Health Referral Services for Armed Forces Rejectees

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EVER SINCE the present Selective Service System was inaugurated in the United States at the time of World War II, large numbers of young men have been found ineligible for military service because of health problems.

In the country as a whole for the fiscal year ending June 1960, of 169,000 registrants who received preinduction examinations, 45,000 (27 percent) were disqualified for medical reasons (*1*). In New York City alone, among 29,000 men undergoing preinduction examinations during 1960, more than 6,000 (21.3 percent) were disqualified for medical reasons (unpublished data supplied by the commanding officer of the Armed Forces examining station of New York City). These high rejection rates for health reasons continue to the present.

No extensive efforts were then being made to refer, for needed preventive, remedial, or rehabilitative care, the young men with health problems discovered in preinduction examinations. To see what could be done about the health problems of this group, late in 1961 representatives of the Public Health Service and the Selective Service System began discussions with staffs of several public health agencies throughout the country. As a result of these conversations, the New York City Health Department in May 1962 inaugurated a 3-year demonstration program to determine how men rejected for military service because of medical conditions could effectively be referred to the appropriate sources of care. This report sets forth the department's experience with this demonstration program.

Based in part on the results of demonstrations in New York City and at other locations, the Federal Government subsequently appropriated funds for similar health referral services throughout the nation. These programs are administered through contracts with State health departments, vocational rehabilitation agencies, and other agencies. In New York City, the referral service now operates as a regular service program of the New York City Department of Health through a subcontract with the New York State Department of Health. Procedures used in the service program have been modified on the basis of the experience in the demonstration program. The Armed Forces, through the New York City Armed

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Forces examining station staff, played an essential role in the successful operation of the referral program.

General Description of Program

Only New York City residents rejected at the Armed Forces examining station (AFES) for medical reasons were eligible for the New York City Health Department's referral service (HDRS). Men rejected for serious medical reasons by their local draft boards were not examined at the AFES offices and were not eligible. According to "Results of Registrant Examinations by Army Area and Induction Station," prepared by the Office of the Surgeon General, Department of the Army, there were 140,121 preinduction and induction examinations done at the New York City Armed Forces examining station in the period October 1962 through September 1964. Of these, 32,136 resulted in designations of medical rejection. Some were repeat examinations, and therefore there were fewer than 32,136 men rejected for medical reasons. A total of 12,062 medical re-

Correcting a Physical Defect

The case history of Maurice demonstrates the role of a referral program in guiding a young man rejected for military service because of a health problem—cardiovascular disease (mitral and aortic insufficiency). A 22-year-old Georgia high school dropout, Maurice had been living in New York City for 4 years. He had no previous knowledge of his heart condition and considered himself to be in good health. Maurice entered the New York City Health Department's referral service and, after counseling, agreed to have a diagnostic workup for his cardiac defect. Surgery was recommended for closure of an intraventricular septal defect. The operation was successful, and his prognosis is excellent.

Table 1. Distribution of 12,062 New York City male residents rejected for military service who were eligible for referral service, by disqualifying diagnosis, October 1962–September 1964

Disqualifying diagnosis	Number	Percent
Total	12,062	100.0
Psychiatric	**4,544**	**37.7**
Character, behavior, and intelligence disorders	3,319	27.5
Sexual deviation	1,460	12.1
Inadequate personality	525	4.3
Narcotic addiction	505	4.2
Schizoid personality	298	2.5
Antisocial personality	168	1.4
Immature personality	132	1.1
Intelligence disorders	100	.8
Other	131	1.1
Psychoneurotic disorders	941	7.8
Anxiety reaction	713	5.9
Neurotic depressive reaction	108	.9
Other	120	1.0
Psychoses	284	2.4
Schizophrenic reaction	272	2.3
Other	12	.1
Physical	**7,518**	**62.3**
Diseases and defects of bones and organs of movement	1,742	14.4
Diseases of joints	342	2.8
Limitation of motion	319	2.6
Pes planus	293	2.4
Curvature of spine	177	1.5
Other	611	5.1
Eye diseases and defects	1,714	14.2
Refractive errors	509	4.2
Congenital defects	151	1.3
Strabismus	115	1.0
Other	939	7.8
Diseases and defects of circulatory system	1,378	11.4
Congenital heart disease anomaly	676	5.6
Chronic rheumatic heart disease	476	3.9
Other	226	1.9
Diseases and defects of ear and mastoid process	536	4.4
Otitis media	246	2.0
Acuity of hearing defects	210	1.7
Other	80	.7
Diseases and defects of nervous system	381	3.2
Epilepsy (except focal and Jacksonian)	163	1.4
Other	218	1.8
Allergic disorders	371	3.1
Asthma	357	3.0
Other	14	.1
Albuminuria	357	3.0
Diseases and defects of digestive system	236	2.0
Diseases and defects of cellular tissue	168	1.4
Diseases and defects of genitourinary system	115	1.0
Other	520	4.2

NOTE: Classification follows "Classification of Diseases and Defects for Coding the Medical Reports of Men Examined for Military Service," Induction Examination Records Branch, Medical Statistics Division, Office of the Surgeon General, Department of the Army.

jectees were taken into the HDRS program. The remaining medical rejectees were not taken into the program because (*a*) they did not reside in New York City, (*b*) their medical rejection designation on the AFES examination indicated reevaluation, for example, in 3 months, 6 months, 1 year, or at correction of defect.

The referral service was developed under the direction of a public health physician. Public health nurses acted as counselors to the young rejectees, and social work consultants served as liaison between the referral service and the medical community. Each young man seen in the HDRS office was offered individual counseling by the nurse and he was referred, in accordance with his needs, either to private physicians, to voluntary or municipal hospitals, or to government, social welfare, or community agencies. In addition to offering service to the rejectee, the demonstration yielded data on the characteristics of the rejectee population and on their needs and responses to the program. Information was also assembled on the services available in the community to meet the rejectee's needs.

HDRS established four counseling offices—one within the Armed Forces examining station, one in a local draft board center, and two in New York City Health Department district centers.

Following medical rejection at the Armed Forces examining station, young men were routinely sent to the referral service office located within this examining center. There, an HDRS clerk entered the rejectee's name on the program intake roster and asked him to complete a short personal-data form. Upon completion of this form, one-third of the men, randomly selected, were asked to remain for counseling and referral. The remaining two-thirds, not inter-

Table 2. Rejectees eligible for the referral service, by disqualifying diagnosis and ethnic group October 1962–September 1964

Disqualifying diagnosis	Total eligible	White		Nonwhite		Puerto Rican		Unknown	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	12, 062	9, 045	75. 0	1, 973	16. 4	928	7. 7	116	0. 9
Psychiatric	4, 544	3, 397	74. 8	731	16. 1	339	7. 5	77	1. 5
Sexual deviation	1, 460	1, 120	76. 7	221	15. 1	101	6. 9	18	1. 2
Inadequate personality	525	312	59. 4	153	29. 1	47	9. 0	13	2. 5
Narcotic addiction	505	205	40. 6	160	31. 7	120	23. 8	20	3. 9
Schizoid personality	298	274	91. 9	15	5. 0	3	1. 0	6	2. 0
Anxiety reaction	713	668	93. 7	30	4. 2	9	1. 3	6	. 8
Other psychoneurotic disorders	238	221	92. 9	11	4. 6	5	2. 1	1	. 4
Schizophrenic reaction	272	230	84. 6	28	10. 3	13	4. 8	1	. 3
Other psychiatric disorders	533	367	68. 9	113	21. 2	41	7. 7	12	2. 2
Physical	7, 518	5, 648	75. 1	1, 242	16. 5	589	7. 8	39	. 5
Diseases and defects of bones and organs of movement	1, 742	1, 324	76. 0	277	15. 9	125	7. 2	16	. 9
Eye diseases and defects	1, 714	1, 174	68. 5	341	19. 9	188	11. 0	11	. 6
Diseases and defects of circulatory system	1, 378	1, 003	72. 8	278	20. 2	91	6. 6	6	. 4
Diseases and defects of ear and mastoid process	536	443	82. 6	40	7. 5	53	9. 9	0	0
Diseases and defects of nervous system	381	329	86. 4	31	8. 1	18	4. 7	3	. 8
Allergic disorders	371	311	83. 8	38	10. 2	21	5. 7	1	. 3
Albuminuria	357	243	68. 1	93	26. 0	21	5. 9	0	0
Digestive system diseases	236	200	84. 7	21	8. 9	13	5. 5	2	. 8
Other physical disorders	803	621	77. 3	123	15. 3	59	7. 3	0	0

