Partial Hospitalization: Guidelines for Standards

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Can the chronic mental patient be treated in the community? What is the least restrictive form of treatment that could feasibly be given him? Can the spiraling costs of mental-health care be contained?

Many would name partial hospitalization as an important part of the answer to each of these questions. It has been demonstrated to be a therapeutically effective modality and one that is the least restrictive method of providing intense treatment for a majority of those with severe psychiatric illnesses. Its cost-effectiveness has been clearly shown by several studies, and its distinct advantages of minimizing family disruption, social stigmatization, and excessive dependency are well known.

Nevertheless, insurance coverage for those seeking care by partial hospitalization is poor, and the utilization of partial hospitalization remains low—only 3 percent, versus 70 percent for other ambulatory treatments. In surveying the problem two years ago, members of the New York County District Branch of the American Psychiatric Association were cognizant of the fact that the growing importance of day hospitals and psychiatric day centers had been stressed by the President's Commission on Mental Health. Third-party payers, such as Medicaid, Medicare, and the insurance companies, were asking for standards on partial hospitalization—and, in some cases, beginning to step into the vacuum and pro-
pose their own standards. Our district branch had no written reference material that could serve as guidelines. Recognizing the dilemma, Eugene Feigelson, M.D., President of the District Branch, appointed a task force and asked it to propose standards for partial hospitalization. The authors of this article were all members of the task force, and this is a condensation of their report.

DEFINITION

This is the definition of partial hospitalization contained in our report:

Partial hospitalization is an ambulatory treatment approach that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational treatment modalities usually found in a comprehensive psychiatric hospital program. It is designed for patients with serious mental disorders who require coordinated intensive, comprehensive, and multidisciplinary treatment not provided in an outpatient clinic setting. By offering an alternative under medical supervision to inpatient treatment, it provides a more flexible and less restrictive form of treatment. Therapeutic modalities usually include (a) a balance of various group and/or family therapies, (b) individual therapy, (c) pharmacotherapy, (d) psychodrama, (e) occupational/recreational therapies, and (f) assistance in the development of social and work skills in a structured therapeutic environment.12,13

Partial hospitalization is utilized by individuals who are mentally or emotionally impaired but who are able to maintain themselves in the community at a minimal functioning level and present no imminent potential for harm to themselves or to others.

Partial hospitalization is a generic term embracing day, night, evening, and weekend treatment programs that employ an integrated and comprehensive schedule of recognized psychiatric treatment. A partial hospitalization program will vary according to the unique geographic and demographic community being served, and must be coordinated with its hospital affiliations and community support network.

The partial hospital may be a freestanding unit, a component of a community mental health center, or a part of a hospital complex. It should be conceived, however, as a separate, identifiable, organizational unit representing a significant link in the continuum of therapeutic modalities comprising comprehensive mental health services.

There has been a proliferation of terminology describing various components of partial hospitalization, resulting in a confusion that cannot be readily resolved. Eventually a consensus should develop over the meaning of day (night, evening, etc.) hospital, day treatment center, partial hospital, partial hospitalization program, day-care center, psychiatric day-care center, etc. Until then, we believe the function of the partial hospitalization program should be the determining factor in its description.6

Size. Most programs have between 12 and 30 patients. Supportive and rehabilitation-type programs tend to maintain communities at the larger end of this range, programs focused toward crisis management or transition are smaller. Attendance policies, program goals, and staffing are among the factors affecting community size. Programs using milieu as their treatment approach generally develop into communities with relatively stable size.

FUNCTION

Our task force reached the conclusion that partial hospitalization programs have five primary functions:

1. To facilitate the resolution or stabilization of acute psychiatric symptoms, to arrest or reverse a deteriorating clinical course in outpatients, and to shorten inpatient stay by assisting in the transition to an outpatient status.

2. To facilitate recovery from subacute clinical conditions and provide social and prevocational habilitation and rehabilitation.

3. To provide supportive treatment for those with chronic psychiatric illnesses who could not otherwise remain in the community.

4. To make diagnosis in patients for whom extended observation is needed before psychopathology can be determined and to assess those requiring close medical supervision while on drug therapy.

5. To provide specialized treatment programs where needed (i.e., in specific groups of children, adolescents, or elderly patients, or in alcoholism or substance-abuse programs.)

