DISCUSSION

Dr. Kramer: This provides a transition point to the next paper on the Chichester service.

One of our problems in the United States is that, as a result of our system of medical practice, social welfare, and public health organization, it is difficult to get a comprehensive picture of the provision of psychiatric services in a locality. We do not have situations where all patients come to a central point and are distributed to treatment facilities in a way that offers the best possibilities for care. One of the problems we face is that our services in general hospitals, mental hospitals, domiciliary, private, day- and night-care centers, outpatient clinics are usually under separate control.

It is important to keep in mind the fact that the two services being studied in England have control of everybody referred for psychiatric care.

Dr. Pasamanick: Have referrals increased in the Chichester area from the period before the institution of this service to the period afterward?

Dr. Sainsbury: We don't really know.

Dr. Carstairs: But surely the significant change in the admission figure was when they were halved, in the first year of the community-oriented program. That was their first finding, the rapid reduction in admission figures; and some critics unkindly said they had been admitting far too many before they started the new service.

Dr. Pasamanick: I had that impression because of the significant difference between Salisbury and Chichester. This would imply that a

number of patients who were less ill were being referred, or were coming to your service. In that case, it may be possible that the lack of differences, for instance, in suicide rates or in some of the other measures, was due to the fact that you had in your cohort a number of patients who were less ill, in which case you would have to make some adjustment for this.

DR. SAINSBURY: This is one of the things we looked at when we matched on diagnosis and severity of illness at referral (p. 236). The two services are very similar. If anything, the bias is slightly toward a more severely ill group coming to Chichester, and this is probably because there were more senile and arteriosclerosis disorders. So our figures do *not* suggest that the Chichester referrals are a less severely ill group.

DR. PASAMANICK: Are you saying this is because of the age constitution of the population, or that you are just producing more mentally ill patients?

DR. GARDNER: It may be that both places—perhaps more so Salisbury—are missing a certain group of patients. I suggest this because in Monroe County, our peak rates for psychiatric referrals was in the age group 45 to 64. When we look at that group, it turns out to be due largely to men coming in via services for alcoholics or court referrals. Some are paranoid and some are alcoholic. I wonder if the dip at this age doesn't mean that you are missing these patients. It would seem to me that Salisbury may be missing this group more than Chichester.

DR. SAINSBURY: I think that is the problem. If increased services are provided, and you have the confidence of your community, cases are referred that would not previously have come. If your services are minimal, the referrals will be those sent on orders and others of this sort. But if your services are offered to a wider segment of the population, more severe cases of all kinds are referred, such as the less sophisticated and the underprivileged who would not have been seen when there were not the same opportunities for seeking psychiatric advice.

DR. GARDNER: If you have a unit that particularly serves the courts, you may draw these people, and then this group will affect the results. They are much more difficult to manage. If there is any difference in the areas between this group—

DR. GRAD: But they are a particularly conspicuous group and you would expect them to appear first. There is no evidence you are not getting the others, perhaps—

Dr. Gardner: They may go to jail.

Dr. Pasamanick: I still am not too clear about this. One of the differences, you said, between Chichester and Salisbury was not only in the aged group but also in the young group, 24–30. If it is true, that you are not really getting less ill patients in the total number, this somewhat contradicts the findings in this country—that those who are seriously ill and disabled show up almost completely and immediately in a census of services. Certainly they did in Dutchess County.

Dr. Morrissey: Can I give you an example? Some are severely ill, but were not seen by us until this sort of service started. The patient with severe phobic anxiety, for example, who was housebound. We came across a number of these patients who had been ill for many years but who had never been seen by a psychiatrist because they could not go out, and the doctor had said if you want treatment, you must go to the clinic.

Dr. Pilkington: I have one brief comment to make with relation to Dr. Grad's work on the effect on the family. I am sure that the Chichester people are quite well aware of it, but I accept with considerable reservations the finding that the families were satisfied after one month, because I think that although their tolerance may not have been exhausted after one month it might be after two years. I would think there might be a tremendous difference. In fact, I feel that the one-month interview might be rather misleading.