NOTE: Percentages are based on total rejectees in the designated ethnic group with the particular diagnosis.

viewed at that time, were sent letters inviting them to telephone for an interview appointment to discuss their health problems with a public health nurse at one of the three other field offices of the referral service. The rejectees were randomly assigned to these field sites.

Therefore the HDRS staff were able to compare the rates of successful referral under two methods of initial approach to the rejectees—immediate interview and letter. The same letter was sent on two different letterheads—the draft board's and the health department's; thus it was also possible to assess the influence of the letterhead on the response of the rejectees.

In all interviews, the young men were told that cooperation with the referral service was voluntary. Considerable stress was laid upon the fact that the program was under the auspices of the health department and that information obtained about the young man's medical problems would not be transmitted to the Armed Forces. In interviews lasting from 15 minutes to an hour, the nurse counseled the men concerning their health problems and other social needs. In most instances this interview was the sole conference of the rejectee with the counselor.

The Armed Forces medical examination form, the medical specialists' reports, and the rejectee's personal medical-history form served as guides for the counselor. Additional medical problems or social and vocational difficulties were sometimes revealed by the young man or discovered by the counselor. In many instances, health as an abstraction was not found to be of particular interest to the rejectee. When it

Disposition of rejectees eligible for referral service, October 1962–September 1964

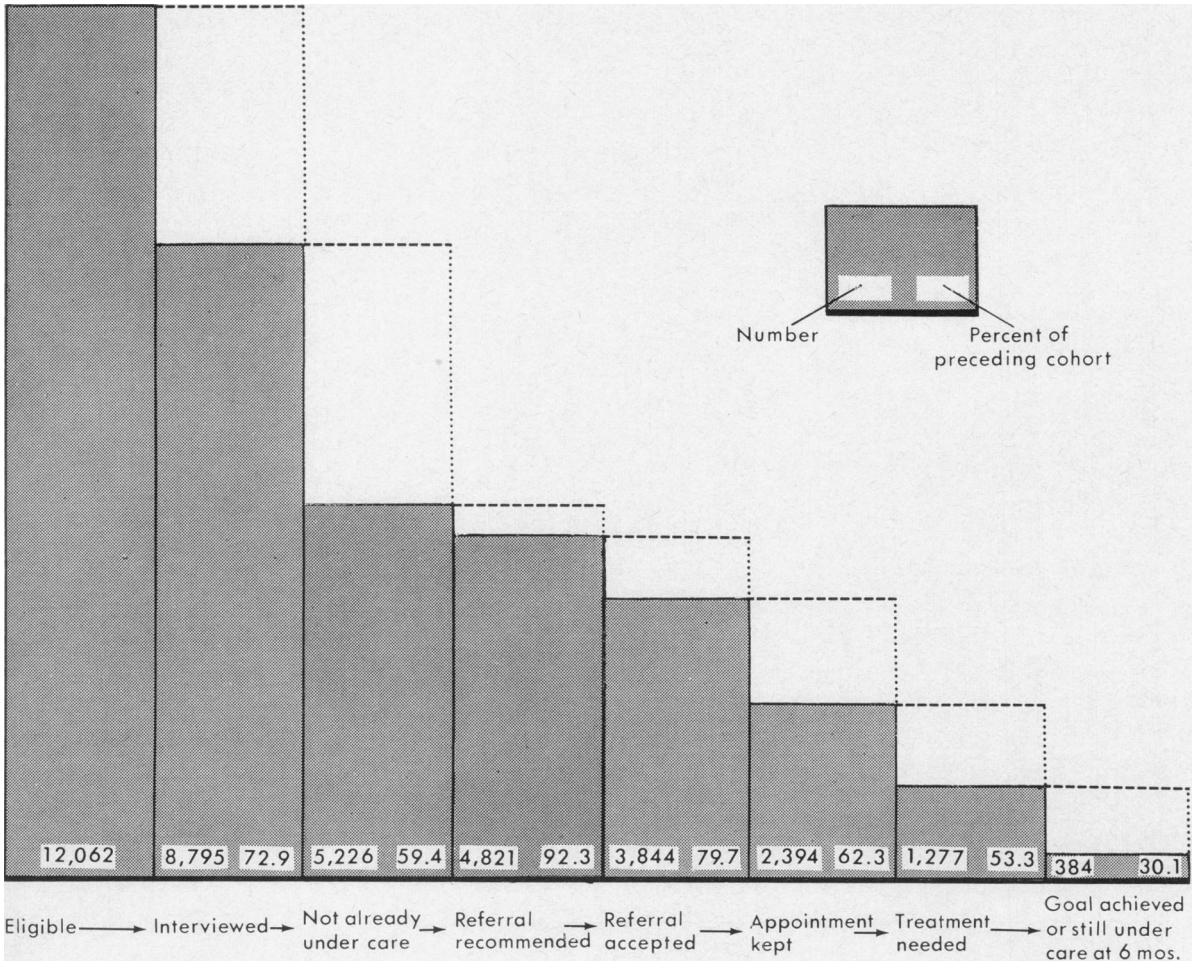

Table 3. Education of rejectees eligible for referral service, by disqualifying diagnosis and ethnic group, October 1962–September 1964

