

THE DUTCHESS COUNTY PROJECT

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In January 1960 we set up a relatively small, geographically decentralized 550-bed Unit within a 5,000-bed state hospital to serve all degrees and types of mental illnesses in the county. The county's population was approximately 175,000 and is now approximately 200,000.

We automatically accepted mentally ill persons into the Unit, with the exception of children under 16 and individuals with open pulmonary tuberculosis. We had to maintain an acute service and an emergency service because this is part and parcel of the New York State system.

We hoped to demonstrate the value of a small community-oriented, malleable, clinically autonomous Unit in accomplishing the following:

1. diagnosing, treating, and releasing patients more quickly;
2. maintaining full continuity of care, with each patient managed throughout hospitalization and aftercare by the same social service worker and the same physician who cared for him during hospitalization;
3. prompt attention, to prevent the growth of chronicity and unnecessarily protracted hospitalization, and with the use of pre-admission screening, gradually reducing our initial inpatient census and thus gaining increased professional time for further concentration on acute patients and prevention of institutional regression;

4. taking advantage of geographical proximity, to utilize community facilities for both case-finding and involvement in after-care;

5. finally, attaining sufficient integration between state hospital and community so that there would be almost daily communication between the inpatient service, the day-care center, the general hospital psychiatric section downtown, the community clinic downtown, the county health department and private practitioners, in order that patients, as well as their medical histories, could be freely and informally moved from one facility to another as their condition improved or worsened.

After five years certain accrued advantages stand out that probably are not statistically measurable but are observed daily by all of us working in the Unit. All of these basically result from the small size and cohesiveness of the facility, as contrasted with the unwieldiness, geographic spread, and complicated administrative structure that any large parent hospital makes almost mandatory. I am convinced that the focal point of these accrued advantages is the frequency and ease of communication between administration, medical staff, social service, nurses, and paramedical services. With the complete clinical autonomy under one roof and the daily interplay of informal consultation between social service and medical staff and Unit director, decisions involving admission, treatment, disposition, and follow-up are considerably accelerated and the patient receives more prompt and consistent attention. This has resulted in shorter hospitalization and less tendency to become passively institutionalized. An added dividend is the maintenance of a favorable teaching atmosphere for residents and younger staff members, and a resultant morale among medical and social service staff members that is quite unusual in a larger institution. Our proximity to the source of our patients promotes frequent telephone communication between staff and referring agencies or physicians to determine past illnesses, medications, and important points in the histories. This not only improves lines of communication and understanding between hospital and community but also stimulates an attitude of personal responsibility in the medical staff.

Since October 1962 we have maintained a large "board" in the Unit director's office which summarizes current status in total census, number of patients on convalescent and family care, number of vacancies in the admission services and in the Unit as a whole, and the

weekly, monthly, and yearly figures for admissions, releases, and deaths. It is brought up to date weekly. The figures, as well as our own monthly and annual reports, are based on actual ward counts and appear monthly as lists of individual patients, thus promoting considerable accuracy in assessing the status and progress of the Unit.

As was pointed out in an earlier annual report,¹ at a time when we were initially overcrowded to the point of having beds set up in the hallways and visiting rooms, the supervising nurses' daily log on January 15, 1960 showed an inpatient census of 530, to which were added in the subsequent two weeks an additional 22 patients who had been admitted to Hudson River State Hospital from Dutchess County in the last weeks of 1959. To these 552 were added, during 1960, an additional 70 patients who were transferred to us from other chronic services as vacancies occurred. Thus our Dutchess County census in 1960 included an accumulation of 622 patients admitted to Hudson River State Hospital prior to January 1, 1960. Our inpatient census today, March 1, 1965, is 414 (including the geriatric and chronic female patients transferred out to other services at the end of 1962, whom we still carry on our books as county residents). This approximately 35 per cent reduction of inpatient census we feel to be a significant accomplishment over a five-year period, even though about half of the reduction is due to release into the community on family care. Another interesting finding, also based on actual ward count of individual patients, and tending to support Dr. Herman Snow's observations concerning the original mass transfer of chronic patients into the Unit, is that 73 per cent of our present male population, and 60 per cent of the female population is *still* made up of those patients transferred to us at the Unit's inception. These 257 "hard-core" patients have successfully resisted all efforts directed at their release over several decades of hospitalization, and continue to attenuate the small medical staff's therapeutic efforts for the new admissions during this five-year period.

