First National Report

Community Oriented Services of Psychiatric Clinics, 1958

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DIAGNOSIS, therapy, and other direct services to patients with mental and emotional disorders are only one phase of the functions of mental health clinics. Clinics assist in the professional training of psychiatric and other mental health personnel and conduct research and evaluation studies. They also attempt to reach the total population by engaging in a wide variety of community-oriented activities concerned with preventing mental illness and promoting mental health in the community (*1*). In these community-oriented activities, clinic staffs provide professional assistance and consultation to various community agencies, aid in the mental health education of other professional and lay groups, and take part in interagency meetings and conferences for community planning and coordination.

Earlier publications describe the outpatient psychiatric clinics in the United States (*2,3*) and the direct services they provide to patients (*4*). These publications are based on data collected in a national reporting program for governmental and nongovernmental outpatient psychiatric clinics, a program established in 1954 by the National Institute of Mental Health, Public Health Service, in cooperation with the State mental health authorities (*5*). As a practical first step, reporting is limited to outpatient mental health clinics where an attending psychiatrist, with regularly scheduled hours, takes the medical responsibility for all clinic patients.

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For national reporting, community mental health service activities are classified by primary purpose into the following general groups: (*a*) information and education services for the general public, (*b*) inservice training for professional groups, (*c*) consultations and conferences with personnel of other agencies concerning emotional problems of individuals served by the agency as well as general mental health problems, and (*d*) participation in community mental health planning and coordination.

Clinics report the number of man-hours, including preparation and travel time, that professional staffs spend in each activity during April, the sample month. These hours, related to estimated total scheduled professional man-hours during the month, provide a measure of the relative effort placed on this particular clinic service.

This report summarizes information on community service activities during April 1958 reported by 595, or 43 percent, of the 1,386 outpatient psychiatric clinics in the United States. Table 1 shows the number of reporting clinics by State. Since information is collected for only 1 month of the year, and since the clinics which report are not a probability sample of all clinics, the data cannot measure the total clinic community service program. Nevertheless, the data suggest the emphasis placed on each aspect of community services by a large number of mental health clinics.

Clinic Staff Time in Community Services

The data available for April 1958 suggest that outpatient psychiatric clinics, regardless

of hours open, groups served, or agency operating the clinic, typically devote a relatively small proportion of time to community-oriented activities. Six percent of the estimated scheduled staff hours (23,000 out of 413,000 professional man-hours) were used for community services. Clinic staff members also spent an additional 6,000 hours of their own time after clinic hours for lectures or other community service as part of the clinic's program. This additional time represents about 20 percent of all reported community service hours.

Unpublished data reported by 419 clinics in the first reporting year (1954) and preliminary figures for 1959 for almost 800 clinics show the same proportion of hours in community services (6 percent).

Approximately three-fourths of the 595 clinics in 1958 reported either no time or less than 10 percent of their scheduled man-hours used for community services in April (table 2). For the median clinic, the percentage is 4.2. Of 71 clinics that reported no regular clinic hours for these services, 29 indicated such activities after hours while others may have participated in other months. Only 8 clinics reported at least half of all scheduled staff hours in community services.

No detailed comparisons of community services are made by type of mental health clinic. The 1958 data suggest, however, that those most likely to participate in such services are full-time clinics, those with a multidisciplinary team (that is, a psychiatrist, psychologist, and psychiatric social worker), clinics that serve more children than adults, and those with relatively large caseloads.

Types of Community Service Activities

During April 1958, the principal clinic community service effort in terms of man-hours was directed toward supplementing the skills of

Table 1. Total number of outpatient psychiatric clinics and number reporting man-hours in community service activities, by State, April 1958