Disqualifying diagnosis	Total number eligible	White rejectees					Nonwhite and Puerto Rican rejectees					Ethnic group unknown
		Number	Percent with education of—				Number	Percent with education of—				
			Less than 12 years	12 years	More than 12 years	Unknown		Less than 12 years	12 years	More than 12 years	Unknown	
Total	12, 062	9, 045	24. 2	28. 7	43. 4	3. 7	2, 901	52. 5	29. 7	13. 9	3. 9	116
Psychiatric	4, 544	3, 397	26. 5	25. 1	46. 4	2. 1	1, 070	58. 5	24. 1	14. 3	3. 1	77
Sexual deviation	1, 460	1, 120	17. 4	30. 7	49. 8	2. 1	322	31. 7	37. 9	28. 9	1. 6	18
Inadequate personality	525	312	49. 4	22. 1	23. 7	4. 8	200	69. 0	15. 5	3. 0	12. 5	13
Narcotic addiction	505	205	66. 3	21. 0	12. 2	. 5	280	81. 1	14. 6	4. 3	0	20
Schizoid personality	298	274	16. 8	23. 4	59. 1	. 7	18	22. 2	44. 4	33. 3	0	6
Anxiety reaction	713	668	15. 6	24. 0	58. 7	1. 8	39	28. 2	28. 2	35. 9	7. 6	6
Other psychoneurotic disorders	238	221	11. 3	23. 6	64. 3	. 9	16	25. 0	37. 5	37. 5	0	1
Schizophrenic reaction	272	230	24. 8	18. 3	53. 9	3. 0	41	48. 8	29. 3	22. 0	0	1
Other psychiatric disorders	533	367	49. 6	21. 0	27. 2	2. 2	154	77. 9	17. 5	4. 5	0	12
Physical	7, 518	5, 648	22. 9	30. 9	41. 6	4. 6	1, 831	49. 0	32. 9	13. 7	4. 4	39
Diseases and defects of bones and organs of movement	1, 742	1, 324	22. 3	29. 1	43. 1	5. 5	402	53. 5	28. 9	12. 4	5. 2	16
Eye diseases and defects	1, 714	1, 174	25. 7	29. 8	41. 0	3. 5	529	55. 4	27. 6	13. 4	3. 6	11
Diseases and defects of circulatory system	1, 378	1, 003	22. 1	32. 3	42. 6	3. 0	369	40. 7	38. 8	17. 9	2. 7	6
Diseases and defects of ear and mastoid process	536	443	28. 2	36. 3	28. 7	6. 8	93	58. 1	25. 8	10. 8	5. 4	0
Diseases and defects of nervous system	381	329	18. 8	30. 4	46. 5	4. 3	49	44. 9	34. 7	20. 4	0	3
Allergic disorders	371	311	9. 0	28. 0	61. 7	1. 3	59	25. 4	49. 2	20. 3	5. 1	1
Albuminuria	357	243	36. 2	31. 7	19. 3	12. 8	114	38. 6	43. 9	6. 1	11. 4	0
Diseases of digestive system	236	200	16. 5	26. 5	52. 5	4. 5	34	47. 1	38. 2	8. 8	5. 9	2
Other physical disorders	803	621	22. 2	33. 5	39. 6	4. 7	182	48. 4	35. 7	11. 5	4. 4	0

NOTE: Percentages are based on total rejectees in the designated ethnic group with the particular diagnosis.

was related to his job, however, he often became interested in obtaining care.

For the rejectee in need of care, the counselor discussed whether care by a private physician or a community agency would be of most help to him. The pattern of the rejectee's past medical care and financial capacity were considered in determining the referral. Referrals were made both for those who had lapsed from care and for those who had had no previous care. In most instances, the rejectee referred to private medical care knew a physician in his community. If he did not, however, the counselor obtained from the local county medical society the names of three physicians near his home or place of work from whom he could select his physician. If nonprivate medical care facilities were to be used, referral was made with attention to clinic hours, fees, and eligibility requirements. A notebook on community resources, compiled by the HDRS social work consultants, summarized special arrangements made with the agencies for men referred by HDRS. This information supplemented other directories used by the counselor.

The nurse-counselor asked the young man to

sign a waiver to permit the exchange of medical information with the source of care. The rejectee was then given an appointment slip with all necessary instructions to facilitate his reaching care. Men disqualified for physical reasons were referred directly for appropriate care, but the procedure was somewhat different for those rejected for psychiatric reasons. Psychiatric rejectees desiring care by a private physician were referred directly to a physician; those not so referred were given an appointment to see the HDRS psychiatrist. The interview with the HDRS psychiatrist, which averaged about 30 minutes, provided a summary description of the rejectee's problems and a recommendation of action to be taken. Frequently, the psychiatrist's recommendation was that no referral be made because the young man was coping with his problems, lacked motivation, or did not have the capacity to profit from the kinds of care available. Based on the psychiatrist's evaluation, the counselor planned any indicated referral with the rejectee.

When referring a man rejected either for physical or psychiatric reasons, the HDRS sent to the private physician or agency an introductory letter explaining the purpose of the referral program and providing diagnostic results of the medical examination. In addition, to obtain followup information, an evaluation form was enclosed. The completed form served to verify that the rejectee was either under supervision for the condition or had kept the referral appointment. The form requested information on prognosis and action planned. If the appointment with the private physician or

Table 4. Length of residence in New York City of rejectees eligible for referral service, by disqualifying diagnosis and ethnic group

Disqualifying diagnosis	Total number eligible	White rejectees				Nonwhite and Puerto Rican rejectees				Ethnic group unknown
		Number eligible	Percent resident in New York City—			Number eligible	Percent resident in New York City—			
			Less than 5 years	5 years or more	Years unknown		Less than 5 years	5 years or more	Years unknown	
Total	12, 062	9, 045	14. 4	80. 6	5. 0	2, 901	25. 9	66. 3	7. 8	116
Psychiatric	4, 544	3, 397	19. 2	73. 7	7. 1	1, 070	21. 7	71. 3	7. 0	77
Sexual deviation	1, 460	1, 120	39. 0	57. 9	3. 1	322	41. 3	55. 3	3. 4	18
Inadequate personality	525	312	8. 7	83. 7	7. 6	200	13. 5	69. 0	17. 5	13
Narcotic addiction	505	205	2. 4	92. 2	5. 4	280	8. 9	86. 1	5. 0	20
Schizoid reaction	298	274	15. 3	79. 2	5. 5	18	22. 2	72. 2	5. 6	6
Anxiety reaction	713	668	10. 9	86. 2	2. 9	39	20. 5	79. 5	0	6
Other psychoneurotic disorders	238	221	12. 2	85. 1	2. 7	16	37. 5	56. 3	6. 2	1
Schizophrenic reaction	272	230	7. 4	87. 8	4. 8	41	9. 8	90. 2	0	1
Other psychiatric disorders	533	367	6. 5	88. 3	5. 2	154	16. 2	74. 7	9. 1	12
Physical	7, 518	5, 648	11. 5	83. 0	5. 5	1, 831	28. 3	63. 4	8. 3	39
Diseases and defects of organs of movement	1, 742	1, 324	12. 4	81. 0	6. 6	402	27. 4	63. 2	9. 4	16
Eye diseases and defects	1, 714	1, 174	14. 1	82. 5	3. 4	529	28. 0	65. 4	6. 6	11
Diseases and defects of circulatory system	1, 378	1, 003	9. 4	87. 0	3. 6	369	32. 0	59. 3	8. 7	6
Diseases and defects of ear and mastoid process	536	443	16. 0	76. 5	7. 5	93	26. 9	63. 4	9. 7	0
Diseases and defects of nervous system	381	329	7. 0	86. 6	6. 4	49	12. 2	83. 7	4. 1	3
Allergic disorders	371	311	5. 1	91. 3	3. 6	59	25. 4	64. 4	10. 2	1
Albuminuria	357	243	11. 9	73. 7	14. 4	114	27. 2	58. 8	14. 0	0
Diseases of digestive system	236	200	10. 5	82. 0	7. 5	34	29. 4	64. 7	5. 9	2
Other physical disorders	803	621	10. 8	84. 1	5. 1	182	30. 2	63. 2	6. 6	0

NOTE: Percentages are based on total rejectees in the designated ethnic group with the particular diagnosis.

