Patients Served by a Mental Health Unit of a City Health Department

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THE RECOGNITION of the public health aspects of mental illness has led to the establishment of mental health units by an increasing number of public health departments. Such units perform many functions which vary in scope and emphasis with the needs of the community and the degree of public support. These functions may include planning and coordination of mental health services, consultation to public and private agencies, inservice training, mental health education, casefinding, surveys, research, and direct services to individuals with mental health problems. Such direct services are usually limited to children but may include adults and special groups such as alcoholics.

Little is known about the characteristics of patients who come to the attention of mental health units of public health departments. The purpose of this study, therefore, was to obtain certain information about individuals known to the division of mental health of the Philadelphia Department of Public Health during the period 1955–57, its first 3 years of operation. Although there are gaps in the data, such material may be useful to health departments contemplating the establishment of mental health units or to already established units as a basis for comparison.

The services provided by the division, available to anyone in the community, include diagnostic evaluation and psychiatric treatment of children, adolescents, and adults; and consultation, information, and referral services directly to the patient or to responsible relatives, interested individuals, or agencies acting on his behalf. In selected cases, psychiatric evaluation and treatment on a continuing basis are available to individuals in their own homes.

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Patient Data

During the 3-year period the division served 1,734 persons. Information about these patients was obtained from the case record, frequently limited to pertinent material noted on a 5- by 8-inch card. Data about the characteristics of the patient had not been gathered routinely because contact with the patient or a responsible relative was for brief periods or was limited to telephone contacts or because of the pressures on an overburdened staff. The material collected from the records was coded and transferred to punched cards.

Of the 1,734 individuals studied, 39 percent were male and 61 percent female. A breakdown by race shows 37 percent were white, 22 percent nonwhite, and 41 percent whose race was not stated. Since the proportion of nonwhites in the Philadelphia population has been estimated to be 24 percent (*1*), it seems probable, considering the large number of those whose race was not stated, that nonwhites were over-represented in the patient population.

The number of patients served varied with place of residence. Using 1957 estimated population figures for Philadelphia (*1*), rates were calculated for the 10 health districts into which the city is divided. They varied from 19.2 to

160.5 per 100,000. Health districts with high rates tended to be areas with high mortality and delinquency rates, substandard housing, and low income. Three percent of the total group resided outside of Philadelphia.

Only a very small percentage of the patients (7 percent) were without a responsible relative. Almost three-quarters (72 percent) had one or more close relatives, but this did not always mean that the relatives were willing or able to assist them. In 21 percent of the cases no information was available regarding the existence of a relative.

The age distribution of the patients ranged from a few weeks to 96 years (table 1). Of the total group, 11 percent were under 15 years, 7 percent between 15 and 24, 23 percent between 25 and 44, 18 percent between 45 and 64, and 19 percent 65 years of age and over.

In 22 percent of the cases, the actual age of the patient was not stated, but it was possible to estimate from the case record the age of most of these patients: 4 percent were children, 73 percent were adults, and an additional 21 percent were known to be older adults. For purposes of analysis, these cases were combined with those with ages specified in the following manner: children without a specified age were considered to be under 18 years; adults were considered to fall within the 18- to 64-year age range; and older adults were considered to be 65 or older.

Such an age grouping seemed reasonable in view of the special problems of children and the aged, both of whom tend to be dependent upon others for their agency contacts. Comparisons with general population figures for Philadelphia showed that children were underrepresented (15 percent in the patient population and 27 percent in the general population), adults were about equal (62 percent and 65 percent, respectively), and older adults were overrepresented (23 percent and 8 percent, respectively).

There were significant differences between the sexes in the age distribution. The children included 10 percent of the females compared with 18 percent of the males; the older adults, 19 percent of the males compared with 26 percent of the females.

Table 1. Age distribution of 1,734 patients served by the division of mental health, Philadelphia, 1955–57

Age group, in years	Percent	Age group, in years	Percent
Under 5	5	50–54	5
5–9	3	55–59	4
10–14	3	60–64	5
15–19	4	65–69	3
20–24	3	70–74	5
25–29	5	75–79	4
30–34	6	80–84	4
35–39	7	85 and over	3
40–44	5	Not stated	22
45–49	4		

Sources of Referral

Patients were referred to the division through many different channels, representing 87 unduplicated types of referral source (table 2). Twenty-seven percent were referred by medical sources, such as various divisions of the health department, general hospitals and clinics, and psychiatric hospitals and clinics.

