County Psychiatric Emergency Services

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THE NEW and more effective techniques for treatment of mental illness which have become available in recent years have stimulated some county health administrators to increase their efforts to discontinue detention in jail of mentally ill persons awaiting commitment to a State hospital.

Until the spring of 1959, Washington County, Md., residents who became violent or exhibited bizarre behavior were held in the county jail to await completion of hospital admission forms. Many persons were held for long periods while commitment certificates were obtained from two physicians and the patient's legal residence and the family's ability to pay were determined. Lack of hospital space sometimes further delayed the patient's admission to the hospital.

In 1958 county leaders had attempted unsuccessfully to obtain emergency care for mentally ill patients in a local general hospital, a State chronic disease hospital, a church-owned hospital for care of the mentally ill, and several private nursing homes. In the spring of 1959 a committee appointed by the county commissioners to obtain temporary care for mentally ill patients again approached these institutions, but their efforts also were fruitless.

Therefore, the commissioners requested the writer to organize an emergency service that would end jail detention of the mentally ill, except mentally ill persons charged with violation of law and the rare patients who could not be taken directly to a State hospital. On May 5, 1959, the commissioners approved the plan outlined below.

Emergency Service

All requests for aid in dealing with what is thought to be mental illness are to be telephoned to the county health department, day or night. During the day emergency calls are received in the health department. After business hours and on Saturdays, Sundays, and holidays, a telephone service receives all messages and transmits them to the health department personnel who are on call. If the sheriff's office is called first, as has long been the custom, the call is to be referred to the health department. However, if the sheriff has reason to believe that his services are needed, he may go to the scene after asking the health department to dispatch medical aid.

If a physician desires assistance for a patient, he may call the health department, which is prepared at all times to aid in obtaining prompt hospital admission or psychiatric evaluation in the local mental health clinic.

In response to each emergency call, a health department physician and a nurse, preferably one with psychiatric training, are to go to see the patient. If the patient is reported particularly menacing or unmanageable, one or more deputy sheriffs may be asked to accompany the emergency team.

If the investigating physician believes the patient should be hospitalized immediately, he may give appropriate treatment and take steps to expedite the commitment routines. As soon thereafter as practicable, the patient is to be taken directly to a State hospital.

At night or on a holiday, every reasonable and proper effort is to be made to delay admission of the patient to the State hospital until the full staff is on duty.

If health department investigators find that the case is not an acute emergency, treatment may be prescribed and the patient referred for

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examination at the next session of the local mental health clinic. The clinic is open Monday, Tuesday, and Saturday of each week.

Experience Under the Plan

The emergency service has been functioning a little more than a year. The 100 cases investigated to date have included the following:

- An individual who insisted on stepping in front of automobiles as they entered an intersection.
- A man who had accumulated guns and ammunition in his home and threatened to shoot anyone who approached.
- A man, arrested for a serious traffic violation after his car crashed into a tree, who was found to be mentally disturbed. (Did the mental condition exist before the incident or was it a result of the accident?)
- A husband who on two occasions attempted to kill his wife with a pair of scissors.
- A person perched on the edge of a high building who repeatedly threatened to jump.

No two cases were exactly alike, although patterns appear to be emerging. Each case presented a challenge, if not an adventure, and from experience with these and other cases we hope to learn how best to manage abnormal persons.

Although the number of cases investigated is too few for statistical analysis, they have provided a variety of experiences. Important lessons have been learned and observations have been recorded that may be of value to others. These are summarized below.

There is no substitute for a visit in the patient's home. In a few minutes in the home, an experienced observer can gain more pertinent information about the patient and his environment than can be gained during hours of probing in an office, using miles of recording tape and hours of typing time.

It is advantageous to have both a physician and a nurse answer each call. In most emergencies one must deal with a disturbed patient and with his distraught family. In Washington County, one member of the health department team, usually the physician, deals with the patient while the nurse discusses the situation with members of the family. The physician, the nurse, and the family then confer until agreement is reached as to the most appropriate action to be taken.

On many calls the emergency team has been accompanied by the sheriff and one or more of his deputies or by one or more policemen from Hagerstown, depending on the place of residence of the patient. From these experiences we have developed a deep sense of appreciation of the courage, skill, and devotion to duty of local officers of the law.

Better results are obtained when a psychiatrist serves as the physician member of the emergency team. A psychiatrist usually can identify rather quickly the patients who are better suited for clinic care; he is able in a short time in the home to obtain a great deal of information that aids him in evaluating the patient and in planning for his treatment; and he is much better qualified to make decisions of this kind than the general practitioner or health officer.

At present two part-time psychiatrists are available 3 days each week. Ultimately, we hope to employ a full-time specialist in this field. Meantime, we are endeavoring to defer decisive action on as many cases as possible until each case can be screened by a psychiatrist.

It is important that a responsible member of the family accompany the patient to the hospital and to the clinic. In most cases only a close relative can provide the information needed to complete the patient's history and establish a link between the institution or clinic and the family.

Of the first 100 "emergency" cases 34 either were not in need of hospitalization or a decision was deferred until a clinic study could be completed. In many instances, obvious signs of mental illness had been noted by members of the family long before the emergency arose. In these cases, there is no record of serious efforts to obtain psychiatric evaluation of the patient, although psychiatric service has been available in the community for many years.

