THE DUTCHESS COUNTY PROJECT AFTER FIVE YEARS

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In this paper I want to stress the role of administrative decisions and functions. I feel that the role administration plays has been partially overlooked and not given enough stress. The decisions which are made can affect the clinical aspect of the program directly, for better or worse. While most of my comments deal with the Dutchess County Project, I will also make comparisons with other units that I know.

When Dr. Harry Solomon gave his presidential address to the American Psychiatric Association in 1958,[1] he brought into prominence the large mental hospitals which, he felt, contributed to prolonged hospitalization and increasing mental disability. He started an increasing controversy of the large versus the small hospital and the community mental health units. Since his address there has been a scramble toward the ever-elusive millenium, the search for the magic combination of factors that would do away with the large hospital and its chronic residual population, and at the same time treat arriving patients in a setting that would prevent any long-term illness. Suddenly there appeared on the scene many facilities and plans, each with its own philosophy for the combination of opening the locks on the gates to Utopia. The planners seemed to take it for granted that the large hospital was detrimental to the patient, without really having any evidence that it was so, or that the small hospital would in any way be better. Size in itself seemed to be emphasized when in reality it was not the size but the type of personnel and the program for the patient which were important.

Most people, in their honest zeal to reach the goal, developed a rigid philosophy and a unifocal vision. They were so inflexible as to leave no room for detours into new ideas or for new experiences, or to consider the possible value of other projects.

For the purposes of orientation to the New York State Department of Mental Hygiene and the Hudson River State Hospital, I should like to make the following comments. I hope these comments will ultimately clarify for you the position of the Dutchess County Unit.

In this state, the Commissioner of Mental Hygiene is a cabinet officer. He is appointed by the Governor and works directly under the Governor. The commissioner has two deputy commissioners, one of whom is in charge of program administration while the other is in charge of professional standards and services. These two deputy commissioners have a number of assistant and associate commissioners under them who are in charge of various divisions such as the hospitals, institutions for the mentally retarded, community services, forensic psychiatry, and the various ancillary services such as occupational therapy, recreational therapy, and other programs. The commissioner also has an administrative and fiscal manager who is his business adviser as well as the person in charge of all the financial dealings of the department.

The purchases for all of the institutions in the department are made, for the most part, through the central office where everything has to be approved and then is further approved by the division of standards and purchases and the budget division. It takes approximately one-third of the New York State budget to support the Department of Mental Hygiene. We work on a line item budget with some leeway allowed, depending on the occasion. Through a great deal of study over the years, the central office has arrived at a certain number of factors which are relatively stationary from one year to another, for example, the cost of food per patient, or the amount of clothing per patient, or the amount of maintenance and upkeep in a general way. Over the years a program for personnel has also been developed, so that a table of organization applies to the whole department and a director of one institution does not have more than another. There is a patient-nursing service personnel ratio for a reception service, or a geriatric service, or a continued treatment service. All of these figures are calculated to arrive at a suitable number of personnel in the nursing service. If the population of a hospital should drop, there would be certain adjustments, with personnel taken away gradually.

If the population increases in a hospital, there are adjustments at a certain time and an increase in personnel will be made. There are similar formulas for occupational and recreational therapists, social workers, etc.

The appropriation of the budget for new equipment is generally divided into new equipment, replacement equipment, and capital projects. How much each hospital receives depends on the amount of money available at a given time. Generally speaking, projects, new equipment, and replacements are carefully scrutinized all along the line and, for the most part, the hospitals get most of the necessary items. There are 20 state hospitals in New York State, caring for approximately 84,000 patients; six state schools serve approximately 23,000 patients, and one institution for epileptics has a population of about 2,000. These are resident patients and do not include those on convalescent and family care.

All the hospitals are organized in about the same way. There is the director, who is the head of the institution. He has an associate director and several assistant directors to aid him. The number depends on the size of the hospital. At the Hudson River State Hospital we have five assistant directors, three of whom do clinical work and two of whom do administrative work; their positions and duties are interchangeable at any time. On the next level are the supervising psychiatrists; these doctors are in charge of services or important projects and are assisted by the senior psychiatrists and residents.

There are 4,600 resident patients at the Hudson River State Hospital. To take care of them, we have 50 doctors, 1,200 nursing service personnel, and about 800 other personnel, including all of the ancillary services, business office, and general maintenance personnel.

