Montgomery County Health Department's Mental Health Program

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SIR OLIVER LODGE once commented that the last thing in the world a deep-sea fish could be expected to discover would be salt water. This statement wryly and too aptly describes the situation of mental health in many communities in this country today. I should like to discuss the development of some of the mental health services and programs in Montgomery County, Md., pointing out what might be considered discoveries of some "salt water" facts about community mental health, particularly those concerning health department responsibilities and future needs for services and facilities.

Montgomery County is a suburban area adjacent to and northwest of Washington, D.C. The estimated population of about 350,000 represents an increase of over 100 percent in 10 years. A large portion of the working population commutes daily to the District of Columbia, the Federal Government being the largest employer of Montgomery County citizens. Many medical and research organizations are being established within the county. The population is considerably younger than the national average because of the influx of young working people. The population 65 years of age and over is approximately 22,000. One of the striking peculiarities of the county is its relatively high income. In 1959, out of 63,500 households, 46,000 had incomes of more than $7,000, and the median family income was $9,000.

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The Mental Health Program

The mental health program in Montgomery County began in 1938 with the establishment of the mental hygiene clinic for diagnosis and treatment of children and adults under the sponsorship of the mental health association. The clinic had a part-time psychiatrist, a social worker, a psychologist, and clerical personnel. Later it was partially subsidized by the Maryland State Health Department.

The clinic has been supported since 1958 by funds from the community chest, fees, and the county health department, which has a fee-for-service contract with the clinic. Individuals who are unable to pay for services or can only pay for part of them are subsidized. Their ability to pay is determined by the county welfare department. At present, $30,000 is budgeted for the 1960 fiscal year to pay for clinic services. The clinic is now staffed with two psychiatrists, four social workers, and two psychologists, plus clerical staff.

Since 1956 the county has also had contractual arrangements with a private mental hospital to accept patients for a period of not more than 10 days for observation and psychiatric diagnosis. There are no beds in Montgomery County general hospitals for mental patients, and until 1956 psychotic patients who were to be committed, including those with severe alcoholic psychoses, were kept in the

county jail until they could be certified and transferred to the State mental hospital. Under the present arrangement, after a short stay at the private hospital, many of the patients have not proceeded to the State mental hospital but instead have been returned to their jobs and homes.

Persons may be referred to the private hospital for observation by the police, juvenile court, health department, or welfare department. Under the present commitment law, if the patient will not enter the private hospital voluntarily, the police retain custody of him at the hospital until two physicians who are not on the hospital staff can provide the necessary certification. Because of this arrangement, several training sessions were held for police officers in the proper handling of mental patients.

Prior to 1954, the health department had no direct mental health services. The Youth Commission, appointed by the Montgomery County Council, began a study in 1953 to determine the mental health needs of youth. The study, reported to the council in 1954, revealed that the needs were overwhelming and that children were being neglected in the mental health field. The study prompted the council to appropriate funds establishing a new clinic in the health department devoted to the diagnosis and treatment of the mental disorders of children. No adults were to be treated except as they were involved in the emotional disturbances of the children under treatment. In addition, the clinic was to give consultation to various community agencies such as the board of education, juvenile court, welfare department, family service bureau, and other agencies concerned with the mental health of children. The clinic began operation in October 1954 with a part-time psychiatrist, social worker, and a psychologist. Over the next 6 years, the clinic staff increased to two full-time psychiatrists, a half-time psychiatrist, four psychiatric social workers, three psychologists, and a larger clerical staff. At present the clinic is spending about 50 percent of its total working hours in consultation to community agencies, and 15 percent each in training and community education.

A clinic for treatment of the patient with alcohol problems was also established in 1954. This clinic resulted from the work of a study commission appointed by the Governor. The clinic is open once a week and is staffed by a psychiatrist, a psychologist, a social worker, an internist, and a public health nurse. Each week 8 to 12 patients are seen. Most of them come to the clinic of their own accord. Others are referred by the courts, private physicians, and community agencies. Results of therapy have been encouraging for patients that are seen at least three times.

Planning Committee

The Joint Mental Health Planning Committee of Montgomery County was organized in 1954 as a result of the study by the youth commission in 1953–54. The committee consists of representatives from all agencies having an interest in mental health. Two noteworthy planning projects have been accomplished by the committee. The first was a plan for followup of patients discharged from the State mental hospitals. The other was a survey in 1960 of county mental health needs.

