Outpatient Mental Health Statistics Program, 1964

RECENT DEVELOPMENTS in the nationwide outpatient mental health statistics program are particularly important in view of the emphasis on comprehensive community mental health services and of the augmented planning activities for such services. In the area of outpatient care, psychiatric clinics have been the major focus of data collection. (An outpatient psychiatric clinic is defined as an "outpatient mental health service unit with a psychiatrist in attendance at regularly scheduled hours who takes the medical responsibility for all clinic patients.") Basic information on characteristics of patients served and the services provided by these facilities are collected annually for use in administrative and program planning, professional training, and epidemiology. Studies on other mental health services provided on a non-residential basis, such as psychiatric day-night services, private psychiatric practice, mental health facilities with a consultant psychiatrist, and services provided for certain diagnostic or problem groups (alcoholics and drug addicts) are now planned or underway.

Outpatient Psychiatric Clinics

Nationwide reporting through State mental health agencies by the approximately 1,800 psychiatric clinics in the country includes administrative and staff information (*1*, *2*) and data about individual patients, such as referral source, age, sex, diagnosis, type of service, number of interviews received, and disposition (*3*). Certain of these items, such as number of patients served during the year and number terminated from service by age, sex, and diagnosis (*4*), are reported each year by each State to the National Institute of Mental Health, Public Health Service. Other items are reported to the Institute as requested on a special study basis.

Each year, for example, States prepare a series of "special" tabulations on a particular topic considered by State or national groups to be of program importance. In 1961, the demographic and psychiatric characteristics of patients were reported in some detail and related to the census for the study of rates of clinic utilization (*5*, *6*). In 1962, the tabulations dealt with clinic services to adolescents, and in 1963 with services to psychotic and mentally deficient patients. The older-age patient will be the focus of the special tables for 1964. States are being surveyed for their special study interests for the next few years.

New Items for National Reporting

To broaden the scope of information collected about patients, an advisory committee, following extensive experimentation and testing, has recently recommended the routine reporting of the following two new items.

Description of patients' problems. A large proportion of clinic patients, especially children, do not receive a formal diagnosis. In part, this reflects the substantial proportion of patients who receive only intake services. Difficulties in using the diagnostic nomenclature, particularly for outpatients, is probably another factor accounting for the large proportion of undiagnosed patients. To get a more adequate description of patients who request clinic services, therefore, an ad hoc committee developed a uniform way of describing the problems of the patient as perceived by the intake worker. The method consists of the use of a checklist of 37 categories (including, for example, impaired physical growth and mental development, drinking problem, suicidal attempt), which is believed to cover all areas of psychosocial disturbance. The advisory committee recommended that this checklist of

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problems be used by all clinics for at least 2 years.

The checklist will then be reevaluated with regard to: (*a*) the relationship of the reported problems to other information about the patient, such as diagnosis, referral source, demographic characteristics, services received, and outcome; and (*b*) the usefulness of this type of information to lay, legislative, and professional groups.

Types of treatment. Information on the range of treatment services provided to various outpatients would be of considerable interest to program planners, clinicians, and teaching groups. Uniform treatment categories (individual therapy, group therapy, chemotherapy, therapy through collateral, somatic therapy, educational therapy, family therapy, and rehabilitative therapy) were developed, therefore, for routine nationwide clinic reporting. These categories appear to be appropriate also for reporting treatment received by inpatients and day-night care patients.

Other Items Under Study

Areas of clinic reporting and data analysis on which experimentation has just begun or is continuing include:

1. Methods of reporting services to family units as well as to individual patients. This methodological study reflects a growing trend toward the treatment of the "family disturbance," often through conjoint therapy. Trial reporting on a family unit basis will be initiated in a dozen clinics. It was suggested that further work in developing a family diagnostic classification by interested groups should be encouraged.

2. Methods of studying the socioeconomic status of patients who use clinic services and the interrelations of these characteristics with services and outcome. Such information will assist in the planning of mental health services to meet the needs of all segments of the population. As a preliminary step, the socioeconomic data now being collected by States will be reviewed. Similiar descriptive data for the various kinds of mental health resources will assist in determining the selective pathways to care used by different groups.

3. Methods of reporting the community-oriented services of clinics, such as professional consultation to other community agencies, mental health education, and participation in coordinated community planning. Although the proportion of scheduled clinic man-hours spent in these activities is now reported (about 6 percent in April 1959), a more complete statistical description of these activities is being sought.

4. Analysis of clinic policies and practices in selecting patients. A recent questionnaire obtained information on clinic admission policy with respect to the patient's source of referral, income or financial status, and problems or service needs. Data were also collected on the number of persons waiting for intake or other services and the principal functions of the clinic. Hopefully, this information will be particularly useful for community and State planning in identifying gaps in service. Collection of such information in future years will depend on the results of this survey.

5. Analysis of geographic distribution of clinics. A recent analysis described the distribution of clinic resources for children in rural, small urban, and large urban areas (*7*). Other ways of investigating the adequacy of available services for different geographic areas are being explored. For example, an analysis of clinic services by State economic area is being published (*8*).

