Evaluation of Community Psychiatric Practice

BACKGROUND

As a result of various studies of the Washington Heights community by the Department of Psychiatry and the School of Public Health of Columbia University, a hospital improvement grant application was submitted to the National Institute of Health. The project was approved and began operation in February 1965, as the Washington Heights Community Service of the New York State Psychiatric Institute. Prior to the inauguration of the service, psychiatric care for residents of the Washington Heights District had been inadequate and fragmented. Patients from the area were admitted first to Bellevue, an overcrowded city hospital; if continued hospitalization was indicated, they were then transferred from there to Rockland State Hospital. Upon discharge, only inadequate follow-up care was available.

The Washington Heights Community Service was established at the Psychiatric Institute and offered inpatient, day and night hospitalization, home care, outpatient aftercare, and a "halfway house" that was located in the local community. In addition, a close collaboration was initiated with the 24-hour emergency service and outpatient department of the Columbia-Presbyterian Hospital.

The original catchment area included Health Areas 3 and 4, with a population of approximately 50,000. On July 1, 1970, Health

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Area 5 was added, increasing the population served to approximately 75,000; the area served now ran from 158th to 181st Street and from the Hudson River to the Harlem River.

With regard to Washington Heights as a whole, there are two dominant population trends in evidence: (1) an exodus of older white families of European extraction, and (2) an influx of younger Negro, Puerto Rican, and other Latin American groups. The numerical drop in the white population between 1950 and 1965 was 52,000, while the non-white gain was about 11,000 and the Puerto Rican gain about 24,000.

All residents of the catchment area, above thirteen years of age, who are in need of psychiatric hospitalization are now admitted to the service. The ward has 55 beds and an open-door policy, except for a small 8-bed intensive care unit, which permits appropriate observation and control of severely disturbed patients. Inpatients, day and night patients are all treated in the same program. In order to insure continuity of care, a team approach is utilized, with the same staff following the patient through all phases of his treatment, including any subsequent readmissions. A full range of psychiatric treatments is available, including individual psychotherapy, group, family, milieu, and somatic therapy.

Program Evaluation

Soon after the inception of the service, a collaboration was established with Drs. Robert Spitzer and Jean Endicott of the Evaluation Section of Biometrics Research. Through this collaboration, program evaluation was built into the program from almost its very beginning.

Routine scales of demographic and psychopathological data are filled out by the psychiatric residents and research interviewers on all patients admitted to the service. These data—for example, the Psychiatric Status Schedule (1), the Psychiatric Evaluation Form (2), and Social Background Record (3) devised by Spitzer, Endicott, et al.—are useful in various ways: first, for research studies that are being carried out; second, for the planning and evaluation of treatment services; and third, for providing material used in the reporting of services.

The number of patients admitted to the service increased during the first three years of operation, but then leveled off at
approximately 265 a year. With the addition of Health Area 5 in July, 1970, a marked increase in the admission rate was expected, since it is a low socioeconomic area, with a previously reported high admission rate. During the last year, there were 314 admissions. Information derived from the Social Background Record reveals that the patient group has come predominantly from the lower socioeconomic groups. Length of stay has decreased each year. When 1966 was compared with 1970, it was found that the mean went from thirteen to eight weeks; the median, from six to almost three weeks; and the mode, from two weeks to one. Figures for the percentage of patients who left the inpatient service during the first and second week of hospitalization are as follows: in 1966, 11% during the first week and 27% within two weeks; in 1970, 30% during the first week and 43% within the first two weeks. Fewer than 10% of the patients treated on the Community Service have been transferred to Rockland State Hospital for further care; last year, the figure was a total of seventeen patients from the entire catchment area. Prior to the inception of the service, over 40% of the patients admitted to Bellevue Hospital from Washington Heights had been transferred to Rockland State Hospital; it must be remembered, of course, that Bellevue was not attempting to offer definitive treatment to all admissions.

Another major function of the service is education: it is the main resource within the Columbia-Presbyterian Medical Center for the teaching of community psychiatry in a clinical setting. The service continues to train large numbers of psychiatric residents; trainees in community psychiatry; psychology interns; medical students; students of social work, nursing, and occupational therapy; and foreign students on fellowships. Prior to July 1, 1970, half of the second-year residents spent a year on the service; beginning July 1, 1970, all first-year residents were assigned to the service for the major portion of the year.

**Research**

While the routine collection of psychopathological and demographic data is useful, it does not help in evaluating the efficacy of alternative modes of treatment that are available in community mental health programs. A decision was made to commit the Service to conducting controlled studies related to the delivery of mental
health services, because there is an urgent need to provide guidelines for optimal patient care that are based on "hard" research data.