The Hudson River State Hospital is the sixth largest hospital in the state, and it costs approximately 12 million dollars a year to run it. About 10 years ago, there were 6,800 resident patients; about four years ago this dropped to 5,800 patients, and in the past three years the figure has dropped to 4,600. The hospital was established in 1890, when most of the buildings were erected. Since then several modern buildings have been constructed so that you see both old and modern types of architecture as you go through the grounds. The building opposite the Dutchess County Unit is called the Cheney Memorial Building. It has a capacity of 1,000 patients. Each ward has between 30 and 40 beds, with small dormitories and many private rooms. There are 450 geriatric patients in the building and a complete reception

service for about 250 patients. It has two admission wards where patients are admitted, studied, started on their treatments, and then transferred to the reception ward where they will stay until they are well enough to go home, or, if the prognosis after several months in the reception center still appears poor, they will be transferred to another part of the hospital. Patients are kept in the reception center as long as possible since we have found that the farther they get from this center, the longer it will take them to get home. This huge building also has an operating room and a complete medical service. There is a school of nursing, a pharmacy, and a complete clinical setup for every medical specialty, a dental department, an x-ray unit, physiotherapy, occupational therapy divisions, recreation rooms, beauty parlors, and the research unit which is associated with Dr. Gruenberg.

ORGANIZATION

At the end of 1959, plans were made to start a geographically decentralized unit in Dutchess County, New York State. This was to function as independently as possible from the Hudson River State Hospital, the parent organization. There were many reasons why the New York State Department of Mental Hygiene and the Milbank Memorial Fund finally decided on Dutchess County. It has a population of approximately 190,000. It has the highest or the next to highest admission rate for any county in New York State, approximately 375 patients per 100,000 population being admitted in the past several years; it also has the dubious distinction of having nearly the highest percentage of emergency health officer certificates issued for patients' admission. The county government had a good mental health board and an active mental health society and a good community mental health clinic. The relationship of the Hudson River State Hospital to the community was a good one.

In retrospect, it is necessary to point out mistakes that were made so that others could consider them and, hopefully, not make the same mistakes again. The criticisms are not a reflection on the original planners. The criticism merely shows that a program must be elastic and must change as local conditions warrant, and that a rigid, unifocal philosophy in a small unit can be detrimental.

The first step in the original plan put into effect in 1960 was to set aside two buildings which housed 517 patients. Almost all of the patients who had ever come from Dutchess County were then trans-

ferred to this unit. Only 80 beds were left for newly admitted patients. With an admission rate of approximately 50 a month, the bed vacancies disappeared and the unit became "choked," so to speak. The patients who were transferred into this unit were people who had been in the hospital from one day to 45 years, with every form of psychiatric diagnosis; they ranged from very active young people to bedridden, incontinent old people, from the severely excited to the severely regressed. New patients admitted after January 1, 1960 were put in any bed which happened to be vacant. A young depressed neurotic or an early schizophrenic or a paranoid individual would find himself between regressed and bedridden patients or among withdrawn and asocial individuals, or in the midst of a very aggressive group of paranoid individuals. This situation created new symptoms for the newly admitted patients not related to their own illness.

I wish to stress this point very strongly because I feel that had the unit started with the first patient admitted on January 1, 1960 and had not taken anybody who had been admitted before that date, it could have accomplished much more. Although it has accomplished a great deal, part of what was accomplished was an effort to show how mistakes could interfere with the efficient running of an effective mental health service. It is rather poor medicine to put a case of gonorrhea on an obstetrical ward, and, by the same token, to put a case of meningitis on a surgical ward where there are head injuries. And it does no good to put newly admitted mentally ill patients in with schizophrenics who have been in the hospital 25 to 30 years, or with bedridden senile patients. The original idea that the new patients would somehow or other stimulate and miraculously bring about improvement in these long-term residual patients by mere contact or inunction just did not work.

THE PROGRAM

From January 1, 1960 until November 1962, a period of almost three years, a great deal of effort was spent in trying to create vacancies among the residual Dutchess County patients. These people needed treatment; there is no question about that. They had not been forgotten previously, but they had not received much intensive treatment. When these patients were transferred to the Dutchess County Unit they began to receive intensive attention. Although the types of programs used for long-term patients was the same in the Dutchess County

Unit and in the chronic services of Hudson River State Hospital, these programs were applied with more vigor in the Dutchess County Unit. The attempts of the physicians in the Unit to take care of a newly admitted patient and return him to the community in the shortest time possible was diluted to a great extent by the efforts which they devoted to the elderly or long-term patients. This defeated part of the aims of the program. A great effort has to be made to get patients back to the community after they have been away for long periods of time. Jobs have been passed on to someone else. Family ties and attitudes have changed. However, if the patient can stay in the hospital for a short time and be treated in the community for part of his illness, the empty place that is created is kept open for the patient and not filled in by someone else. For this reason, it is imperative to give the newly admitted patient every possible benefit so that he will not lose his place in the community and become another statistic in the residual population.

