The Role of the Mental Health Service in the Local Health Department

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DRAMATIC changes in mental health programs have occurred throughout the United States during the last decade. Prior to that time, certain States had made significant progress in coping with their mental health problems, but for the most part, the national picture was marked by scarcity of trained personnel, inadequate programs, and a woeful lack of significant research into causes and treatment of mental disorders.

With the passage of the National Mental Health Act of 1946, the picture began to change. Through the National Institute of Mental Health, Public Health Service, funds became available for training mental health personnel in the various disciplines, and there was also a tremendous increase in the funds which could be made available for important psychiatric and mental health research. Included in this new law were provisions for grants to States which enabled them to initiate community mental health programs. Recent legislation provides for mental health project grants for studies of improved methods in the care and treatment of mental patients, and thus we can look forward to constant improvement in our State mental hospital systems, hitherto an almost neglected area. Running parallel to all this, and to a large degree responsible for these advances, has been an awakening of interest by the people of this country. Citizens' mental health groups are demanding that even more attention be paid to mental illness and the prevention of such illness wherever possible.

The mental health service in the local health department is assuming increasing importance in our attempt to deal with these serious, unsolved mental health problems. There are two main reasons why the local health department is important in building the mental health of the community. First, and this is somewhat negative, we now recognize that we must look to local health departments and other nonpsychiatric groups because we will never have enough psychiatric personnel to do the job. By other nonpsychiatric groups I mean various community health and welfare organizations which have an interest in people who are in trouble. Despite 10 years of greatly expanded training in psychiatry, clinical psychology, psychiatric social work, psychiatric and mental health nursing, and a large expenditure of funds, we are still woefully lacking an adequate number of workers in this field.

Second, and certainly more significant, is the reservoir of knowledge, experience, and proved methods public health workers can offer to the mental health field. The psychiatric and ancillary professions are improving their skills in individual treatment and stepping up their efforts to find causes and cures for mental disorders, but there is also a recognized need to go beyond this to the building of improved mental health generally. In order to make a dent in this problem, we must devise ways of working

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effectively with large groups of people. We must think in terms of early case finding and prevention. Is this not the area in which public health workers have labored so long and in which they have achieved such success?

Thus, a local health department has the same responsibility for the mental health of a given community as it does for the community's physical health. The department may of necessity approach the mental health problems of the community in a slightly different way. There may be even greater reliance on other community agencies in carrying out the work. In some communities another agency may have primary responsibility for the mental health program. Nevertheless, the local health department will always be a factor, and a potent one, in the community's efforts to grapple with the mental health problems of its population.

Without laying out a blueprint for an ideal program in mental health for every local health department—the literature contains many descriptions of specific programs—I shall describe a few common situations in which some departments may find themselves and discuss the implications of each in the local mental health program.

The Psychiatric Clinic

First, let us consider a local health department which is blessed or, as some health officers feel, saddled with a full-time, fully staffed mental health clinic. Probably there has long been pressure in this community to make this service available, and much preliminary work has gone into the establishment of the service, not the least of which was the recruitment of personnel. In these days, a community of modest size that has a full psychiatric clinic team, all present for duty at the same time, can boast of a real achievement. There has been a tremendous effort to increase the number of mental health clinics. Some States have a fairly complete geographic coverage, and service is available either on a full-time or part-time basis even to rural communities, whereas in earlier days only a large urban community had this service. When these clinics were planned they were visualized as a reference point from which the community's mental health program would emanate. Sometimes there was no real clarity as to how all this would come about, and too often those responsible for starting the clinics did not look beyond the organization and the recruitment, which, incidentally, was a difficult task in itself. There was an expectation that certain mental health miracles would take place once these capable individuals were set up in a clinic.

No doubt in many communities the advent of a clinic has provided this reference point. Where the clinic has been located in the health department, it has made this department a center for mental health instead of functioning as a psychiatric service for a limited number of patients needing care. In many instances the addition of a clinic team to the health department staff has meant a broadened mental health-public health approach to community mental health problems, and there is every expectation that this service will bear fruit in the future.

In too many localities, however, results have not always been successful. A clinic starting out in a local health department with much enthusiastic support and bubbling optimism is, after a period of time, too often found to be moving away from instead of toward a broad solution of mental health problems. When the clinic opens its doors, it generally has an original rush of business which swamps the staff. Very early, staff members become deeply involved in situations which seem to require psychiatric treatment. This results, ironically, in the clinic becoming less and less available as a community resource. The staff retires to the relative protection of a long waiting list, which seems to justify how much the clinic was needed in the community. Then we sometimes find a discontent arising within the health department and in the community. The question is asked: "What have we bought?" The service available seems much narrower than public health people have expected, and disillusionment sets in.

