THE IMPACT OF A DAY TREATMENT CENTER ON READMISSIONS TO A STATE HOSPITAL

by

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This study is dedicated to my husband

Chester

and three children

Robert, Jill, and James

whose support and love have made

this study possible.

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CHAPTER I

INTRODUCTION

Introduction to the Problem

> Apparently the treatment of mental illness within the known history of man has been dominated by social, political and ideological factors. Mental health programs are rooted more in moral and legislative elements than in medical and scientific ones. (Freeman, 1965, p. 717)

The mental hospital of today has exerted control over the individual by a process that has extended into the community (Fairweather, Sanders, Maynard, Cressler, & Bleck, 1973). The first part of this process, called "labeling," is one in which the individual gets attention for his illness, and the medical profession with the help of courts assists him to the mental hospital. Theorists believe that a person then becomes "locked" into the "sick" role depending on his degree of deviation (Scheff, 1963, 1964, 1966). The second part of the process, involving socialization of the patient into the mental hospital society, has been defined as "stripping" the self (Goffman, 1957, 1962) and described as "institutionalization." The third part of the process, known as "requalifying," is preparation for the return of the former mental patient to the community. The fourth part of the process can best be

described as "weaning," particularly for patients who have spent considerable time in a mental institution (Fairweather et al., 1969).

These four processes have led to many problems for the mental patients' adjustment back into the community. In addition, poor treatment outcomes have led to hospital readmission. In her study of 1,045 ex-state hospital mental patients, Miller found that because patients did not have experience in maintaining social skills such as employment, transportation, shopping, budgeting, grooming and cooking, seven out of ten were unable to succeed in their community (1964). Research done over the past several years has shown that chronic patients tend to return to the hospital at the rate of about 70 per cent within eighteen months after leaving, regardless of the type of treatment received during hospitalization, and women having the highest rate of readmission (Fairweather, 1964). These failures and others have caused legislators to look to alternatives other than hospitalization for care of the mentally ill.

Mental health programs are affected by what is happening in society. As previously stated, this concept has been summarized by H. E. Freeman, a long-time student of the ways in which mental health care has been allocated in American society which is worth re-emphasizing and restating:

> . . . treatment of mental illness within the known history of man has been dominated by social, political, and ideological factors . . . which are rooted more in moral and legislative elements than in medical and scientific ones. (Freeman, 1965, p. 717)

We are now entering a dangerous period which will determine whether a new direction will emerge in the quality of life or whether a counteracting new super order of repression will be imposed. The question could be whether we are approaching the year 1984 and a "big brother" society. Will the order be a programmed society envisioned by B. F. Skinner in "Beyond Freedom and Dignity" (Skinner, 1971) or a person-centered society as suggested by Carl Rogers (Rogers, 1961). An awareness of society, changes that bring stress to the individual, and future implications must be looked at intelligently as we evaluate mental health and facilities now. Individual and institutional assessment and evaluation are becoming an extremely important part of living and functioning in today's society.

The development of alternative services was formed as a direct result of the social and political unrest of the 1960's. Before that time, such services were being tested primarily by professionals, in various experimental treatment and service contexts. Although crisis intervention services, outpatient clinics, and evening clinics have been available through state and city hospital systems, they

are poorly organized. Recent research has demonstrated that treating a psychiatric patient in his own home community is more therapeutic than sending him to a distant city (Kruger, 1972). Day treatment centers are one alternative presently being used. The rapid social change of today has caused the mental health delivery system to be ineffective in meeting the broad range of human needs in the community locations served. As a result pressure has been placed on the alternative service structures (Baldwin, 1975).

One of the alternatives to hospitalization was suggested by the Mental Health Center Act of 1963 which recommended the replacement of large institutions by smaller community or regional facilities (Caplan, 1964). The emphasis of these centers was to help the community utilize its own resources to help citizens cope with a psychological crisis (Rust, 1974).

Alternative services are human service agencies responding to the need of certain segments of the community not reached by traditional services. These alternative structures are usually small, flexible, and survive on minimal budgets, and use many non-professionals with a minimum of professional supervision (Baldwin, 1975). These community-based alternative services have become instrumental in defining new directions in developing effective service delivery modalities. Their relative strengths and

weaknesses have become a learning base for planning new services and modifying existing services to meet current needs. These services should not be viewed as reactive to, or as "safety valve" adaptations to societal changes, but rather as proactive and predictive of the alternatives which might become functionally dominant in society. In both retrospect and prospect, the differences and contrasts between alternative services and professional practice seem desirable in providing for community mental health (Baldwin, 1975).

Statement of the Problem

Alternative hospitalizations have become increasingly sophisticated in their ability to serve the communities that support them. In a sense, there is a shift from the so-called medical model, emphasizing one-to-one treatment, to a community intervention model involving all staff in a range of services, including: group therapy, counseling, prevention, consultation, and education. The day treatment program centers fit this description. The function of the day treatment program is to support the person until he can make changes (Janzen, 1974). This paper deals with the effect of a newly-formed day treatment center in Clackamas County on readmission rates to Dammasch State Hospital. One of the purposes of the day treatment program was to reduce readmissions to Dammasch State Hospital from

Clackamas County. Therefore, the question to be addressed in this study is: Has the day treatment center in Clackamas County significantly reduced readmission to the state hospital?

Review of Literature

History of Community Mental Health

The late President John F. Kennedy issued a statement for his bold new approach on mental health and mental retardation to the congress of the United States on February 5, 1963:

> . . . a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill. . . . Central to a new mental health program is comprehensive community care. . . . We need a new type of health facility, one which will return mental health care to the main stream of American medicine, and at the same time upgrade mental health services. I recommend, therefore, that the congress (1) authorize grants to the States for the construction of comprehensive community mental health centers . . . (2) authorize short term project grants for the initial staffing costs of comprehensive community mental health centers . . . and (3) to facilitate the preparation of community plans for these new facilities as a necessary preliminary to any construction or staffing assistance, appropriate $4.2 million for planning grants under the National Institute of Mental Health. (Kennedy, 1963, pp. 4-5)

In addition to this major proposal for community mental health centers, Kennedy called for improved care in state mental hospitals and increased grants for research and training. With respect to improved patient care, the

late President suggested

> . . . Until the community mental health center program develops fully, it is imperative that the quality of care in existing State mental institutions be improved. . . . If we launch a broad new mental health program, now, it will be possible within a decade or two to reduce the number of patients now under custodial care by 50 percent or more. (Kennedy, 1963, p. 6; p. 4)

Several observations can be made about the already presented historical background of the federal community mental health program. First, the goal of reducing the patient population in state hospitals has already been reached. At the present rate, resident patient population will have been reduced by 50 per cent in less than two decades. Second, the community mental health center concept combined the most forward-looking aspects of the Joint Commission report into a single comprehensive program. Third, the implicit message in the late President's message seemed to view that state mental hospitals, as they existed in 1963, were to be phased out and replaced by the new community mental health centers (Bloom, 1973).

One of the great challenges of the community mental health center concept was to develop the kinds of coordinating mechanisms that would make it possible for communities to provide comprehensive mental health care. These centers were to provide five essential services: inpatient care; outpatient care; emergency services; partial hospitalization; consultation; and education. Eventually, five

additional services were to be provided: diagnostic services; rehabilitation services; precare and aftercare services; training; and research and evaluation. The services to be provided in each mental health center were to be available to all persons residing in the catchment area. The three major characteristics that distinguish community mental health practice from traditional practice are: prevention of mental and emotional distress; consultation as an indirect service; and crisis intervention (Bloom, 1973).

Economic Factors

Recently there has been a major shift in the role of the federal government toward a new federalism and revenue sharing and away from the categorical training grants and federal seed money for community mental health centers. In other words, the federal direction is away from central control and toward local community control. The administration has recommended there be no more federal support of community mental health centers, but rather only local support (Brown, 1973).

The cost of maintaining and staffing mental hospitals and clinics is a major item in annual budgets of most states. There is constant pressure to hold such costs to a minimum. When the government economizes, it frequently does so at the expense of mental health programs (Freeman,

1972). Therefore, it is extremely important that evaluations and assessments be made to document needs with supporting data. Dr. Talkington, President of the American Psychiatric Association, agrees with reassessment of mental health care in the United States, stating that there is a need for continual program evaluation (1973). Dr. Brown, Director of the National Institute of Mental Health, feels efforts would be more effective if evidence could clearly state where there is more or less emotional or mental distress in the population and whether the increase or decrease has come about as a result of organized treatment (Brown, 1973).

Evaluation of Alternatives and Readmissions

In order to reduce the high cost of care, many alternatives to hospitalization are being used in community mental health today. For example, because outpatient and partial hospitalization are less expensive than full 24-hour hospitalization (Caffey, Galbrecht, & Kleth, 1971), it is now recognized that long-term hospitalization of emotionally disturbed people often does not serve the purpose of rehabilitation (Rust, 1975). Actually, it now appears that community-based programs of varying intensity such as day treatment centers, group-living facilities, outpatient care, evening clinics, and crisis intervention clinics are at least as, or at best, more effective than

the traditional twenty-four hour, seven-days-a-week care (Rusk, 1972). Recent studies (Woodbury, 1969; Laffal, Fischer, Beck, & Nelson, 1970; Beigel & Feder, 1970; Herz, 1971; Brook, 1973; Vonbrauchitsch & Mueller, 1973; Schlachter, Miller, & Lenkaski, 1973; Lorenz, 1974) support this same viewpoint. Another study on alternatives to hospitalization reported by Franklin, Kittredge, and Thrasher shows the alternatives to be effective and in fact do prevent hospitalization (1975).