In those three years, it was very difficult to have a suitable occupational therapy program on a ward where there was an admixture of different ages, different types of mental illnesses, different grades of withdrawal and regression. It was not any easier to put a good recreational therapy program into operation in a ward where there was a varying degree of physical disabilities as well as tremendous disinterest on the part of some patients. No matter what program one considered—the nursing service program, group therapy, the psychotherapeutic program, remotivation or drug therapy, everything became more involved with this heterogeneous grouping of new and old patients. The wards were also left open, in keeping with a good open-door hospital policy. This allowed many of the new patients to go for walks, to the community store, or wherever they wished. Most of the newly admitted patients took such an advantage of this privilege—to get away from the more deteriorated and long-term patients—that their attendance at scheduled programs was interfered with. It got to the point where the staff had to make definite appointments and have patients stay for psychotherapy or any sort of therapeutic session. Again, I wish to emphasize that this intensive treatment did help many of the long-term patients, but the same thing has been accomplished in the rest of the hospital where the patients are not grouped geographically but where the program itself has changed in keeping with the needs of each patient group.

CHANGES

In an effort to correct this situation, 100 patients were transferred from this Dutchess County building to another area in November 1962. These were all people over 75 years of age, who had been admitted to the hospital long before January 1, 1960 and who were bedridden. This allowed two wards to be used for admission purposes, one for females and one for males. This was done by me as director of the parent hospital. Dr. C. L. Bennett, who was the head of the Dutchess County Unit, could not do this because he had no power or control to take 100 patients out of the hospital that he was running and put them into the parent hospital. He had realized for a long time that he needed something like these two admission wards, but he could get them only through reducing the number of the elderly people or by creating vacancies and then putting his newly admitted patients together so far as possible. The creation of these two wards made it much easier for him. In retrospect, it seems that almost overnight the morale of all the patients, the personnel, and the doctors changed. People who worked in the various ancillary programs took a new lease on life. Dr. Bennett then set the standard for the unit as follows: 1. Patients were not to be transferred from the admission wards to other wards, unless, 2. the staff could agree that maximum benefit had been reached, or, 3. the admission ward was so crowded that the transfer became necessary, or 4. there was no possibility of placing the patient under some sort of supervision in convalescent care or family care, or 5. the patient was in need of specialized medical or surgical treatment. This move by the director of the hospital established good understanding and interpersonal relationships. Eventually it was much easier for the staff to place a patient on convalescent care, or on family care, or discharge him rather than get permission to transfer him to another ward within the Dutchess County Unit or to another area in the hospital. This "stone wall" erected by Dr. Bennett made his staff treat patients—no matter how severe the problem—rather than taking the easy way out by transferring a behavior problem or escaping patient to another area.

MAINTENANCE

The next aspect where administration played a part over which Dr. Bennett, as the head of the Dutchess County Unit, had no control,

was in the maintenance and furnishings in the ward. When the building that housed most of the Dutchess County patients was taken over, the old furniture from the building was left there. Beginning in January 1963, efforts were made until the whole building had new furniture. Tensions in patients over such little things as wanting a drink of water and not being able to have it were reduced by putting electric drinking fountains in every ward. New pianos were eventually bought, new record players were put into the wards, little library rooms were established. This was done not only for the newly admitted patients but—and again, I wish to emphasize this—the benefits received by the newly admitted patients on the two wards were not different from those enjoyed by long-term resident patients on the other six wards. They also received drinking fountains, clothes washers and driers, and television sets. Of course, Dr. Bennett, as the clinical head of the unit, was consulted about all changes that were going to take place, but he actually did not have to concern himself about the budget and the hiring and discipline of personnel. He and his staff were made to be more and more independent clinically and to spend more time with the patient. We found it easier and more advantageous to provide the unit with as much as possible and to correct all unsuitable conditions not related to clinical psychiatry.

PERSONNEL

This unit was also hampered in personnel. I have seen units in some hospitals that were so geographically decentralized that the head of the unit did his own hiring and firing, and prepared his own budget. To me this is in direct contradiction to the philosophy of getting as many psychiatrists as possible back to clinical work, to take care of the patient so that he does not become lost in the administrative phase of the hospital. At no time did I, as director of the parent hospital, interfere with any of the clinical aspects of the program that Dr. Bennett wished to carry out. I tried to foresee problems and ask his advice on planning administrative functions with a minimum demand on his time, so that he could spend more time with his staff, his patients, and his personnel. The parent hospital personnel director, nursing services, and ancillary services all provided him with consultants and personnel so that he always had a complete organization. The one exception was psychiatrists, but percentage-wise he received as much

help as the other services. This had a good effect in increasing the release rate.

SOME RESULTS

It occurred to me that if the patients began to stay a shorter time in the reception service and left the hospital sooner, the doctors would have more time to follow them up and have them return as outpatients. If the original plan had been to keep the family together, and a patient nearer to his home and community, then this plan could be carried out only by treating him so far as possible in the community. If one keeps a patient in a small unit in the center of his home town for two to five to ten years, it does not do him any good to be sitting in the middle of his community. The idea would be to have him *in* the community as much as possible and let his hospitalization be as short as possible; he would be treated in the Dutchess County Unit, or in a community mental health clinic, or as an outpatient. The physicians then would have more time to see patients who were out of the hospital and try to keep them out, if possible, instead of returning in wholesale numbers whenever there were some breaks in adjustment.