State	Number of clinics		State	Number of clinics	
	Total	Reporting		Total	Reporting
Total	1,386	595	Nevada	4	4
			New Hampshire	26	22
Alabama	9	8	New Jersey	61	0
Arizona	5	1	New Mexico	1	0
Arkansas	3	2			
California	79	56	New York	307	0
Colorado	17	11	North Carolina	14	12
Connecticut	40	0	North Dakota	1	1
Delaware	7	5	Ohio	54	35
District of Columbia	18	14	Oklahoma	5	1
Florida	26	23	Oregon	15	11
Georgia	11	5	Pennsylvania	100	21
			Rhode Island	9	8
Idaho	1	1	South Carolina	6	5
Illinois	83	77	South Dakota	3	2
Indiana	18	16			
Iowa	16	12	Tennessee	10	10
Kansas	23	0	Texas	27	14
Kentucky	20	14	Utah	5	4
Louisiana	21	15	Vermont	7	7
Maine	8	6	Virginia	24	21
Maryland	44	14	Washington	10	8
Massachusetts	89	25	West Virginia	8	6
			Wisconsin	22	17
Michigan	55	33	Wyoming	0	0
Minnesota	13	11	Alaska	5	5
Mississippi	3	0			
Missouri	29	15	Hawaii	8	5
Montana	4	4	Puerto Rico	2	1
Nebraska	9	6	Virgin Islands	1	1

Table 2. Distribution of 595 outpatient psychiatric clinics according to proportion of scheduled professional man-hours spent in community service activities, April 1958

Community service hours per 100 estimated total scheduled man-hours	Number of clinics	Percent
Total	595	100.0
None	[1] 71	11.9
Less than 1	39	6.6
1	38	6.4
2	76	12.8
3	64	10.8
4	52	8.7
5–9	129	21.7
10–14	54	9.1
15–19	27	4.5
20–29	28	4.7
30–49	9	1.5
50–69	8	1.3
Median		4.2

[1] Includes 29 clinics reporting no community services during scheduled hours but some services after hours.

various other professional groups in their handling of problems of mental disturbance (table 3). The clinics' professional staffs provide this service through consultations or conferences with agencies and by participation in the inservice training programs for other professionals.

Consultations and conferences with agencies about individuals who are agency cases but not clinic patients, or about general problems for which the agency requested help and advice, account for the largest proportion (about one-third) of clinic professional man-hours in community service activities. Schools use these consultation services more than other agencies. Social agencies and health agencies (including physicians) rank next. Consultations with correctional agencies (courts, probation officers, and police) and with all other groups (such as clergy, employers, and unions) take relatively little of clinic staff time.

Clinics participate in the inservice training programs for professionals of other agencies who "are in a strategic position to foster the mental health of the people they serve" (*6*). Planning or conducting these discussions, lectures, or seminars accounts for 23 percent of the clinic man-hours in community services. About half of this time (11 percent) is used for training health personnel, usually physicians and nurses. Inservice programs for personnel of schools account for 4 percent, for social agencies 5 percent, and for correctional agency personnel, less than 1 percent.

Almost 30 percent of community service time is used for mental health information and education services to the general public. More than two-fifths of this time is spent in one-time presentations or lectures to the public and to

Table 3. Percent distribution of total professional man-hours of community service activities, according to type of activity during or after clinic day, 553 outpatient psychiatric clinics, April 1958 [1]

Type of activity	Total	During clinic day	After clinic day
Total man-hours of community service	29,006	22,876	6,130
Consultations and conferences with other agencies	34.1	39.0	15.9
Schools	10.8	13.0	2.5
Courts, probation officers, police	4.0	4.7	1.4
Social and welfare agencies	8.1	9.2	3.9
Health agencies (including private physicians)	7.4	8.4	3.7
Other agencies	3.8	3.7	4.4
Inservice training for professional groups	22.6	25.7	11.2
School personnel	3.6	3.7	2.9
Courts, probation officers, police	.6	.6	.7
Social and welfare personnel	4.6	5.3	2.2
Health personnel	11.2	13.1	4.4
Others	2.6	3.0	1.0
Information and education services, general public	27.5	21.9	48.3
Single presentation	11.8	6.6	31.4
Group study:			
Intensive limited period	4.8	4.9	4.4
Periodic sessions, over longer period	1.8	1.3	3.6
Mass media	3.2	2.7	4.9
Visitors, general public	5.9	6.4	4.6
Participation in community planning and coordination	15.7	13.4	24.6

[1] Excludes 42 reporting clinics with no community service activities in April.

student groups; the remaining three-fifths is spent in leading group discussions, providing information to lay and professional visitors, and preparing public education items for radio, television, and other mass media.