Table 5. Rejectees approached initially by letter who were not interviewed, by disqualifying diagnosis and ethnic group

Disqualifying diagnosis	White rejectees		Nonwhite and Puerto Rican rejectees	
	Number	Percent not interviewed	Number	Percent not interviewed
Total	6, 574	37. 5	2, 015	38. 0
Psychiatric	2, 355	50. 8	620	51. 1
Sexual deviation	876	73. 5	266	68. 4
Inadequate personality	228	44. 7	140	42. 9
Narcotic addiction	41	42. 5	34	52. 9
Schizoid personality	193	30. 8	11	27. 2
Anxiety reaction	438	33. 9	23	54. 5
Other psychoneurotic disorders	146	34. 2	13	46. 2
Schizophrenic reaction	171	41. 3	28	28. 6
Other psychoneurotic disorders	262	37. 8	105	32. 4
Physical	4, 219	29. 8	1, 395	32. 0
Diseases and defects of bones and organs of movement	1, 021	36. 8	310	37. 7
Eye diseases and defects	851	31. 8	405	32. 3
Diseases and defects of circulatory system	705	23. 1	257	28. 4
Diseases and defects of ear and mastoid process	330	32. 7	69	30. 4
Diseases and defects of nervous system	246	26. 4	33	33. 3
Allergic disorders	223	24. 2	51	31. 4
Albuminuria	228	23. 2	107	30. 8
Diseases of digestive system	148	27. 7	27	33. 3
Other physical disorders	467	27. 2	136	27. 2

agency was not kept, a followup letter about the broken appointment was sent to the rejectee. Progress reports were obtained from the referral resource 3 months and 6 months after the date of the first appointment.

Characteristics of Rejectees

The referral program included only young men who had been rejected for military service because of medical problems found on examination at the Armed Forces examining station. Therefore, in considering the HDRS results, it must be kept in mind that the group studied is not a random cross section of New York City youth with health problems.

During the first 2 years of operation, 12,062 men were taken into the HDRS program. The lowest intake of men for a single month was 142; the highest was 934. Variation in intake was due to fluctuation in the number of men called up by Selective Service for examination.

The personal-data form provided a description of rejectees. Items included were age, ethnic group, education, and place and length of residence in New York City. The majority of the rejectees (67 percent) were 21 to 22 years of age, 16 percent being under 21 years old and the remaining 17 percent being 23 or older. The range was from age 17 to 27. Of the 12,062 rejectees, 75 percent were white, 16 percent nonwhite, 8 percent Puerto Rican; for less than 1 percent, the ethnic group was unknown. (The rejectee was classed as Puerto Rican if he or either of his parents had been born in Puerto Rico.) Sixty-five percent of the rejectees had completed high school—72 percent of the white group, and 44 percent of the combined nonwhite and Puerto Rican group. While only 14 percent of the white rejectees and 26 percent of the nonwhite and Puerto Rican rejectees had resided in the city less than 5 years, these percentages represent more than 2,000 men during the 2-year period.

Nearly 38 percent of the rejectees were disqualified because of psychiatric conditions, primarily character and behavior disorders (table 1). The principal causes of physical disqualification were diseases and defects of the bones and organs of movement (14 percent), of the eye (14 percent), and of the circulatory system (11 percent).

There were 775 rejectees who had two disqualifying conditions, and 50 who had three. Rejectees having more than one disqualifying condition were classified under the diagnosis having the higher frequency. Although referral and followup were done as needed for any condition found at the Armed Forces examining station, in the interest of simplicity, results are presented in terms of the rejectee's disqualifying condition.

Some interesting differences were observed between whites and nonwhites in the frequency with which various disqualifying diagnoses

were made, particularly among those with psychiatric disorders (table 2). Of the 4,544 men rejected for psychiatric conditions, 75 percent were white and 24 percent nonwhite and Puerto Rican. Only 59 percent of the rejectees diagnosed as having an inadequate personality were white; 38 percent were nonwhite or Puerto Rican. By contrast, 94 percent of the cases of anxiety reaction were diagnosed among the white rejectees and only 6 percent among the nonwhite and Puerto Rican group. These variations may be attributed in part to differences in educational achievement and socioeconomic factors.

As would be expected, the percentage of rejectees completing high school was higher in the white group than in the nonwhite and Puerto Rican group (table 3). This relationship held for all diagnostic categories. The diagnostic category of narcotic addiction showed the lowest percentage completing high school. Only one-third of the white and one-fifth of the nonwhite and Puerto Rican narcotics addicts had completed high school.

There were also some interesting variations in the place of residence of the rejectees with various diagnoses. Distribution of the various diagnoses was not uniform over the 30 health districts in the five boroughs. In the Lower West Side health district in the Borough of Manhattan, for example, 66 percent of the medical rejections were for psychiatric reasons, while in Staten Island, psychiatric diagnoses accounted for only 24 percent of the rejections. Two contiguous districts in Manhattan which had only 5 percent of the rejectees accounted for 20 percent of the diagnoses of narcotic addiction. Three other districts in Manhattan which had 13 percent of the rejectees accounted for 37 percent of the rejections for sexual deviation. It is, of course, to be expected that young men with like inclinations would tend to live in the same areas. These figures show the importance of varying the content of the health program in a large urban area like New York City to take account of local variations in certain types of health problems.

In general, irrespective of diagnostic category, the nonwhite and Puerto Rican rejectees were more likely to be newcomers in the city than the white rejectees. In certain diagnostic categories, the difference was marked (table 4). For example, nearly 9 percent of the nonwhite and Puerto Rican rejectees who were classed as narcotics addicts had been in the city less than 5 years, in contrast with less than 3 percent of the white rejectees in that group. Again, among the 369 nonwhite and Puerto Rican rejectees with circulatory disorders, nearly a third were newcomers to the city; the comparable figure was less than 10 percent in the white group. One of the few diagnostic categories in

Table 6. Percent distribution of rejectees designated as already under care, by basis for such designation, type of disqualification, and type of care resource

Type of disqualification and of care resource	Total number designated under care	Documentation received from care resource	Medical supervision alleged by rejectee [1]		
			Rejectee refused to sign waiver	Report not returned by resource	Resource not recognized by referral service
Total	3,569	69.9	23.2	3.6	3.3
Agency care	551	69.0	22.5	8.5	----
Private care	3,018	70.1	23.3	2.6	3.9
Psychiatric	923	62.7	29.8	2.5	5.0
Agency care	196	70.4	26.0	3.6	----
Private care	727	60.7	30.8	2.2	6.3
Physical	2,646	72.4	20.9	3.9	2.8
Agency care	355	68.2	20.6	11.3	----
Private care	2,291	73.1	20.9	2.8	3.2

[1] Information as to supervision was based solely on rejectee's allegation.

NOTE: Percentages are based on the total number designated as being under care in each care category under the particular type of disqualification.

which there was practically no difference between the ethnic groups in length of residence was that of sexual deviation. About 4 of every 10 men with this diagnosis had lived in the city for less than 5 years. Length of residence in New York City is significant in programs of casefinding, referral, and treatment for young adults. Most of the rejectees residing in New York City less than 5 years had not attended New York City primary or secondary schools and therefore had not been reached by the city's school health program.

