

Use of Mental Health Services by Poverty and Nonpoverty Members of a Prepaid Group Practice Plan

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THE ORGANIZATION of mental health services has received considerable attention in the past decade as one result of the changes in general social policy regarding treatment of the mentally ill (1). Changing attitudes and a rising awareness of the extent and cost of such treatment have encouraged increased benefits for psychiatric care for general populations and broadened prepayment for outpatient services (2). At the same time psychiatric services have become more available to poverty groups through developments such as the neighborhood health centers and the community mental health movement.

Data are generally lacking to evaluate or even describe the impact of these changes on utilization, costs, and other outcomes, particularly regarding the urban poor compared with general urban populations. Higher rates of psychiatric illness among the urban poor are reported generally but are not adequately explained. In addition, treatment methods often vary between the two populations even when diagnoses are the same. Some observers explain these differences by pointing to the generally deteriorated or disrupted social milieu of the urban poor (3-5). Others emphasize cultural differences leading to behavior patterns that are likely to be interpreted as mental illness by the medical care system and the larger society (1,6). Powerlessness as a consequence of lower class position has been offered as an explanation of psychiatric disorder in poverty populations (7).

Many early studies focused on the distribution of psychoses from geographic and social perspectives (3,8). Other investigators have attempted to measure the extent of mental impairment in the general population. Srole and co-workers (9) reported that only 18.5 percent of the total respondents in midtown Manhattan were mentally healthy. Leighton (10) and Manis and associates (11) reported similar findings in studies using the sample survey method. Many investigators have attempted to measure either the incidence or the prevalence of mental illness in various populations, but the variety of their methods makes comparison difficult (12).

Because measures of mental illness are still imprecise, only relative differences among population groups can be assessed (13,14). All the factors cited contribute to the difficulties en-

countered when one attempts to analyze differences in levels of mental illness between the urban poor and the balance of urban populations.

The effect of physicians' attitudes on the diagnosis and treatment of mental illness has not been extensively studied. This is an important area since many patients have minor transient mental illnesses that are diagnosed and treated by community physicians who are not specially trained in psychiatry (15). Data are limited on the effectiveness of treatment and on the number and types of patients seen by community physicians. Many questions remain regarding the nature and determinants of referral patterns for psychiatric care (16,17).

The urban poor face financial and social barriers to medical and psychiatric care that hamper early diagnosis and treatment. It has been suggested that if services were available for early diagnosis and treatment, the disproportionate number of the poor committed to mental institutions would be reduced (7). Because of the existing barriers, it has not been possible to determine the extent to which the urban poor would seek diagnosis and treatment if they had ready access to medical and psychiatric care.

The objectives of this study were to (a) determine the distribution of psychiatric diagnoses and psychiatric utilization rates for a defined urban poverty group and a sample of the general membership of the Kaiser Foundation Health Plan, a prepaid group practice plan, (b) compare referral routes for the two groups to the plan's mental health clinic, and (c) compare the appointment-keeping behavior of the two groups in the mental health clinic.

Background

Under the Kaiser Foundation Medical Care Program in Portland, Oreg., a poverty population and a general membership population have access to the same mental health clinic as part of a comprehensive health care system. Thus, it was possible to investigate, for our study groups, all persons with psychiatric diagnoses whether or not they went to the mental health clinic.

The Kaiser Foundation Health Plan is directly responsible for organizing and providing comprehensive medical care for more than 170,000 members. All persons in this study are

members of the Kaiser Foundation Health Plan. Physician services are provided by the Permanente Clinic, a physician partnership. A broad range of medical care services are provided, including both outpatient and inpatient care delivered from five geographically dispersed neighborhood clinics and a 250-bed hospital. Members comprise approximately 15 percent of the 1970 population of the Portland Standard Metropolitan Statistical Area (SMSA). In occupational and socioeconomic characteristics, the general plan membership is representative of the Portland SMSA population. The poverty population's characteristics, its integration into the Kaiser Foundation Health Plan, and the services provided have been described by Colombo and associates (18). The use of health care services by the poverty group has also been described and compared with a sample of the general plan membership (19).