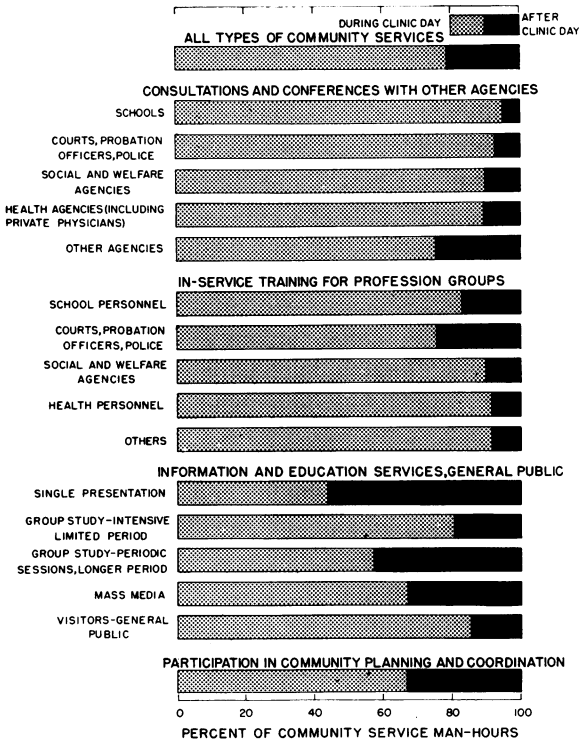
The fourth major community service, participation in community planning and coordination, which includes such activities as working with interagency committees, conducting local mental health surveys, and promoting local mental health resources, accounts for only about 15 percent of the total time in community service activities.

After clinic hours, the principal community service activity consists of preparing talks and presenting them to the public. More than half of the time devoted to this type of activity is given after clinic hours (fig. 1).

Most clinics engage in more than one type of community service activity (table 4). Less than 10 percent of 553 clinics participate in only one of the four major groups of services; 35 percent participate in some aspects of each of the four types.

The emphasis on consultation is illustrated by the large proportion of clinics reporting this service. Of the 553 clinics, 88 percent consult

Figure 1. Percent of total community service man-hours spent during and after the clinic day, for each selected type of community service activity, 553 outpatient psychiatric clinics, April 1958 [1]



[1] Excludes 42 clinics with no community service activities in April.