Nonmedical city and State agencies referred 25 percent: 10 percent from such sources as the mayor's office of information and complaints, department of public welfare, licenses and inspection, personnel department, commission on human relations; 7 percent from law enforcement agencies such as courts, district attorney's office, police department including the juvenile aid bureau, and prisons; and 8 percent from State agencies such as the department of public assistance, department of welfare (bureau of aging services, bureau of hospitals, and State council for the blind), bureau of rehabilitation, and the board of parole.

Fourteen percent were referred by voluntary agencies concerned with child care and protection, financial assistance including shelters, nursing services, employment, rehabilitation, legal aid, and services for special groups such as the blind, prisoners, and transients. In 15 percent of the cases, the patient was referred by himself or his family. Eleven percent were referred by various interested persons including friends, neighbors, politicians, councilmen, lawyers, and landlords. Four percent were referred by miscellaneous sources including private nursing homes, employers, churches, labor

Table 2. Percentage of patients served by the division of mental health, Philadelphia, 1955–57, according to referral source

Referral source	Under 18 years (N=256)	18–64 years (N=1,061)	65 years and over (N=398)	Total [1] (N=1,734)
Medical facilities:				
Health department	43	7	5	12
General hospitals and clinics	8	11	8	10
Psychiatric hostals and clinics	4	4	3	4
Out-of-State psychiatric hospitals	0	1	1	1
City and State agencies (excluding medical):				
Law enforcement agencies	14	6	5	7
Other city departments	7	10	13	10
State agencies	[2]	7	17	8
Voluntary welfare agencies	4	17	10	14
Schools	4	[2]	0	1
Self or family	10	18	12	15
Other interested persons:				
Friends, neighbors	2	5	7	5
Councilmen, politicians	[2]	1	2	2
Lawyers	[2]	2	2	2
Landlords	0	1	4	2
Miscellaneous	2	4	6	4
Not stated	[2]	5	4	4

[1] Includes 19 cases not classifiable by age.
[2] Less than 0.5 percent.

NOTE: $\chi^2=406.60$; df=20; $P<.001$ (for the χ^2 analysis, psychiatric hospitals and clinics were combined with out-of-State psychiatric hospitals; other interested persons were combined with schools).

unions, Federal agencies (Army recruiting station, Bureau of Old-Age and Survivors Insurance, Housing Redevelopment and Relocation), chamber of commerce, American Legion, and others.

Significant age differences were found with respect to referral source. Health department referrals accounted for 43 percent of those under 18 years compared with 7 percent of those between 18 and 64, and 5 percent of those 65 and older. These findings were not unexpected in view of recent program developments in the division focusing on preschool children seen in child health conferences at local health centers. Referrals from law enforcement agencies also accounted for a higher proportion of those under 18 years than of those in the two categories of adults, probably because such agencies are more likely to use community resources for children and adolescents than for adult offenders. Persons 65 and older were more likely than the other age groups to be referred by State agencies other than hospitals (primarily the department of public assistance), and persons between 18 and 64 years were most likely to be referred by voluntary welfare agencies.

The difficulties for which help was sought covered a wide range. Among the children were some who were not developing normally or who presented other problems of management, others with difficulties in school adjustment, and still others who had had a brush with the law.

The adults presented psychiatric problems of varying degree. In some cases the psychiatric problem contributed to marital difficulties. Some patients exhibiting paranoid tendencies appeared periodically at the mayor's office of information and complaints, at the police department, and at other public and private agencies demanding restitution or protection. Other mentally ill persons created public health or fire hazards by throwing garbage out of windows or accumulating trash. Some created a public nuisance by quarreling with or taunting their neighbors. In some cases the mentally ill person constituted such a potential danger to himself or to others that it was necessary in the absence of a responsible relative or interested agency to petition the court for psychiatric examination.

Some patients were public assistance clients for whom the agency requested evaluation of mental competency because there was a question about their ability to handle funds. Many patients were older persons who presented a variety of problems involving an impairment of their ability to maintain themselves economically, psychologically, physically, and socially.

One small group of patients in the most urgent need of hospitalization had been placed in jail because of the shortage of hospital beds. This practice has been terminated through

new program. A small number of patients had recently been discharged from a mental hospital and needed help with employment, housing, social contacts, or psychiatric care on an outpatient basis. In a few cases social history data were required by a State hospital to help in planning for the patient or determining whether the home was ready to receive him.