Dr. Grad: This is why I am so sorry we haven't yet got the findings on the situation two years later and why we didn't put that particular point in the paper.

Dr. Miller: I would like to return to the question Dr. Pasamanick raised, because I think it is a critical question we really have not dealt with.

You gave some reasons why it might be plausible that there had been no decrease in severity—in fact, reasons to expect that the level would have remained the same. You also reasoned, from certain indirect situations, that the level has not changed. But I think it is very important to know what direct assessments were made and what the methods used have been.

I cite this because there are so many indirect ways in which this factor can be concealed or lost sight of. A study now in progress in New York State is making an effort to measure where there are duplications of services. What has been found is that the use of some of the

conventional terms —for example, diagnostic terms—was misleading because clinics now expect to be seeing ill patients, and this is reflected in the diagnoses used. On closer examination, it rarely reflects an actual change in severity as measured by independent factors.

DR. SAINSBURY: I think there are two points here: First, is the question whether there are more severe diagnoses referred to our service. Table 8 gives the referral rates for the broad diagnostic groups in the two services.

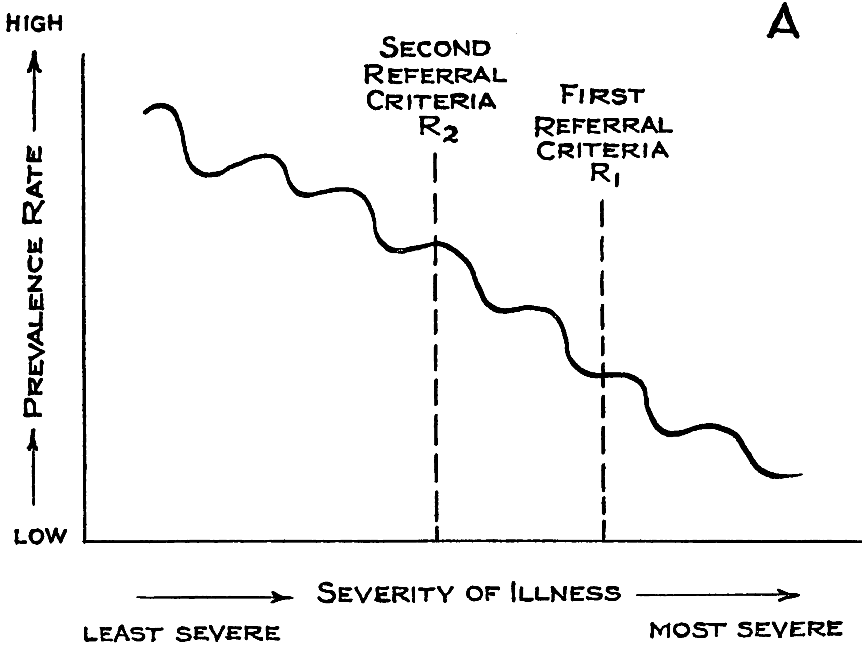
Next, our independent measure of severity was the burden on the family, which is quite a good one as really ill people will disturb their families, and if the illnesses are of comparable severity in the two areas the families will be equally burdened. At the time the psychiatrist was first called, we found no difference in the severity of illness in the two areas. We used other measures of severity, such as duration of illness and diagnosis, which are less satisfactory, we agree. Another method used was to rank the frequency with which different symptoms were recorded: there was a close correlation between the services.

DR. BROWN: The Boston survey reported in the *Prevention of Hospitalization* found the identical two groups that Dr. Morrissey has spoken about. I would like to emphasize the similarity across the ocean. For example, we found a group of housebound phobics who were willing to come into outpatient service after a few home visits (male psychiatrists—female patients); another similar group was the elderly housebound with organic conditions, whose families had not reached the point of complete intolerance.

DR. GRUENBERG: I want to come back to Dr. Pasamanick's point because I think he is not satisfied. I am not sure that I am satisfied. I think it is terribly important when it comes to interpreting these data.