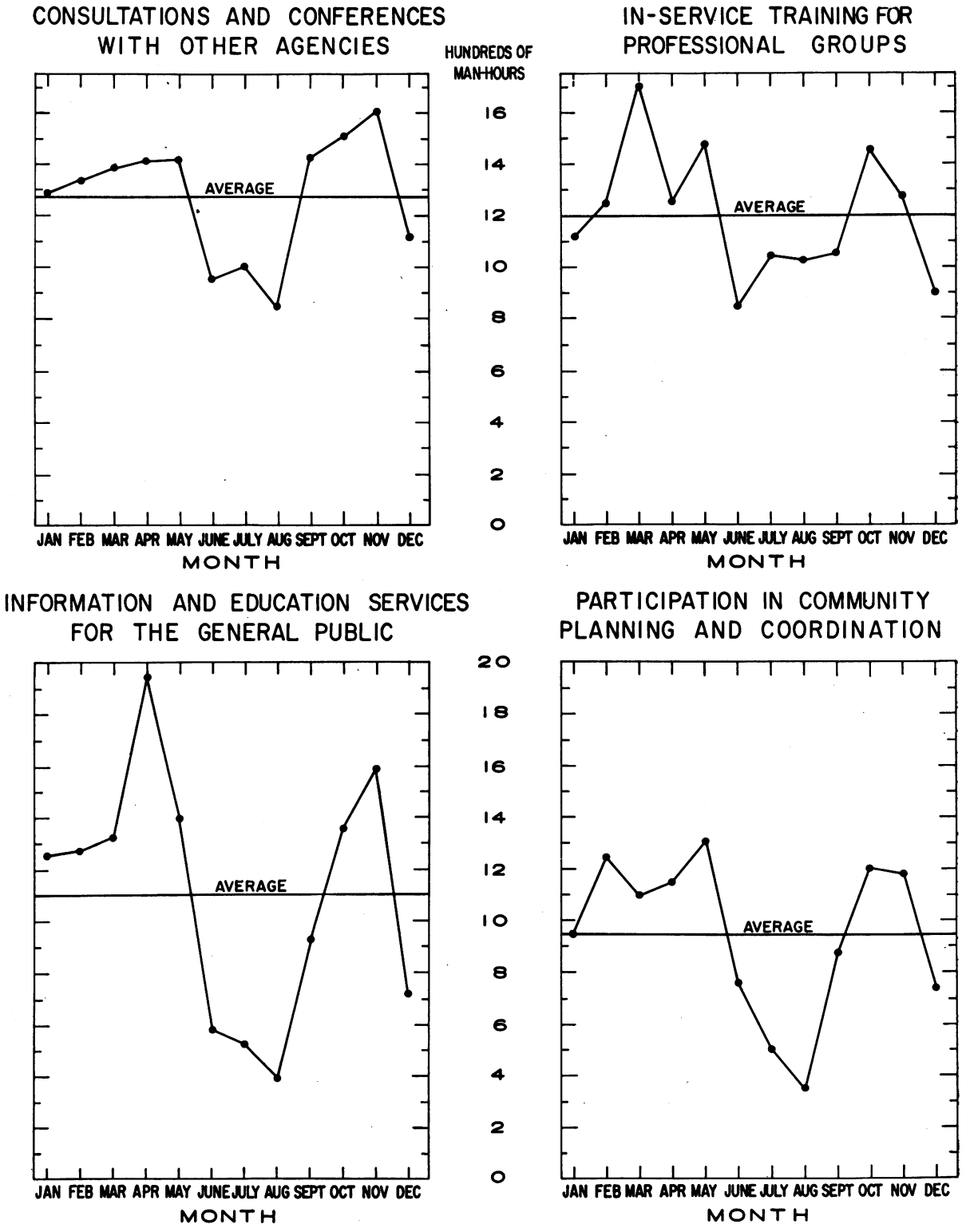
Table 4. Distribution of 553 outpatient psychiatric clinics according to the number engaged in one or more types of community service activities and the number engaged in each selected activity, April 1958 [1]

Type of activity	Number of clinics	Percent
Total	553	100.0
Number of major types		
One	52	9.4
Two	131	23.7
Three	175	31.6
Four	195	35.3
Specified type		
Consultations and conferences with other agencies	[2] 486	[2] 87.9
Schools	328	59.3
Courts, probation officers, police	268	48.5
Social and welfare agencies	374	67.6
Health agencies (including private physicians)	306	55.3
Other agencies	196	35.4
Inservice training for professional groups	[2] 346	[2] 62.6
School personnel	130	23.5
Courts, probation officers, police	46	8.3
Social and welfare personnel	136	24.6
Health personnel (physicians, nurses, etc.)	231	41.8
Others (clergy, etc.)	113	20.4
Information and education services for general public	[2] 461	[2] 83.4
Single presentation (lectures, talks)	413	74.7
Group study:		
Intensive limited period (workshop, institute)	106	19.2
Periodic sessions, over longer period	73	13.2
Mass media (radio, television, newspapers, pamphlets)	165	29.8
Visitors, general public	229	41.4
Participation in community planning and coordination	329	59.5

[1] Excludes 42 clinics with no community service activities in April.

[2] The sum of the sub-items is greater than the figure shown for each major type of service because most clinics reported participation in more than one type.

Figure 2. Total professional man-hours in selected types of community service activities, by month and average for year, 101 reporting outpatient psychiatric clinics, 1956



or confer with other agencies, 68 percent with social agencies, 59 percent with schools, and 55 percent with health agencies. Participation in inservice training programs for other professional personnel is an activity of 63 percent of the clinics. In contrast with the consultation service they provide, relatively few clinics participate in the inservice training program for several professions. About 83 percent of the clinics provide information and education services for the general public, most frequently through lectures and talks. Sixty percent of the clinics participate in community planning.