MEDICAL ASPECTS

Let me move on to another phase of effective mental health services that one must consider. In an inpatient unit, such as Dutchess County, physical examinations must be done and people who are taken sick must be cared for. In our New York State system most of the illnesses and every-day occurrences are treated by a psychiatrist. It is true that a psychiatrist should have as much general experience as possible. He should be able to recognize a heart attack or a case of pneumonia or appendicitis, but this does not mean that he should have to treat them, and thereby forfeit his main functional role as a psychiatrist. We found that from 10 to 50 per cent of the psychiatrist's time, as well as that of the psychiatric nurse, was taken up in the medical, rather than the psychiatric, care of the patient. Originally a general practitioner was brought into the unit who took care of the ordinary illnesses of the patients, thus relieving the psychiatrist of this particular effort. As time went on, the work of this general practitioner was increased. If it were possible to have two such men for this type of

unit, it would increase the amount of time the psychiatrists spend with the patients. Unfortunately a second general practitioner was not available.

Another point to be considered from an administrative standpoint is what to do with the patient who needs an operation or an oxygen tent, or who breaks a leg and needs a cast applied. If this were done within the unit, it would be extremely expensive to set up an operating room, maintain it, and get trained personnel. The location of the Dutchess County Unit within the confines of the Hudson River State Hospital was at an advantage here. The Unit used the facilities of the parent hospital for x-rays, physiotherapy, all sorts of medical and surgical consultations, and clinical work to good advantage. It has been estimated that the cost per patient for the first five months of stay in the parent hospital is approximately $10 a day. It was felt that this was higher by about three dollars in the Dutchess County Unit, and this was the part of the work that was subsidized by the Milbank Memorial Fund. If, however, the unit were to maintain its own operating room, its own x-ray department, laboratory, and other facilities, the cost would quickly mount to the usual fee in the private city hospital, and would go to $30–$35 a day or more. The cost in itself is not so important as the fact that, again, the services of a psychiatrist and of the head of the Dutchess County Unit would be further diluted in administrative problems.

MILBANK MEMORIAL FUND GRANT

I should now like to turn to the important work for which the funds given by the Milbank Memorial Fund were used. When the program was set up, arrangements were made for a pre-hospital diagnostic service. This was done through the County Medical Society, the Mental Health Society, and other interested groups. Supposedly every patient would be seen by a competent psychiatrist before being admitted to the hospital, and only those for whom hospitalization was contemplated. For this we needed two extra, capable psychiatrists, and for a while this Dutchess County community project had them. But as they became trained and adept at social and community psychiatry, they left for greener fields and were not easily replaced. We learned two things then. First, we did not have enough physicians to go out to see the patients. The burden fell on Dr. Bennett who, as director of the Unit, was paid from the grant funds. He became the only experienced doctor

who could see the patient and decide if he should go into a private facility, into the psychiatric ward of a general hospital, to the community clinic, or be treated by the general practitioner.

Secondly, we learned that the general practitioner was not very willing to take care of psychiatric patients, and many of the relatives were unhappy with the thought that the patient would be treated at home or in a clinic. We had to face the fact that most of the general practitioners—at least in this locality—and most of the relatives wanted the patient in the hospital where he could be treated until he was well enough to return to his home. They were unwilling to go through the acute phase with the patient, but they were very willing to take the patient as soon as he improved sufficiently. There is no question or criticism about this. The general practitioner was satisfied to follow the patient after he made sufficient improvement, but he was not willing either to spend the time or to take the responsibility of having the patient go through an acute phase outside the hospital. I realize the tremendous effort that is being made across the country in giving special courses to non-psychiatric physicians to enable them to treat a certain number of psychiatric problems in their offices or in a general hospital; while this may work well in one state or one community, it does not follow it will in all states and in all communities. There are still vast pockets of resistance to this type of treatment by the general practitioner, and—judging from our experience—it is going to take a long time and a lot of education before this part of the mental health services is really accomplished.

There was another phase in which the Milbank Memorial Fund grant played an important part, by providing funds for the aftercare of patients. It was necessary to have two extra social workers and an extra doctor to follow through after the patients left the hospital. It should be noted that, although we had money for him, a capable psychiatrist could not be obtained for this work; the psychiatrists on the state payroll and part of the regular organization did this work. Since most of the patients were within a radius of easy traveling and easy telephone communication, the clinical psychiatrists were able to return them a little sooner to the community than if they had been 75 miles away with no care, or, at the most, some minimum supervision that we were not satisfied with. This made a great difference in the release pattern of patients from the Dutchess County Unit and of patients from the parent hospital, where they might have to go as far away as 75 to 100 miles. The convalescent care service ran

on almost a 24-hour basis. Here, again, the doctors were hindered in caring for new patients who were just let out of the hospital by their duties toward the long-term residual population in the Unit.