Halfway houses have been a positive influence on individuals in lieu of long-term hospitalization (Richmond, 1968; Jansen, 1970; Mosher, Menn, & Matthews, 1974; Rog & Rausch, 1975). Day hospitals and day treatment clinics have also been used advantageously (McDonough, 1965; Glasscote, 1969; Michaux & Rossi, 1969; Furst, 1970). The number of these facilities has increased from 140 in 1963 to 230 in 1971 (Silverman & Val, 1975).

The traditional mental health services have been inappropriately divorced from the communities in which their patients have lived. There has been too much concern for the individual who finds his way to the mental health clinic and not enough on developing a broader concern for a population. Traditionally emphasis has been on treatment of psychopathology without devoting adequate resources to prevention and on direct patient care with individual long-term therapy to the exclusion of other therapeutic

strategies, agencies, and persons who might be helpful to a greater number of patients. These traditional orientations have been limiting in scope (Bloom, 1973).

Too many mental health services have developed without adequate coordination with other existing services such as manpower sources. Mental health professionals, as a rule, have ignored the community in developing mental health services. In their negligence to identify the community characteristics that appear to enhance or inhibit growth and development, there has been an inefficient use of community resources (Bloom, 1973). One way to appropriately use community resources is through the use of the day treatment centers in the community which has been one alternative method of not only improving availability of mental health services, but also in involving the professionals with citizens of the community.

One of the major goals of community mental health centers legislation was that the patient be treated in the community near his family and friends rather than in a larger, centrally-located state hospital. These centers have been expected to reduce admissions to state institutions. Barnes discovered an increase in state hospital admissions in one catchment area in his study (Barnes & Adams, 1974). It has been noted that good day treatment centers permit the psychiatrists to discharge high-risk patients into the community quicker than if such centers

were not available (Blackburn, 1972).

However, there are many reasons for readmissions. Concern over high levels of hospital readmissions has generated hundreds of research studies during the last few decades. For example, Rosenblatt and Mayer in review of past studies dealing with recidivism concludes:

> Traditional methods of treating hospitalized psychiatric patients, including individual therapy, group therapy, work therapy, and drug therapy, do not affect differentially the discharged patients' community functioning as measured by recidivism and post hospital employment. (Rosenblatt et al., 1974, p. 698)

Readmission Factors

Investigations by Freemon and Simon (1963) and Angrist, Dinitz and Pasamanick (1968) revealed that patients' symptomology is strongly related to their return to the hospital. These studies demonstrated that an increase in symptom intensity resulted in increased readmission. On the other hand, Odegard (1961) and Gurel and Lorei (1972) showed little relationship between symptoms and readmissions. Review of past studies of recidivism of mental patients revealed that the one variable consistently predicting readmission was past or previous admission (Rosenblatt et al., 1974). Franklin also reported several studies suggesting that a history of multiple hospitalizations was an accurate predictor of readmissions (1975). It was also discovered that a major effect of psychiatric

hospitalization is psychiatric rehospitalization (Freeman et al., 1963; Mendel, 1966). In addition Miller (1964), Barnes et al. (1974), and Cripps (1974) revealed women return for treatment and are readmitted more often than men.

Bertram Brown's assessment of previous admission studies is pertinent here:

> Therefore the results . . . are sometimes ambiguous, often contradictory and frequently fragmented. (Rosenblatt et al., 1974, p. 699)

One viewpoint regarding readmissions is that a person tends to return to the place he received help during a crisis. This concept was supported in Langsley's study, where a follow-up six and eighteen months of patients who had been treated as outpatients and inpatients showed those without hospitalization were less likely to be hospitalized and, if hospitalization was necessary, it was for a shorter period of time (1971). Home care as an alternative to hospital treatment with schizophrenic patients revealed that after termination more of them could remain in the community than could hospital patients (Pasamanick, Scarpetti, & Dinitz, 1967).

Another study of two hundred schizophrenics randomly assigned to a standard or brief hospital stay showed that patients under brief stay had no greater incidence of readmission (Caffey et al., 1971). In a study in family crisis intervention in Denver, Pittman demonstrated that

84% of the families seen could have been treated as effectively in an outpatient basis. All of the studies cited clearly pinpoint the need to prevent hospitalization of psychiatric patients. By using some alternative to hospitalization, "labeling" is prevented which succeeds in allowing the patient to remove the stigma of the "sick" role.

A comparison of 24-hour inpatient care with 12-hour day hospital care was conducted by Herz (1971). It was discovered that not only did day patients return to full-time life in the community and resume their occupational roles sooner, but they were also more likely to remain in the community without subsequent readmission to the hospital. The day treatment program at Clackamas County Mental Health Center is similar to day hospitalization.

Clackamas Day Treatment

The Clackamas County day treatment program is designed for the individual who requires more than the usual outpatient treatment. The program involves week-long, daytime treatment for coping with life circumstances and seeking productive vocational and recreational outlets. The center also provides a transitional peer support group for individuals who have been cut off from natural social support systems because of their disability. Patients at Dammasch Hospital are currently seen two weeks prior to

discharge by a psychiatrist. Arrangements are made for follow-up care, and those who will benefit for day treatment care are given the opportunity.

Dammasch State Hospital, which is a 460-bed "open door" state mental hospital, is one of the major referring institutions for patients into the Clackamas Day Treatment Center. Catchment areas for the hospital until recent months included four counties: Multnomah, Clackamas, Washington and Columbia. Tillamook and Clatsop counties have just been added as catchment areas. None of the other counties had a day treatment program or anything similar during the years 1971-72 and 1974-75. However, in the last two months Washington County has been in the process of setting up a day treatment program. According to the population center at Portland State University, Washington County is similar to Clackamas County in regards to yearly income and population characteristics and could be used as a comparison county. Washington County has a population of 189,400 with a yearly income per person of $3,181. Clackamas County has a population of 196,911 with a yearly income per person of $2,986.

Statement of Purpose of the Study

The present mental health programs are vulnerable to fiscal reduction due to tight money. The ability to evaluate, defend, and improve mental health programs must be

strengthened if they are to survive in any effective way now and in the future. Programs that can justify existence have a better chance of survival. Legislators and politicians who hold the purse strings look at cost analysis critically and have shown hospitalization costs are higher than outpatient services (Halpern & Benner, 1972). Therefore, the purpose of this study will be to evaluate the impact of the day treatment center on Dammasch State Hospital readmissions for the eight-month period since the center's opening. Clackamas County readmissions rate will be compared with that of Washington County for the fiscal year prior to the opening of the day treatment center July 1, 1971 to June 30, 1972, and for the fiscal year after the opening of the center, July 1, 1974 to June 30, 1975.

Hypotheses

1. There will be no significant difference in readmission rate to Dammasch State Hospital from Clackamas County to Washington County for the fiscal year 1971-72.
2. There will be a significantly lower readmission rate to Dammasch State Hospital from Clackamas County than for Washington County in fiscal year 1974-75.

CHAPTER II

METHODOLOGY

Subjects

All patients readmitted to Dammasch State Hospital from Clackamas and Washington counties in 1971-72 and 1974-75 were utilized in this study. Demographic information such as age, sex, and education was collected on each subject. Other information regarding type of admission, number of admissions, length of hospital stay, and diagnosis was also gathered. Records show that in 1971-72 there were 211 individual admissions from Washington County and 338 from Clackamas County, and in 1974-75 there were 220 individual admissions from Washington County and 389 from Clackamas County.

Additional information was identified on subjects who were subsequently admitted to the day treatment program in Clackamas County. Information gathered regarding their living arrangements at discharge, length of treatment at day care center, whether day treatment preceded or followed hospitalization, or both, was documented.

This statistical information was obtained from the state computer record system of the Mental Health Division

in Salem, Oregon. The computer programming was developed by a research analyst and the information was gathered from records at Dammasch State Hospital from patients' charts.

Design

This study was an evaluation research project designed to investigate the extent of program success in reducing readmission to a state mental hospital, and to provide information about demographic characteristics of the population served.

Procedure

The individual readmission was calculated using the computer print-out for the years 1971-72 and 1974-75. The age, sex, length of hospital stay, diagnosis, type and number of previous admissions were prepared in tables and compared by percentages in graphs for Washington County and Clackamas County.

Day treatment patients were cross checked with day treatment records and the computer print-out for the year 1974-75 in Clackamas County. The age, sex, education, length of hospital stay, length of day treatment stay, number of previous admissions, pre/post hospitalization and living arrangements at discharge were prepared in tables. A comparison in graphs and tables was compiled.

Analysis of Data

This study compared the number of readmissions to Dammasch State Hospital from Clackamas and Washington counties during the fiscal year July 1, 1971 to June 30, 1972 with the number admitted to Dammasch from these two counties between July 1, 1974 to June 30, 1975. Clackamas and Washington counties were selected for comparison because of similarities in the following characteristics: 1) Population per capita; 2) Size of catchment areas; 3) Type of income and median income per capita. These similarities were verified by the population center at Portland State University.

The age range of the patients for Clackamas County in years 1971-72 and 1974-75 was reported as well as the percentages of patients found within each age group. The percentage of patients found in various categories of sex, length of hospital stay, type of admission, number of previous admissions was reported.

The age range of patients for Washington County in years 1974 and 1975 was reported as well as percentages of patients found within each age group. The percentage of patients found in various categories of sex, length of hospital stay, type of admission, number of previous admissions was reported.

The age range of patients who were subsequently

admitted to the day treatment program having previously been patients at Dammasch State Hospital in the year 1974-75 was identified. Also identified were numbers of males and females, education, length of hospital and day treatment stay, living arrangements at discharge, and pre and post hospitalization visits at the day treatment center.

