Outpatient Mental Health Statistics Program

A NATIONWIDE program on outpatient psychiatric clinic statistics was initiated on July 1, 1954, by the National Institute of Mental Health, Public Health Service, in cooperation with the State mental health authorities. The goals of this program are to obtain basic information—for program planning, professional training, and epidemiology—on the geographic distribution of outpatient psychiatric clinics and their professional staffs, the number and characteristics of the persons served, the amount and type of service received by patients, and the community-oriented services provided. The reporting program is expected to yield data useful to States, communities, and clinics, as well as nationally.

A trial run in a hundred clinics throughout the country, professional workshops, and a national conference preceded the initiation of reporting outpatient psychiatric clinic statistics. Since 1954 clinic participation in reporting has gradually improved. A principal factor has been the cooperative arrangement between clinics and State mental health agencies whereby the State agencies prepare punchcards and tabulations from patients' reports submitted by clinics. In 1959, 95 percent of the 1,429 clinics in the country reported on their professional staffs; 74 percent, information on patients; and 58 percent, data on community services.

In 1960 the National Institute of Mental Health held regional meetings with State mental health authorities in order to establish a better understanding of the needs and problems relating to outpatient psychiatric clinic statistics at different levels. In these meetings it became apparent that, in addition to incomplete reporting, a number of reporting items and definitions required further study. An advisory committee was formed, therefore, representing different geographic areas, professions, and levels of operation, to review and advise the institute on the nationwide reporting program for mental health clinics throughout the country. This committee, the Outpatient Advisory Committee, which will constitute a permanent advisory group, met in June 1961 and in January 1962. In the interim between the two meetings, five ad hoc committees met to prepare detailed reports on selected aspects of mental health statistics, and the opinions of State mental health authorities on committee recommendations were solicited through questionnaires.

Meetings of the Outpatient Advisory Committee emphasized the important role of outpatient psychiatric clinics in community and national mental health and the significant contribution already made by data collected in this program. In these meetings the need to continue to make statistics on outpatient psychiatric clinics a vital element in program planning, epidemiology, and administration at every level was stressed. With the assistance of State mental health authorities, the advisory committee will endeavor to insure that this goal is met.

The next meeting of the Outpatient Advisory Committee is scheduled for October 1962. It is expected that six ad hoc committees will hold meetings in the interim. Following is a more detailed description of the topics considered by the advisory committee and the task of each ad hoc committee.

Patient Characteristics and Services

Routine reporting. The immediate task of the Outpatient Advisory Committee and the one to which the most time was devoted was the critical review of the reporting definitions to be used in a revised reporting manual. Reporting on clinic patients was reviewed in the

This report was prepared by the Outpatient Studies Section, Biometrics Branch, National Institute of Mental Health, Public Health Service.

light of (*a*) changes in programs and services, (*b*) practical experience with the definitions on the clinic level, and (*c*) analyses of the data in reports to organizations, such as local boards and legislative groups. As a result of extensive discussions at the 1961 and 1962 committee meetings and of interim work, the basic definitions of and categorizations for a patient, type of admission, referral source, psychiatric classification, person-interview, type of service, termination of services, and disposition were modified for routine national reporting. A set of revised definitions is available upon request to the Outpatient Studies Section, Biometrics Branch, National Institute of Mental Health, Public Health Service, Bethesda, Md.

Type of treatment. Further work is needed on some routine items. For example, because of differences in clinic goals and operations, one of the most important but most difficult classifications is type of service. The following classification was recommended:

Application only.
Evaluation for other agencies.
Other diagnostic services only (including incomplete diagnosis).
Treatment services.

Further delineation of type of treatment is needed, however, because of the interest of mental health program planners in the wide variety of new services offered by outpatient clinics. The ad hoc committee on type of treatment will study the feasibility of further specifications of treatment, such as aftercare for former hospital patients, marital counseling, remedial reading, and rehabilitation.