The first major research project undertaken by the Washington Heights Community Service was a joint endeavor, conducted by the clinical staff and the Evaluation Section of Biometrics Research (4). It was a study of the efficacy of inpatient versus day hospitalization for newly admitted patients. The study began in the spring of 1967, and was completed on July 1, 1969. Acutely ill patients were at that time being admitted from the Emergency Room to our hospital service for care, and treated in the traditional manner as inpatients. Until the time of the study, the use of our day hospital had been extremely limited. There had been a great deal of controversy in the literature with regard to the supposedly positive versus deleterious effects of hospitalization. Zwerling and Wilder (5), for example, had demonstrated that day hospitalization was a feasible alternative to inpatient care; they found that about two-thirds of the newly admitted inpatients could be treated in a day hospital. Their report, however, was not designed to answer the next logical question: Should an acutely ill patient be treated in a day hospital rather than on an inpatient service? When this project was first presented to the clinical staff, there was much resistance to carrying it out. A good deal of anxiety and anger was voiced, because staff members were afraid of the consequences of having seriously disturbed patients go home at night and on weekends; many also quite frankly thought that it would increase their workload.

Four hundred and twenty-four unselected patients were admitted to the inpatient service of the Washington Heights Community Service during the study period, and screened with their families within the first few days for inclusion in the study. If there was no contraindication to either day or inpatient care, patients were randomly assigned to either. Twenty-two percent of the patients were randomized; by chance there were forty-five in each group. An interesting finding was that twenty percent had been excluded from the study because they were considered too psychiatrically healthy for inpatient care, and were instead usually sent home with appropriate follow-up. On the other hand, thirty-one percent were excluded as being "too psychiatrically ill for day hospitalization." Study patients were evaluated on various rating scales devised by
Spitzer, Endicott et al., so as to measure their psychopathology and role functioning; this was done by both the therapist and an independent research interviewer on admission, and again at two and four weeks after they entered the study. The final follow-up evaluation was begun five months after the last patient entered the study, to determine whether there were any long term differences between the two treatment groups. The results of the study were as follows:

The average length of stay for day patients was approximately 48 days; for inpatients, it was 119 days. Even though day patients were discharged earlier, their readmission rate was approximately half that of the inpatients, at three and again at nine months. On measurements of psychopathology, at two weeks there was essentially no difference between the groups; both had improved. At four weeks, however, the day patients had made more improvement than inpatients had, on five of the twenty test scales: agitation-excitement; inappropriate affect, appearance, and behavior; suicide-self-mutilation; grandiosity; and suspicion-persecution. The inpatient group showed greater improvement on only one scale, retardation-lack of emotion. The differences, while statistically significant, were not of great magnitude. At the long-term evaluation, the only notable differences were that day patients showed greater improvement on scales evaluating daily routine-leisure time impairment and housekeeper role impairment.

Thus the results showed that, on virtually every measure used to evaluate outcome, day care was superior. We can only speculate as to why this was so. Day care does seem to reduce the regression that is generally associated with total institutionalization. These patients had a greater opportunity to maintain healthy areas of functioning, including the preservation of social and instrumental roles. Perhaps another major factor is that the powerful therapeutic effect of psychotropic drugs makes it unnecessary to subject the patient to the stress of complete separation from familiar ties in order to effect a remission of the illness.

One major limitation of the day study was that there was no evaluation of families or of the utilization of community agencies. No systematic effort was made to determine the impact of having a seriously ill member of the family at home. It may well be that a treatment plan that is desirable for a patient, such as early hospital
release, may create serious problems for his family, or for the community agencies that take care of him. Second, at the time when the study was formulated, the major interest was in day care as an immediate alternative to inpatient care. In addition, almost a third of the admissions were judged clinically to be too psychiatrically ill for immediate day care. Within a week, many of these patients would probably have been suitable for day care, but the design of the study did not allow for their inclusion. Clearly, for many acutely disturbed psychiatric patients, the pertinent clinical issue is not to avoid hospitalization completely, but rather to reduce the length of stay at the hospital. The conclusion was reached that a more inclusive design would be to study the effects of brief hospitalization, as compared with immediate day care, as an alternative to inpatient care for acute patients. Third, since many of the patients in the day care group very quickly became outpatients, the question arose whether the day patients would have done just as well if they had been discharged directly to outpatient care, without the use of a transitional day facility. A report by the Joint Information Service, "Partial Hospitalization for the Mentally Ill" (6), states, "A search of the literature revealed that there was not a single controlled study of a day program as a means of smoothing the patient’s transition from inpatient care to release from the hospital, with the possible added advantage of shortening the inpatient stay."