Chi-square was utilized to determine significant differences in readmission rate for the two counties being studied and for significant difference between male and female readmission rate. Chi-square may be used in testing hypothesis to the significance of difference between two or more groups (Downie & Heath, 1970). In this research chi-square was computed utilizing the number of individual readmissions as well as the readmissions separated into male and female categories.

Percentages of readmission were used in each category as a comparison from these two counties for periods 1971-72 and 1974-75 from Dammasch State Hospital.

Since data for readmissions from Clackamas County were available for a six-month interval for the remainder of 1975 (July 1 to December 31) a trend analysis was done to determine whether the readmission rate was decreasing or increasing during that period.

CHAPTER III

RESULTS

Clackamas and Washington Counties

A comparison of readmissions to Dammasch State Hospital was done by using the chi-square statistics for each county for the fiscal years 1971-72 and 1974-75. For the fiscal year 1971-72 the calculated chi-square was 1.076 which for one degree of freedom was not significant. In Washington County there were 133 first-time individual admissions and 78 readmissions for a total of 211 (See table 1). In Clackamas County there were 198 first-time individual admissions and 140 readmissions, for a total of 338. The total first-time individual admissions for the year 1971-72 for both counties were 331, while the individual readmissions were 218, showing a final total of 549 (See table 1).

For the fiscal year 1974-75 the calculated chi-square was 4.401 which for one degree of freedom was significant. In Washington County there were 220 individual admissions, of which 97 were readmissions (See table 2). In Clackamas County there were 389 individual admissions of which 138 were readmissions. The total first-time individual

Table 1. Readmissions for Clackamas and Washington Counties 1971-72.

County	Readmitted	Not Readmitted	Total Admissions
WASHINGTON	78	133	211
CLACKAMAS	140	198	338
TOTALS	218	331	549

$X^2 = 1.076$; $p < .05$

Table 2. Readmissions for Clackamas and Washington Counties 1974-75.

County	Readmitted	Not Readmitted	Total Admissions
WASHINGTON	*97	123	220
CLACKAMAS	*138	251	389
TOTALS	235	374	609

$*X^2 = 4.401$; $p < .05$

admissions for the year 1974-75 for both counties were 374, while the individual readmissions were 235, showing a final total of 609 (See table 2).

As can be seen in figure 1, the individual readmission rate in Washington County in 1971-72 was 36.9% and in Clackamas County 41.4%. In 1974-75 this readmission rate decreased in Clackamas County to 35.5% which is a decrease of 6% from 1971-72. Conversely, in 1974-75 the readmission rate in Washington County increased to 46.1% which is an increase over 1971-72 figures of 9.2%. Washington County had no day treatment program during that period.

Similar data for the six month period following from July 1 to December 31, 1975 reflect monthly readmissions for Clackamas County as follows: individual readmission rate in Clackamas County was 33.6%, which indicates an increase of 1.9% from the fiscal year 1974-75.

Male and Female Comparison

From figure 2 it can be seen that male and female readmissions in Washington County were essentially the same. For 1971-72 the male readmission rate was 30.5% and the female was 31.2%. In 1974-75 the male readmission rate was 38.5% and the female was 39%. There was a higher total male admission rate in 1971-72 (56.5% male and 43.5% female) as well as in 1974-75 (59% male and 41% female).

Figure 3 shows male and female percentage of admissions

Figure 1.
PERCENT INDIVIDUAL READMISSIONS TO DAMMASCH STATE HOSPITAL FROM CLACKAMAS AND WASHINGTON COUNTIES IN FISCAL YEARS 1971-72 AND 1974-75

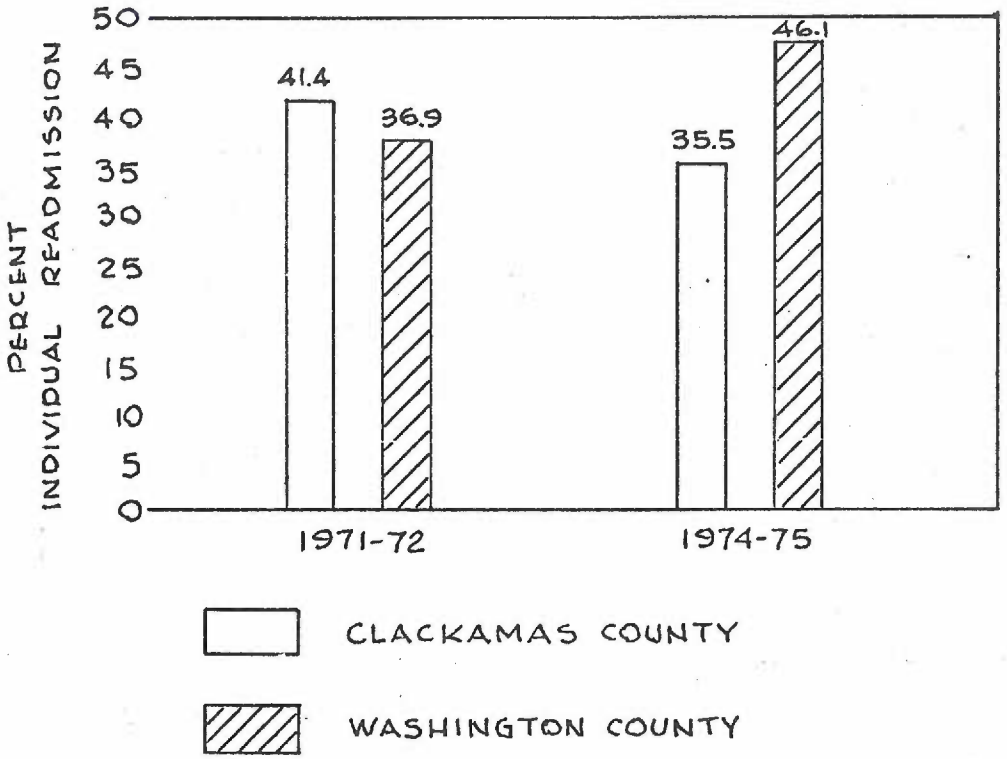


Figure 2.
MALE/FEMALE TOTAL ADMISSIONS AND READMISSIONS IN WASHINGTON COUNTY 1971-72 AND 1974-75 FISCAL YEARS

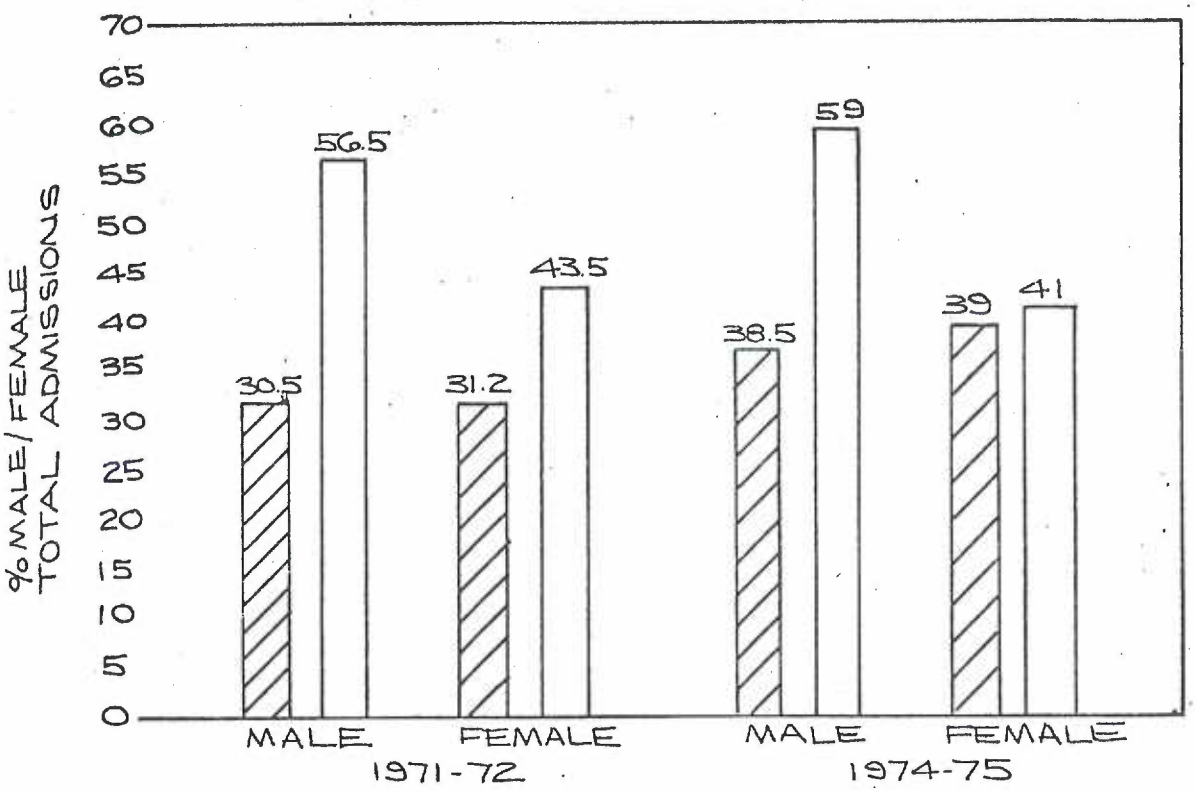
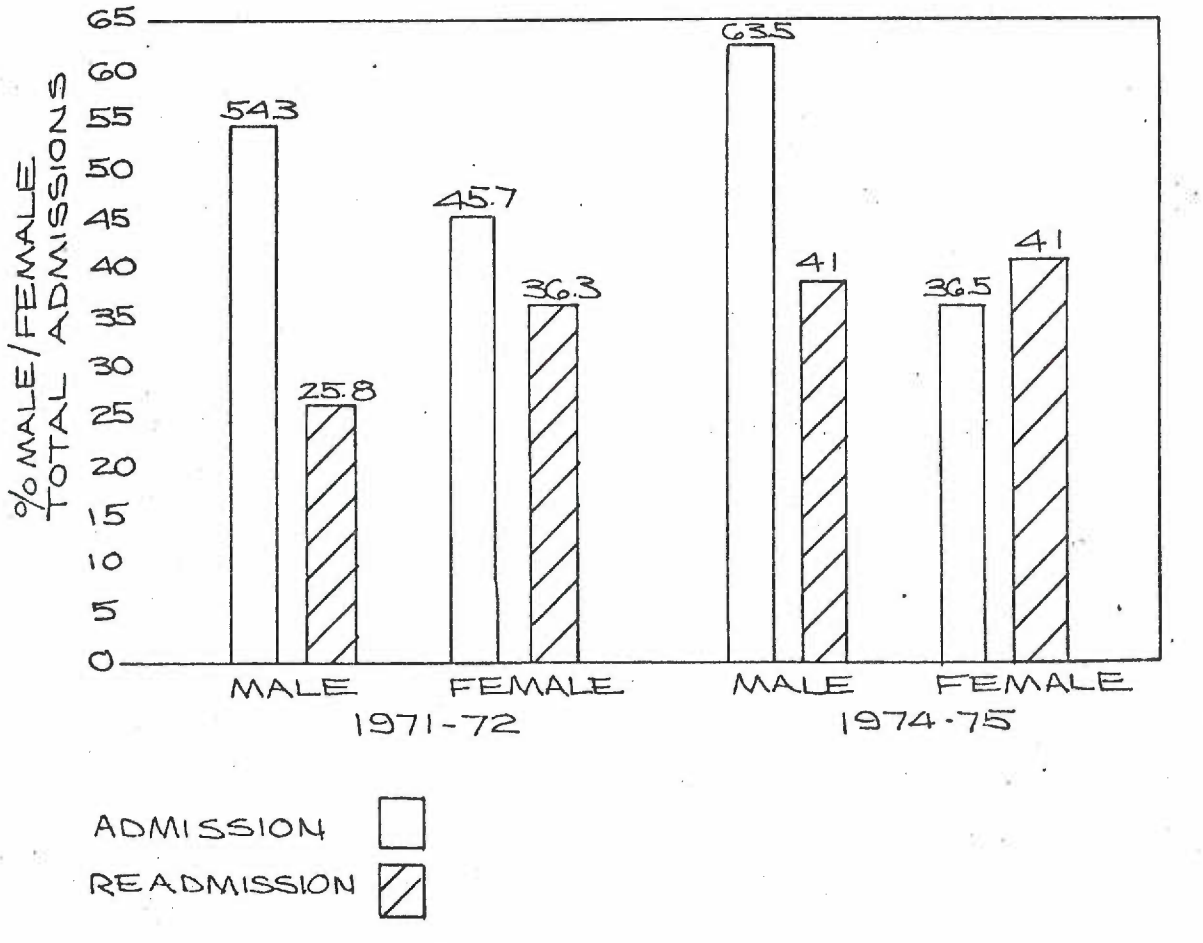