There are many reasons for the development of such situations. Some of the difficulty may be due to the method by which these clinics were originally set up. Ordinarily, the State mental health authority, which is the State health department in roughly 32 out of 53 States and Territories, is active in originating the clinic. And much of the early support comes from State and Federal funds. Perhaps the continuing role of the health officer in relation to the clinic is not made clear enough at this time. He may feel that this is a State operation and while he tacitly agrees to a clinic in his county, he has no real involvement. Thus, from the beginning, especially if there is insufficient planning as to how this service will blend into existing services provided by the local health department and the community at large, the clinic is viewed as an appendage rather than an integral part of the department. Significantly, many of these clinics are not even located physically in the health department building, and this has seemed to me to highlight the separation.

The psychiatric and ancillary personnel share some of the responsibility for this state of affairs. Generally, they are new to the particular community, with little idea as to the community's needs and problems. For the most part, they come with treatment backgrounds, and since they immediately run into the backlog of cases which can profit from their treatment skills, they never fully realize that there can be more to a mental health service in a local health department than seeing a maximum number of perhaps 30 cases for treatment. They are hesitant in moving out into the community, except for a few speaking engagements on general mental health subjects. Perhaps they are too busy and feel they are pilfering this time from their treatment responsibilities, but also they may be uncomfortable in this broad community public health role.

Within the health department itself, members may look on the clinic as merely a treatment resource or as a welcome haven for those psychiatric emergencies which periodically plague the health officer and his staff, and they may be suspicious of any service beyond that. There is little effort to obtain consultation from the clinic group for those aspects of the total health department program which have mental health implications.

The National Institute of Mental Health, with cooperation from States and hundreds of local clinics, has set up a system of clinic statistics which are now collected on a regular basis. This system makes it possible to learn what is being done nationally in outpatient treatment settings. It had been suspected that many of these clinics, set up as community mental health activities, were actually devoting a very small fragment of their time to community work in preference to direct treatment activities. A recent compilation of these statistics verified the truth of this belief. We are not prepared to say at this point what percentage of clinic time should be devoted to community mental health activities, but we believe that it should be higher than our statistics tell us it is at the present time.

Perhaps I appear to be minimizing the importance of the treatment role of the clinics in order to make a point about the different kind of responsibility a clinic takes on in a public health setting. I hasten to emphasize that treatment services are valuable and should be available in every community. What more then do we ask of the health department clinic in its relationship to the local health department? I am certainly not suggesting that, in addition to giving treatment services, the clinic staff set itself up as a group of some sort of "super consultants" in all health department activities. However, the clinic staff and health department personnel should move toward a fuller partnership which will make all of the skills of both groups available to the citizens served by both departments. Mental health personnel can no longer live as boarders in the health department household; they must become active members of the family with all that implies.

Does the clinic have a responsibility and desire to promote mental health through educational methods? The health educator, with years of experience in selling health and health programs, can expand his efforts to include mental health. He can be of invaluable assistance to mental health personnel as they move from their treatment activities into their community role. The difference here as far as health education is concerned is in program content, not in method. Likewise, a psychiatrist who acts as staff consultant in a maternal and child health program, or who works with public health nursing groups on the emotional components in various illnesses, is thereby a member of the public health staff rather than a walled-off treatment resource for a limited number of cases.

Departments Without Clinics

But what of the health department which has no mental clinic and which in all probability will never have one? What are its responsibilities in the mental health field? Do we expect it to develop such a program?

I have visited health departments where the health officers make no claim to a fancy mental health program nor do they expect, with the funds available, to have such an organized program in the foreseeable future. These health officers will, however, describe in glowing terms the activities of their well-baby clinics, where, in addition to good physical care, there is time to help parents learn better parent-child relationships. They speak of public health nurses who know their county—its people, its schools, and its teachers—and who are interested in early case finding of children with emotional difficulties. When you discuss all of this in mental health terms, they brush it off and perhaps disavow it as having any connection with mental health. They say this is all "commonsense," and "good public health practice." Whether it is called by any particular name or not, from my point of view, strengthening this kind of service in a local health department leads to improving mental health in the community.