The mental health clinic was established in 1965 when outpatient psychiatric services were added to the comprehensive medical care available to members of the health plan. The professional staff at the clinic during the time of our study consisted of one psychiatrist, one clinical psychologist, and two psychiatric social workers, all full-time personnel. All members of the staff provided therapy and counseling services. Drug therapy was supervised by the psychiatrist. Generally, the mental health clinic functions as a psychotherapeutic clinic as defined by Kadushin (20). Organizationally, it is part of the department of medicine.

Members of the general plan and the poverty group population have approximately equal benefits for general medical care services (18). The poverty group has the broadest coverage available to any members. The main difference is that while most members pay a \$1 or \$2 registration fee, this fee is prepaid for the poverty group and some others, who also pay no fees at the time of service.

There are, however, major differences in the mental health benefits provided for the two study populations. The poverty group has total coverage for services. For the general plan members, co-payment varies from 20 to 50 percent. The extent to which these differences in coverage influence utilization is yet to be determined. However, since three-fourths of the psychiatric

utilization reported here is for general clinic visits for psychiatric diagnoses, rather than for mental health clinic visits where co-payment would be a consideration, the existing variation in coverage cannot explain all the findings.

Data and Method

The data for this study were obtained from a continuing study of the total medical care utilization of approximately 14,000 health plan members; the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare financed the health care of 7,000 of these members (314e funds). The other 7,000 members represented a 5-percent sample of the total membership of the health plan. The continuing study—data collection, coding procedures, and disease classification system—has been described in previous publications (19,21).

The period covered by this study is the 26-month period from October 1967 (the beginning of funding for the poverty group) through December 1969.

The diagnostic categories used in this study are confined to those mental disorders described by the American Psychiatric Association as being without clearly defined organic cause. (The diagnoses were coded according to the tabular list in the 1962 revised edition of the International Classification of Diseases (ICDA)). The subcategories used were: (a) psychophysiological, autonomic, and visceral disorders (ICDA 323), termed psychosomatic for purposes of this study; (b) psychoneurotic disorders (ICDA 324); (c) personality disorders, including transient situational and personality disorders (ICDA 325–328); and (d) one subset of (c), hyperactivity, identified as ICDA 327.1, which is a special supplemental code used in this research data system. Hyperactivity was diagnosed often enough among children in both populations to be of interest, and it has medical and social implications that merit special attention (22).

Most, but not all, persons included in the study populations were health plan members for the full 26 months of observation. Therefore, to compute rates for diagnosed cases of mental illness, the data were adjusted to person months at risk and controlled for age. (This procedure requires the summation for each person of the

total months in the health plan during the observation period. The sum is divided by the length of this period, which in this study was 26 months. The result is "person equivalents" at risk for a full 26 months.)

Findings

Population characteristics. Table 1 shows the age and sex composition of both the general plan sample and the poverty group. There was a significant age difference between the two.

Table 1. Distribution of members of general plan sample and poverty group for study period, by sex and age group

Sex and age group	General Plan		Poverty group	
	Person equivalents ¹	Percent	Person equivalents ¹	Percent
Males.....	2,072	100.0	1,869	100.0
0-18.....	904	43.7	1,465	78.4
19-64.....	1,168	56.3	404	21.6
Females.....	2,232	100.0	2,589	100.0
0-18.....	904	40.5	1,578	61.0
19-64.....	1,328	59.5	1,101	39.0
Both sexes.....	4,294	100.0	4,458	100.0
0-18.....	1,808	42.1	3,043	68.2
19-64.....	2,496	57.9	1,415	31.8

¹ Adjusted to membership for full study period (26 months).