Figure 3.
MALE/FEMALE TOTAL ADMISSIONS AND READMISSIONS IN CLACKAMAS COUNTY 1971-72 AND 1974-75 FISCAL YEARS



and readmissions in Clackamas County. The male admission rate is higher in both years than the female. The males had a readmission rate of 25.8% while the females had a readmission rate of 36.3% in 1971-72. The readmission rate for males and females in 1974-75 was 41%. Although a higher percentage of males was admitted during these two years than females, the difference was minimal and not statistically significant.

Age Range

During the period 1971-72 the age range of individuals admitted to Dammasch State Hospital from Washington County was from 13 to 100. The highest percentage of readmissions was found in the 25-34 year age group and constituted 20.4% of total admissions. In this group 9.5% were male and 11.1% were female (See table 3). In Clackamas County during the same period the age range was from 13 to 85. The highest percentage of readmissions was found in the 25-34 year age group which is the same as Washington County and constituted 20.7% of total admissions (See table 4). The male percentage was 10.8% and female 10.1% which is more evenly balanced than in Washington County. The male percentage of total admissions was 50.6% while the female was 49.4%. About 3% more males were admitted to Dammasch State Hospital from Washington County than Clackamas County in 1971-72.

The age range of the individuals admitted to Dammasch

Table 3. Age of Dammasch State Hospital Patients in Fiscal Year 1971-72 - Washington County.

	Male	%	Female	%	Total	%
Age:						
13-17	8	3.8	7	3.3	15	7.1
18-20	13	6.1	9	4.2	22	10.4
21-24	11	5.2	12	5.7	23	10.9
25-34	20	9.5	23	11.1	43	20.4
35-44	21	10.	20	9.5	41	19.4
45-54	18	8.5	6	2.8	24	11.4
55-64	13	6.1	10	4.7	23	10.9
65 & up	9	4.3	11	5.2	20	9.5
TOTALS	113	53.5	98	46.5	211	100.

Table 4. Age of Dammasch State Hospital Patients in Fiscal Year 1971-72 - Clackamas County.

	Male	%	Female	%	Total	%
Age:						
13-17	9	2.6	13	3.9	22	6.5
18-20	18	5.3	12	3.6	30	8.9
21-24	16	4.7	21	6.2	37	11.
25-34	36	10.8	34	10.1	70	20.7
35-44	24	7.0	37	10.9	61	18.
45-54	35	10.4	21	6.2	56	16.6
55-64	20	5.9	14	4.1	34	10.
65 & up	13	3.9	15	4.4	28	8.3
TOTALS	171	50.6	167	49.4	338	100.

State Hospital from Washington County in 1974-75 was 12 to 88. The highest percentage of readmissions was found in the 25-34 age range showing 21.4% of total admissions in which 15% were male and 6.4% were female. The male population was 59.1% of total admission while the female was 40.9% (See table 5). The same period in Clackamas County revealed an age range from 13 to 100. Again the 25-34 year age group was the highest percentage with a total admission 27.3% of which 21.3% were male and 5.9% were female. The total admission was 63.2% male and 36.8% female during that period (See table 6). This figure shows 4% more males were admitted to Dammasch from Clackamas County than Washington County in 1974-75.

Previous Admission

During 1971-72 the highest category for previous admissions was one admission, in both counties. In Washington County 62% of patients had been admitted to Dammasch State Hospital once before and 71% in Clackamas County. However in 1974-75 in Clackamas County there was a 4% decrease in this category over 1971-72. Washington County showed an increase of 14% in 1974-75 in the one previous admission category.

Type of Admission

A comparison of type of admission in the two counties

Table 5. Age of Dammasch State Hospital Patients in Fiscal Year 1974-75 - Washington County.

	Male	%	Female	%	Total	%
Age:						
12-17	12	5.5	13	5.9	25	11.2
18-20	13	5.9	5	2.3	18	8.2
21-24	18	8.2	5	2.3	23	10.4
25-34	33	15.0	14	6.4	47	21.4
35-44	15	6.8	16	7.2	31	14.1
45-54	15	6.8	16	7.2	31	14.1
55-64	11	5.0	18	8.2	29	13.3
65 & up	13	5.9	3	1.4	16	7.3
TOTALS	130	59.1	90	40.9	220	100.

Table 6. Age of Dammasch State Hospital Patients in Fiscal Year 1974-75 - Clackamas County.

	Male	%	Female	%	Total	%
Age:						
13-17	13	3.3	5	1.3	18	4.6
18-20	24	6.2	11	2.8	35	9.0
21-24	40	10.3	18	4.6	58	14.9
25-34	83	21.3	23	5.9	106	27.3
35-44	50	12.8	40	10.3	90	23.1
45-54	14	3.6	19	4.9	33	8.5
55-64	10	2.6	17	4.4	27	6.9
65 & up	12	3.1	10	2.6	22	5.7
TOTALS	246	63.2	143	36.8	389	100.

is reflected in figure 4 and figure 5. Voluntary admission, the most frequent mode of entry into Dammasch State Hospital for both males and females, increased in both counties in 1974-75. The male voluntary admission in Washington County showed an increase of 2% over 1971-72 and a decrease of 1.4% in female in the same period. In Clackamas County the voluntary admission in males in 1974-75 increased 11.8% while females decreased 4% over 1971-72. Admission for emergency care increased in both counties in 1974-75, with Clackamas County showing 13% for males and 4.8% for females, and Washington County showing 10% male and female 3%. There was a decrease in both counties of court commitment cases. In Clackamas County there was a decrease for males of 10% and females 7.8% (See figures 4 and 5). In Washington County there was a decrease for males of 8.6% and for females of 6.6%. Voluntary admission reflects the philosophy of Dammasch State Hospital in which statistics show 67% of the yearly total admissions are voluntary and 20% are court committed.