PRE-CARE

The effect of selecting patients through pre-admission screening is an important element of the process by which this type of statistical result has been obtained. Before the Unit was opened in 1960, virtually 100 per cent of persons seeking voluntary hospitalization were accepted; this is still true of those admission services throughout the state that

do not provide alternatives associated with community facilities. It has been our policy since 1960 to review these cases carefully, either at the hospital or in the community, and direct them toward the facility that was best suited to meet their immediate needs; full hospitalization is only one of five available possibilities. Only about 30 per cent of these prospective admissions have been accepted, the rest being directed to day care, community clinic, the St. Francis psychiatric service, or back into private practice channels. We retain and concentrate on the most seriously ill 30 per cent for inpatient services, thus loading the scales against ourselves from the standpoint of recovery, release, and duration of hospitalization as compared to inpatient services which accept all degrees of illness without screening. In view of this factor, it seems quite significant to me, in evaluating the comparative efficiency of this small, geographically decentralized facility, that of our 2,586 admissions only 178 still remain on our wards (two months after the termination of the five-year period); more than 100 of this residual from five years' admissions are over 65 years old and represent the most difficult segment to return to the community.

We call the pre-admission work "pre-care." Its chief purpose is to render community service to people with serious mental illness who cannot avail themselves of the services of a private psychiatrist and are badly in need of help. Referrals have come from general practitioners, private psychiatrists, welfare, public health, courts, and police; there are also many self-referrals, with or without family pressure. Every effort is made on initial telephone contact to persuade these self-referrals to get in touch with a family physician of their own choice, so that we can confer with him, as well as with the patient and the family. Even if this fails, consultation is not refused and the patient is subsequently examined.

From the beginning, we have made it clear through meetings with the County Medical Society and communication with the county agencies that we wish to be consulted only in that area of serious mental illness where hospitalization was being actively considered. This policy was dictated, first, by the fact that we had neither the time nor the personnel to become involved with marital problems or mild neurotic decompensation, and, second, the fact that the patient who most needed help, because of a developing emotional break of major proportions, seemed the least likely to receive it under clinic and private psychiatric facilities as they existed in the community. This pre-admission consultation, for which we have gone into patients' homes,

the general hospitals, jails, county and city infirmaries, even hotels and bus stations, permits some control over unnecessary hospitalizations and also enables the Unit's psychiatrists to share in the determination of which facility will best meet the therapeutic requirements of a specific case and then steer him positively in that direction.

Whenever full hospitalization is not indicated, the first appointment with community clinic, day-care center, alcoholism clinic, or private practitioner is made by telephone while the patient is still in the office, thus putting him under some moral obligation to "follow through." Wherever possible, we have, in the interest of saving both time and personnel, carried out these screening interviews in our own offices in the hospital; in the last two years of the project we have had to give up home visits because they were found to be particularly time-consuming. The frequent "telephone consultations" with various agencies and outside physicians are not included in our pre-care figures since we keep a record only on persons and families actually interviewed by the psychiatrist. We keep individual file cards on these patients, indicating the source of referral, a brief history of the problem, the disposition determined, and a record of subsequent communications with either the patient or his physicians. If the patient is eventually admitted to the hospital, this material is made available to the admitting physician and goes into the record ahead of the admission note.

The general hospitals present some special problems. The county has used this hospital for 75 years as a means of disposing of their geriatric patients without cost to the county. The result has been that the county has only about 40 beds for the aged and infirm welfare patients. Not a week goes by that we don't have to admit a person 70 or 75 years of age, not because he really is primarily a psychiatric problem, but because if we do not admit him, God knows what will happen to him. About 35 per cent of all our admissions are over 65, and better than 50 per cent of our wards are made up of people over 65.

There has also been an unfortunate tendency, which we have had to battle against, for our general hospitals to send us pneumonia deliriums and postoperative deliriums, to remove them from the general hospital ward because they are a nuisance there. At two o'clock in the morning we will get somebody who is practically moribund. Every time the local general hospitals get a new chief of staff, I have to go to work again and say to please stop these unnecessary transfers.

From the earliest days of the Unit's existence, it was clearly appreciated by Dr. Robert C. Hunt and others that the professional personnel going directly into the community and the general hospitals would have to be quite thoroughly screened themselves, in order to avoid misunderstandings and detrimental public relations with both the community and the county medical society. For this reason, pre-care examining, especially in the community, has been limited to the director of the Unit and the two or three members of a constantly changing medical staff who were best qualified by psychiatric experience and mature judgment. We have also had very valuable, although transient, assistance in this field from advanced residents associated with St. Luke's and Montefiore Hospitals, in New York, and from some physicians of very considerable experience in both psychiatry and public health, who were taking advanced courses in the College of Physicians and Surgeons of Columbia University, Division of Community Psychiatry, who came to us for field work. While this rapid turnover of physicians involved in screening was of considerable benefit to the Dutchess County Unit and to the citizens of the county, it necessarily made for an informality of record-keeping which virtually guaranteed that there were, particularly in the frenetic early days of the Unit, at least 200 patients seen and examined of whom we had no written record whatever.