The first graph that Dr. Sainsbury referred to (Figure 1, A) showed two age referral curves—the Chichester curve and the Salisbury curve. There is a big area between them. But we are told the severity of illness in the people referred is the same in the two groups of referrals. The patients referred have the same severity. Is that the doctrine we are being given?

I think the idea we have in mind is that, if you think of all the population in the community, there is a grading of illness severity. If you look at a frequency distribution—or prevalence rates—there are very few very sick patients. Then you get a higher prevalence of less sick patients. The less sick the patients are, the higher the frequency



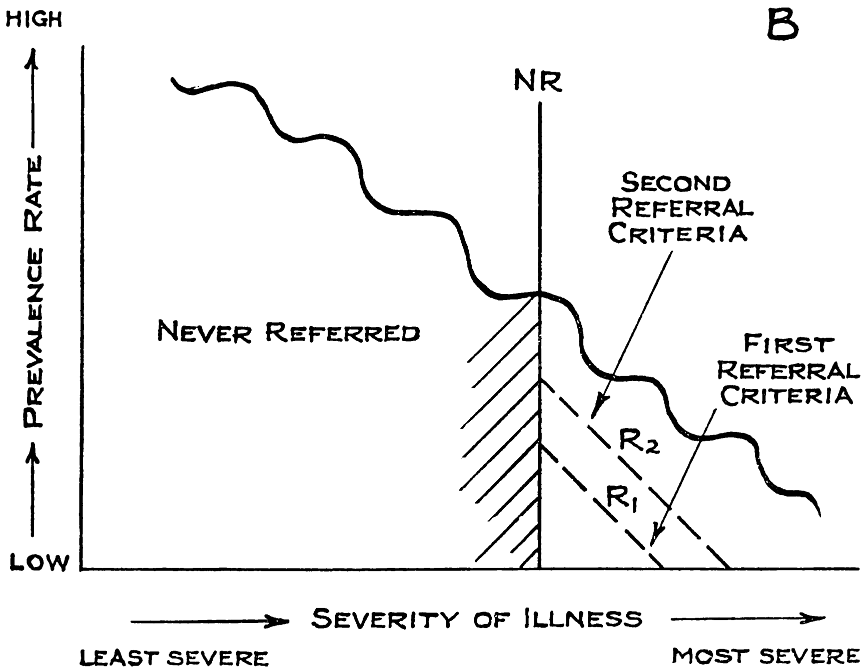


Figure 1. Two models of how higher referral rates from a population might tap cases of different severity.

of such patients in the general population. This is the kind of assumption which lies behind the discussion, I believe.

In Figure 1, A, at the bad end (R_1) you get all the cases, or nearly 100 per cent, by your referral criteria. If you shift your criteria and get more cases, it means you move over to R_2 and you include less severe cases—you get all those obtained by R_1 plus some other less severe cases. If you get any more, you must have changed the criteria to include a less severe group.

But what our friends are telling us is that, the way their criteria are set up, there is sort of a rigid line at NR (Figure 1, B) and that is the least severe case that you ever get by any referral criteria. In Salisbury, say, they get only a small part of the referrable group (R_1) and in Chichester, they get a slightly bigger part of this group (R_2) and the distribution of severity of the cases referred is the same.

Is that right? You are not sampling by going down the gradient of severity to the left; you are not widening the spectrum of severity. You are only picking up more of the same severity.

DR. SAINSBURY: Does this surprise you?

DR. GRUENBERG: No, I am trying to understand you.

DR. BRANDON: But isn't duration another factor here?

DR. GRUENBERG: Duration can be another parameter of severity.

But the kind of evidence given us on whether these two popuations have the same severity has to do with the *distribution* of diagnoses, and the *distribution* of severities among the cases referred in each community. All I asked was do you have a larger referral rate of mild cases from one than from the other?

DR. SAINSBURY: No, we have not.

DR. GRUENBERG: How do you know? Did you count the number of mild cases and compute referral rates of mild cases?

DR. SAINSBURY: The referral rates for neuroses barely differentiate the services, but the referral rates for psychoses of old age and functional psychoses do.