Such strengthening need not wait for the arrival of full-time psychiatric, clinic personnel. It can be propelled along by a health officer who recognizes that he has a broad mental health responsibility. It can be aided by the careful use of occasional consultants for in-service training of staff and evaluation of mental health aspects of certain programs. It can be helped by adding to the staff, from any one of the ordinary psychiatric clinic disciplines, a worker who may bring the knowledge and skills of his specialty to the program and never function in the ordinary, clinical treatment role. In some local health departments, psychologists, social workers, and mental health nurses are operating in this way. This approach can be advanced when the health department is in the forefront in coordinating community resources or where new resources are being set up to meet the needs of the community.

There are many localities without health departments or possibly with part-time men heading the public health program. To talk of a strong mental health program in these departments is unrealistic, for one can only have such a program where basic health services are adequate and strong. As a matter of fact, strong mental health programs are built not only on strong basic health services, but are dependent also on the availability of other community health and welfare services. Some communities have sought a mental health clinic to meet what appeared to be a pressing need, and it has been necessary to advise the community that it might be better to strengthen the health department or add counseling service to the school system, or provide some form of family service in a private family agency. Are we perhaps asking the impossible of a mental health service when we require it to operate without basic health and welfare services?

Followup Services

Thus far we have looked briefly at the role of the local health department in community education, broad preventive activities, and treatment of early signs of emotional illness. What about that which is referred to as "last ditch service?" We should not discount the role of the health department in providing tangible service to patients entering or leaving the State psychiatric hospitals. Pioneer work in this field has been done in such States as Georgia and Maryland, where public health nurses have been used in an imaginative way in following up these patients. While these programs give indication that they can make a valuable contribution to the care and treatment of mental patients, and while they require continuing evaluation and adaptation, there is no doubt but that there is a place for a local health department to function in this area. Such a program calls for close coordination with the State hospital system with insistence on a clearcut line of medical responsibility, more important now with the advent into the community of so many patients on drug therapy.

To some localities this kind of followup seems like a new service, and perhaps in its formal aspects it is. But public health nurses and, in some States, public assistance workers have for years been visiting homes with one or more hospitalized relatives. They have worked with these families before, during, and after hospitalization. The newness in the program is the hospital's awakening interest in what assistance the health department can provide to the hospital in carrying out its responsibilities and to the patient in furthering his adjustment in the community. There must be continued work on the exact nature of the nurse's role. Health departments must know what service the hospital should request from the nurse, and provisions must be made for continued inservice training for the participants so that they are better able to meet the demands which are being made upon them. It means that nurses in health departments will require continuing consultation in the psychiatric and social aspects of these cases. Time and effort spent in this kind of training and consultation will be a worthwhile expenditure since the public health nurse is the department's most effective tie with the entire community.

There is also the responsibility of the local health department for the study of mental health problems in its own local area and for at least modest research into some of these problems. The local health department should also know the adequacy of resources to meet the needs of its people both in the incipient stage of illness and later, and should be able to use its own records and statistics creatively to better determine the needs and the best kind of service which the community should provide. These surveys need only be the simple, descriptive kind of study and reports which come out of the everyday activities of public health workers.

Conclusion

The health department has an important role in the mental health activities of its community. Clinical treatment of mild cases of emotional disturbance on an outpatient basis is an important community service, but we also recognize that it is only as we approach people's problems on a broader base that we can hope to make a significant contribution toward diminishing the mental health problem.

A mental health program can find room to develop and flourish when it is vested in a strong local health department. Those interested in mental health should see strengthening of their local health departments as a prerequisite to the establishment of their own programs. As pointed out by Charles Mitchell of the Texas State Department of Health, the local health department wishing to make a contribution in the area of mental health must have a deep conviction that since it meets "many people at critical stress periods of their lives, it thereby has an opportunity to affect their mental health favorably." We can only hope that more and more health departments will recognize their potential for so doing.

Increase in Welfare Expenditures

Public spending for social welfare activities of all kinds increased from \$32.2 billion in 1955 to \$34.5 billion in fiscal year 1956, largely as a result of the expanding social security program and increased outlays by States and local communities for education. The increased expenditure represented the same proportion, 8.6 percent, of the gross national product as for the previous fiscal year.

Almost three-fifths of the 1956 expenditures (\$19.9 billion) came from State and local funds, and a little over two-fifths (\$14.6 billion) from Federal funds. The latter figure represented 11.7 percent of the Federal general revenue budget, of which 7 percent was spent on veterans' programs.