Other Psychiatric Resources

Information comparable to that collected for outpatient psychiatric clinics will be needed in the future from the many other mental health services. This is particularly important with respect to psychiatric services not now routinely included in the nationwide data collection program.

Private practice of psychiatry. Studies in selected areas suggest that the number of patients seen in private practice during a year may be as great as that of outpatient psychiatric clinics, which in 1961 served more than half a million persons (*9*). A continuous or routine reporting system on all private psychiatric outpatients is not possible at this time on a nationwide basis. However, reporting by a sample of psychiatrists for a limited period would seem feasible. Twenty-four States indicated their interest in such a sample survey and the Out-

patient Advisory Committee recommended that a survey be undertaken.

The National Institute of Mental Health, in cooperation with the Committee on Private Practice of the American Psychiatric Association, developed and tested a form which describes the characteristics of private patients seen in 1 month and the services received. If sample reporting is carried out over a 12-month period, the information obtained will permit the estimation of the number of patients served during a year.

Trial surveys will be conducted in five geographic areas with the assistance of the district American Psychiatric Association Societies. Five methods of conducting the survey will be attempted and the results in terms of participation and completeness of reporting evaluated. If the results of the trial are satisfactory, a nationwide sample survey of psychiatrists will be carried out.

Psychiatric day-night services. Of growing importance is the psychiatric day-night service, a resource for patients who require less than 24-hour hospitalization but need more help than can be given by an outpatient psychiatric clinic or a psychiatrist in office practice. The many requests for relevant information about these services stimulated the collection of baseline data about these facilities.

To provide some guidelines for the uniform nationwide identification of psychiatric day-night services, a committee composed of National Institute of Mental Health personnel and of clinicians in the field developed the following definition: "A psychiatric day-night service is a therapeutic facility for patients with mental or emotional illnesses or mental retardation who spend part of the day or night in a planned treatment program in this facility and in which a psychiatrist is present on a regularly scheduled basis who assumes medical responsibility for all patients."

Included in this definition are psychiatric day-night services, which are operated under the auspices of a hospital, outpatient clinic, other community resource, or as an independent facility.

A one-page survey form was designed by the committee to include items on auspices and eligibility requirements for admission, caseload, professional staff, and types of services provided. One hundred and fourteen psychiatric day-night services in which a psychiatrist assumed medical responsibility for all patients were identified in the survey conducted in May 1963. An analysis of these findings has been prepared (*10*). These facilities will be listed in the 1963 Directory of Outpatient Psychiatric Clinics and Other Mental Health Resources (*11*).

Nonpsychiatric Mental Health Resources

A variety of community facilities have primary concern with the provision of nonresidential mental health services to persons with adjustment or behavioral problems or mental retardation. These facilities are not under the medical direction of a psychiatrist but are staffed by one or more persons qualified in a related profession, such as medicine, clinical psychology, or psychiatric social work. To provide a more complete picture of available mental health services, on the recommendation of the advisory committee, certain of these facilities that are most similar to psychiatric clinics are included in the 1964 nationwide reporting. These facilities are mental health clinics with a consultant psychiatrist, clinics for alcoholic and narcotic addicts under medical direction, and day-night services with a consultant psychiatrist. Other facilities, such as family service agencies and psychological clinics, may be included in the near future.

Community Mental Health Centers

Perhaps the most important recent development in the mental health area is the emphasis on the continuum of patient care and on the provision of all necessary mental health services (inpatient, outpatient, day-night, and emergency services) in the community-based mental health centers. These innovations imply that the distinction between outpatient and inpatient care is less rigid and that patients may receive a variety of services in rapid succession within the same center in accordance with his needs.

The impact of these program changes on statistical recording and reporting of mental

health data is being explored. Techniques must be developed for obtaining certain comparable information from each type of service within the center, with minimum effort. Such data can then be integrated by the community center, the State, and the National Institute of Mental Health to reflect accurately the amount and type of care provided to patients, the characteristics of the groups served, and volume of patient flow between service units.

Several of the techniques to assist in such data integration are (*a*) development of appropriate recordkeeping systems for case management, (*b*) use of comparable items and categories for reporting by the different service units, (*c*) use of the same patient case number (unit number) by all services he receives at the community center, and (*d*) technique of case registers at community or State levels (*12*, *13*).

A committee composed of NIMH personnel, State program directors of community mental health centers, and clinicians and statisticians will work intensively to develop data-collection techniques for these centers in keeping with the changes in case management.

Program Use of Data

In view of the potential value to program planning of the wide variety of service data described in this report, improved techniques of use and communication of research findings are required. This phase of a statistics program has recently been emphasized: "The end result of an evaluative or research investigation is the communication of findings by internal report or publication to those who may be expected to reach decisions on the basis of the findings" (*14*).

Techniques for effective use of data in the planning operation, and concomitantly for improved data collection to meet programing needs, will be the subject of investigation by an ad hoc committee. A series of workshops on this topic is also being planned.

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