Comparatively, the poverty group was a much younger population. This difference reflects the criteria for membership in the poverty group that had been established jointly by the Kaiser Comprehensive Health Project staff and a community-selected medical care advisory committee set up under OEO guidelines. Highest priority was given to large families with small children when enrolling this group (18). As a result there are few persons in this group over age 65. Thus, those over 65 were excluded from both groups for this study.

Distribution of psychiatric diagnoses. Psychiatric diagnosis rates are presented in table 2 for the general plan sample and the poverty group. This table shows the number of persons in each group who were treated for a psychiatric illness during the study period. This rate is for prevalence and includes: (a) cases existing before the study period, continuing throughout the study period, and still existing at the end of it; (b) cases existing before the study period and terminating during the study; (c) cases beginning during the study period and still existing at the end of it; (d) cases beginning and terminating during the study period (23). It includes persons treated for psychiatric illness in the general clinic, as well as in the mental health clinic. Therefore the rates apply to the total health care system, not just the mental health clinic.

Relatively small differences in rates exist between children in the two groups. For the mental

Table 2. Distribution of members of general plan sample and poverty group having psychiatric diagnoses and the psychiatric diagnoses rates, by sex and age group

Sex and age group	General Plan			Poverty Group		
	Number of persons with psychiatric diagnosis	Person equivalents ¹	Psychiatric diagnosis rate per 1,000	Number of persons with psychiatric diagnosis	Person equivalents ¹	Psychiatric diagnosis rate per 1,000
Males.....	94	90	43	97	81	43
0-18.....	30	28	31	51	42	29
19-64.....	64	62	53	46	39	97
Females.....	165	155	69	238	204	79
0-18.....	17	15	17	41	35	22
19-64.....	148	140	105	197	169	153
Both sexes.....	259	245	57	335	285	64
0-18.....	47	43	24	92	77	25
19-64.....	212	202	81	243	208	147

¹ Adjusted to membership for full study period (26 months).

Table 3. Distribution of visits of members of general plan sample and poverty group for psychiatric diagnoses

Sex and disease category	Age 0-18				Age 19-64			
	General plan		Poverty group		General plan		Poverty group	
	Number	Percent	Number	Percent	Number	Number	Number	Percent
Males.....	193	100.0	250	100.0	328	100.0	230	100.0
Psychosomatic (323).....	0	.....	8	3.2	82	25.0	59	25.7
Psychoneuroses (324).....	3	1.6	8	3.2	219	66.8	118	51.3
Personality and situational disorders (325-28).....	124	64.2	141	56.4	27	8.2	53	23.0
Hyperactivity (327.1).....	66	34.2	93	37.2	0	.....	0	.....
Females.....	60	100.0	118	100.0	761	100.0	889	100.0
Psychosomatic (323).....	4	6.7	36	30.5	160	21.0	135	15.2
Psychoneuroses (324).....	12	20.0	26	22.0	532	69.9	600	67.5
Personality and situational disorders (325-28).....	34	56.7	51	43.3	69	9.1	154	17.3
Hyperactivity (327.1).....	10	16.6	5	4.2	0	.....	0	.....
Both sexes.....	253	100.0	368	100.0	1,089	100.0	1,119	100.0
Psychosomatic (323).....	4	1.7	44	12.0	242	22.2	194	17.2
Psychoneuroses (324).....	15	5.9	34	9.3	731	69.0	718	64.3
Personality and situational disorders (325-28).....	158	62.4	192	52.2	96	8.8	207	18.5
Hyperactivity (327.1).....	76	30.0	98	26.5	0	.....	0	.....

NOTES: Visits include those to the general clinic and the mental health clinic. The numbers in parentheses represent ICDA diagnostic categories.

illness categories studied here, however, adults in the poverty group have considerably higher rates than do adults in the general plan sample. The psychiatric diagnosis rate for adult males (97 per 1,000) in the poverty group is almost double the rate for males in the general plan sample (53 per 1,000). Rates for females are higher than for males in both groups. These find-

ings confirm other studies that show higher rates of diagnosed psychiatric illness among the poor.