Contacts and Outcome

The type of contact with the patient is shown in table 3. In half the cases (48 percent) contact with the patient or on his behalf was by telephone or correspondence or both; such contacts included information, referral, and consultation services. These contacts were not necessarily of short duration, since extensive exploration was often necessary to locate the appropriate community resource. In 24 percent of the cases, patients were interviewed in the division's offices or in health centers, usually by a psychiatric social worker but also by a psychiatrist or psychologist. Office contacts demanded more intensive work in clarifying the problem and in helping the patient and family accept referral for psychiatric help.

In 21 percent of the cases, visits to the patient's home were necessary, usually by psychiatric social workers, but in some cases by a psychiatrist, whose medical opinion was required regarding the mental competency of the patient. In some cases it was necessary for both psychiatric social worker and psychiatrist to make the home visit. In 2 percent of the cases, contact included diagnostic psychological testing or individual or group psychotherapy, or both, with or without a home visit.

Table 3. Percentage of patients served by the division of mental health, Philadelphia, 1955–57, according to type of contact

Type of contact	Under 18 years (N=256)	18–64 years (N=1,061)	65 years and over (N=398)	Total [1] (N=1,734)
Telephone contact or correspondence or both	53	46	48	48
Office interviews [2]	20	28	15	24
Home visits:				
By psychiatric social worker	8	16	25	17
By psychiatrist	(3)	2	3	2
By both	(3)	2	3	2
Diagnostic testing or individual or group psychotherapy or both [4]	11	1	(3)	2
Not stated	7	5	5	6

[1] Includes 19 cases in which age was not stated.
[2] May include telephone contacts or correspondence.
[3] Less than 0.5 percent.
[4] With or without home visits.

NOTE: $\chi^2=170.70$; df=8; $P<.001$.

Table 4. Percentage of patients served by the division of mental health, Philadelphia, 1955–57, according to length of contact

Length of contact (in days)	Under 18 years (N=256)	18–64 years (N=1,061)	65 years and over (N=398)	Total [1] (N=1,734)
1	29	36	35	35
2–6	11	15	18	15
7–13	7	8	11	8
14–20	6	5	6	6
21–29	5	6	5	6
30–59	8	11	11	11
60–89	6	4	4	4
90–119	2	3	2	2
120–149	1	1	1	1
150 and more	12	4	3	5
Not stated	13	6	4	7

[1] Includes 19 cases not classifiable by age.

NOTE: $\chi^2=53.72$ (omitting contribution of not-stated cases); df=20; $P<.001$.

There were significant age differences in type of contact. Home visits were required most for older adults, less for younger adults, and least for children. By contrast, such services as diagnostic psychological testing and psychotherapy were limited almost entirely to children, reflecting program emphasis.

There were also significant differences between the sexes in type of contact. Twenty-four percent of the women compared with 15 percent of the men required home visits.

Length of contact with the patient varied from 1 day to more than 5 months (table 4). The 1-day contacts generally were limited to telephone calls or an office visit. The longest contacts were with patients requiring more extensive psychiatric casework assistance or psychotherapy on a continuing basis. In 50 percent of the cases, contact with the patient lasted less than 1 week. In 20 percent of the cases contact was maintained from 1 week to 29 days,

in 18 percent from 1 to 5 months, and in 5 percent for 5 months or more. Persons receiving service for at least 5 months were more likely to be children.

Outcome of contact with the patient is shown in table 5. Thirty-three percent of the cases were closed after information had been given regarding psychiatric resources or procedures, or after a referral had been made to a specific community resource, contacted by the division for this purpose. Five percent of the patients were referred to ancillary resources such as nursing homes and family, employment, and group work agencies. Seven percent of the patients were advised that a community resource which had previously served them would be more helpful to them.

Sixteen percent of the cases were closed after service had been completed for the public or private agency currently active in the situation. Most of these cases involved consultation and advice in meeting the patient's psychiatric problem, but in some cases a supplementary service was performed, such as a home visit to determine mental competency.

In 13 percent of the cases, the patient or family refused help; in another 8 percent, the patient or family or both, were encouraged to seek psychiatric help, but the record contained no information that they had done so. Two percent of the cases were closed after the division had petitioned the court for psychiatric examination. In 14 percent no further contact was required for various reasons; the patient had shown improvement through extended casework or through individual or group psychotherapy, had died, disappeared, been sent to jail, had broken contact, or did not present a psychiatric problem.

There were significant age differences with respect to outcome of contact. A higher proportion of children than adults or older adults refused help; while a higher proportion of both adult groups than children was given information about psychiatric resources and procedures.