Household or family unit. In addition to reviewing patient reporting of already collected items, work was initiated in several new areas. A need for counting and classifying services to the family or household unit, as well as services to individual members, is evidenced by a growing trend toward the treatment of the family as a unit, regardless of which family member is first referred to the clinic or considered as a patient. This trend stems from recognition of the significance of family relations in the etiology of mental disturbance and of family intra-action in therapy. The ad hoc committee on household or family unit will explore methodological problems in present psychosocial classifications of families and will develop a systematic way of counting services to the family.

Presenting symptoms. The reporting of presenting symptoms or problems to supplement the psychiatric nomenclature was considered of high priority. Such reporting would permit collection of data on special problems of current public and professional interest and a clearer description of complaints than is possible through the current diagnostic categories.

Based in part upon information now collected by some States, the ad hoc committee on symptoms and presenting problems prepared a list of 29 symptom complexes or problems, classified under the major headings "Slow Growth or Development," "Mood Disturbances," "Performance Symptoms," "Social Relationship Disturbances," and "Special Symptoms." From these groupings, major impairments can be readily determined. It is expected that the admission worker will check as many items as are descriptive of the patient or will check the item "Without Symptoms." The symptom classification will undergo a series of tests during the coming year.

Tabulation of data. Annual tables provide basic data, by clinic. These data can be related to the clinic administrative report for purposes of clinic comparison. Special tables provide detailed cross-tabulations of patients or services either on a statewide or clinic group basis. The focus of these special tables will vary from year to year to reflect different aspects of services to patients and changing program needs and emphases. For 1961, the tables provide data on characteristics of patients which will be related to the recent census in an American Public Health Association Vital Statistics Monograph on Mental Disorders. For 1962, in response to the interest expressed by the States, the special tables will focus on services to adolescents.

Integration of inpatient and outpatient data. The variety of psychiatric facilities and the extent of interfacility movement of patients today makes it essential for the Biometrics Branch to consider as a next step how an integrated patient reporting system for all psychiatric facilities can be achieved. The most ad-

vanced level of integration of data is identification of patients by all reporting facilities, with subsequent linking of case records through a psychiatric case register. Although such a system is being undertaken in a few areas, it does not appear to be a feasible goal for national reporting.

The report of the ad hoc committee on liaison between the Outpatient Advisory Committee and the Model Reporting Area for Mental Hospital Statistics recommended partial integration of national data through (*a*) collection of information on referrals into and out of each facility, (*b*) identification of patients who are simultaneously on hospital and clinic rolls, and (*c*) reporting of previous contacts of patients with other mental health facilities. The reliability of previous psychiatric contacts reported by patients needs testing, however, by comparison with data available through a psychiatric case register or by other means.

The report of this ad hoc committee emphasized the importance to national and State planning of complete reporting by all State, private, and Veterans Administration mental hospitals, psychiatric services of general hospitals, day treatment centers, and outpatient psychiatric clinics in the country. Also, to effect liaison among statistical programs, the Outpatient Advisory Committee recommended regular exchange of observers at meetings of the committee and of the Model Reporting Area group.

Community Services

Outpatient psychiatric clinics report the number of man-hours devoted to a wide variety of community-oriented activities: professional assistance and consultation to various community agencies, mental health education of other professional and lay groups, and participation in community planning and coordination. In April 1959 about 6 percent of the scheduled man-hours in clinics were spent in these activities.

While the information provided by these reports is useful, it is inadequate for a number of reasons. The need or demand of different community agencies for such services and the number of agencies that receive these services are not known. More detailed information is needed on the purpose, content, and outcome of each clinic consultation. Adequate tools must be developed for evaluating the quality and effectiveness of community services. The ad hoc committee on community services will design and test in the field a practical model for more detailed reporting of these nonpatient clinic services.