Dr. Miller asked whether the severity of illness in the two services at referral, as measured by an effect on the family, was the same in both services. It was.

Unless it is supposed that the mental hospitals took care of all the community's severe cases prior to the introduction of the service, then the first cases the service will pick up will be those with severe illness

remaining in the community, such as psychoses in the aged still in the care of the general practitioners.

They provide a source of severe psychiatric problems which were not being dealt with previously.

DR. CECIL G. SHEPS: I feel that if you are really going to evaluate services, the single most important prerequisite is specificity of objective, and this has been lacking so far as I can see.

I understand that when community services are set up they have to be set up broadly, and one has to see all sorts of people to get going; but I wonder if it is not possible to concentrate one's efforts on certain specific categories.

I am asking about specificity of objective as far as ultimate *value* is concerned, making clear what you are trying to achieve in a manner definitely delineated from what you have to do in order to get the program started.

Another problem which appears to need attention is the assessment of severity. As a non-psychiatrist, I have had experience in other fields at attempts to characterize severity. Is severity to be judged by more than one factor? Perhaps so. But if so, what should these factors be? The possibilities of damage to one's self on a life-or-death basis? The possibility of damage to others on a life-or-death basis? As distinguished from noneffectiveness as a social person, as distinguished from the effect of the individual's problems on the members of the family and the neighborhood? And so on? It strikes me that there is confusion about the concept of severity. The evaluation of these programs will depend to a significant extent on agreement about these two issues: specificity of objectives, on the one hand, and defining severity, on the other.

DR. SAINSBURY: I think that in a community service a reasonable measure for judging severity is how it hits the family which has tc bear the burden.

DR. GRAD: If we count the proportion of patients referred who require constant nursing attention at home, that is similar in both services. The proportion of patients who are reported to be excessively demanding by families is also similar in both services.

DR. GARDNER: I agree with Dr. Sheps. I think one of the mistakes we can make when evaluating services is to try to include too much at one time, to include too many variables we can't control. There are

different categories of illness, perhaps different groups within each category, and how we measure severity depends on the particular group we are dealing with.

If we try to describe a group of psychiatric patients and, to control variability get a homogeneous group—say, male psychiatric patients, and then go out to measure women, or older men—then we may find our instruments are not applicable, so that we cannot even determine severity. I agree that it is necessary to be more specific.

DR. KESSEL: Do you have any measure of the available psychiatric time per thousand of the population in the two areas? Can any of the ratio of 8.8 be explained by a greater availability of psychiatric care?

DR. SAINSBURY: The ratio of psychiatrists to the population is about the same in the two areas.

DR. KRAMER: I would like to come back to the point Dr. Sheps made because I think it is crucial to evaluation.

This particular study has a good description of who enters the universe of services and the resulting effects on the family and other parts of the community.

One can get into another problem by focusing on why a specific disposition was made of the patient at a particular point in time. There was a certain objective to this action. I wonder if anybody is looking at what objectives were desired when making a referral at a specific point in time—to be kept at home, sent into the mental hospital or clinic, or whatever. There must have been some objective in making this decision.

It is becoming increasingly important to get more deeply involved in the decision-making process as of a moment in time, so as to obtain data for classifying the objectives of these decisions in some generally acceptable way, either in terms of safety to the patient, safety to the community, less burden on the family, the need for certain kinds of treatment that could not be given at home, and so on.

Now, if it were possible to define objectives at the time a referral is made, perhaps you could then get at the kind of essential variable Dr. Sheps talked about.

The emphasis on building up more services encourages more people to use them. We seem to rely on clichés like "continuity of care," "reducing the burden on the family," and we find few persons involved in finding out what underlies these clichés.

If you want to evaluate these important areas, somebody has to

spell out in careful terms the purpose of each specific referral. We have to find some way of getting leverage on these problems, and I think with such specifications we can.

Because measurement is so very, very difficult, I hoped we would take to heart the point Dr. Sheps made and get into our evaluations more specific statements of what goes on at specific points in time and what leads to certain referral patterns, so that we could get some basis for evaluating the effect of these actions.