Utilization patterns. Table 3 shows the total number and percent of visits made throughout the health care system for each mental health ICDA category. Again, the data reported are not limited to visits to the mental health clinic but include all visits for psychiatric diagnoses to any Kaiser-

Table 4. Average number of visits per 1,000 persons per year made by general plan sample and poverty group for psychiatric diagnoses

Sex and disease category	Age 0-18		Age 19-64	
	General plan	Poverty group	General plan	Poverty group
Males.....	98	79	130	263
Psychosomatic (323).....	0	3	32	67
Psychoneuroses (324).....	1	3	86	135
Personality and situational disorders (325-28).....	63	44	11	61
Hyperactivity (327.1).....	34	29	0	0
Females.....	64	37	264	406
Psychosomatic (323).....	2	13	55	62
Psychoneuroses (324).....	6	8	185	274
Personality and situational disorders (325-28).....	18	15	24	70
Hyperactivity (327.1).....	5	1	0	0
Both sexes.....	64	55	201	364
Psychosomatic (323).....	1	6	45	63
Psychoneuroses (324).....	4	5	139	234
Personality and situational disorders (325-28).....	41	29	18	67
Hyperactivity (327.1).....	19	25	0	0

NOTES: Visits include those to the general clinic and the mental health clinic. The numbers in parentheses represent the ICDA diagnostic categories.

Permanente clinic. Major differences in utilization patterns occur between the groups in each age and sex category. To bring these utilization patterns into clearer focus, the average number of visits for each ICDA category per 1,000 persons per year is shown in table 4.

In general, both male and female members of the poverty population used more services for a psychiatric diagnosis than the general plan membership. The one exception occurs for males 0–18 years old; the poverty group used less services for a psychiatric diagnosis than did the general plan sample. The 0–18 year old males in the poverty group, on the average, made 79 visits per 1,000 persons for all mental health ICDA categories, whereas the 0–18 year old males in the general plan sample made 98 visits per 1,000 persons. When visits for specific diagnoses are examined in this age and sex category, the largest difference is found in visits for diagnoses of personality and situational disorders. This category includes transient situation reactions which may not involve underlying personality disturbance. The average number of visits for personality and situational disorders was 63 per 1,000 persons for 0–18 year old males in the general plan sample and 44 per 1,000 persons for poverty group males of this age group.

The utilization rate for psychiatric diagnoses for adult males in the poverty group is more than double that of adult males in the general plan sample for the same diagnoses. Again, the most striking difference is in the number of visits for personality disorders—poverty group males made 61 visits per 1,000 persons in contrast to 11 visits per 1,000 persons for males in the general plan sample.

The 0–18 year old females in both populations were the lowest users of services for psychiatric diagnoses; the poverty population females showed only slightly higher use than females of the general plan sample. The difference between the two younger female groups is greatest for diseases of psychosomatic etiology.

Adult females had the highest utilization patterns in both groups, and poverty population females averaged 54 percent more visits per 1,000 persons than females in the general plan sample. The greatest difference occurred in visits for personality and situational disorders, a result that corresponds to the finding for adult males. Poverty population females averaged three times

as many visits per 1,000 persons for this cluster of diagnoses as females in the comparison group.

To summarize these utilization patterns, the poverty population used more services for psychiatric diagnoses in every age and sex category except for 0–18 year old males. For all adults in both groups, psychoneuroses account for a majority of visits. However, differences between the two groups are greatest for personality disorders. In this diagnostic category, poverty population males averaged more than five times as many visits as males in the general plan sample, and poverty population females made three times as many visits as the comparison group. For 0–18 year olds, the findings are more variable—personality and situational disorders, rather than psychoneuroses, account for most of their visits. But the pattern differs in that males in the general plan sample make 50 percent more visits for this diagnosis than males 0–18 years old in the poverty group. And 0–18 year old females in the poverty group make almost as many visits for disorders in the psychosomatic category as they do for personality and situational disorders.