The pre-care aspect of the project is felt to be most important from the standpoint of community benefit and in cementing long-term community relations through medical channels. It also tends to sort out the less seriously ill so that only the most emotionally decompensated patients find their way to full hospitalization. Interviewing patients prior to hospitalization has been most helpful in promoting short-term, voluntary admissions, with the understanding that after a very brief period of observation and study, the patient will be shifted to either day or night care within the hospital, to promote his early release. Ideally, of course, pre-admission examination by the psychiatrist should be made a requisite of hospitalization, as it has been in parts of England. This goal could be achieved if there were enough experienced personnel; but the limitation of time and of available psychiatrists has forced the unit to avoid overcommitment to that extent, and only about 30-35 per cent of cases can be seen prior to admission. In the past two years, the writer has noted an unfortunate and mistaken tendency on the part of decentralized units and comprehensive mental health centers, currently shaping up throughout the country, to under-

estimate the importance of this screening function and to leave it in the hands of either the Social Service Department or the least experienced of the psychiatric residents. Wherever possible, we have tried to influence the directors of these services toward utilizing their most experienced personnel for this purpose, because the decision as to which modality is selected for the patient is probably the most important decision that will be reached throughout his course of treatment.

A very conservative estimate (based on approximately 700 filing cards) is that at least 850 pre-care patients have been examined since this aspect of the service began in July 1960. This does not include patients examined at the day-care center specifically for admission there, and excludes also that large number of patients, about 125 per year, who turn up spontaneously at the hospital requesting admission. These latter were, of course, examined, and alternative measures arranged for many of them, but they were not referred directly by any "outside" agency or physician, and it was considered improper to include them in the figures of a newly organized service since these self-referrals had presented themselves at Hudson River State Hospital in many previous years. Follow-up of these transient patients is particularly difficult and time-consuming, would require literally hundreds of telephone calls and cross-checking between various facilities to determine eventual outcome, and is simply not practicable. A check on approximately 400 cards for people with clearly defined symptoms and recommendations showed 30 per cent admitted, 25 per cent referred to day care, 10 per cent referred to community clinics, 20 per cent referred (or returned) to private channels, including psychiatrists, private psychiatric facilities, or general practitioners, while the remaining 15 per cent did not appear to take any definite action in keeping appointments made for them and did not subsequently appear at the inpatient service or day-care center. In some of this latter group, it is possible that a 30- to 45-minute consultation enabled them to carry on alone.

It is felt that this pre-admission screening helped to prevent some unnecessary admissions, and strongly promoted communication and co-ordination between hospital and community. At the time of writing, the only patients from Dutchess County we regard as unnecessarily hospitalized are a portion of the 35 per cent of admissions sent in as "emergencies" by health officer designees, who rarely request pre-admission screening and who could not be fully accommodated by our small medical staff if they did.

INTERRELATIONSHIPS OF SERVICES

The relationship has been progressively building up between the state hospital and the community over a five-year period. The framework was laid down to promote this when Drs. Robert C. Hunt and Ernest M. Gruenberg collaborated to plan a county-oriented sub-hospital within Hudson River State Hospital, and the experimental project was made possible by the Milbank Memorial Fund's underwriting the extra personnel needed, over and above normal state hospital staffing, to carry out pre-care and attempt to extend the hospital further into the community. That this planning was solid and perceptive is attested by the fact that the Dutchess County Unit, organized within a state hospital, was actively fulfilling all of the functions involving pre-admission screening, full continuity of care, emergency services, and integration with the community two and one-half years before these activities were advocated by the Joint Commission Report² and President Kennedy's message³ as the necessary components of a Mental Health Center.

Owing to this foresight in planning, the unit enjoyed an invaluable "jump" of two or three years' experience on most other facilities that have subsequently entered the field of planning for comprehensive psychiatric care in its various phases. This early trial-and-error experience also has caused us to be visited and examined by professional representatives from half the states and provinces in North America and several foreign countries, and by committees from State and Regional Planning, Joint Information Service⁴ and the National Institute of Mental Health. These visits have not only been pleasurable to us, but have provided a fine opportunity to give and take from the experiences of others in the field.

The initiation of pre-admission screening, and the persistent efforts by Dr. Hunt and me, during the first two years, to involve the community, its agencies, and the county medical society by taking all opportunities to speak out and acquaint them with the Unit's goals, did make a start toward community involvement. But progress was slow and discouraging, as Dr. Hunt pointed out at a previous Milbank Memorial Fund Annual Conference.⁵ In January of 1963, however, about two months after Dr. Herman Snow had succeeded Dr. Hunt as hospital director and had made some far-reaching changes on the inpatient service, the New York State Department of Mental Hygiene and the local mental health board themselves "pressured" for the appointment of a county director of mental health services, in order

properly to implement the 1954 Mental Health Act.⁶ I resigned from the mental health board to act as county director; Dr. Snow accepted appointment to the board and, almost overnight, there was a giant step forward in cementing hospital-community co-ordination and in guaranteeing the hospital's future active participation in all community mental health facilities.