Day Treatment Center Impact

A day treatment center, which provided the impetus for this study, has been functioning in Clackamas County since October, 1973. This facility has great significance to the expanded role of the psychiatric nurse. The psychiatric nurse role has expanded beyond the stereotyped

Figure 4.
TYPES OF ADMISSION BY MALE/FEMALE IN WASHINGTON COUNTY 1971-72 AND 1974-75 FISCAL YEARS

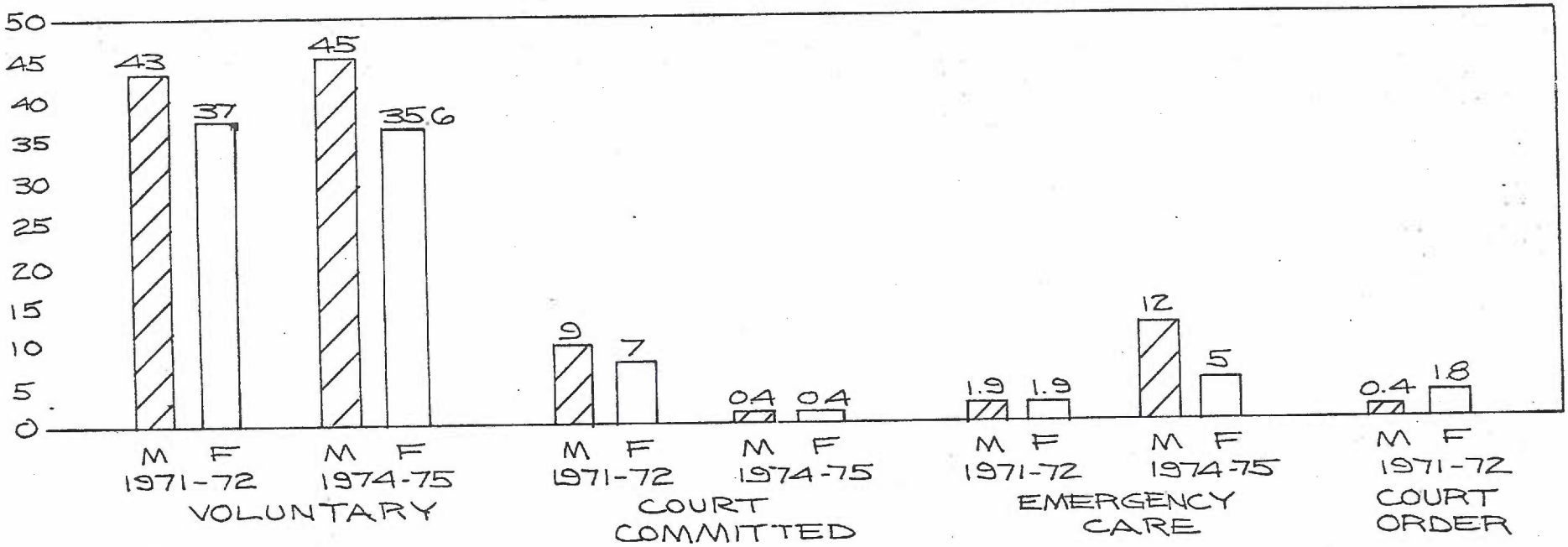
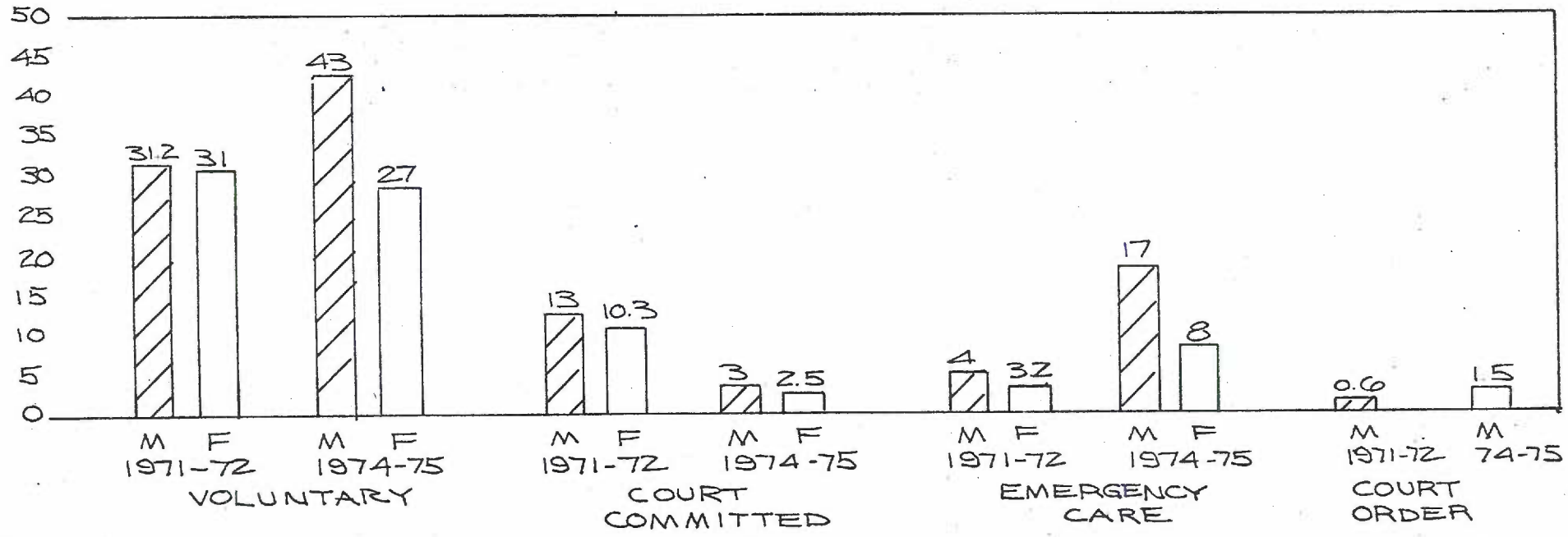


Figure 5.
TYPES OF ADMISSION BY MALE/FEMALE IN CLACKAMAS COUNTY 1971-72 AND 1974-75 FISCAL YEARS



duties of keeping wards clean and overseeing meals and medication. Nurses now serve as co-leaders in group psychotherapy, conduct individual therapy, and make pre-post hospitalization home visits (Bowling, 1974). Dr. Kruger, Chief of Psychiatric Service at Palo Alto California Veterans Administration Hospital, states: "One unusually capable nurse in our hospital provides crisis intervention in the admitting office and thus helps avert the need for hospitalization" (1972, p. 45). Nurses are beginning to set up day treatment centers and to perform follow-up care in the community (Janzen, 1974; Stewart, Kerr, & Dunlop, 1974). The psychiatric nurse of today is involved in primary, secondary and tertiary prevention in health care. Primary prevention seeks to reduce prevalence by reducing incidence. Secondary and tertiary prevention seeks to reduce prevalence by reducing duration. Therefore it is essential for nurses to assess and evaluate the kind of care given in day treatment centers and the types of patients admitted and readmitted, and familiarize themselves with day treatment organizational plans.

Poor liaison exists between Dammasch State Hospital and the Clackamas County day treatment program. The only contact is a psychiatrist presently on staff at the Clackamas Mental Health Center who is able to devote 2-3 hours a week to follow through care with Dammasch State Hospital patients. Therefore, there is insufficient time to make

contact with all discharged patients, keep thorough records, or discover who is recommended to the day treatment center but does not follow through.

A budget was proposed to the state to increase the staff and expand the services in the Day Treatment Program in Clackamas County in the fiscal year 1974-75. A psychiatric nurse was included in this budget for use in follow-up with post-hospital Dammasch State Hospital patients in Clackamas County, medication monitoring, and a liaison link between the hospital and the various programs. A budget of $104,000 was proposed. The program received $68,000 with $5,340 being from the state. The psychiatric nurse position was one of the areas deleted.

A regional specialist who worked with the budget expressed the state's support of this program and budget conceptually, but stated that strong evidence did not back up the need for the program. Several factors were involved in making the decision: 1) Organizational and developmental process needed to be worked through since it was a new program. 2) The other three counties feeding into Dammasch State Hospital had been given no money to set up day treatment programs. 3) This program was to have reduced readmissions from Clackamas County into Dammasch State Hospital and not enough concrete statistics were available to test the impact. Therefore, money was divided among the other three counties for development of day treatment

centers in each area.

Demographic Data on Day Treatment Patients Who Were Dammasch Admissions

A total of 104 individuals was seen at the day treatment center in Clackamas County in the fiscal year 1974-75, of which twenty-eight of those patients, or 27%, had been admitted to Dammasch State Hospital. Patients seen at the day treatment center comprise 7.2% of all patients who were hospitalized. Of the total number of readmissions in Clackamas County 16% were seen at the day treatment center. Six of these 28 patients had been readmissions, while the remainder had never previously been admitted to Dammasch State Hospital (See table 7).

Fifty percent of the individuals seen during this period were new admissions to the center. Twenty-two patients, or 21%, were referred to day treatment in order to prevent commitment. Thirteen patients were placed in day treatment as an alternative to hospitalization which represents 12.5% of the total patients seen.

