed. Thousand Oaks, CA: Sage Publications; 2013.
12. Braun V, Clarke V. Successful qualitative research. London: SAGE Publications; 2013.
13. Francis JJ, Johnston M, Robertson C, et al. What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology & Health.* 2010;25(10):1229–1245.
14. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care.* 2007;19(6):349–357.
15. Dimidjian S, Hollon SD, Dobson KS, et al. Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting Clinical Psychology.* 2006;74(4):658–670.
16. Dimidjian S, Barrera M, Jr., Martell C, et al.. The origins and current status of behavioral activation treatments for depression. *Annual Review of Clinical Psychology.* 2011;7:1–38.
17. Martell CR, Dimidjian S, Herman-Dunn R. Behavioral activation for depression: a clinician's guide. New York: Guilford Press; 2010.
18. Jacobson NS, Dobson KS, Truax PA, et al. A component analysis of cognitive-behavioral treatment for depression. *Journal of Consulting and Clinical Psychology.* 1996;64(2):295–304.
19. Martell C, Addis M, Jacobson N. Depression in context: strategies for guided action. New York, NY: Norton; 2001.
20. Hopko DR, Lejuez CW, LePage JP, et al. A brief behavioral activation treatment for depression. A randomized pilot trial within an inpatient psychiatric hospital. *Behavior Modification.* 2003;27(4):458–469.
21. Gollan JK, Hoxha D, Hanson B, et al. A comparison of a milieu-based Behavioural Activation Communication with treatment as usual for acute psychiatric inpatients. *Journal of Psychiatric Intensive Care.* 2013:1–10.
22. Folke F, Hursti T, Tungstrom S, et al. Behavioral activation in acute inpatient psychiatry: a multiple baseline evaluation. *Journal of Behavior Therapy and Experimental Psychiatry.* 2015;46:170–181.
23. Gollan J. Behavioral activation patient guide. In. Chicago Illinois: The Stone Mental Health Center, Northwestern Memorial Hospital Department of Psychiatry and Behavioral Sciences Northwestern University's Feinberg School of Medicine; 2013:1–37.
24. Hanson B, Hoxha D, Roberts P, et al. The checklist of unit behaviours (CUB): psychometric properties of a measure of patient milieu engagement on an acute inpatient psychiatric unit. *Journal of Psychiatric Intensive Care.* 2013:1–9.
25. Lariviere N, Melancon L, Fortier L, et al. A qualitative analysis of clients' evaluation of a psychiatric day hospital. *Canadian Journal of Community Mental Health.* 2009;28(1):165–179.
26. Lariviere N, Desrosiers J, Tousignant M, et al. Revisiting the psychiatric day hospital experience 6 months after discharge: how was the transition and what have clients retained? *The Psychiatric Quarterly.* 2010;81(2):81–96.
27. Kazantzis N, Whittington C, Zelencich L, et al. Quantity and quality of homework compliance: a meta-analysis of relations with outcome in cognitive behavior therapy. *Behavior Therapy.* 2016;47(5):755–772.