It is highly unusual for a state hospital director to be appointed to a county agency of government, and it is unique to have the same hospital's assistant director carry the dual responsibility of county inpatient care combined with responsibility (in conjunction with the mental health board) to "encourage the development and expansion of mental health services and facilities operated or supported by the board," as outlined under the Community Mental Health Services Act. This includes the approval of budgets submitted to county and state by the psychiatric facilities; the approval of fees paid to consultants, health officer designees, clinic staffs, and "supervision over the treatment of patients in such services and facilities." It is evident that integration between hospital and community is ensured within this framework, *provided* the director of mental health services has the confidence and co-operation of the mental health board and the hospital director.

In the past two years the county appropriation for mental health services has gone from \$62,000 to \$173,000, and within the same period we have been able (with awakened public interest and matching state funds) to initiate and expand a general hospital psychiatric wing, an alcoholism clinic, a county rehabilitation facility for mentally retarded and mentally ill, full-time psychological service for Family and Children's Court, and we are currently involved with the establishment of a child guidance clinic to take some of the load from the present All-Purpose Mental Health Clinic and further reduce its waiting list.

With the county mental health administrative arrangement that began in January 1963, both Dr. Snow and I have been closely involved in either the initiation or implementation of the above services, frequently both. Knowledge of the organization, policies, and procedures of the department in Albany, as well as previous personal acquaintance with department officials concentrating on hospital and community relationship problems have also been very helpful in attaining good communications and prompt, favorable attention to our community needs.

Some further examples of co-ordination are as follows:

1. The county health department, at its own request, is now sharing the treatment and supervision of every tenth patient released from the Dutchess County Unit on convalescent care, thus ensuring frequent consultation with our social service and medical staffs.

2. Spontaneous one- to two-hour joint conferences are held at the Unit and Hillcrest children's section of the hospital whenever the public health nurses or hospital staff find they share thorny problems in caring for their common patients.

3. Co-ordination with the community alcoholic clinic has progressed to the point where they are informed ahead of time on released alcoholics who seem motivated for continued treatment, and there is free exchange of medical records with this facility as well as all other county mental health agencies. Frequently clinic personnel or an Alcoholics Anonymous representative is here to pick up the patient on release.

4. Communication and informality of procedure between the inpatient service and community clinic, general hospital psychiatric service, and day-care center have reached the point where there is almost daily consultation between the physicians in charge of these services. This permits the uncomplicated transfer of patients from one modality to another in a matter of hours as their condition improves or arouses new concern.

5. Informal luncheon meetings in Poughkeepsie are frequently held to discuss appropriate budget, fiscal, and mental health planning with the county health commissioner, family court judge, county treasurer, and clerk of the board of supervisors.

Finally, I would like to take this opportunity to inform the Milbank Memorial Fund of some of the more obvious dividends that have accrued from their grant funds:

1. New York State has recognized the value of the demonstration project set up five years ago, has provided for a new assistant director at Hudson River State Hospital to direct this unit, and has now twice budgeted for the establishment of similar services in other selected state hospitals.

2. I think it is safe to say that the experience gained by the early

establishment of the Dutchess County Unit has had an appreciable influence on regional, state, and federal planning for comprehensive mental health facilities of the future.

3. I seriously doubt that the rapid advance in county facilities, and co-ordination with the already existent state hospital, which has certainly benefited the emotional health and welfare of large numbers of county residents, would have occurred at this time without the Milbank Memorial Fund's having made the Dutchess County Unit possible as a demonstration project.

REFERENCES

¹ Seventy-second Annual Report of the Department of Mental Hygiene, State of New York, Legislative Document (1961) No. 113, (Albany) 1963.

² ACTION FOR MENTAL HEALTH: FINAL REPORT OF THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, New York, Basic Books, Inc., 1961.

³ Kennedy, John F., Message from the President of the United States Relative to Mental Illness and Mental Retardation, House of Representatives Document No. 58, February 5, 1963.

⁴ Glasscote, R. M., Sanders, D. S., Forstenzer, Hyman M., and Foley, A. R., The Community Mental Health Center: An Analysis of Existing Models, the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health in association with the Department of Mental Health, American Medical Association, and the Division of Community Psychiatry, Columbia University, September 1964, Washington, D.C., pp. 105-120; 133-148.

⁵ MENTAL HOSPITALS JOIN THE COMMUNITY, *The Milbank Memorial Fund Quarterly*, Volume XLII, No. 3, Part 2, July, 1964.

⁶ New York State Department of Mental Hygiene, Community Mental Health Service, Community Mental Health Services Act (Albany), 1954.