Seasonal Variation in Community Services

A special report from 101 clinics on community service activities for each month in 1956 indicates that time spent varies markedly during the year (fig. 2). School sessions, vacation periods, and holidays seasons, in particular, appear to affect these activities. Generally, peak seasons for all types of activities are spring and fall, with minimum activity in the summer months. Consultations and conferences and inservice training activities have the least seasonal variation.

Three-fifths of the clinics report peak activity in one of four months (April, May, October, or November), but a few clinics report summer months as their most active. Activities during April, the sample month for annual reporting, generally account for about one-tenth of all community service hours during the year. Because of the sharp drop in information and education services for the general public in the summer months, however, 15 percent of the yearly total hours for these activities are in April. Both the percentage of staff hours for community service activities and the distribution of these hours by type of activity are similar for April 1956 and April 1958. This suggests that community service hours reported for April 1958 may also represent approximately 10 percent of the total community service hours for the year.

Discussion

Reports from 43 percent of all outpatient psychiatric clinics in the United States for a sample month, April 1958, indicate that 6 percent of clinic staff time is used for the promotion of mental health in the entire community. For the clinics that have reported to date, there is little evidence of any change in the proportion of clinic time spent in this activity during the period 1954–59.

Reporting by a larger proportion of all outpatient psychiatric clinics in subsequent years will make possible more detailed analyses by type and location of clinics. In addition, reporting of community service hours during each month of the year will provide a more comprehensive picture of community service activities generally, as well as a more accurate measure of activities for any one clinic. Reporting for each month is being considered because of the seasonal variations in community service activities.

Several research areas may be suggested for further study of community service activities. The present data measure the amount of community services clinics provide. However, data are not available on community agency demands for such services and the extent to which these demands are being met. The need for training clinic professional personnel to promote and carry out community activities might also be surveyed. Adequate tools must be developed for evaluating the quality and effectiveness of community services. Thus, more detailed reporting with respect to the content and goals of consultation and education activities and some measure of the accomplishment toward these goals might be desirable in expanded data collection in this area.

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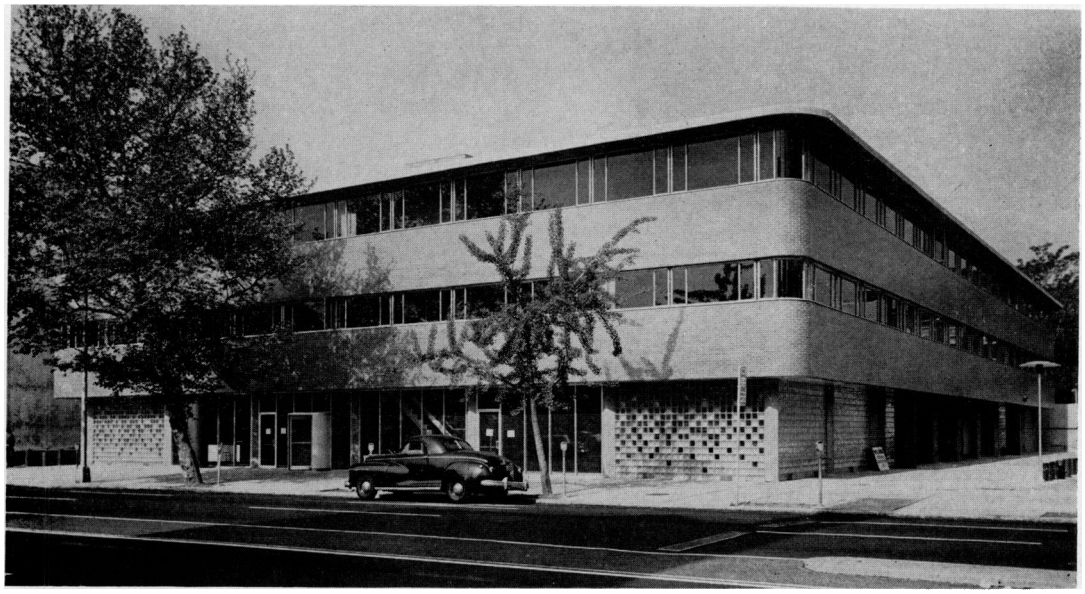

Philadelphia's Community Health Services Building

THE CONCEPT of providing neighborhood centers for health services is sound—for health is too personal, too individualized to be forced into any one mold. Health services offered by a community center like this become a part of each citizen's life and habits; not something strange, apart, and threatening to be used only in an emergency. Washington, Harrisburg, and city hall—all may help provide those health benefits; but the closer to home they can be housed, the more they will be utilized and appreciated.