The mean age of the subjects listed in table 8 is 36 years. The range is 19 to 64 with a mode of 23 years. The percentage of males admitted is 46.3% and of females is 53.7%. The age range 35-44 was the highest category with 28.8% male and female combined. This combined age category concurs with the mean age for both counties in

Table 7

DAY TREATMENT -- DAMMASCH STATE HOSPITAL
Day Treatment Patients previously admitted to Dammasch State Hospital in 1974-75

	Sex	Age	Type of Admission	Diagnosis	Length Hosp. Stay	Living Arrange.	Day Treatment--Pre/Post	
* Case 1	F	24	Voluntary	Schiz/depression	4 days	Parent/Relative	6 days	Post
Case 2	F	64	Voluntary	Manic/depression	69 days	Indep. home	23 days	Pre
Case 3	F	35	Voluntary	Paranoid Schiz.	34 days	Indep. home	3 days	Post
* Case 4	F	39	Emergency Care	Paranoid Schiz.	75 days	Indep. home	3 days	Post
Case 5	M	33	Vol. via Clinic	Schiz/chronic	14 days	Parent/Relative	1 day	Pre
Case 6	F	19	Voluntary	Manic/depression	2 days	Parent/Relative	5 days	Post
Case 7	M	23	Emergency Care	Adjustment reaction	8 days	Jail/trial	68 days	Pre/Post
Case 8	F	26	Emergency Care	Chronic Schiz/drug	98 days	Foster home	44 days	Post
Case 9	M	42	Court Commit.	Paranoid/Schiz.	50 days	V.A. Roseburg	2 days	Post
Case 10	M	23	Court Commit.	Schiz.	6 days	Parent/Relative	2 days	Post
Case 11	M	25	Emergency Care	Paranoid Schiz.	194 days	Parent/Relative	32 days	Pre/Post
Case 12	F	45	Court Commit.	Paranoid Schiz.	302 days	Indep. home	1 day	Post
* Case 13	M	49	Voluntary	Chronic Schiz.	10 days	Indep. home	94 days	Post
* Case 14	F	22	Court Commit.	Paranoid Schiz.	27 days	Parent/Relative	2 days	Pre

Table 7 continued Day treatment patients previously admitted to Dammasch State Hospital in 1974-75

	Sex	Age	Type of Admission	Diagnosis	Length Hosp. Stay	Living Arrange.	Day Treatment	--Pre/Post
* Case 15	M	41	Emerg. Commit.	Catatonic Schiz.	30 days	Indep. home	2 days	Post
Case 16	M	52	Emerg. Care	Schiz. Chronic	4 days	Jail/trial	10 days	Post
* Case 17	M	56	Court Commit.	Invol. Paranoid	30 days	Indep. home	1 day	Post
Case 18	F	34	Court Commit.	Passive/Agressive Personality	10 days	Indep. home	1 day	Pre
Case 19	F	26	Voluntary	Schiz. Chronic	10 days	Parent/home	14 days	Pre/Post
Case 20	F	39	Emerg. Care/Vol.	Paranoid Schiz.	126 days	Indep. home	60 days	Pre/Post
Case 21	F	22	Voluntary	Passive/Agressive Personality	90 days	Indep. home	9 days	Post
Case 22	F	23	Vol. via clinic	Schizophrenic	84 days	Parent/Relative	20 days	Post
Case 23	F	54	Voluntary	Depressive Neurosis	33 days	Indep. home	1 day	Pre
Case 24	M	34	Voluntary	Simple Schiz.	4 days	Indep. home	3 days	Post
Case 25	M	41	Vol. via clinic	Schizophrenic	167 days	Indep. home	8 days	Pre/Post
Case 26	M	29	Voluntary	Manic/depressive	40 days	Indep. home	1 day	Pre
Case 27	F	35	Voluntary	Schizophrenic/chronic	77 days	Indep. home	1 day	Post
Case 28	M	44	Voluntary	Depressive Neurosis	49 days	Indep. home	2 days	Post

*Readmissions

Table 8. Age Categories of Day Treatment Patients Who Had Previously Been 1974-75 Dammasch State Hospital Patients.

Age	Male	%	Female	%	Total
18-20	0		1	3.5	1
21-24	2	7.0	5	18.3	7
25-34	3	10.7	2	7.0	5
35-44	4	14.4	4	14.4	8
45-54	3	10.7	2	7.0	5
55-65	1	3.5	1	3.5	2
TOTALS	13	46.3	15	53.7	28

1971-72 and 1974-75 which was 38 years.

The education history of the day treatment patients previously admitted to Dammasch State Hospital in 1974-75 indicated 58% either had attended or completed high school (See figure 6).

The type of hospital admission of this group of patients was primarily voluntary with a percentage of 53% of which 10% were recommended for admission through the Clackamas Mental Health Center. Emergency care admission was 25% while the court committed group was 22% (See figure 7). These figures reflect the new commitment law which makes it more difficult to admit patients involuntarily to mental hospitals.

The living arrangements for this group at discharge was predominantly an independent home involving 57% of the

FISCAL YEAR 1974 - 1975

EDUCATION

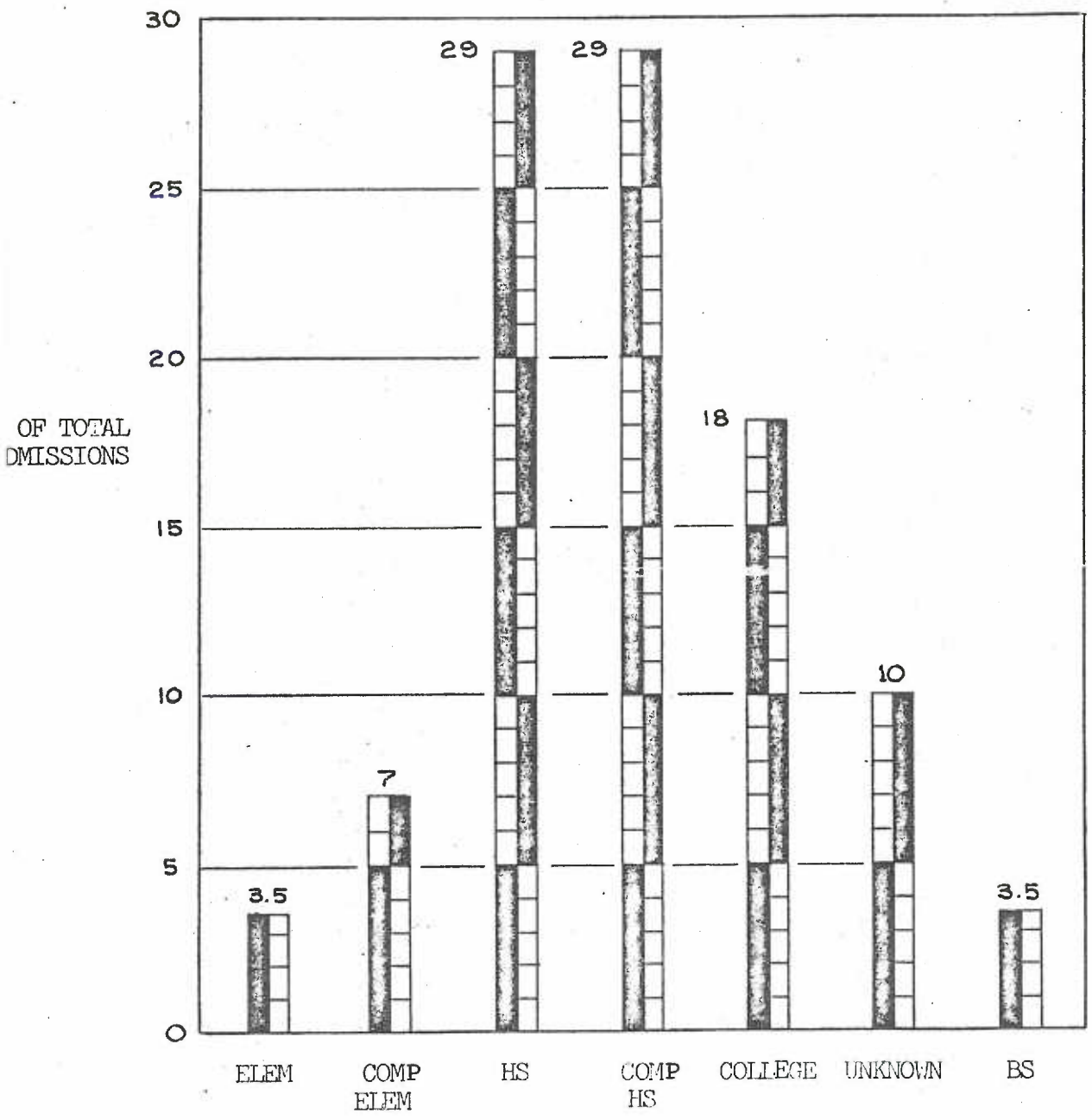


Figure 6.