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*Psychosocial rehabilitation resources should not be confused with partial-hospitalization treatment programs—many of which include psychosocial components in their schedule of therapeutic activities. The distinction is that psychosocial rehabilitation resources are usually not under medical supervision, generally have daily scheduled activities that are less multifaceted and less intensive than partial hospitalization, and may be staffed by other than mental-health professionals. Psychosocial rehabilitation services go by such names as lounge programs or are therapeutic social groups like Recovery, Inc. They assist in the extramural maintenance of the chronically mentally ill, provide opportunities for developing improved social interaction, and usually are staffed by other than mental health professionals who work in a nonmedical setting.
POPULATION AND TREATMENT GOALS

A partial hospitalization program should provide psychiatric treatment to persons with serious mental disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, of the American Psychiatric Association. For those requiring resolution or stabilization of acute psychiatric symptoms, the goal of partial hospitalization is to provide an intensive therapeutic experience that will eliminate or relieve psychiatric dysfunction so that the patient can return to his or her premorbid level of functioning in the family and community and at work or school. Partial hospitalization offers an advantage over full hospitalization in this regard, since it lessens the disruption of social, family, and community ties.

For those in partial remission from severe psychiatric illness, the goals of partial hospitalization are to reduce symptoms and mental disability, restore the patient to the best possible role-functioning level, and prevent deterioration from that level.

For those with a major chronic illness resulting in profound social and vocational skill deficits, supportive partial hospitalization may be indicated. Such a person has precarious extramural adjustments and usually functions poorly in the community. Close medical and psychiatric monitoring, along with a structured, supportive environment, is needed. The goals of partial hospitalization for this group of patients are (1) to make it possible for them to live in the community by improving levels of autonomous and independent functioning; (2) to prevent deterioration, relapse, or rehospitalization; and (3) to improve their quality of life. Some patients in this group will require continuous supportive care; others will require it only periodically. For those with specialized needs, goals vary. Programs usually are designed to accommodate specific treatment strategies and approaches that are particularly applicable to that unique population. Children and adolescents usually require more physical activities, drama, and play therapy, for example. Partial programs with alcoholics will usually accentuate AA doctrine and incorporate AA meetings into the program schedule.

THERAPEUTIC MILIEU

Partial-hospitalization programs nearly always try to develop some variation of the therapeutic community described by Maxwell Jones and others in the 1950s. Generally there is a multidisciplinary team working with groups of patients, operating under the assumption that ego functions can be strengthened through consecutive therapeutic activities during the treatment day.

The complex of patients and staff usually describes itself as a "community." Each community develops traditions, values, group expectations, and pressures that tend to reflect the philosophy of the treatment program. The community thus becomes both an ongoing agent of therapeutic leverage in itself and a context in which a series of specific therapeutic activities can take place.

Each specific therapy group has its own clearly defined short-term focus or goal. Regardless of the patient's diagnosis or the community's theoretic approach, the patient has a sense of belonging to or bonding with the membership in the community, and this is central to the therapeutic process. Emphasis is directed toward each member's immediate relationships with others in the community and—by extension—to his or her relationships in the family, community, and school or job setting.

Therapeutic communities tend to be tolerant of a new member's pathology and encourage progressive involvement through participation, sharing of responsibility, risk taking, and self-disclosure. A member's strengths are noted and reinforced, while his faulty ways of relating to his environment and unrealistic expectations are uncovered. The community thus becomes a safe arena in which the patient can try out many of the elements in his or her treatment plan, and it encourages patients to apply new insights, skills, and behaviors outside, in their natural environment.

COMPONENTS OF A PARTIAL-HOSPITALIZATION PROGRAM

While partial-hospitalization programs must be flexible and structured to meet the needs of the pa-
tient population, all should address these four areas: psychological, psychopharmacologic, interpersonal, and vocational. Content of individual programs will vary according to the specific needs of the patient population, therapeutic philosophy, function of the partial-hospitalization program itself, and specific skills of the staff. Specific programs, for example, might offer individual or group psychotherapy, chemotherapy, occupational therapy, recreational therapy, psycho-drama, creative expressive therapies (art, dance, music). They might provide goal-oriented social groups, community meetings, therapeutic field trips, activities centered around meal planning and preparation, or the development of motor skills. Family evaluation and counseling, work adjustment, prevocational evaluation, aftercare, and other activities could be a part of the program.

SPECIFICATIONS

While a wide range of valid programs exists, standards need to be specific, and therefore sub-groupings are necessary. The “level of care” treatment-delivery model provides a useful way of making such subgroupings according to the patient’s capacity for responding to treatment. Intensive care, transitional care, extended intensive care, and supportive care are four subgroupings that can be made.

Intensive-care programs. These include crisis intervention and the resolution of acute problems and stabilization. The patient population consists of persons whose psychiatric problems are acute, severe, and disabling, yet not of a nature to present a severe or dangerous management problem in the home or community.

Primary thrust of these programs is stabilization of the patient and his or her environment, to eliminate the need for 24-hour hospitalization. Precipitating stresses are identified and ways are found for resolving them, alleviating them, or learning new ways of coping with them.

Frequency, duration, and length of stay. Patients come to the hospital five to seven days per week, for a period ranging from three weeks to three months. They remain for at least three hours a day, during which time they undergo at least two separate treatment modalities; six hours per day is typical of most such programs.