Taking the findings and limitations of the day study into account, a new study was designed, "Brief Hospitalization: The Effects on Patient and Family." In it, newly admitted inpatients have been assigned at random to one of three treatment programs: (1) standard inpatient care, with discharge at the therapist’s discretion; (2) brief hospitalization, generally less than one week, followed by transitional day care; and (3) brief hospitalization, with discharge to the community. Where indicated, outpatient therapy has been offered to individuals in all groups. The differential effects of these three treatment programs on patients and their families is being investigated by cross-sectional evaluations on admission, at two and four weeks, and at three, six, twelve, eighteen, and twenty-four months after admission. Evaluation of the patients includes manifest psychopathology and role functioning, amount of time spent in the community, and readmission rate. The evaluation of the
families includes measures of both objective and subjective burden, as well as the positive effects of having a patient either at home or in the hospital.

As far as the families are concerned, there has been considerable discussion in the psychiatric literature of the ways in which a family reacts to having a member who is mentally ill. Unfortunately, few studies have evaluated the effects of alternative treatment modalities on the families themselves. In addition, there have been few attempts to develop and use systematic procedures for measuring some of the dimensions involved. Furthermore, most of the reported systematic evaluations ignore any positive impact that a patient may have on his family. In England, Sainsbury and Grad (7) compared the effects on patients' families of community care (Chichester) versus traditional, hospital-based care (Salisbury). Results showed that the two services were equally effective in relieving a severe burden on the families, during the two year follow-up period, whether or not the patients were hospitalized (8). For the patients under 65 who caused some burden to the families and among whom there was at least one admission, traditional care (Salisbury) was apparently more effective. Sainsbury and Grad attribute this result to the active social case work offered to families in Salisbury; what they feel is that perhaps the most significant finding of the study was that the social cost of psychiatric care in the community service was higher, in terms of its effect on the mental health of family members. They did not assess the positive gains to the family of having the patient continue to reside in the home.

Sainsbury and Grad described a home-visit schedule that had been used by a social worker in interviewing members of the patient's family in their study. In a study of home-care treatment in the prevention of hospitalization of a group of schizophrenics, Pasamanick et al. (9) used a subset of the items developed by Sainsbury. Two treatment groups (placebo and drug) were compared and found to differ on the frequency of individual items as well as on total score. The families of the placebo group reported more troublesome behavior than did the families of the drug group.

Drs. Spitzer and Endicott evaluated these forms as well as others used in their studies of families. They found that no comprehensive form existed that could evaluate both the positive and negative effects of having the patient at home or in the hospital. Since this
area of study is a crucial one with regard to the optimal treatment of the psychotic patient, they began work on a new instrument. This instrument, the Family Evaluation Form, is currently being used in the Brief Hospitalization project. Thus a new measuring instrument was developed out of the clinical and research needs of a community evaluation service.

The subject of aftercare for psychiatric patients has long been a problem for psychiatry. How can we maintain patients in the community and yet prevent their rehospitalization? The Washington Heights Community Service was faced with a growing roll of aftercare patients, and insufficient staff to deal with these patients in the ordinary clinical way. It was decided to conduct a study utilizing alternative methods of aftercare treatment. Each psychiatric resident would be assigned about 15 aftercare patients, and these patients would be followed either in group or individual therapy. The basic purpose of this study was to determine the following: if a psychiatric resident is to allocate 1½ hours per week to the treatment of a cohort of patients, which treatment will be more effective—seeing each patient individually for a short time, or seeing the patients as a group for the full 1½ hours each week? Not only patients but residents were randomized into group or individual therapy cohorts. The study began July 1, 1971; it is planned to terminate on June 30, 1972. Measures of psychopathology and role functioning are being carried out periodically, as well as studies of readmission rates to the hospital.

Finally, what can one say about the effects of research activities on the service? In our opinion, clinical research conducted on a psychiatric service is bound to be enriching, both educationally for the staff and clinically for the patients. For this to be true, however, it is necessary that the research staff be viewed as an integral part of the service, and not as a "foreign body," impinging on clinical operations. Certainly at the New York State Psychiatric Institute, our educational goals include more than the training of individuals to be competent clinicians. In addition, we hope to be able to stimulate their curiosity and teach them methods of research through which to further knowledge in psychiatry. Clinically, the service has undoubtedly profited. Prior to the day study, clinical practice was in many ways similar to what it had been at the time when the service was devoted to long-term psychotherapy of selected patients. As a result of the day study, newly admitted inpatients were
evaluated immediately, and no longer forced to wait from one to two weeks for an admission conference. Use of partial hospitalization has increased greatly, and the length of inpatient stay has been considerably shortened. Finally, another benefit for the service has been the attendance of research personnel at staff meetings and rounds. While they may ask embarrassing questions, and even at times depart from their "scientific detachment" during heated discussions, their presence has proven to be stimulating and rewarding for the regular clinical staff.

REFERENCES