EDUCATION PROFILE OF PREVIOUSLY

ADMITTED PATIENTS TO DAMMASCH STATE HOSPITAL

WHO WERE ALSO DAY TREATMENT PATIENTS

FISCAL YEAR 1974 - 1975

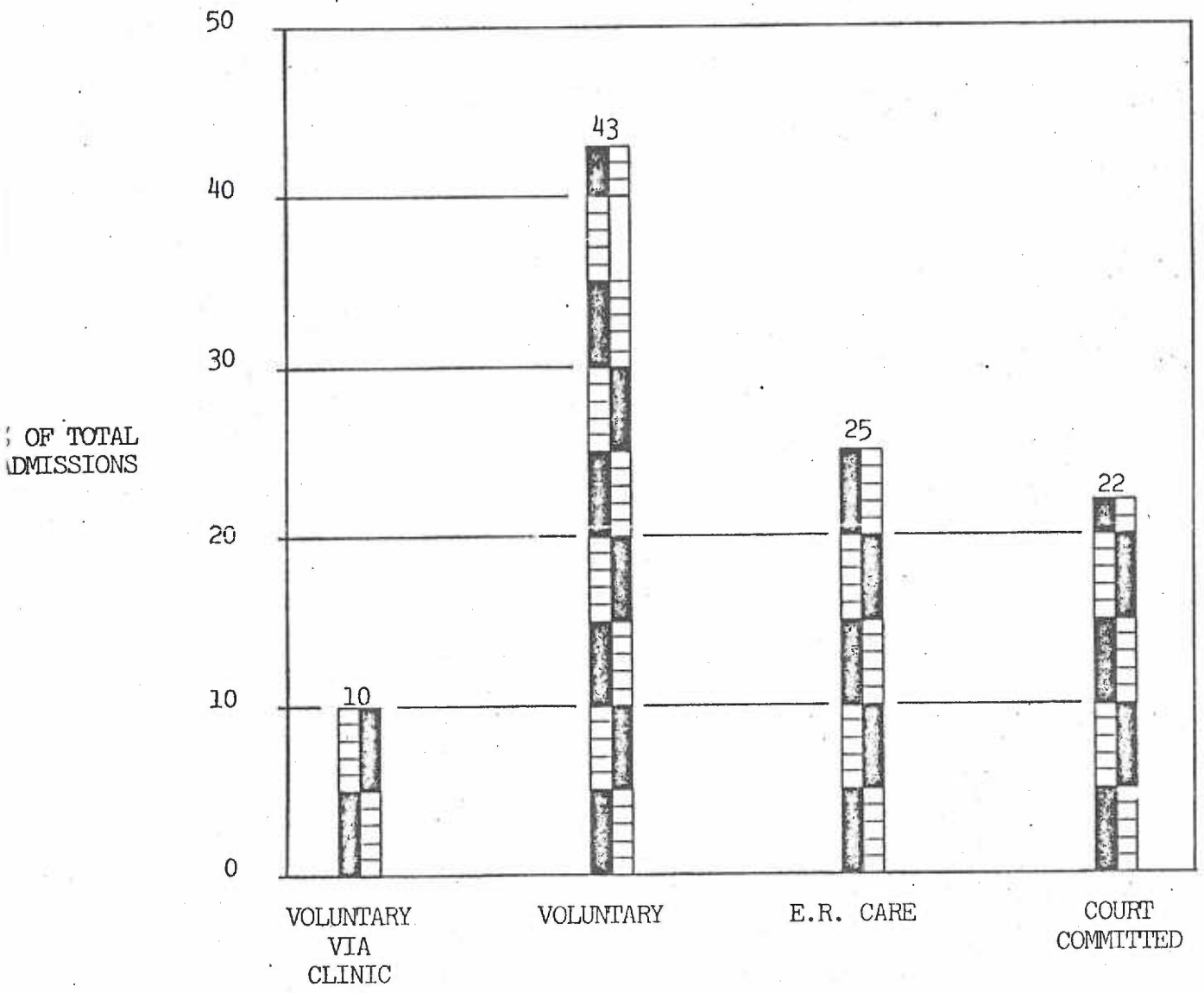


Figure 7.

TYPE OF HOSPITAL ADMISSION OF

DAY TREATMENT PATIENTS

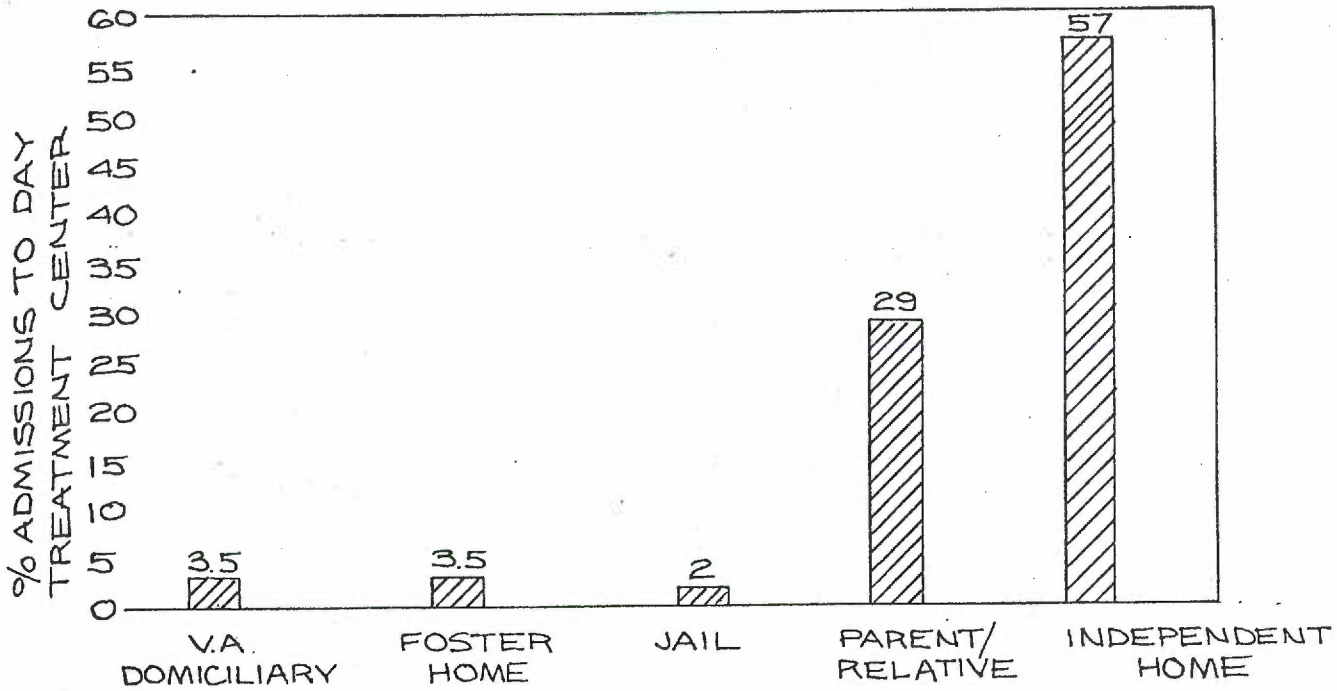
PREVIOUSLY ADMITTED TO DAMMASCH STATE HOSPITAL

ILLUSTRATION BY
John M. Munch

patients (See figure 8). The independent home means they live alone in single or multiple dwellings. About 29% of this group live with parents or family.

Figure 8.

LIVING ARRANGEMENTS POST HOSPITALIZATION FOR DAY TREATMENT PATIENTS PREVIOUSLY DAMMASCH STATE HOSPITAL PATIENTS



CHAPTER IV

DISCUSSION

General

Some variables were responsible for the readmission rate in Clackamas County to decrease in 1974-75 and Washington County to increase during the same period. During that time period a day treatment program was operating in Clackamas County. A day treatment program similar to that instituted in Clackamas County in October 1973 has been found to reduce hospital readmissions (Baldwin, 1975; Talkington, 1973). Another influence on readmissions is reflected in the new Oregon commitment law, Senate Bill 75, enacted July 1, 1974. This law has made it more difficult to commit mental patients. Under Senate Bill 75, in order for a person to be committed two people must petition in writing indicating mental illness and documenting the need for treatment and hospitalization. This petition comes to the Community Mental Health Center in the county in which the person resides and an investigation including an interview and examination of the patient is conducted. A recommendation based upon this investigation is made and submitted to the court. If the court, following the

investigation, concludes a person may be mentally ill, a hearing is scheduled within 72 hours to determine whether or not the person is actually mentally ill. The period of commitment is not to exceed 180 days (Senate Bill 75). Both the day treatment program and the new commitment law could be responsible for this decrease in readmission rate in Clackamas County in 1974-75. Washington County had no day treatment center during this period, and the new commitment law did not decrease readmissions. Instead there was a 9.2% increase in readmissions. The circumstances causing this increase is not presently known, but would be suitable for future research.

The six month trend analysis was done to determine if there was a change in readmission rates during that period. Some contributing factor caused a 1.9% decrease in readmissions during that period. As stated previously, both the day treatment program and the new commitment law are possibilities.

An influx of male admissions occurred during 1971-72 and 1974-75 in both Washington and Clackamas counties. Just why this should occur is not completely understood. This finding does not coincide with that of Miller (1961) who found women have a higher admission rate or Barnes (1974) who found two-thirds of the total admissions were women. Cripps (1973) discovered that men were not as frequent repeaters in his study, not because the need was not

there, but due to adherence to the masculine norm of occupying themselves with earning a living. However, some researchers believe the recent recession and continuing inflation have led to a rise in mental illness in men, especially ages 45-60 (Wellborn, 1976). This supposition was supported by Dammasch State Hospital statistics for the year 1973-74 where the total admission rate was 65% for males and 35% females. During this time period Portland, as well as the rest of the country, was experiencing a gas shortage. This added stress could have an impact on male admissions. Further research on this supposition is indicated.

The mean age of individuals for the study periods and counties involved was 38 years. This age does not concur with Barnes (1974), who found 61% of patients admitted were 40 years or older, or Arieti (1974) who discovered in the state of New York 50% of patients are over 65 years of age. However, this study does agree with Brown and Kosterlitz (1974), who found the age group from 30-39 tended to stay in treatment longer.

Multiple admissions have been of great interest to mental health researchers. Langsley (1971) found that wherever a person first gets help during a crisis, he tends to return to that area. The second admission was the highest category in both Washington and Clackamas counties. There was a reversal in Washington and Clackamas counties'

percentage in one previous admission from 1971-72 to 1974-75, which reveals something different was happening in both counties. The review of past recidivism in 36 populations revealed that the more often patients have been admitted to mental hospitals, the more likely they will return in the future (Rosenblatt, 1974). A study of growth in the proportion of all admissions who are readmissions found in four years that 50% of all admissions were readmissions (McPartland & Richart, 1965). Franklin (1975) found that history of multiple hospitalizations was an accurate predictor of readmission. This evidence would attest to the need for additional research using the two counties above.

Day Treatment

Information presented in table 7 illustrates that patients seen in the day treatment center were more chronic in nature. There is a belief, backed by studies, that admission to a mental hospital (particularly if one's residence there lasted more than several months) would eventually become a lifetime process (Zusman, 1966; Stuart, 1970). However, Rosenblatt and Mayer's (1974) review of recidivism found that a rise in readmission is due in part to a corresponding decline in the length of hospital stay. The present study shows there is a larger population of ex-patients in the community now than there was in former

years. Data concerning factors related to mental hospital readmission (Franklin, 1975) suggest many patients are readmitted because they find the hospital a familiar, comfortable environment. Perhaps they find the mental hospital more attractive than the alienation and deprivation found in the community. Therefore, to help prevent readmissions, alternative services need to be planned and available to bolster the resources of ex-patients (Franklin, 1975). The day treatment center in Clackamas County is this type of alternative and needs financial support for expansion.