Staffing. At least one staff member per four patients is needed; a higher ratio will be required for some patient populations, particularly children and adolescents. Personnel will be needed to mediate patients and closely monitor medications.

Other points. Some patients may require individual and/or family therapy in addition to group therapy given during hospitalization. Groups in these intensive-care programs need to be well structured by the therapist. Back-up staff should be available to follow up immediately on patients who walk out of groups and to reach out to patients who drop out of treatment.

Transition-care programs. These are for patients who have been briefly hospitalized and are now in partial remission, but with moderately severe residual or resolving disabilities. A patient, for example, may have had six or eight brief hospitalizations in the past two years, is now home, and is beginning to decompensate. Another patient appropriate for such a program is the person who has been isolated at home for a period of time and is functionally disabled. Most patients in transition-care programs, however, have not been chronically disabled; that is, they will have been working or attending school, or otherwise will have demonstrated an ability to function adequately prior to the onset of disabling symptoms.

The goal of transition-care programs is to return the patients to a level of functioning at which they will be self-supporting albeit sometimes at a lower level than they previously attained.

Frequency, duration, and length of stay. Patients come five times per week, meeting at least three to six hours each day. The program lasts from two to eight months.

Staffing: One staff member for every four patients.

Other points: Group modalities and community milieu are emphasized, so regular attendance is required. Group spirit and a sense of belonging are encouraged.

Extended intensive-care programs. These are de-continued

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signed for patients in partial remission from severe psychiatric illnesses who require continued care if psychosocial and vocational deficits are to be remedied. Multiple therapeutic modalities are needed, in a structured environment. Patients generally have a history of disability that has persisted for years—a history of repeated breakdowns and several hospital admissions is typical.

The goal of extended intensive-care programs is to bring about symptomatic and functional improvement, arrest the deterioration caused by chronic psychiatric illness that otherwise might necessitate admission as an inpatient, help the patient return to a premorbid level of functioning (if possible) so that he or she is capable of remaining safely in the community.

*Frequency, duration, and length of stay.* These programs range from three days per week to six days per week, last three to six hours per day (or evening), and extend for a year or two.

*Staffing.* Staff-patient ratio may vary from 1:4 to 1:7.

*Other points:* These programs should be treatment-oriented rather than social or recreational in nature (although recreational and informal socializing periods may be appropriate as secondary elements). Programs may range from those that are primarily “verbal” to those that are concerned with “doing.” Those emphasizing rehabilitation and maintenance will be more “doing” than “verbal” in design. Attendance should be required on a regular basis, with specific consequences if a patient is consistently absent (although the emphasis on attendance will be less stringent than in a transitional program).

*Supportive-care programs.* These are designed for chronically and severely disturbed patients whose condition is such that substantial reduction in disability is not likely. They serve to assist in the maintenance of such patients in the community, providing a regular daily structure of interpersonal relationships and helping to prevent relapse and return to inpatient (or intensive partial hospitalization) status. The goal is to increase the patient’s social integration and help him or her to achieve the highest possible level of autonomous functioning.

*Frequency, duration, and length of stay.* Patients may be seen from two to six times per week, with each program lasting from three to five hours. Therapy is periodic or continuous, as clinically indicated. Patients may be furloughed for several months to reduce dependency on the program or may be tapered from the program via a sheltered
workshop, etc. An open-door policy should allow for re-entry as needed.

**Staffing:** One mental-health professional for every eight patients.

**Other points.** These programs provide non-threatening group experiences focused on concrete topics; they are low-key, low-stress in tone. The gradual formation of therapeutic relationships is often facilitated by patient help with concrete services.

**Program variants.** Larger day-treatment programs may divide patients into subcommunities whose members function at different levels or receive specific treatments. Patients may move from one community to another as they progress or relapse or as new diagnostic information is received.

Some large programs randomly mix acute and chronic patients. Others make no attempt to develop close-knit communities but track patients through available groups during each week according to their specific needs, with the patient's group changing as he changes.

**ADMISSION CRITERIA**

Admission criteria should be both inclusionary and exclusionary in nature and comprehensive enough to justify a given patient's treatment by partial hospitalization. Diagnosis, symptoms and their severity, and presence or absence of adequate support systems must all be evaluated.

**Diagnosis.** There are no diagnoses that in themselves uniformly mandate or preclude utilization of partial hospitalization. Patients treated are those diagnosed as having a mental disorder as defined in *DSM-III*.4

**Severity of symptoms.** Descriptive functional criteria should be used in addition to the diagnosis to present an accurate picture of the patient's condition.

Inclusionary and exclusionary criteria are shown in Tables 1 and 2.