Table 7. Interviewed rejectees who were under medical supervision at time of interview, by disqualifying diagnosis and ethnic group

Disqualifying diagnosis	Number interviewed				Percent of interviewed under medical supervision			
	Total [1]	White	Nonwhite	Puerto Rican	Total	White	Nonwhite	Puerto Rican
Total	8,795	6,582	1,447	706	40.6	48.1	17.5	18.3
Psychiatric	2,987	2,201	515	246	30.9	38.4	8.3	11.7
Sexual deviation	621	477	99	43	16.4	19.9	4.0	4.7
Inadequate personality	357	210	108	34	10.9	17.6	1.9	0
Narcotic addiction	453	184	154	110	11.7	13.6	8.4	13.6
Schizoid personality	210	194	12	3	59.5	61.3	33.3	33.3
Anxiety reaction	569	532	23	9	52.7	53.8	30.4	44.4
Other psychoneurotic disorders	182	172	5	5	58.2	60.5	0	40.0
Schizophrenic reaction	206	171	23	11	58.7	62.0	43.5	36.4
Other psychiatric disorders	389	261	91	32	19.8	28.0	3.3	3.1
Physical	5,808	4,381	932	459	45.6	53.0	22.5	21.8
Diseases and defects of bones and organs of movement	1,246	952	192	92	31.1	36.6	12.5	14.1
Eye diseases and defects	1,311	900	251	150	48.9	58.0	32.3	22.0
Diseases and defects of circulatory system	1,143	839	234	65	47.6	55.9	20.9	35.4
Diseases and defects of ear and mastoid process	405	333	28	44	37.3	42.3	10.7	15.9
Diseases and defects of nervous system	305	264	24	15	70.2	73.1	50.0	46.7
Allergic disorders	302	258	27	17	74.8	79.8	44.4	47.1
Albuminuria	271	189	64	17	28.0	38.1	3.1	5.9
Diseases of digestive system	185	158	14	11	65.4	71.5	35.7	18.2
Other physical disorders	640	488	98	48	44.5	52.5	22.4	12.5

[1] Includes 60 rejectees for whom ethnic group was unknown.

Table 8. Interviewed rejectees who were under medical supervision at time of interview, by education and ethnic group

Education (years)	Number interviewed			Percent of interviewed under medical supervision		
	Total [1]	White	Nonwhite and Puerto Rican	Total	White	Nonwhite and Puerto Rican
Total	8,735	6,582	2,153	40.6	48.1	17.7
Less than 12	2,780	1,596	1,184	22.8	30.5	12.5
12	2,611	1,953	658	41.1	47.3	22.6
More than 12	3,208	2,925	283	55.0	57.7	27.6
Unknown	136	108	28	55.1	63.0	25.0

[1] Does not include 60 rejectees for whom ethnic group was unknown.

These figures illustrate the need for health programs for young adults to supplement existing programs in the New York City schools. The health department referral service meets the need of one segment of the young adult newcomer group—men rejected for military service because of health reasons. There are doubtless many other young people, however, in need of assistance who are not being reached by health programs. Possibly other screening mechanisms exist in the community around which similar referral mechanisms could be devised.

Results

The overall results of the referral program are shown in the chart.

Contacting the rejectee. The New York City Health Department referral service of course experienced no difficulty in contacting the rejectee who was seen at the counseling office in the Armed Forces examining station immediately following intake, but (as explained previously) this group represented only one-third of the rejectees. The other two-thirds were contacted by letter. If the rejectee failed to respond to the first letter within a week, a second letter with a reminder was sent; if again no response was received within a week, a counselor telephoned the rejectee; if the rejectee could not be reached by telephone, another of the initial letters was sent by certified mail. If no response was obtained within a week of this mailing, the man was dropped from the program. By these procedures a reply was elicited from 80 percent of the group who were initially to be contacted by letter. Half of these 80 percent answered either the first or the second letter. There was no appreciable difference in the response to these two letters between those disqualified because of physical reasons and those disqualified because of psychiatric reasons. Letters were sent from three field offices of the referral service, one in a draft board center and two in health department district centers. Because of the men's association with the Selective Service System, it was believed that they might respond differently to a letter with a draft board heading than to one with a health department heading. No difference in response to the first two letters was found between those sent on a draft board letterhead and those sent on one of the health department letterheads. Response to other letters on the health department letterhead, however, was somewhat lower.

Table 9. Rejectees recommended for referral who accepted it, by disqualifying diagnosis and type of resource

Disqualifying diagnosis	Number recommended for referral to—		Percent who accepted referral to—	
	Agency	Private resource	Agency	Private resource
Total	3,056	1,765	79.9	79.4
Psychiatric	1,709	328	72.7	58.5
Sexual deviation	408	103	67.6	33.0
Inadequate personality	279	34	77.4	64.7
Narcotic addition	381	15	63.8	53.3
Schizoid personality	61	24	63.9	58.3
Anxiety reaction	185	81	81.1	74.1
Other psychoneurotic disorders	51	25	78.4	88.0
Schizophrenic reaction	71	10	77.5	80.0
Other psychiatric disorders	273	36	81.7	66.7
Physical	1,347	1,437	89.1	84.2
Diseases and defects of bones and organs of movement	300	338	85.3	77.2
Eye diseases and defects	362	252	89.2	84.5
Diseases and defects of circulatory system	275	322	95.3	89.1
Diseases and defects of ear and mastoid process	133	115	88.0	82.6
Diseases and defects of nervous system	35	40	85.7	92.5
Allergic disorders	20	44	65.0	90.9
Albuminuria	70	123	98.6	91.1
Diseases of digestive system	19	32	78.9	93.8
Other physical disorders	133	171	86.5	78.9

Interviewing the rejectee. Altogether 73 percent of the eligible medical rejectees were interviewed (see chart). The proportion, of course, was 100 percent among those seen immediately at the Armed Forces examining station. Of the men to whom letters were sent, only 62 percent were interviewed. The remainder of these men failed to respond to the letter, refused an interview, or broke their appointments with the

counselor. Approximately 50 percent of the psychiatric rejectees and 30 percent of the physical rejectees were not interviewed. As can be seen from table 5, when the initial approach of the referral service to the rejectees was by letter, the losses before interview were substantial—nearly 40 percent—in spite of followup procedures. Losses were slightly lower for rejectees with at least a high school education, but little difference in losses was noted among the ethnic groups.

Medical care status. Of the nearly 8,800 rejectees interviewed, 41 percent were already under medical supervision (see chart). Of these 3,569 men, 84 percent were being cared for by private physicians.

The care status of most rejectees in the "already under care" group could be documented (table 6). (Those designated as already under care included rejectees for whom documentation of current medical supervision was received from the treatment source, as well as those for whom documentation was not obtained—because the rejectee refused to sign a waiver giving permission to HDRS to contact the alleged treatment resource, because the alleged treatment resource did not return a report to HDRS, or because the treatment resource was not a recognized medical care resource.) The response to requests by the referral service for reports was for the most part good. The policy of one large agency not to complete reports was largely responsible for our inability to document the care status of 11 percent of the physical rejectees claiming to be under care.

The percent already under care in the white

Table 10. Rejectees accepting referral, by disqualifying diagnosis, ethnic group, and type of referral resource

Disqualifying diagnosis	Total [1]	White rejectees				Nonwhite and Puerto Rican rejectees				Percent referred to an agency	
		Agency referrals		Private referrals		Agency referrals		Private referrals		White	Nonwhite and Puerto Rican
		Number	Percent	Number	Percent	Number	Percent	Number	Percent		
Total	3,777	1,212	100.2	1,123	100.1	1,192	100.1	250	100.0	51.9	82.7
Psychiatric	1,412	687	56.7	177	15.8	537	45.0	11	4.4	79.5	98.0
Sexual deviation	307	169	14.0	32	2.8	105	8.8	1	.4	84.1	94.3
Inadequate personality	233	100	8.3	19	1.7	112	9.4	2	.8	84.0	98.2
Narcotic addiction	248	71	5.9	7	.6	169	14.2	1	.4	91.0	99.4
Schizoid personality	53	32	2.6	12	1.1	7	.6	2	.8	72.7	77.8
Anxiety reaction	205	133	11.0	55	4.9	14	1.2	3	1.2	70.7	82.4
Other psychoneurotic disorders	62	32	2.6	22	2.0	8	.7	0	0	59.3	100.0
Schizophrenic reaction	63	41	3.4	8	.7	14	1.2	0	0	83.7	100.0
Other psychiatric disorders	241	109	9.0	22	2.0	108	9.1	2	.8	83.2	98.2
Physical	2,365	525	43.3	946	84.2	655	54.9	239	95.6	35.7	73.3
Diseases and defects of bones and organs of movement	505	121	10.0	220	19.6	129	10.8	35	14.0	35.4	78.7
Eye diseases and defects	517	127	10.5	150	13.4	188	15.8	52	20.8	45.8	78.3
Diseases and defects of circulatory system	544	104	8.6	223	19.9	157	13.2	60	24.0	31.8	72.4
Diseases and defects of ear and mastoid process	209	70	5.8	87	7.7	44	3.7	8	3.2	44.6	84.6
Diseases and defects of nervous system	67	19	1.6	32	2.9	11	.9	5	2.0	37.3	68.8
Allergic disorders	52	7	.6	25	2.2	6	.5	14	5.6	21.9	30.0
Albuminuria	180	26	2.1	80	7.1	42	3.5	32	12.8	24.5	56.8
Diseases of digestive system	44	4	.3	25	2.2	10	.8	5	2.0	13.8	66.7
Other physical disorders	247	47	3.9	104	9.3	68	5.7	28	11.2	31.1	70.8