Referral Patterns

The data and interpretation thus far have dealt with psychiatrically defined patients and their use of the services provided in a total health care system without taking into account the origin of the diagnosis and subsequent treatment patterns.

We also examined, however, the extent to which patients are referred to the mental health clinic and whether referral is made from within the system or from outside sources.

Table 5 shows the number and percentage of persons diagnosed as psychiatrically ill, by place of treatment. It also shows, for persons referred to the mental health clinic, whether the referral was made by a Permanente physician at Kaiser or others (parents, schools, social service agencies and other community and public institutions, some of which contain psychiatrically trained personnel). The data indicate that a larger percentage of the general plan sample are treated solely by primary physicians and not referred to the mental health clinic. While there is little difference between the rates of diagnosed mental illness for the 0–18 year old groups (table 2), the percentage of these children treated solely by primary physicians varied markedly between

Table 5. Percentage of persons in general plan sample and poverty group treated for psychiatric diagnoses in general clinic and in mental health clinic, with percentage referred and referral sources

Sex and age group	Treated in general clinic (not referred)		Treated in mental health clinic and referred by—				Total number ²	
	General plan	Poverty group	Permanente physicians		Others ¹		General plan	Poverty group
			General plan	Poverty group	General plan	Poverty group		
Males:								
0-18.....	48.0	42.0	31.0	42.0	21.0	16.0	29	50
19-64.....	76.5	58.0	11.0	22.0	12.5	20.0	64	46
Females:								
0-18.....	82.0	50.0	12.0	20.0	6.0	30.0	17	40
19-64.....	83.0	70.0	11.0	19.0	6.0	11.0	147	195
Both sexes:								
0-18.....	60.9	45.6	23.9	32.2	15.2	22.2	46	90
19-64.....	81.0	68.0	10.9	19.5	8.1	12.5	211	241
All ages.....	78.0	62.0	13.0	23.0	9.0	15.0	257	331

¹Includes parents, schools, social service agencies, and other community and public institutions, some of which have psychiatrically trained personnel.

²Unknown—6; 2 from general plan sample, 4 from poverty group.

the two groups. Overall, two-thirds of the 0-18 year olds in the general plan sample who had a psychiatric diagnosis were treated exclusively by primary physicians. Slightly less than half of the 0-18 year olds in the poverty group were treated exclusively in a general medical setting.

Conclusions drawn from these data must be tentative because the numbers are small and health plan coverage for mental health therapy is not uniform for the groups compared. Indeed, the more extensive benefits available to the poverty group may account for a large portion of the differences between the two groups, and this possibility needs to be specifically tested. (Data available at the time of this study did not allow controlling for co-payment variation. This factor is being investigated in a current study.) However, other possible explanations also merit further investigation. Since the overall diagnosis rates for psychiatric illness were approximately the same for both groups, it may be that poverty group children are subject to more severe episodes of mental illness that require treatment in a mental health clinic. Or variation in the physician-patient relationship in the treatment of poor persons could account for the lower percentage of poverty group children treated by the primary physicians.

These alternatives can be partially examined by comparing the percentages of children in both groups referred to the mental health clinic by

physicians in the general clinic and by others. The data contained in table 5 show that both primary physicians and others tend to view the psychiatric problems of children in the poverty group as requiring professional psychiatric therapy to a greater extent than those of children in the general plan sample. The primary physicians referred approximately 10 percent more of the poverty children to the mental health clinic. Twenty percent of the poverty group children with psychiatric diagnoses in this medical care system were referred to the mental health clinic by others. This figure was less than 10 percent for children in the general plan sample.