When original plans were made for staffing this project, it was done in accordance with the organization patterns of the Department of Mental Hygiene of New York State. The grant funds permitted extra personnel as indicated. We had no difficulty, as time went on, in providing personnel, with the exception of the psychiatrist. Even though money was available, we could not get capable doctors. Yet, we are within short traveling time from New York City, as well as Albany, and are in a large community where much that one desires socially can be easily had, where there is sufficient opportunity to mix with other psychiatrists as well as doctors who practice other specialities or are in general practice. It is a good community with cultural opportunities and good schools and colleges.

COMMUNITY RELATIONSHIPS

The Dutchess County project was organized as a county and community project. Therefore, this dicussion would not be complete without mentioning the advantages and disadvantages of such a relationship. Dr. Bennett has been the Director of Mental Health for Dutchess County for some time and, as such, is now Executive Officer of the Community Mental Health Board of Dutchess County. After I was appointed director at the hospital, the County Board of Supervisors appointed me as a member of the mental health board. This is very unusual, since appointments of hospital directors to community mental health boards are rare and infrequent. Furthermore, since there is no other county project like ours, Dr. Bennett is the only man who is also director of mental health for the county. This provided both of us with an opportunity to give directly to the mental health board a great deal of information which we had available. The board could then decide to approve or disapprove actions, and make recommendations to the board of supervisors. I am a member of the Board of Directors of the Community Chest that has, as one of its agencies, the Community Mental Health Society which contracts for the Community Mental Health Clinic. Dr. Bennett is well known in the Dutchess County Medical Society, in which he has been very active for many years. I was in close connection with the Department of Mental Hygiene and the commissioner, and knew the program that the com-

missioner was planning. This will give the reader some idea of how we could both be in favorable positions to further the efforts for mental health. We were both on the Regional Mental Health Planning Committee. Moreover, we were active in the community, speaking to non-professional groups and getting qualified people to speak to them. These groups included service organizations, the PTA, church organizations, etc.

The duties of the mental health director (Dr. Bennett) are varied and many. Although, theoretically, he spends only one day a week at this work (for which he is paid by the county), he actually puts in many evenings and other off-duty hours. Dr. Bennett's position is becoming more and more a full-time job. At some time in the future, it will be necessary for him to have a clinical assistant director who will spend his full time in the project duties while Dr. Bennett extends a guiding hand and co-ordinates this activity with the other local mental health facilities, St. Francis Hospital, the Community Mental Health Clinic, and the Mental Health Society as well as the parent hospital. This is a very important part of the Dutchess County project, and the unit's position and co-ordination with other faculties cannot be stressed too strongly.

"LOST IN THE SHUFFLE"

One can only speculate about what might have happened, but since the topic of this discussion is the effectiveness of mental health services, I shall dream of what might have been.

The admission and reception services of the parent hospital are not burdened with the long-term residual population; this is not so in the organization of the Unit which had almost 500 long-term patients. What did this interfere with?

For over two years, I tried to find ways of starting a day-care center within the Unit but could not do so, the main reason being lack of space within the building. It is true that Hudson River State Hospital has a day-care center, but it was organized long ago as an independent unit, years before the Dutchess County Unit was started. Each worked independently with its own philosophies and programs. Co-operation was only superficial and, therefore, the hospital and the unit could not make full use of one another. It was difficult to make one subservient to the other, although this could have been accomplished in "bulldozer" fashion by putting the day care within the

Dutchess County building. This could have made for an easy flow of patients from one to the other.

The day-care center is necessary for two reasons: Dr. Bennett has determined, and I have satisfied myself, that one-third of the patients regularly admitted could have been treated outside the Unit. Therefore, this one-third could have been transferred to the day-care center and then quickly to the Community Mental Health Clinic or other psychiatric facility or to a general practitioner. Secondly, had the Unit physicians had more time and received more co-operation in the pre-hospital diagnostic service, they could have prevented hospital admissions by referring the patient directly to the day center for further care and follow-up.

As will be explained later, the residual population of the Dutchess County Unit was increased by the number of patients over the age of 65. It was evident for a long time to Dr. Bennett, and to me soon after my arrival at Poughkeepsie, that many of the patients over 65 would not have had to be admitted to the Unit if a geriatric day center or a short-term night hospital had been available. We have concluded that one-third of the elderly patients need mostly psychiatric care, one-third need some psychiatric consultation and mostly medical care, and one-third require little psychiatric care but need either medical or nursing attention, or just plain attention—amusement, diversion, conversation, and friendship.