—BERWYN F. MATTISON, M.D., *executive director, American Public Health Association, dedicating the Community Health Services Building, Philadelphia.*

Relation of Nucleic Acid to Malignancy

"Beware, lest in feeding the stream, thou driest up the spring." These wise words appeared 350 years ago in one of the essays of Francis Bacon, Viscount St. Alban, Lord Chancellor of England under James I. This great statesman and philosopher foresaw in broad outline the tremendous role that scientific research and knowledge would come to play in the strength of nations, the welfare of populations, and the profits of corporations.

It is interesting to examine the ways in which the principles enunciated by Francis Bacon have found application and fruition in the cancer field. Through the greater part of the history of mankind malignant disease has posed a hopeless problem for those stricken by it and for physicians charged with their care. Two great discoveries, however, have served as springs from which healing streams have carried hope to the hopeless. The first of these great discoveries was made more than 120 years ago by two German biologists, Schleiden and Schwann, who recognized that all living creatures were comprised of units called cells. . . . Within a decade the importance of these discoveries to diseases was trumpeted forth by a brilliant young German pathologist, Rudolph Virchow, who, in 1848, at the age of 27, boldly announced his recognition of the principle that disease processes involved the cells which had been discovered a few years before and that malignant disease was characterized by abnormal growth and multiplication of cells in the body.

The realization of this simple truth opened up the most effective approach to treatment of malignant disease which is available to us at the present time. Successful cures depend on the removal or the killing of all the cells which have undergone malignant change in an individual afflicted with this disease. . . .

There has been a steady improvement in the effectiveness of treatment, so that a disease which was once hopeless for all stricken with it can now be handled with effective cures for a certain portion of the affected, all too small, we know, but happily growing as our knowledge and skills increase. More than a century after the initial breakthrough discoveries, we are still developing applications of this knowledge.

A second and equally crucial breakthrough discovery, in my view, can be attributed to Dr. Avery and his associates at the Rockefeller Institute, who in 1945 demonstrated that nucleic acids affect the genetic characteristics of cells. To be sure, these people were working on bacterial cells. Malignancy may have been far from their minds. Yet the principles which they unearthed are, we now know, applicable to all cells. We know that healthy and malignant cells contain within them types of large molecules which scientists call nucleic acids. These may occur in the form of long molecular chains. We now realize that the pattern of the atoms in these nucleic acid chains provides a set of instructions which the cell follows in its activities. Small or large alterations in the atomic arrangements in these chains may provide the cell with altered instructions which, in some cases, may lead to malignancy and be transmitted to the offspring of such a cell. Thus an important clue to malignant disease, we feel sure, must reside in the nucleic acid content of the cells.

We are in the very early phases of the development of knowledge which will permit this important spring to flow into a stream which will power additional weapons for the management and prevention of malignant disease. Just as we are still refining applications of Schleiden and Schwann's cell theory more than a century after its discovery, so we can be sure that many decades will be consumed in developing the applications of Dr. Avery's discovery in the cancer field.

But we have need for more springs of fundamental discoveries which may provide us with decisive breakthroughs in the cancer problem. We have need to create and strengthen many streams which will develop the knowledge derived from these discoveries as they can be applied to the special problems of malignant disease. And finally we need the trained physicians, the equipment, the hospitals, and the specific knowledge which will permit these discoveries and their refinements to be applied individually for the benefit of patients and for the prevention of malignant disease in the population as a whole.—*Remarks of Dr. H. Stanley Bennett, dean of the division of the biological sciences of the University of Chicago, before the Board of Trustees of the University of Chicago Cancer Research Foundation, December 1960.*