It is important to insert a cautionary note here. Poverty group children probably have greater contact with various social service agencies, and this factor adds to the likelihood of their being referred to the mental health clinic by persons outside the medical care system. Once again, the differences cannot clearly be accounted for. These differences in referral patterns among poverty group children may be psychopathogenic in origin; they may be related to type of coverage, to professionals' preceptions of different socioeconomic groups, or to other factors. It is clear, however, that the percentage of children in the poverty group referred to the mental health clinic for treatment was significantly higher than for children in the general plan sample.

Fewer adults than children were referred to the mental health clinic. While more than half of the

younger members of the poverty group were treated in the mental health clinic, only a third of the adults in this group received treatment there. For the general plan sample, one-third of the children and one fifth of the adults were referred to the mental health clinic. In both the general plan sample and the poverty group, more males were referred, while more females were treated for psychiatric diagnoses by their primary physician.

Table 6 shows, by diagnosis, the number and percentage of visits (based on total visits for psychiatric diagnoses) that males and females of each group made to the mental health clinic.

Approximately one-fifth of the visits from the general plan sample for psychiatric diagnoses were to the mental health clinic, whereas one-third of such visits from the poverty population were made to this facility. When the data are examined by sex, the major difference is that 36.6 percent of the poverty group males with hyperactivity were treated in the mental health clinic as opposed to 4.5 percent of the males in the general plan sample with this disorder. In other diagnostic categories, the percentage of visits to the mental health clinic was also greater for the poverty population with one exception—psychosomatic disorders.

Table 6. Number and percentage of all outpatient visits for psychiatric diagnoses that were accounted for by visits to mental health clinic, by general plan sample and poverty group

Sex and disease category	General plan visits			Poverty group visits		
	Total	Mental health clinic		Total	Mental health clinic	
		No.	Percent		No.	Percent
Males.....	521	96	18.4	480	181	45.6
Psychosomatic (323).....	82	8	9.8	67	0	.....
Psychoneuroses (324).....	222	37	16.7	126	44	34.9
Personality and situational disorders (325-28).....	151	48	31.8	194	103	46.9
Hyperactivity (327.1).....	66	3	4.5	93	34	36.6
Females.....	821	152	18.5	1,007	311	30.9
Psychosomatic (323).....	164	5	3.0	171	4	2.3
Psychoneuroses (324).....	544	86	15.8	626	160	25.6
Personality and situational disorders (325-28).....	103	61	59.2	205	147	71.7
Hyperactivity (327.1).....	10	0	.....	5	0	.....
Both sexes.....	1,342	248	18.6	1,487	492	33.1
Psychosomatic (323).....	246	13	5.3	238	4	2.3
Psychoneurosis (324).....	766	123	16.1	752	204	27.1
Personality and situational disorders (325-28).....	254	109	43.0	399	250	60.1
Hyperactivity (327.1).....	76	3	4.5	98	34	36.6

NOTE: The numbers in parentheses represent the ICDA diagnostic categories.

Table 7. Number and percentage of scheduled mental health clinic appointments kept and percentage broken, by general plan sample and poverty group

Sex and age group	General plan appointments			Poverty group appointments		
	Scheduled	Kept	Percent broken	Scheduled	Kept	Percent broken
Males.....	115	96	16.5	222	181	18.5
0-18.....	48	41	14.6	140	115	17.9
19-64.....	67	55	17.9	82	66	19.5
Females.....	182	152	16.5	409	311	24.0
0-18.....	23	19	17.4	62	39	37.1
19-64.....	159	133	16.3	347	272	21.6
Both sexes.....	297	248	16.5	631	492	22.0

Appointment Keeping

The last objective of the study was to examine differences between the two groups in keeping appointments. Comparative data for the two populations—number of scheduled appointments, number of kept appointments, and percentage of appointments either canceled or broken by the patient—are shown in table 7.