Suppose that on January 1, 1960, when the first patient was admitted to Ryon Hall (where the Unit is housed) there had been no residual population in the building. A day-care center and a geriatric center could have been started very quickly. All efforts could have been directed toward keeping the hospital days to a minimum, and to transferring and following the patient in a community psychiatry setting. The patient would have retained his family, community, and economic ties. The residual population would have been smaller than it is now.

EVALUATION

There are certainly many ways to evaluate any program. I have selected the one that I know best from an administrative standpoint. Yet this method does not really measure the success of a program. In the past year, I have heard comments at some state and national meetings about the length of a patient's stay in the hospital. It seemed

the condition of the patient did not matter to some of these people but rather how soon he got out of the hospital. There is a real danger in this, if there is no adequate follow-up. I shall, therefore, say nothing about length of time in the hospital.

I will discuss the "geographical location" of the patient, that is, is he in or out of the hospital, and compare this in Dutchess and Albany Counties. Albany County, with a population of 130,000, is served by this hospital, but the patients come from at least 75 miles away. They are not separated in the hospital on arrival and stay on the service with all other patients from the several counties, as opposed to the segregated Dutchess County patients. The "level of adjustment" of the patient outside the hospital, so very important from so many

TABLE I. ALBANY COUNTY PATIENTS ADMITTED EACH YEAR TO HUDSON RIVER STATE HOSPITAL, (APRIL 1, 1960 TO MARCH 31, 1964) AND NUMBER REMAINING ON BOOKS, MARCH 31, 1964

Fiscal Yr. Ending Mar. 31 and Age Group	*Total Admissions*	*On Books March 31, 1964*				
		Total	*In Residence*	*In Convalescent Care*	*On Family Care*	*On Escape*
1961						
Total	271	67	44	17	6	0
less than 65	195	49	28	16	5	0
65 and over	76	18	16	1	1	0
1962						
Total	260	68	42	21	5	0
less than 65	181	48	24	19	5	0
65 and over	79	20	18	2	0	0
1963						
Total	311	122	69	39	12	2
less than 65	207	81	38	33	8	2
65 and over	104	41	31	6	4	0
1964						
Total	299	193	131	55	4	3
less than 65	199	139	84	49	3	3
65 and over	100	54	47	6	1	0
Total						
admissions	1141	450	286	132	27	5
less than 65	782	317	174	117	21	5
65 and over	359	133	112	15	6	0

Active case load	39.4% of original admissions
Residual pop. in hospital	25.1% of original admissions
Patient pop. in C.C. and F.C.	13.9% of original admissions

TABLE 2. DUTCHESS COUNTY PATIENTS ADMITTED EACH YEAR TO HUDSON RIVER STATE HOSPITAL (APRIL 1, 1960, TO MARCH 31, 1964) AND NUMBER REMAINING ON BOOKS, MARCH 31, 1964

Fiscal Yr. Ending Mar. 31 and Age Groups	*Total Admissions*	*On Books March 31, 1964*				
		Total	*In Residence*	*On Convalescent Care*	*On Family Care*	*On Escape*
1961						
Total	534	61	31	19	11	0
less than 65	356	46	18	18	10	0
65 and over	178	15	13	1	1	0
1962						
Total	560	87	50	28	9	0
less than 65	396	56	28	20	8	0
65 and over	164	31	22	8	1	0
1963						
Total	530	110	66	47	7	0
less than 65	372	60	26	37	7	0
65 and over	158	50	40	10	0	0
1964						
Total	415	189	133	46	10	0
less than 65	272	118	71	38	9	0
65 and over	143	71	62	8	1	0
Total admissions	2039	447	280	140	37	0
less than 65	1396	280	143	113	34	
65 and over	643	167	137	27	3	

Active case load	21.9% of original admissions
Residual pop. in hospital	13.7% of original admissions
Patient pop. in C.C. or F.C.	8.7% of original admissions

aspects, will in this case be narrowed to the proposition that if the patient remains out of the hospital, he is at least maintaining some sort of level of adjustment, from being completely supervised and not well to the other extreme of being completely independent and recovered from his mental illness. We will see in the tables that relapses and returns to the hospital, and the number of patients on family care and on convalescent care for more than one year will give us a clue to the number of basic mental cases that have to be followed and cared for in a community setting on a long-term basis.

Tables 1 and 2 are self-explanatory, but some figures deserve comment. Although the total admissions from Albany County were much less than those from Dutchess County in the years 1961–1964, the

residual hospital population on March 31, 1964 from the Albany admissions was nearly as great as, or greater for some groups than, the residuals from the Dutchess County patients for each year's admissions and each age group. The number of patients over 65 remaining in residence after two years decreases sharply, as is shown in Table 3. Percentage-wise, Albany County has more patients on convalescent care but the total number is about the same as for Dutchess County. Usually, patients are discharged after one year of convalescent care unless their adjustment is only marginal. The number in this category, even after three or more years, in both counties reflects the need for psychiatric care for this small number of patients.