Administrative Report

Clinic type. Location of each clinic, auspices under which it operates, age of patients, special groups it serves, hours of service, number and type of professional staff, and scheduled man-hours are reported as of April 30 each year. The ad hoc committee on clinic characteristics has been concerned with the development of a more comprehensive clinic classification indicating primary function of the clinic, types of referrals accepted, and types of cases which may be excluded by clinic policy. This information will make possible more valid comparisons of clinics and appraisal of activities performed against clinic program goals. The information may also provide a basis for clinic stratification for sample surveys. The data on criteria for admission to clinic service should be of interest in planning for comprehensive community mental health services. A supplementary form for collecting this information will be tested during the coming months as a preliminary to a special study in 1963.

Staff hours. The number of professional staff and scheduled man-hours in filled positions in outpatient psychiatric clinics are an index of the availability of clinic services. The number of man-hours for each 100,000 population measures whether the growth of clinic services is keeping pace with population growth nationally and by geographic area. Staff data are generally reported only on April 30, however. Therefore, because of vacancies and staff turnover, it is not known whether these data represent the normal staffing of the clinic. In addition, because of vacations, sick leave, and other absences from duty, there may be considerable discrepancy between scheduled and actual hours worked. The feasibility of collecting annual data on hours worked will be investigated by the Outpatient Studies Section.

Clinic costs. At present, detailed informa-

tion on source and amount of clinic funds is omitted from the statistics because the quality of cost information reported nationally has been poor. Some of the difficulties are the separation of inpatient and outpatient costs when there is joint administration, the allocation by appropriation of funds spent, the use of shelter and services "in kind," and the need for cost accounting and time studies to answer some of the pertinent questions. Data are needed on the total cost of supplying clinic care and on unit costs—cost per patient, per staff interview, per community service, and per training activity. The ad hoc committee on outpatient clinic costs will study the technical problems in achieving these goals and will make appropriate recommendations.

Extension of Reporting

A variety of nonpsychiatric facilities—family service agencies, medically directed clinics for alcoholics and the mentally retarded, psychological clinics, and counseling centers—have services similar to those of outpatient psychiatric clinics. Family service agencies and clinics for the mentally retarded are already reporting workload data to national organizations. Reporting by these agencies on a basis comparable to reporting by outpatient psychiatric clinics will enable compilation of data for a more complete picture of available services, by type, and will add to an understanding of where patients go for help and what help they receive for various types of problems.

The Outpatient Advisory Committee has approved a survey of State mental health authorities to determine their interest in extending reporting to mental health facilities other than outpatient psychiatric clinics, their willingness to assume responsibility for an extended reporting program, and their readiness to participate in such a program on a pilot study basis.

RS Virus Linked to Pneumonia in Children

Respiratory syncytial virus has been linked to a severe outbreak of pneumonia among infants and children in a public institution for homeless children in the District of Columbia. Of 90 children, ranging in age from 8 months to 4 years, 36 were affected over a 4-week period.

The virus was isolated from 24 of the 36 children and was significantly associated with the onset of fever of 100.6° F., or higher. The average highest fever was 103° F., with a 4-day mean duration of 100.6° F. or greater. Coryza and cough were predominant symptoms during the illness, and fine or medium rales could be heard in circumscribed areas of the chest.

Unlike other viral infections, pneumonia in this outbreak did not appear to be influenced by the presence or absence of neutralizing antibodies to RS virus. Forty-five percent of the children without such antibodies and 39 percent with the antibodies developed the same illness. Possible explanations for this phenomenon are under study.

Investigation of the pneumonia outbreak was reported in the November 1961 *American Journal of Hygiene* by Drs. A. Z. Kapikian, J. A. Bell, K. M. Johnson, R. J. Huebner, and R. M. Chanock of the National Institutes of Health and Dr. F. M. Mastrota, formerly with the District of Columbia Department of Public Welfare. The outbreak was studied as part of long-term research on diseases among institutionalized children, which began in 1955.