[1] Does not include 67 rejectees for whom ethnic group was unknown.

group was more than twice as high as that of the nonwhite or Puerto Rican groups (table 7). In general, the proportion among the psychiatric rejectee groups under medical supervision was lower than among the physical rejectee groups. This proportion was consistent in the three ethnic groups.

With increased education, the percent of rejectees already under care also increased (table 8), varying from a low of 23 percent for those with less than 12 years of education to 55 percent for those with more than 12 years. The percent under care in each educational level for whites was more than twice as high as that for the nonwhite and Puerto Rican groups. For those residing in New York City 5 years or longer, the percent under care was higher than for those who had resided in New York City less than 5 years. These differences were in the same direction for all diagnostic categories. As would be expected, since differences in the percent already under care were observed by

Table 11. Rejectees accepting referral, by type of disqualification, education, ethnic group, and type of referral resource

Type of disqualification and education (years)	White rejectees				Nonwhite and Puerto Rican rejectees			
	Total number [1]	Agency referrals		Number of private referrals	Total number [1]	Agency referrals		Number of private referrals
		Number	Percent			Number	Percent	
Total	2,308	1,198	51.9	1,110	1,423	1,174	82.5	249
Under 12	806	512	63.5	294	841	740	88.0	101
12	701	305	43.5	396	415	323	77.8	92
More than 12	801	381	47.6	420	167	111	66.5	56
Psychiatric	859	682	79.5	177	541	530	98.0	11
Under 12	312	273	87.5	39	369	365	98.9	4
12	218	159	72.9	59	111	108	97.3	3
More than 12	329	250	76.0	79	61	57	93.4	4
Physical	1,449	516	35.7	933	882	644	73.3	238
Under 12	494	239	48.4	255	472	375	79.4	97
12	483	146	30.2	337	304	215	70.7	89
More than 12	472	131	27.8	341	106	54	50.9	52

[1] Does not include 113 rejectees for whom education or ethnic group was unknown.

Table 12. Rejectees accepting referral, by type of disqualification, length of residence in New York City, ethnic group, and type of referral resource

Type of disqualification and length of residence (years) in New York City	White rejectees				Nonwhite and Puerto Rican rejectees			
	Total accepting referral [1]	Agency referrals		Number of private referrals	Total accepting referral [1]	Agency referrals		Number of private referrals
		Number	Percent			Number	Percent	
Total	2,279	1,178	51.7	1,101	1,380	1,136	82.3	244
Less than 5	407	275	67.6	132	412	350	85.0	62
5 or more	1,872	903	48.2	969	968	786	81.2	182
Psychiatric	839	667	79.5	172	520	509	97.9	11
Less than 5	141	117	83.0	24	111	107	96.4	4
5 or more	698	550	78.8	148	409	402	98.3	7
Physical	1,440	511	35.5	929	860	627	72.9	233
Less than 5	266	158	59.4	108	301	243	80.7	58
5 or more	1,174	353	30.1	821	559	384	68.7	175

[1] Does not include 185 rejectees for whom length of residence or ethnic group was unknown.

ethnic group and education, differences were also noted by district of residence.

Need for referral. Although approximately 40 percent of the rejectees interviewed were already under medical supervision, the nearly 60 percent (5,200) who were not were potential candidates for referral by an HDRS nurse counselor. The fact that so many young men were not under care shows the need for an Armed Forces rejectee referral program. Most of these men needed referral at least for a screening examination to determine the significance of their symptoms and their need for therapy. Only 8 percent of the rejectees not under care (see chart)—primarily those disqualified for defects of bones and organs of movement—were considered by the nurse counselors not to require referral. Although the medical problems for which these 8 percent had been disqualified limited their ability to perform in a military setting, their conditions in most cases did not significantly affect their ability to function in civilian life. For some, no referral was made because the maximum health goal had been achieved.

Referral data. To recapitulate, of the 12,062 men entering the HDRS program, approximately three-fourths were interviewed; of those interviewed, 40 percent were already under medical supervision (see chart). The remaining 60 percent, or 5,226 rejectees, were potential candidates for referral and, in the judgment of the nurse counselors, more than 90 percent of these men were in need of referral. Thus, the counselors recommended referral for 4,821 rejectees during the 2-year period. Of these referrals, 36 percent were to private medical care facilities, 29 percent to municipal hospitals and health department clinics; 24 percent to voluntary hospitals, and 11 percent to vocational, mental health, and social agencies. To initiate the referral process, the nurse, in an interview with the young man, counseled him, interpreted his medical findings, and attempted to awaken or strengthen his motivation to accept and follow through with referral recommendations. Of the 4,821 rejectees recommended for referral, 80 percent (3,844) accepted the referral. There was no formal attempt to determine the reasons for a rejectee's failure to accept the referral. Several factors, however, which seemed important were a personal or family history of unsatisfactory experiences with medical facilities, apathy, and the time it was necessary to take from employment to attend medical facilities. Considering the limitations imposed by a single interview and the suspicion of some rejectees that information about them would be fed back to the Selective Service System, the percentage accepting referral was gratifying.

The percent accepting referral was lower in the group with psychiatric diagnoses than in the group with physical diagnoses for both

Table 13. Rejectees accepting referral who did not keep initial referral appointment, by disqualifying diagnosis and type of resource

Disqualifying diagnosis	Agency referrals		Private referrals	
	Number accepting referral	Percent not keeping appointment	Number accepting referral	Percent not keeping appointment
Total	2,426	35.2	1,378	40.2
Psychiatric	1,238	37.6	189	33.9
Sexual deviation	275	36.7	33	39.4
Inadequate personality	216	28.7	22	31.8
Narcotic addiction	243	63.4	8	75.0
Schizoid personality	39	23.1	14	42.9
Anxiety reaction	149	25.5	58	31.0
Other psychoneurotic disorders	40	27.5	22	36.4
Schizophrenic reaction	55	29.1	8	50.0
Other psychiatric disorders	221	33.5	24	8.3
Physical	1,188	32.8	1,189	41.3
Diseases and defects of bones and organs of movement	252	36.9	256	42.6
Eye diseases and defects	319	40.8	202	51.5
Diseases and defects of circulatory system	262	21.0	283	38.5
Diseases and defects of ear and mastoid process	114	36.0	95	49.5
Diseases and defects of nervous system	30	50.0	37	40.5
Allergic disorders	13	38.5	39	41.0
Albuminuria	68	19.1	112	23.2
Diseases of digestive system	15	33.3	30	40.0
Other physical disorders	115	28.7	135	39.3

agency and private referrals. The overall percentage of men accepting referral did not differ, however, for agency and private-resource referrals (table 9). In general, the percent in the white group was lower than in the nonwhite and Puerto Rican group, and the percent decreased slightly with increasing education.