Table 5. Percentage of patients served by the division of mental health, Philadelphia, 1955–57, according to outcome of contact

Outcome	Under 18 years (N=256)	18–64 years (N=1,061)	65 years and over (N=398)	Total [1] (N=1,734)
Information given re psychiatric resources or procedures	10	17	20	16
Referred to psychiatric resources	19	17	15	17
Referred to ancillary resources	4	4	8	5
Encouraged to seek psychiatric help	2	10	5	8
Petitioned court for psychiatric examination	[2]	2	4	2
Patient or family refused help	27	12	7	13
Service completed for public or voluntary agency	16	16	15	16
Directed back to resource previously involved	5	7	9	7
No further contact required, other	12	14	17	14
Not stated	4	2	1	2

[1] Includes 19 cases not classifiable by age.
[2] Less than 0.5 percent.

NOTE: $\chi^2=119.32$; df=18; $P<.001$.

Discussion

Although the 1,734 patients served by the division of mental health during the first 3 years of operation included persons of all ages, children were under-represented and older adults over-represented by comparison with general population figures. The reason for this fact was that much of the work of the division in its early years was necessarily devoted to meeting the needs of chronic patients, since facilities in the community for the care and treatment of the mentally ill were inadequate. With the development of new programs and increased facilities, however, there has been a reduction in the backlog of mentally ill persons with unmet needs, making possible a greater emphasis on preventive work with children.

It might be expected that the major channel of contact for patients would be through the private and public health and welfare organizations. However, more than 40 percent of the patients came to the division through other sources, and almost all of these were appropriate referrals. This suggests a considerable degree of sophistication on the part of lay per-

sons and organizations in recognizing psychiatric problems.

The study presents useful information about some characteristics of patients served by a mental health unit. Unfortunately, there were gaps in data on race, religion, marital status, and occupation. Although more information was available for patients seen face-to-face than for those served by telephone or correspondence, the gaps in data on the former group were too great to permit statistical analysis. Information on the factors previously mentioned and others such as income, amount of schooling, mobility, and previous psychiatric care is essential for a better understanding of the patient load, and for program planning and improvement of services.

REFERENCE

(*1*) Division of Statistics and Research, Philadelphia Department of Public Health: Annual report, public health statistics. Philadelphia, 1957.

Career Opportunities

Columbia University and the Institute for Crippled and Disabled will conduct a work conference June 8–26, 1959, on the roles of medicine, counseling, psychology, and social work in a vocationally oriented rehabilitation center. The conference is supported by a grant from the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare. Enrollment is limited to professional workers in the field of rehabilitation.

Yale University Department of Public Health offers for the academic year 1959–60 a new program designed to prepare nurses for positions in supervision, education, and consultation in chronic illness nursing. Funds for the course were made available through the Connecticut State Department of Health by a graduate training grant from the National Heart Institute of the Public Health Service.

The program covers a minimum of one academic year for students with advanced experience and training and leads to the degree of master of public health with a major in chronic illness nursing. Admission requirements include a bachelor's degree, graduation from an approved school of nursing, and experience in public health or teaching.

The University of Minnesota School of Public Health offers the second annual workshop on air pollution July 6–17, 1959.

Designed for engineers, physicians, chemists, and sanitation personnel concerned with community air pollution from the educational, governmental, or industrial viewpoint, the course will consist of lectures, demonstrations, field trips, and the application of fundamental knowledge in solving the air pollution problem of a community. Enrollment is limited to 25. Applications may be filed with the University's School of Public Health, 1325 Mayo Memorial Building, Minneapolis 14, Minn.

The University of Minnesota has also announced a summer continuation course of instruction in chronic diseases, July 27 through August 22, 1959. The course is presented with the cooperation of the schools of public health of the United States and the Conference of Chronic Disease Training Program Directors as a non-academic-credit program in chronic diseases on the graduate level for physicians in health agencies and research workers in the medical sciences.

Subject areas are epidemiological methods in noninfectious diseases, recent advances in experimental and clinical aspects of heart disease and cancer, and public health chronic disease control programs with emphasis on heart disease.

Further information may be obtained by writing to Dr. Leonard M. Schuman, Professor of Epidemiology, School of Public Health, at the university.

Teachers College, Columbia University, will hold a work conference on the sheltered workshop as a community resource in the vocational rehabilitation of mentally retarded adolescents and adults July 27 through August 14, 1959, under the sponsorship of the Association for the Help of Retarded Children, Inc.

Information may be obtained from Dr. Abraham Jacobs, Box 35, Department of Psychological Foundations and Services, Teachers College, Columbia University, New York 27, N.Y.