The educational status of the day treatment patients previously admitted to Dammasch State Hospital concurs with Arieti (1974) in his study, who discovered that state hospital patients have eight years of schooling or less (See figure 6).

The majority of the day treatment patients previously admitted to Dammasch State Hospital were living in an independent home (See figure 8). According to Lamb and Goerzel (1972) the longer a person has been hospitalized the more likely he is to be living in a boarding home, which is like an institution. Conversely, the shorter the hospitalization the more likely he is to be living in non-institutional settings. Also, people with the shortest hospitalization are more likely to be living alone or with a spouse. Therefore, this group represents a high potential

for rehabilitation, and yet need a facility, like the day treatment center, to help deal with the loneliness of living in the community after hospitalization.

Psychiatric hospitalization is an important part of a comprehensive community program for those few patients who can not maintain themselves mentally, emotionally, and physically. For the most part, any and all attempts should be made to avoid hospitalization unless there is a clear cut reason for it, such as harming oneself or others. If hospitalization does occur it should be brief and aimed toward rapid reintegration of the patient with resolution of the immediate crisis that led to hospitalization. Follow-up care should be available with some continuity of personnel working as a liaison to the community (Herz, 1971).

Torrey (1974) refers to a study in which patients were refused admission to a psychiatric hospital. It was discovered that eighty-five percent continued to function satisfactorily. In another study a population in a mental hospital was reduced from 2,600 to 585. A two year follow-up demonstrated that eighty percent continued to function satisfactorily outside of the hospital (Torrey, 1974). These reports suggest that there needs to be more emphasis on putting people in the community and helping them function.

The community learns slowly to tolerate a person with deviant behavior in its midst, even though he may be

receiving treatment and presents no danger. In the same way the concept of the day treatment program becomes a reality only slowly in the minds of citizens. The economic cost of containment in the community based programs of all types has, in general, been less than institutional containment (Rust, 1974). It has been demonstrated that the majority of emotionally disturbed persons or offenders will not present a serious community threat if placed in appropriate community programs (Rust, 1974).

Information on most readmissions suggests that there is no one causal factor but rather a variety of interactions in and between a host of personal and environmental factors which influence a person's life after discharge. Frequently, people who have been rehospitalized are seen as socio-psychologically and economically dependent, as having poor interpersonal relationships, lack of meaningful social outlets, poor self image, poor cooking or nutritional skills, and an inability to coordinate activities (Franklin, 1975). Given these limitations, attention must be focused on aftercare facilities with a variety of programs designed to assist and bolster the psychological and socioeconomic skills and resources of "ex-patients" (or before they become ex-patients).

One program which addresses all of these concerns was developed at the Mendota Mental Health Institute in Madison, Wisconsin (Stein, Test, & Marx, 1974) and was called a

Community Treatment Program. This program included education in the skills needed for daily living such as: laundry, shopping, cooking, eating in restaurants, grooming, budgeting, using public transportation, finding a place to live, finding a job or sheltered workshop, using leisure time, and developing effective socialization. The staff was available for follow-through or for monitoring problems when necessary. The program was successful in these aspects. This kind of comprehensive care could be added to the day treatment center to determine whether the same results would occur. Some of these needs are: reduction of length of hospital stay, helping long-range adjustment to the community, reducing the chronic patient role without increasing the family burden, reducing social stigma, and helping families cope with disruption in their life. Mendota's Community Treatment Program appears to have a powerful potential which speaks to the shift from the medical model to the education model that Torrey (1974) recommends. An "ounce of prevention is worth a pound of cure." As Torrey (1974) expressed it: "Prevention is powerful, efficient, and American" (p. 63).

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study was prepared since comparisons of readmission rates are commonly used to establish the relative efficacy of different treatment programs (McPartland et al., 1975). Hospitalization rates are often taken as a measure of clinic effectiveness, and more specifically, the therapeutic effect of treatment and evaluation research is mandated today by funding organizations (Mayer, Hotz, & Rosenblatt, 1973). It has been reported by Reider (1974) that the state mental hospital system and the patients are in danger of being phased out without an effective alternative source of care being available. The day treatment program in Clackamas County is an alternative service that needs expansion. Therefore, it is expected with the available data more money will be made available to the day treatment program making it possible to expand and include more rehabilitating services to the mentally ill in Clackamas County. It is also expected that a psychiatric nurse with expanded education will be part of the expansion service, as demonstrated by Bayer (1976) in her program of

easing mental patients back into their communities.

Conclusions

The first hypothesis--there will be no significant difference between Washington and Clackamas counties' readmission rate in the fiscal year 1971-72--was accepted. Clackamas County had a readmission rate of 41.5% while that of Washington County was 36.9%, indicating that there was no significant statistical difference for chi-square with one degree of freedom.

The second hypothesis, stating the readmission rate to Dammasch State Hospital from Clackamas County will be significantly lower than Washington County during the year 1974-75, was accepted. Clackamas County had a readmission rate of 35.5% while that of Washington County was 46.1%. Chi-square for one degree of freedom was significant at the .05 level.

Recommendations for Further Study

It is recommended that a number of studies be carried out as a result of the data obtained in this study. These may include:

1. Replication of this study comparing other counties.
2. Investigate the increase in readmission in Washington County for the period 1974-75.
3. Continue evaluation of the Day Treatment Center

to assess effectiveness of the program.

4. Institute the Mendota, Wisconsin, Community Life Study using the Day Treatment Center as a study setting.
5. An evaluation study on multiple admissions.
6. A study on types of admission and how it affects readmission.
7. Study the ideology of different treatment disciplines and how it affects the outcome of treatment.
8. Utilization of a Nurse Clinical Specialist in the treatment program and check the effect in readmissions.

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APPENDIX

Phone: (503) 655-8401
1427 S. Keen Road

McLOUGHLIN MENTAL HEALTH CENTER
OF CLACKAMAS COUNTY

OBERT Wm. DAVIS, Ph.D.
Administrator/Director

Oregon City, Oregon 97045

August 1, 1975

Mr. Calvin C. Cooper
Management Service Unit
Mental Health Division
2570 Center Street N. E.
Salem, OR 97310

Dear Mr. Cooper:

A day treatment center was opened October, 1973 in Clackamas County as one alternative to hospitalization in our county. This center has been expected to reduce re-admission to Dammasch Hospital particularly. We are interested in evaluating and assessing our program. We would like to get some information programmed on the computer which would allow us to check recidivism rate from Dammasch State Hospital. A comparison of patient return by the county of origin would help us evaluate the effectiveness of the Clackamas County Day Care Center in reducing re-admission rates to Dammasch Hospital.

We talked with both Larry Sharp and Glenn Hitchcock about getting the necessary information. Glenn stated it was possible to provide this information by reversing the length of stay by diagnosis report (which is furnished to the hospital periodically already) and comparing it to the length of stay in the county on the same people for dismissed patients.

Larry Sharp is very interested in receiving this information for Dammasch Hospital. We feel it would be most helpful to Clackamas County as well as the other catchment areas. If in fact these alternatives to hospitalization are working, we would like to have some data to support the program. We would appreciate any information you could give us. The attached sheet provides the format in which we would like the information programmed and what kind of information we need to make our evaluation complete.

Sincerely yours,

Carolyn Taylor, R.N.

W. H. Cloyd, M.D.
Supervising Psychiatrist
McLoughlin Mental Health Center

ct
Copies to: Glenn Hitchcock
Research Analyst
Mental Health Division
Salem, OR 97310

Larry Sharp
Jon McCormick

We would like the raw data punched on computer cards and the cards sent to us, so we can manipulate our own tables.

(1) All patients in fiscal years 1973 through 1975 from Multnomah, Clackamas, Washington, and Columbia Counties.

It would be helpful if we also had the fiscal year 1972 to 1973. However, Larry Sharp indicated we were not on the computer until 1973 and it would be more difficult to obtain this information. So, if possible this would be very useful information. It would give us a picture of our county when there was no day treatment center.

(2) Please punch cards with this information. Perhaps this would be a good format:

All admissions at Dammasch State Hospital by county fiscal years 1973-1974, and 1974-1975:

	Code	
Patient name	1-4	
Sex	5	
D.O.B.	6-11	
Length of stay	12-14	
Type of admission	15-16	
Marital status	17	
Ethnic	18	
Education	19-20	
Religion	21	
Living arrangement	22-23	
Financial source	24	
Date of return	25-30	
Previous institution-		
OSH	33	
LDHTC	34	
DSH	35	
FHTC	36	
Other	37	
CPHTC	38	
Day Treatment CC	39	
Discharge plan-		
Woodland Park	40	
Providence Hospital	41	
VA Hospital	43	
Diagnosis	44-46	
Occupation	47	
Alcohol & Drug	48	(treat as a separate group)

AN ABSTRACT OF THE CLINICAL INVESTIGATION OF

CAROLYN J. TAYLOR

For the: MASTER OF NURSING

Date of receiving this degree: June 11, 1976

Title: THE IMPACT OF A DAY TREATMENT CENTER ON READMISSIONS TO A STATE HOSPITAL

Approved: [redacted]
Marie Berger, M.S. Advisor

The purpose of this study was to evaluate the impact of a day treatment center on readmissions to a state hospital. Similar counties were compared; one with a day treatment center and one without a day treatment center. All readmissions from these two counties were used for a year prior to opening of the day treatment center, and a year during the operation of the day treatment center.

Conclusions

There was no significant difference in readmission rate in both counties in the year prior to the opening of a day treatment center. However, there was a significant difference in the readmission rate in the county with a day treatment program in the year during the operation of the program.