Participating in the planning of the followup service were representatives from the State health department and from Springfield State Hospital, which receives all of the Montgomery County mentally ill except for a few nonwhite admissions. The group decided that the public health nurse was the one best suited to follow the mental patient and his family during and after hospitalization. This would in no way place the nurse in the role of a psychiatrist or psychologist, but rather she would be carrying on her familiar task of helping families that have medical problems.

The nurse's functions would be to help the family release the feelings of guilt usually built up around the commitment procedure, to interpret hospital procedures to the family, and to give basic information concerning visiting, convalescent leave, and foster care. She would help the family understand and accept the patient's mental illness, evaluate the effects of the patient's illness on other members of the family, try to plan with the family in arranging for the patient's return home, and work with community resources to assist the patient and his family, particularly after parole or

discharge. She would also help with the procurement of prescribed drugs, particularly if there was financial difficulty.

A pilot project was begun in January 1956. At the beginning it was felt that the nurse should not be involved in admitting the patient, since this might create animosity in him and also prejudice his family in future relationships with the nurse. As the project progressed, however, it became increasingly clear that the nurse should take part in the admission procedure.

Since there was no established procedure by which the health department received information concerning patients admitted and discharged from the hospital, a working committee of health department and hospital representatives was established. It met periodically to discuss problems of patients, to convey information from the hospital to public health nurses working with discharged patients, and to convey information from nurses back to the hospital concerning conditions in the home. This part of the program was conducted primarily by social workers from the State hospital. In addition, a psychiatrist from the hospital was employed by the health department for 3 months, greatly improving communications. He consulted with nurses about the patients and the community and frequently obtained information concerning home situations of patients still under treatment in the hospital. Later, a nurse from the hospital was also assigned duties on the committee. The health department has since conducted orientation sessions for many State hospital staff members to acquaint them with the community and the functions of a local health agency.

The public health nurses doing followup have been able to establish good rapport with private physicians caring for the discharged patients. The nurses consult with the physicians about drug treatment and any other medical care needed by patients.

An essential part of the program was psychiatric consultation for the nurses. The first attempt to provide consultation was through the community psychiatric clinic, but this was not satisfactory. The second was with a health department psychiatrist who saw every discharged patient accepting appointment for interview, and in some instances a number of interviews took place. A third phase was the employment of a psychiatrist from the State hospital, as previously mentioned.

On the basis of the pilot project, a clinic was established in October 1960 in the health department consisting of a psychiatrist, a public health nurse, and a clerk to follow patients discharged or on furlough from the State hospital. The clinic is held once a week. Approximately four to six patients are seen during each clinic session. A total of 32 patients have been seen in the clinic, and 18 are being followed at the present time.

Only one patient has been returned to the hospital on the advice of the psychiatrist since the clinic began. Two patients returned without the recommendation of the psychiatrist. Many of the patients are in serious psychiatric circumstances. One young girl with a serious regression was treated by the clinic psychiatrist for 4 months; she has now improved enough to go back to work.

Since the followup project began, the State department of mental hygiene and the State department of health (now incorporated under one board of directors) have directed all the counties of Maryland to establish relationships between hospitals and local health departments similar to those established in Montgomery County to follow patients entering and being discharged from mental hospitals.

Mental Health Survey

As mentioned earlier, the other notable project of the joint mental health planning committee was a survey to determine the need for additional mental health services in Montgomery County. The Joint Commission on Mental Illness was consulted as a result of conferences with the Community Services Branch of the National Institute of Mental Health. It was finally decided that a survey would be made of the mental health needs of persons being seen by or receiving care from the various community health and welfare agencies in Montgomery County at that time. The survey was made in 1960 by 12 agencies on a do-it-yourself basis. A random sample of 26 members, or 10 percent, of the county medical society also participated in

the survey. These physicians were mainly in general practice, internal medicine, pediatrics, and psychiatry.

The study covered all clients seen during a single work week. Participating agencies and physicians completed questionnaires for each client they believed to be mentally or emotionally disturbed. The questionnaire covered certain basic information about the individual, the services he needs, whether or not such services were available at that time, and, if needed services were not available, the reasons why.

About 7,500 persons were given service by the respondents during the survey week, and 1,136, or 1 out of 7, were considered to be disturbed. Of these reported patients, 90 percent were in need of continued or additional service, 4 percent had no need for further service, and for 6 percent the need was not determined.