Table 3 shows more dramatically in percentages the difference in residual population, especially when the difference in total admissions is also taken into account (2,039 plus vs. 1,141 plus). The residual rate in Dutchess County reaches almost one half that in Albany County in some years.

TABLE 3. PERCENTAGE OF ADMISSIONS EACH YEAR FROM ALBANY COUNTY AND FROM DUTCHESS COUNTY REMAINING IN HUDSON RIVER STATE HOSPITAL, MARCH 31, 1964, AND PERCENTAGE FROM DUTCHESS COUNTY IN HOSPITAL SEPTEMBER 30, 1964

Fiscal Yr. Ending Mar. 31 and Age Group	*In Residence 3–31–64* *Albany County* (%)	*Dutchess County* (%)	*In Residence 9–30–64* *Dutchess County** (%)
1961			
Total	16	6	3.6
less than 65	14	5	2.8
65 and over	21	7	5.0
1962			
Total	16	9	5.7
less than 65	13	7	3.3
65 and over	23	13	11.6
1963			
Total	22	12	9.6
less than 65	18	7	4.6
65 and over	30	25	21.5
1964			
Total	44	32	16.9
less than 65	42	26	10.3
65 and over	47	43	29.4

* Figures for per cent of patients from Albany County six months after latest admission in fiscal 1964 are not available at this time for comparison. It is felt, however, that there would be a drop in residual population, but not as great as the one for Dutchess County.

The three tables show that consistently over more than a four-year period a smaller percentage of patients from Dutchess County have been retained. This applies to patients over and under 65 years of age.

Table 4 was prepared only for the Dutchess County Unit. It shows the results six months after the last patient was admitted in the fiscal year 1964. The percentage in residence given in Table 3 shows how substantial the drop in cases was in this short time. This reflects two things: First, most of the patients under 65 years of age will be released from the hospital in less than six months, and, secondly, in the older group the death rate will usually be high.

TABLE 4. DUTCHESS COUNTY PATIENTS AT HUDSON RIVER STATE HOSPITAL SIX MONTHS AFTER THE LATEST ADMISSION IN FISCAL 1964*

Fiscal Yr. Ending Mar. 31 and Age Group	*Total Admissions*	*Status of Those Still Under Care As of Sept. 30, 1964 (Case Load)*				
		Total	*In Residence*	*On Convalescent Care*	*On Family Care*	*On Escape*
1961						
Total	534	39	19	9	11	
less than 65	356	28	10	9	9	
65 and over	178	11	9	0	2	
1962						
Total	560	56	32	15	9	
less than 65	396	34	13	14	7	
65 and over	164	22	19	1	2	
1963						
Total	530	77	51	17	9	
less than 65	372	39	17	16	6	
65 and over	158	38	34	1	3	
1964						
Total	415	125	70	45	10	
less than 65	272	73	28	36	9	
65 and over	143	52	42	9	1	
Total	2039	297	172	86	39	
less than 65	1396	174	68	75	31	
65 and over	643	123	104	11	8	

Total case load still active	14.6% of original admissions
Residual pop. in hospital	8.4% of original admissions (60% are over age 65)
Active patient pop. in community or family care supervision	6.1% of original admissions

* Figures are not available for a similar survey for Albany County patients six months after last admission.

TABLE 5. TOTAL NUMBER OF DEATHS IN EACH CALENDAR YEAR, 1960–64, AMONG PATIENTS ADMITTED EACH YEAR TO HUDSON RIVER STATE HOSPITAL FROM DUTCHESS COUNTY*

Admitted 1960		*Admitted 1961*		*Admitted 1962*		*Admitted 1963*		*Admitted 1964*	
Died		Died		Died		Died		Died	
1960	55	1961	67	1962	70	1963	69	1964	70
1961	19	1962	19	1963	29	1964	24		
1962	10	1963	9	1964	11				
1963	9	1964	10						
1964	8								
Total	101		105		110		93		70
20% of admissions		18% of admissions		20% of admissions		21% of admissions		14% of admissions (1 yr.)	

* *See* Table 6 for number of admissions in each calendar year.

Table 5 shows the number of deaths which occurred among Dutchess County patients and the percentage of total admissions in each calendar year that died by the end of 1964. The figures are fairly consistent, including those for 1963, but for admissions in 1964 the deaths are for less than one year. We can assume then that between 14 and 21 per cent of patients admitted (as long as patients of all ages are admitted) will die within a two-to-four-year period. With a few exceptions, these deaths occurred in the age group over 65. If instead of using total admissions, the figures for only those over 65 were used, the percentage of deaths in this group would probably double. This again reflects what was said earlier—that one-third of patients over 65 need little psychiatric treatment but a great deal of medical treatment, and at that the prognosis would be poor. These people, although receiving good medical care in a psychiatric unit, could just as well have been treated medically in a medical unit. This would have allowed more time for the psychiatric functions of this unit.