Since most of the rejectees were unable to afford private psychiatric care, it was not surprising that in both the white group and the nonwhite and Puerto Rican group referrals for psychiatric difficulties were primarily to community agencies rather than to private resources (table 10). For the rejectees with physical disqualifications, the picture was somewhat different. In the white group, only 36 percent of the referrals were to community agencies, while the comparable figure for the nonwhite and Puerto Rican group was 73 percent. The higher figure largely reflects the lower economic status of the nonwhite and Puerto Rican group and illustrates the difficulties of providing adequate medical care to such groups in large urban populations.

As would be expected, the greater the education, the lower the proportion of referrals to a community agency, rather than to a private source of care (table 11). At every educational level, however, the percentage of agency referrals was lower in the white group than in the nonwhite and Puerto Rican group. Clearly other socioeconomic factors besides educational achievement determine the type of referral.

Length of residence in New York City had relatively little influence on the proportion of psychiatric rejectees for whom an agency referral was made (table 12). For those disqualified because of physical conditions, however, an agency referral was much more likely to be made for a man whose length of residence was less than 5 years than for one who had resided in the city for a longer period.

Nurse counselors stressed to the rejectees the importance of keeping the referral appointment. Of the 3,800 men who indicated they would accept referral, 62 percent kept their initial appointments with agencies or private physicians. There were 1,450 men (38 percent), however, who failed to keep their appointments. Perhaps some of these accepted the referral recommendation by the public health nurse counselor rather than explain their unwillingness to cooperate.

Approximately 37 percent of the rejectees with psychiatric diagnoses broke their initial referral appointments. Table 13 shows that there was little difference in the percent failing initial appointments between those referred to private resources (34 percent) and those referred to community agencies (38 percent). For those with physical defects, however, the proportion breaking initial appointments with

Table 14. Initial referral appointments kept, by rejectees' type of disqualification, type of referral resource, and ethnic group

Type of disqualification and of resource	Referral appointments [1] of—					
	White rejectees		Nonwhite rejectees		Puerto Rican rejectees	
	Number made	Percent kept	Number made	Percent kept	Number made	Percent kept
Total	2,335	63.2	983	63.1	459	61.0
Agency	1,212	65.4	800	65.6	392	62.0
Private	1,123	61.0	183	51.9	67	56.7
Psychiatric	864	66.7	378	61.0	170	51.2
Agency	687	66.8	369	60.2	168	51.2
Private	177	66.1	9	66.7	2	50.0
Physical	1,471	61.3	605	64.8	289	67.1
Agency	525	63.6	431	70.3	224	70.1
Private	946	60.0	174	51.1	65	56.9

[1] Does not include appointments of 67 rejectees for whom ethnic group or type of referral resource was unknown.

Table 15. Initial referral appointments kept and percentage distribution among three subgroups of rejectees, by disqualifying diagnosis and ethnic group

Disqualifying diagnosis	Number keeping appointments		Percent keeping appointments[1] among—					
			Those eligible for HDRS		Those interviewed by HDRS		Those HDRS recommended for referral	
	White	Nonwhite and Puerto Rican	White	Nonwhite and Puerto Rican	White	Nonwhite and Puerto Rican	White	Nonwhite and Puerto Rican
Total	1,478	901	16.3	31.1	22.5	41.8	47.3	54.3
Psychiatric	576	315	17.0	29.4	26.2	41.4	43.2	46.0
Sexual deviation	122	72	10.9	22.3	25.6	50.7	32.5	53.3
Inadequate personality	82	85	26.3	42.5	39.0	59.9	48.0	62.0
Narcotic addiction	30	59	14.6	21.1	16.3	22.3	19.2	25.1
Schizoid personality	30	8	10.9	44.4	15.5	53.3	40.0	80.0
Anxiety reaction	139	11	20.8	28.2	26.1	34.4	57.2	52.4
Other psychoneurotic disorders	39	4	17.6	25.0	22.7	40.0	38.5	50.0
Schizophrenic reaction	35	8	15.2	19.5	20.5	23.5	57.4	40.0
Other psychiatric disorders	99	68	27.0	45.3	37.9	53.3	53.5	57.1
Physical	902	586	16.0	32.0	20.6	42.1	50.3	60.1
Diseases and defects of bones and organs of movement	204	101	15.4	25.1	21.4	26.3	45.5	54.9
Eye diseases and defects	139	146	11.8	27.6	15.4	36.4	40.8	54.3
Diseases and defects of circulatory system	225	155	22.4	42.0	26.8	51.8	61.1	68.3
Diseases and defects of ear and mastoid process	88	33	20.1	35.4	26.4	45.8	46.3	56.9
Diseases and defects of nervous system	31	6	9.4	12.2	11.7	15.4	53.4	35.3
Allergic disorders	23	8	7.4	13.6	8.9	18.2	54.8	36.4
Albuminuria	83	58	34.2	50.9	43.9	71.6	72.2	74.4
Diseases of digestive system	18	9	9.0	26.5	11.4	36.0	52.9	56.3
Other physical disorders	91	70	14.7	38.5	18.6	47.9	46.4	67.3

[1] Does not include appointments of 15 rejectees for whom ethnic group was unknown.

private resources was somewhat higher (41 percent) than when the referral was made to community agencies (33 percent).

For those referred to a community agency, a greater proportion of the nonwhite or Puerto Rican rejectees kept their appointments than of the white rejectees. The reverse was true for referrals to private physicians; the white group had the higher proportion of kept appointments (table 14).

It does not necessarily follow that rejectees who did not keep referral appointments did not benefit from the HDRS program. Many of these young men may have been made aware of the importance of health care and of the community resources which could provide the needed treatment. There is some indication that this awareness resulted in some of the rejectees making use of this knowledge. For a sample of rejectees, queries were made approximately 2 years after the initial appointment had been broken to determine whether or not medical care had been obtained in the interim. One out of four was found to have obtained medical care for the condition on which the original referral was based.

We have now followed the rejectees from intake into the referral program through arrival at the referral resource. The productivity or yield of the program up to this point can be expressed in several different ways. First of all, if we consider the referral yield from the population taken into the program, 20 percent of the rejectees entering the program arrived

at a care resource. If, however, we omit those rejectees who were not interviewed and consider only the yield among the interviewed group, the proportion arriving at a referral resource increases to 27 percent. One might also express the yield only in terms of those who were recommended for referral by the public health nurse counselor. On this basis, 50 percent of those recommended for referral arrived at a care resource. Each of these three different measures of yield in its own way provides information that is of value in planning, developing, and improving health referral service programs. Table 15 presents these measures of yield by ethnic group.

Outcome of referral. Although the immediate objective of the referral program is realized when the rejectee keeps his initial appointment with the referral resource, referral is not an end in itself; the long-range goal is achievement of maximum health potential. Therefore the referral service continued to follow the health progress of the rejectee through the community resource to which he had been referred. Of the 2,394 rejectees who kept their appointments, 1,496 had been referred for physical conditions, and the remaining 898 for psychiatric conditions (table 16). Based on screening by the resource, one-half of the 1,496 rejectees disqualified for physical reasons were considered not to need medical care. Although this proportion is substantial, in most instances an initial screening examination by the resource was necessary to determine the significance of diagnostic results and the need for therapy. Rejectees referred because of circulatory system diseases or defects present a case in point. Of the 381 rejectees screened who were disqualified because of such conditions, 60 percent were classified as "no care recommended" by the treatment agency. Most of these young men had cardiac conditions which, following extensive diagnostic workup, proved to be functional in nature. Nevertheless the "delabeling" was of obvious importance to the rejectee in terms of his emotional adjustment and increased job potential. Agency and private resources usually differed little in the proportion of rejectees not recommended for care.