The general plan sample had a combined cancellation and no-show rate of 16.5 percent, and the poverty group's rate was 22 percent. When the data are examined by age, sex, and membership status, a pattern emerges showing the highest rates of broken appointments among the poverty group females. Poverty group females 0–18 years old failed to keep 37.1 percent of their scheduled visits, but females of this age group in the general plan sample failed to keep only 17.4 percent of their visits. Adult females in the poverty group failed to keep 21.6 percent of their scheduled appointments, while females in the general plan sample failed to keep 16.3 percent. The poverty group had a somewhat higher broken appointment rate for males, but the difference is small.

In an earlier study of these same two populations, a comparison of their appointment behavior in the total medical care system showed more variance between the two (24). It appears that members of the poverty population break fewer appointments for mental health clinic services than for other medical services, and that members of the general plan sample break more mental health appointments.

Discussion and Conclusion

Our study on use of outpatient services for psychiatric diagnoses for a defined poverty group and a sample of the general membership of the Kaiser Foundation Health Plan revealed that most persons treated for mental illness in this system are treated in the general clinics as opposed to the mental health clinic. Our findings confirmed previously reported higher rates of mental illness among the poverty population. But these higher rates were mainly confined to the adults, ages 19–64. Children, ages 0–18, in the poverty and nonpoverty groups had approximately the same rate for total psychiatric diagnoses.

The average number of visits for a psychiatric diagnosis per 1,000 members was higher for the poverty population in every category except one.

The exception was in the 0–18 age group, where males in the general plan sample made more visits per 1,000 persons than did poverty population males in this age category. The distribution of diagnoses varied considerably between the two groups in every age and sex category.

Patterns of referral to the plan's mental health clinic showed that poverty children with psychiatric diagnoses were more likely to be referred to the clinic than were similarly diagnosed children in the general plan sample. Physicians and others, including schools and social service agencies, referred children in the poverty population to the mental health clinic for treatment more often than other children in the health plan. Adults were referred less frequently than children, but a higher percentage of the adult poverty population was treated in the mental health clinic as compared to adults in the general plan sample.

The poverty population broke more appointments to the mental health clinic, but their appointment-keeping behavior was "better" for visits to the mental health clinic than for other medical care.

Thus, poor people with equal or better access to a total health care system are more likely than others in that system to receive a psychiatric diagnosis. They also make more visits to the system for treatment for psychiatric diseases. Both the poverty group and the general plan sample received most of their psychiatric treatment from the general clinics. About 40 percent of the poverty group with psychiatric diagnoses went to the mental health clinic in contrast to 20 percent of the general plan sample.

The differences between the two groups in diagnoses, rates, use, and referral patterns may have stemmed from several causes. The coverage for outpatient psychiatric care varies considerably between the two groups although their medical care benefits are approximately the same, and this factor could account for some differences. However, since almost three-fourths of the psychiatric utilization reported here is for general clinic visits for psychiatric diagnoses (table 6) rather than for visits to the mental health clinic where co-payment would be a consideration, the differential in mental health coverage cannot explain all the differences found. Variation in social class and perceptions of mental illness between poverty and nonpoverty groups and between providers and patients have been identified in other studies, and these factors may affect diagnoses and treatment

patterns. For instance, do the higher rates of diagnosed mental illness among the poor stem in part from the physician's perception of the patient's behavior and the way symptoms are presented? Hollingshead and Redlich's study indicated that social class affected the way mental illness was defined by physicians, and persons of lower socioeconomic status were more likely than other socioeconomic groups to be labeled as mentally ill (25). Other variables not considered in this study, such as environmental conditions, may also account for variation in patterns of mental illness and use of services between poverty and nonpoverty groups.

In conclusion, the findings of this study suggest a need to search beyond the description and the reports of more mental illness and higher rates of utilization among the poor. An intensive analysis of the social interaction process influencing the definition and treatment patterns for psychiatric disorders is indicated, as well as further investigation of the differences in benefits or organizational arrangements. In addition to making a contribution to understanding basic human behavior, an important focus for such research would be to examine these factors as they help or hinder the provision of appropriate outpatient psychiatric services for all segments of the population.

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