As of *December* 31, 1964, there were 163 patients who had been admitted to the Unit after January 1, 1960 and who were in the hospital more than six months (since June 30, 1964). Of these 163, 112 never left the hospital, even for short periods of family care or convalescent care, while 41 patients were out for varying periods of time and for a various number of times. This means that 25 per cent of the residual population are in a revolving-door pattern and would

have to be treated in some community facility at times and in this hospital when their condition became worse.

Only one comment need be made in regard to Table 6. This shows that an average of 305 patients per 100,000 population are being admitted. Previously, this number was around 375 per 100,000. One can only surmise that the pre-hospitalization consultations have had some effect in lowering the figure.

TABLE 6. TOTAL ADMISSIONS TO THE UNIT FOR EACH CALENDAR YEAR

	Male	*Female*	*Total*	*100,000 Population in Dutchess County*
1960	294	214	508	299
1961	311	272	583	343
1962	312	244	556	333
1963	221	218	439	255
1964	250	250	500	294
Total	1388	1198	2586	1524
			Average	305

DISCUSSION

I think it is quite appropriate to have the organization and reorganization of the Dutchess County Unit discussed at this time. We are now in the midst of a vast program of the United States Public Health Service, to provide millions of dollars for community mental health centers, many of which will be similar to this center at Poughkeepsie. To treat patients close to their families, friends, and neighborhood, the medical profession, including psychiatrists, should have some knowledge of existing units, including their advantages and disadvantages. The new planners should be aware of mistakes and try to avoid them. They should have some idea of how such a unit should be organized, how it should function, and what its relationship to other community agencies should be. Many regard the new community mental health center as the future panacea for the care and treatment of mental illness, or, by insinuation, believe that there will never be another large hospital. I need not go far from my own state to point out that, in spite of community mental health clinics in almost all counties, established under an Act in 1954, the admissions to state hospitals

continue to rise. Furthermore, in spite of the wide use of tranquilizers or antidepressants by all physicians in every phase of medical practice, the admissions continue to rise and the readmissions to recur with more regularity than previously.

One must consider what is best for the patient; it is not *where* the patient is but *how* he is being treated and the *level of function* which he can maintain during and after treatment. If he can be treated in a therapeutic hospital in or near his community, he will benefit more and his level of function will be better.

The establishment of community centers is now a reality and is progressing rapidly. The challenge to these smaller facilities is to keep them out of a cold war and see that they maintain themselves in a good co-operative relationship and in a suitable interpersonal atmosphere. As each facility becomes more independent in its own community personalities will emerge, some of whom will become prima donnas and little Jehovahs. This is to be avoided.

As the late Dr. Paul Hoch, Commissioner of the Department of Mental Hygiene of New York, said: "The mental health center is a very sound idea but it is not feasible to treat most of the patients in these centers, and the first task is to convert the mental hospital into proper therapeutic community-centered organizations offering treatment programs for every patient who can possibly benefit from it." In the *new* centers, those patients may be kept out of the hospital because of the *new* philosophies of community treatment, when they might be the very ones who really should be hospitalized.

The great problem of interpersonal relationship between all the disciplines, including psychiatry, and between the various centers will in large measure determine the success of the centers as well as the benefits from care and therapy which the patient will receive. In the future, one must consider many small centers; but will this guarantee that they function at high levels? With the increasing speed of transportation, will some patients begin to feel that they should go to a "large" center or city where there are "better" doctors? Some of the small units will, no doubt, merge, but will there come a time—50 or 75 years, more or less—from now when so many small centers will consolidate that we will again have large hospitals? The only real factor which might stop this is a breakthrough in research into the cause and/or therapy of mental illness. In order to preserve small community facilities, the expert in any field must not get lost in a small facility when lack of ambition or loss of initiative develops. Con-

versely, to prevent this, his status in a small community must be raised to the point where this will not happen and he will not be tempted to gravitate to large centers for purposes of increased professional standing.

CONCLUSIONS

1. The Dutchess County Project shows that such a unit can produce good results, which will be definitely better than those in a hospital with a large population.

2. The lack of trained psychiatric personnel is an ever-present problem.

3. Administrative functions must be removed from the unit to allow for as much clinical independence as possible.

4. A project must have a good philosophy, firm but not rigid, elastic but not dubious, and it must be able to adjust itself to the needs of the community.

5. This project has improved and is serving a useful purpose in the mental health program in Dutchess County. The State of New York has now taken the responsibility for its maintenance, and is considering units like it for some of its other institutions.

REFERENCE

[1] Solomon, Harry C., The American Psychiatric Association in Relation to American Psychiatry, *American Journal of Psychiatry,* 115, 1–9, July, 1958.