**Adequacy of support systems and degree of severity of psychosocial stressors.** In order for a patient to be treated successfully in a partial-hospitalization program, he must be able to maintain himself during the hours he is away from the program. Continued functioning on an ambulatory basis is often dependent on whether he or she has a supportive family or sympathetic friends. The severity of psychosocial stressors (Axis IV on *DSM-III*) should be noted and gauged. Living arrangements, financial difficulties, loss of a volunteer job, or loss of a relationship with a friend, etc., should be noted, especially when the patient's history indicates that these stresses precipitated illness in the past. Stress also arising from any physical illnesses the patient has should be noted and assessed.

**CRITERIA FOR CONTINUED STAY**

Patients should be evaluated periodically to determine whether the care they are receiving is adequate. Local Professional Standards Review Organization standards may be modified as necessary for adaptation to partial-hospitalization facilities.

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**TABLE 1**

**INCLUSIONARY CRITERIA FOR PARTIAL HOSPITALIZATION**

*One or more of the following:*

**Impaired contact with reality, manifested by**
- Hallucinations, delusions, or ideas of reference
- Withdrawal, regression, or confusion not warranting inpatient hospitalization
- Paranoid ideation or behavior

**Impaired functioning**
- Not able to function adequately socially, occupationally, or academically
- Moderate to severe anxiety
- Disabling somatic symptoms

**Needs pharmacotherapy requiring observation**

**Attempts to halt or reverse illness on outpatient basis unsuccessful**

**Needs some care, but inpatient care no longer warranted and outpatient care insufficient to maintain patient**

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**TABLE 2**

**EXCLUSIONARY CRITERIA FOR PARTIAL HOSPITALIZATION**

- Patient is acutely suicidal
- Patient is assaultive
- Severe disorganization
- Severe acting out
- Uncontrollable alcohol or substance abuse
- Medical condition precludes partial hospitalization as an alternative

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*continued*
The following eight criteria justify the continuation of partial-hospitalization care:

1. Reality testing continues to be impaired and interferes with functioning on an outpatient basis.
2. Symptoms and behavior that previously led to hospitalization persist, or new symptoms appear that interfere with patient’s ability to adapt.
3. Patient’s treatment plan receives major revision requiring more therapy time. (This should be explained fully and documented).
4. Patient needs further regulation of medication under close supervision.
5. Drug interactions or other complications of medication.
6. Partial hospitalization up to now has been successful in arresting deterioration, but patient needs continued treatment if he is to sustain his present level of function. (This should be explained fully and documented.)
7. Patient’s discharge must be delayed for lack of appropriate resources in the community and it is apparent that a discharge under such circumstances would lead to relapse.
8. Planned treatment not completed. (This needs to be explained fully and documented.)

PEER REVIEW

The peer-review standards used in other forms of hospital treatment can be applied to partial hospitalization insofar as utilization and quality of resources are concerned. Admission review should reflect criteria developed for the particular ambulatory population being served by the facility. The objective of peer review should be to maintain and promote high-quality patient care and increase effective utilization of partial hospitalization facilities and services.

POLICIES AND PROCEDURES

A partial hospitalization program must have written policies and procedures that meet or exceed the requirements of the Joint Commission on Accreditation of Hospitals. These should include the following:

1. Statement of program philosophy and objectives.
2. Admission policy, including criteria.
3. Requirement that adequate medical records be obtained and maintained for each patient, including the presenting problem(s), mental status, results of physical examination, diagnoses, treatment plan and plan updates, progress notes, and discharge plans.
4. Intake policy, including procedures for multidisciplinary review of admission and treatment plan. The psychiatrist remains ultimately responsible for admission, discharge, and prescribing of treatment plans for all patients.
5. Requirement for treatment plans and procedures that specify both short- and long-term goals, including details on case assignments, case review, discharge planning, and follow-up.
6. Establishment of the clinical and administrative relationship between the partial-hospitalization program and the psychiatric inpatient service, the psychiatric outpatient service, the general medical services, private practitioners, and community agencies that may serve as referral or disposition facilities.
7. Stated policy on proper food preparation, cleanliness, and storage.
9. Job descriptions for all staff members.
11. Personnel policies.
12. Staff development programs.
13. Fire and other emergency procedures.

STAFFING

A partial-hospitalization program should have a full-time qualified professional designated as director or administrator who has had at least two years’ postgraduate clinical experience and one year’s ad-
Partial hospitalization is cost-effective; it can shorten inpatient stays and thus reduce the overall cost of patient care by as much as 50 percent.\textsuperscript{24,25} We believe it is a feasible and relatively inexpensive way to help maintain patients in the community who need social involvement and more intensive therapy than a psychiatric clinic can provide.

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CONCLUSION

Controlled research studies indicate that partial hospitalization is an effective alternative to inpatient treatment\textsuperscript{11-14} There is a better resolution of symptoms in some patients through partial hospitalization than would be possible on an inpatient basis.\textsuperscript{6,13-16}

REFERENCES