Of the 881 rejectees with psychiatric diag-

Table 16. Rejectees keeping initial resource appointments who did not need medical care, by disqualifying diagnosis and type of referral resource used

Disqualifying diagnosis	Number keeping appointments			Percent for whom no care was recommended		
	Total	With agency	With private resource	Total	By agency	By private resource
Psychiatric	898	773	125	41.0	45.9	10.4
Sexual deviation	194	174	20	51.0	56.3	5.0
Inadequate personality	169	154	15	52.1	17.7	6.7
Narcotic addiction	91	89	2	5.5	4.5	50.0
Schizoid personality	38	30	8	34.2	40.0	12.5
Anxiety reaction	151	111	40	34.4	45.0	5.0
Other psychoneurotic disorders	43	29	14	32.6	41.4	14.3
Schizophrenic reaction	43	39	4	41.9	46.2	0
Other psychiatric disorders	169	147	22	46.7	50.3	22.7
Physical	1,496	798	698	50.0	52.3	47.5
Diseases and defects of bones and organs of movement	306	159	147	58.5	61.0	55.8
Eye diseases and defects	287	189	98	57.5	53.4	65.3
Diseases and defects of circulatory system	381	207	174	59.6	66.7	51.1
Diseases and defects of ear and mastoid process	121	73	48	32.2	24.7	43.8
Diseases and defects of nervous system	37	15	22	40.5	53.3	31.8
Allergic disorders	31	8	23	22.6	0	30.4
Albuminuria	141	55	86	37.6	38.2	37.2
Diseases of the digestive system	28	10	18	32.1	30.0	33.3
Other physical disorders	164	82	82	31.7	34.1	29.3

Table 17. Rejectees needing care who achieved health goal or were still under supervision 6 months after initial appointment with care resource, by disqualifying diagnosis and type of resource

Disqualifying diagnosis	Number designated as in need of care			Percent who achieved care goal		
	Total	By agency	By private resource	Total	Agency referrals	Private referrals
Total	1,277	799	478	30.1	23.9	40.4
Psychiatric	530	418	112	18.3	16.3	25.9
Sexual deviation	95	76	19	9.5	9.2	10.5
Inadequate personality	81	67	14	17.3	14.9	28.6
Narcotic addiction	86	85	1	14.0	14.1	0
Schizoid personality	25	18	7	28.0	33.3	14.3
Anxiety reaction	99	61	38	22.2	16.4	31.6
Other psychoneurotic disorders	29	17	12	13.8	0	33.3
Schizophrenic reaction	25	21	4	52.0	52.4	50.0
Other psychiatric disorders	90	73	17	17.8	16.4	23.5
Physical	747	381	366	38.4	32.3	44.8
Diseases and defects of bones and organs of movement	127	62	65	36.2	37.1	35.4
Eye diseases and defects	122	88	34	60.7	47.7	94.1
Diseases and defects of circulatory system	154	69	85	37.7	31.9	42.4
Diseases and defects of ear and mastoid process	82	55	27	23.2	16.4	37.0
Diseases and defects of nervous system	22	7	15	40.9	42.9	40.0
Allergic disorders	21	5	16	61.9	0	81.3
Albuminuria	88	34	54	28.4	26.5	29.6
Diseases of digestive system	19	7	12	47.4	42.9	50.0
Other physical disorders	112	54	58	30.4	22.2	37.9

noses who kept their referral appointments, 41 percent were classified as "no care recommended" (table 16). There was a substantial difference between agency and private resources in the proportion of the rejectees with psychiatric conditions who were not recommended for care. As previously mentioned, the HDRS psychiatrist conducted most of the agency screening examinations. It was his impression that almost all of those he examined had psychiatric problems as judged by civilian standards. About 20 percent of these men, however, were functioning adequately in the community. He considered that the remaining 80 percent needed treatment, but he did not recommend referral in all cases, believing that some rejectees lacked sufficient motivation to use help or were antagonistic to referral for treatment. Also, some men, because of their social backgrounds or lack of sophistication, would not profit from referral to the resources then available in the community. Of the nearly 700 men screened by the HDRS psychiatrist, referral was not recommended for half of the group.

For nearly half of the 2,400 rejectees who kept their initial resource appointments, no treatment was recommended. For the remaining 1,300 rejectees who were to receive care, the referral service found that 6 months after referral 30 percent either had achieved the goal set initially for them by the treatment resource or were still under supervision. When the disqualifying diagnosis had been made because of a physical disease or defect, however, the percent achieving the care goal rose to 38 percent. When the disqualifying diagnosis was psychiatric, only 18 percent had achieved the goal set for them (table 17). In general, whether the disqualifying diagnosis was physical or psychiatric, the proportion achieving the care goal was greater when referral was made to a private resource than to a community agency. This result should not be interpreted as meaning that either type of resource is necessarily superior.

A selective process operates when rejectees are referred to a resource.

It is important to keep in mind that HDRS results reflect the experience with a highly selected group in New York City. They, therefore, do not necessarily indicate the prevalence of various health problems among young men in New York City. The volume of referral work in any of the community resources of New York City is huge, and for many reasons some of these agencies have complex intake and service procedures. While keeping the initial resource appointment is a first step towards obtaining needed services, motivation must be strong if the rejectee is to continue through the maze of diagnostic and treatment procedures necessary to achieve the care goal.

Conclusions

In developing the demonstration program, we set up procedures to determine the problems and pitfalls in carrying out such a program as a continuing project. We viewed the demonstration as a means of learning what the issues were. Data from this program seem to indicate clearly that large numbers of young men who are rejected for military service by the Selective Service System need a medical counseling and referral program. Our results also show that such a referral program is feasible. The program needs to be improved, however, so that the yield will be greater. An increase in yield will require considerable further experimentation. Means must be found to motivate the rejectee to seek care and also to help identify the men most likely to follow the recommendations of the nurse counselor. To conserve nursing personnel, experimentation with carefully trained nonprofessionals, working as interviewers under the guidance of a nurse counselor, should be considered.

Finally, the Armed Forces rejectees can be considered to exemplify all groups who are rejected in screening programs for health reasons and left to cope with their health problems with their own resources, later on perhaps becoming burdens upon the community. Such groups may comprise persons rejected on preemployment examinations in industry or upon application for insurance benefits. The experience of the New York City Health Department with its referral program should provide guidelines for meeting the needs of such groups.

Summary

Health referral services for Armed Forces rejectees was a demonstration project in New York City designed to determine how men rejected for military service by the Selective Service System because of medical problems could most effectively be referred to appropriate sources of medical care.

Public health nurse-counselors used both private and public community health resources in making their referrals. Cooperation of the young men with the project staff was voluntary. Social work consultants interpreted the service to the community.

Based in part on the results achieved in the demonstration in New York City and in other localities, the Federal Government has appropriated funds for the implementation of such health referral services throughout the nation. These programs are administered through contracts arranged with State health departments, vocational rehabilitation services, and other agencies. In New York City, the referral service now operates as a regular service program through a subcontract with the New York State Health Department.

REFERENCE

(*1*) Harting, D.: Health services for Armed Forces rejectees. Follow-up Reporter (National Committee for Children and Youth), November 1961.