Modifications of the Program

Since its inception several modifications have been made in emergency service for mentally ill patients.

Routine psychiatric screening of all cases reported to be in need of care in a State hospital has been instituted. School children are examined by the health department's pediatric consultant or are referred to the mental health clinic. Those classified as disturbed are separated from those classified as disciplinary problems.

Insofar as practicable, all individuals for whom hospital care is requested at public expense are screened by the psychiatric team. As a result of these procedures, a significant number of patients who otherwise would have been hospitalized precipitously are now being treated in the clinic.

Development of a more comprehensive health education program has been started. The following activities have been included in the program:

- Public education, through various media, designed to promote a better understanding of the aims, functions, and costs of the mental health program, with special emphasis on the importance of early diagnosis and treatment.
- Conferences with hospital administrators and boards of trustees. It is hoped that as a result of these conferences more rational hospital admission policies will be adopted, a psychiatric ward will be opened in each hospital, and at least one psychiatrist may be induced to engage in private practice in Washington County.
- Organization of a series of seminars for general practitioners.
- Classes for policemen, school teachers, nurses, welfare workers, and others, providing instruction in the recognition of signs and symptoms of mental illness as well as in methods of management of emergencies.

Local clinic services have been expanded. In Washington County, one part-time psychiatrist and a full-time secretary have been added to the staff of the mental health clinic.

In comparison with other clinics, operation of a mental health clinic is very costly, but the cost of hospitalization is even higher. In 1959 the average cost of care in State hospitals in Maryland was $1,679 per patient. On January 1, 1960, there were 290 Washington County residents under treatment in these hospitals. If the patient load of 290 was constant throughout the year, the total cost of hospitalization for mental illness in 1959 would be $486,910. In 1960 the cost per patient and, therefore, the total cost of hospitalization in State hospitals will be considerably higher.

It seems logical that the huge amount of money now being expended for hospital care of the mentally ill can be reduced significantly by increasing local clinic services.

A more adequate followup service for patients on leave or after discharge from a State hospital has been organized. We realize that some patients require periodic hospital care. For those who do not require such care, however, we believe that we may be able to reduce the number of readmissions to State hospitals by developing a more efficient followup service by public health nurses and by promoting periodic checkups of all clinic patients. In this way, the mentally ill can remain at home and maintain their place in the community.

Summary

In Washington County, Md., a simple and inexpensive emergency psychiatric service has been designed to prevent jail detention of mentally ill patients awaiting admission to a State hospital.

In attaining this objective, something has been learned about the management of disturbed patients in emergencies.

The service has resulted in reduction of admissions to State hospitals by 32 percent and an increase of 51 percent in attendance at the less costly local mental health clinic.

The local mental health program has been expanded to include screening of all individuals thought to be in need of hospital treatment at public expense, a more comprehensive health examination program, expansion of the local mental health clinic, and organization of a more adequate followup system for patients discharged or on leave from State hospital.

Commentary

Mental health workers for years have deplored the practice of detaining mentally ill persons in jail while they await transfer to a mental hospital. They have also deplored any unnecessary involvement of police in measures leading to the hospitaliza-

tion of the mentally ill. Many communities, however, have devised medical methods of initiating the hospitalization of the mentally ill, when necessary, which avoid involving police or jails.

The situation in Washington County, Md., as of the first quarter of 1959, probably is the rule across the Nation rather than the exception. If the service described in this paper is an indication that health departments are beginning systematically to consider the relationship between their programs and unmet needs of mentally ill persons in their communities, including acute episodes of illness which require, or seem to require, immediate hospitalization, it is indeed an encouraging sign.

The program initiated by Dr. Cameron has one unusual and highly desirable feature. This is the home visit by a physician, preferably a psychiatrist, and a teammate, when an acute disturbance suggesting mental illness occurs. In Washington County, the teammate was a nurse, but a skilled psychiatric social worker might be even more effective in aiding the psychiatrist in investigating the need for admission of patients to a public mental hospital. The method described seems to resemble that used in Amsterdam, Holland, as described by Querido.

Dr. Cameron states that hospital admissions decreased significantly during the first year of the program. This trend needs to be followed over a period of years. The experience of other communities has been that as psychiatric services improve hospital admissions increase, just as admissions of patients with tuberculosis increased as public health workers began to intensify tuberculosis control programs. With mental illness, as the public begins to accept improved psychiatric services, many cases of depression will appear in hospitals, especially in the psychiatric units of general hospitals. In the absence of adequate services, we do not know the natural history of these cases, but we need to explore the implications of the question of how many of them should be discouraged from entering the hospital, provided that inpatient treatment is rapid and effective after care is provided.

It is doubtful that further extension of the Washington County community health program will save money, as Dr. Cameron seems to suggest, especially if public funds are used to support psychiatric inpatient units in general hospitals. The type of effort described is essential, but it is misleading to advance it as a method of effecting economies. It is certain that programs of this kind will alleviate human suffering, however.

The side effects of the program are likely to be highly significant, especially if Washington County can effectively follow up discharged mental hospital patients.

Many implications of the program are not mentioned in this paper. A host of complications are yet to be faced. For example, if public health nurses are to carry the burden of followup service for discharged mental hospital patients, they will need mental health training and mental health consultation service.—HAROLD C. MILES, M.D., *director of mental health services, Monroe County Board of Mental Health, Rochester, N.Y.*