The survey showed that, in general, available services met about one-half of the demand as seen by the 12 agencies. Family and personal counseling was in greatest demand, representing one-fifth of the total services needed. Need for psychotherapy represented one-sixth of the total, and need for psychiatric and psychological evaluation comprised another one-sixth of the total services needed.

A long waiting period was by far the most common reason cited for services being unavailable. Lack of agencies to supply the needed services and lack of funds or transportation were other causes. About one-fourth of the "unavailable services" could not be provided because the clients refused the service or did not feel ready for it.

Shortly after survey results became known, the Montgomery County Council appropriated $20,000 for purchasing residential care from various facilities in and around the metropolitan area on a contractual basis through the health department. Until then, the county government had no residential treatment facilities available in the county, and only 60 official agency beds were available in the entire State. Also as a result of the study, staff was added to the mental health services section in the health department to provide increased diagnostic and treatment services.

A sequel to the survey will be a followup study by University of Maryland psychologists with the participating agencies to try to determine what has happened to patients in the study who could not, according to the identifying agency, receive service. Did they eventually receive service? If so, how did they get it? If they did not, what is their present status?

Health Department Responsibilities

Until the State department of mental hygiene and the State health department were combined under the board of health and hospitals, mental hospital care was the responsibility of the department of mental hygience. Outpatient mental care and child guidance clinics were legal responsibilities of the State health department. No organized lines of communication were established between the hospital and the community. The mental hygiene department had no representatives in the community, though there was contact with the local physician about his patient. In the not too distant past, patients who went to a mental hospital were expected to remain there forever. With present methods of therapy, this is no longer the case. An institution 37 to 200 miles away, however, cannot give on-the-scene assistance and cannot be a part of the patient's community. A realization has developed that the health department is the local agency to represent the patient and his interests in the community, for if we believe in psychotherapy and mental rehabilitation, we expect the patient to leave the hospital and return to his home.

An inherent responsibility of the health department lies in the concept that when a community has a medical need and no resources to meet it, the health department's role is to see that the resource is established. This, of course may be done in many ways. We established an outpatient service for discharged mental patients since there was none in local hospital outpatient clinics or elsewhere. This service will grow, I am sure, and hopefully will be adopted by other communities.

Responsibilities exist in the field of preadmission screening and observation for mental disease. We are planning now to develop such services, including a small inpatient facility for observation and short-term therapy such as that recommended by the Joint Commission on Mental Illness and Health. Counseling of

families and patients will be a part of these services, for our survey has shown it to be a definite need. An emergency service to go into homes of acutely disturbed patients for an on-the-spot assessment of the home and family situation, the status of the patient, and the patient's need for specialized diagnosis and treatment is another cog in the wheel of comprehensive mental care. We hope to establish day care facilities in connection with the in-patient facility. There is one facility, Woodley House, in the metropolitan area for overnight care of the mental patient who usually is employed by day but needs shelter and rehabilitative support in the evenings. This type of facility may be of even greater need than day care facilities.

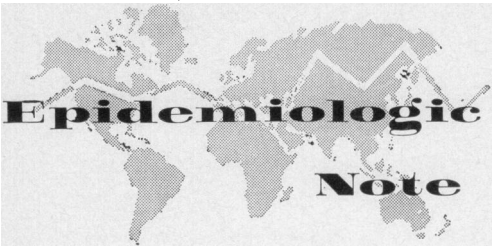
Two years ago the local mental health association established a recreation center, which is open in afternoons for the mental patient. Facilities for day care of the mentally retarded, uneducable child are being established to relieve some of the emotional pressures on the family.

Making the community aware of these possibilities, what the costs are, how they operate, and what they can accomplish is also a health department responsibility. Most public health workers would agree that we never seem to have enough mental health personnel or diagnostic and treatment facilities for children. It falls to the health agency to make the community aware of the situation and to provide leadership in planning to narrow the gap between supply and demand. The community itself must take the action. One agency or even a few cannot do the job alone.

Education in mental health is a loose, broad term which is extremely hard to define. There are many questions concerning mental health education: How should we go about elevating community mental health education? What groups, such as teachers, physicians, public health personnel, clergy, should be in the front row in the class? How can the development of motivations be measured? Do habit patterns change as a result of mental health education? More investigation is needed into the behavioral aspects of mental health education. I believe that leadership here is a responsibility of the health department, with reliance on as broad a representation as possible of professions that can bring new knowledge to bear on this problem.

One way in which health departments might further mental health education among private physicians was exemplified in a seminar sponsored recently by the health department, a private mental hospital, and the mental health association in Montgomery County. The subject was the management of the senile psychotic in the light of research findings indicating that most of the symptoms are due to abject depression, not arteriosclerotic changes in the cerebral vessels. Those attending the seminar were greatly impressed by what could be accomplished by careful interviewing for clues of basic emotional causes of deviant behavior, as well as a thorough physical evaluation, followed by understanding, patience, and supportive therapy.

The general public is largely unaware of the scope of the problem of mental illness. By its very nature, mental disease does not make itself known in forms that can be readily recognized until late in the process. When a leg is paralyzed by poliomyelitis, the affliction can readily be seen, usually arousing a sympathetic reaction toward the individual. The public wants to do whatever is necessary to prevent its reoccurrence in others, possibly one of their own family. This is not the case with mental illness. One way to a change in attitude toward mental illness is to set small goals for attacking the problem, and as we accomplish them, gradually getting the public to understand what we are up against. Attitudes toward mental illness are changing, but only because the community has had its problems made clearer to its citizens. Interest can be aroused but not necessarily by one small project. There should be many activities, with emphasis on care and services for the mentally ill, for the interests of the community to feed upon. Dr. Wilson Smillie once said, "The first step that a community must take in the promotion of mental health is to plan for care of the mentally ill. The more intelligent and adequate the program of care for mental illness, the more advanced is the degree of civilization of the community."



Rabies in a Flying Squirrel

Isolation of rabies virus from a flying squirrel, *Glaucomys volans,* captured in Pinellas County, Fla., on July 12, 1961, appears to be the first recorded observation of rabies in this animal. Negri bodies were observed in smears of brain material stained with Sellers stain. Fluorescein-tagged antibody slides gave a positive reaction for rabies antigen. Suspensions of brain and salivary gland injected intracerebrally into white swiss mice produced deaths in 14 and 16 days, with negrigenesis. Titration of the virus in the salivary gland gave a mouse LD_{50} of $0.03 \times 10^{-1.6}$ ml.

The flying squirrel was captured one afternoon about 5 p.m. by three boys who were fishing in a canal dug through an undeveloped area north of St. Petersburg. It fell to the ground under a tree near where one boy was sitting. It was caught there and taken home. While handling the squirrel two of the boys were bitten. That night the squirrel was fed some salami, but it died about noon the next day.

Appearance of the virus in this animal is of epidemiologic interest because an estimated 3,000 squirrels, mostly gray squirrels, *Sciurus carolinensis,* which had attacked humans, have been examined routinely in the Florida State Board of Health laboratories without evidence of rabies infection being found. Infection with rabies virus has not been confirmed previously in any Florida rodent, although insectivorous bats of seven species and raccoons apparently maintain the disease enzootically (*1,2*).

Eight other adult flying squirrels were trapped in the 300-acre area, but none gave evidence of rabies infection. Only two other mammals were trapped in 1,261 trap nights, both cotton rats, *Sigmodon hispidus.* Both were destroyed by insects and could not be examined. There was no evidence of rabies in pets in a large subdivision a half mile away nor among domestic animals anywhere in the county, although sporadic cases have been observed in bats, cats, and raccoons in previous years (*2*).

Rabies virus was isolated from 1 of 231 bats shot in July within 100 yards of the tree from which the rabid flying squirrel fell. An estimated 1,000 yellow bats, *Dasypterus floridanus,* flew across this area daily just before dark, apparently en route from nursery roosting sites to feeding or drinking locations. Of our sample, 181, including the rabid bat, were pregnant or lactating females. Another rabid yellow bat was submitted from the county in July. Examination of 718 yellow bats from this area since 1953 has revealed an infection rate of approximately 2 percent in those shot at dusk (*1*).

Existence of a concurrent rabies infection in yellow bats, without any evidence of the virus in the other mammals of the area, suggests that the flying squirrel was infected while investigating or capturing a moribund rabid bat. The carnivorous tendencies of flying squirrels are documented in the literature (*3*). Flying squirrels are often a nuisance to mammalogists because they eat small mammals taken in traps. Our eight squirrels were taken in rat traps baited with small sections of weiner. The skin of the rabid squirrel showed no evidence of a recently healed bite wound. These observations indicate that this case was another sporadic appearance of rabies best explained by contact with the insectivorous bat rabies reservoir. Investigations of similar sporadic cases have been consistent with this conclusion (*2*).

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