The Function of the Assessment Center in Community Mental Health

Joseph Zubin, Ph.D.

In a series of studies devoted to the challenge of evaluation, it would be foolhardy to cast any doubt on the need for evaluation; nevertheless, the challenge should extend to evaluation itself. I have been unable to find any consensus on the need, and even less on the goals and purposes of comprehensive mental health centers except in general nonspecific terms. Until these terms are spelled out, no evaluation is possible.

That evaluation is essential becomes obvious when a review is made of the history of the social and mental welfare movements in our country during the last six decades. The list of such movements is rather long, but these are the high spots: 1) the Lady Bountiful approach to social work at the turn of the century; 2) the Americanization movement of the first two decades of this century with Settlement Houses, Y's, and Community Centers as exemplified by the Hull House; 3) the attempts to rehabilitate delinquents; 4) the prohibition movements; 5) the child-guidance

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movement; 6) the rehabilitation of the unemployed during the depression of the thirties; 7) the psychotherapies and somato-therapies of the thirties and forties; 8) the opening up of the mental hospitals and return of the patient to his community and family during the last decade; 9) the war on poverty, Head Start, and similar activities of the current decade; and now 10) comprehensive mental health.

No one could argue with the good intentions of these movements, but they had one common failing—they either had no specified goals or neglected to include an important feedback in their system, that of built-in evaluation of the goals. The absence of evaluation did not go unnoticed. Mary E. Richmond criticized the charity givers of her day in the following terms: “. . . and it is safe to say that the charitable people who do not recognize the limitations of benevolence are mischievous members of society” (7). Each of these movements in turn was criticized for lack of goals and of self-evaluation, but the voices were too weak and the funds too sparse to make an impression. As a result, some of these movements led to catastrophes while others, though no doubt doing good, could never demonstrate their value in any objective way and hence lost public support. Still others persisted despite the lack of convincing evidence for their value. The comprehensive mental health movement seems at least to give lip service to the need for evaluation and assessment. However, the moment actual plans for assessment are discussed, a certain haze covers the issues. The goals of community mental health are not known; how the assessment is to be done is not clear; tools for assessment are lacking; the planners, who are usually administrators or clinicians rather than research men, have concepts of assessment that are far removed from the objective quantitative procedures which basic assessment demands; and finally, funds for service come first and funds for assessment hardly ever are provided in the first stages of planning.

The forces leading to the current community mental health movement could be easily traced to those which began the first formal community care movements initiated in our country. Until the Great Depression of the thirties most of these efforts were limited to local initiative. After 1930 national political forces aligned themselves with movements for improving the lot of the
underprivileged portions of the population. During this entire period, the mental health of the population as such never entered the picture. It was as if mental health were biding its time in the wings, waiting for the earlier movements to complete their act. As a result, the problems in the mental health field were regarded largely as the problems of single individuals who suffered presumably from "natural" causes and had to be cared for as individual cases by individual practitioners. The poor and those who became impoverished under treatment were cast off to the state hospital for custody rather than for care. The social-cultural forces which may have been of etiological import in each case were hardly ever mentioned or studied until the thirties and forties, and even then in a rather desultory manner. The social workers who were in closest contact with the social forces impinging on the mentally ill, despite their sensitivity to these problems, were unable to prevail upon their psychiatric colleagues to pay heed to the social-cultural aspects. Impressed with their failure to deal with the economic sources of poverty and ill health, they began to blame the social order but could do nothing to improve it. As a result, social workers turned elsewhere. The wave of psychoanalysis which swept over the mental health field and focused attention on the patient and his intrapsychic conflicts, rather than on the noxious external environmental forces, became the panacea. This approach, too, failed to meet the need for mental care. What we are witnessing now is the social scientist's revenge—the moving of the focus of care from the patient himself to the community. This may be likened to a shift from a small retail business to a department store, with the necessary changes in record-keeping, merchandizing, and public relations. As a matter of fact, the records kept during the earlier periods of mental care were hardly sufficient to yield a good basis for evaluation, even in advanced places. Like many small stores, our mental health operations were living from hand to mouth, never knowing whether they were making any profit. It is clear that with the department-store approach better record keeping and evaluation are a sine qua non.

What has brought about this change? Like all other revolutionary movements, it was long in the making. But its immediate predecessor is no doubt the revolution of the last decade, brought
about by the opening of the doors of our mental hospitals. I have elsewhere pointed out the sources of this revolution and will summarize them here only briefly (12). While the somatotherapies and psychotherapies of the forties and fifties shook the state hospitals out of their doldrums, the drug therapies of the late fifties were accompanied by such a drastic reduction in resident populations that the state hospitals had to sit up and take notice. Furthermore, the community to which the former patients returned also became involved. A closer examination of the changes, however, indicates that the tranquilizers were not the only agents bringing about this revolution. Reduction of patient populations had gone on gradually in other countries even before the advent of the drug era. A list of the factors which co-existed with the tranquilizers includes the following: 1) the deceleration of social-cultural trends such as immigration, industrialization, and urbanization which had tended to increase hospitalization; 2) the dwindling number of marginal persons pushed into the hospital by the 1930’s depression; 3) the gradual increase in tolerance towards the mentally ill, resulting from the mental hygiene and educational movement; and finally and perhaps unexpectedly 4) the “unborn children of the depression.” There are about 10 million fewer individuals in our population because of the drop in the birthrate during the thirties. And as the decreased population born in the thirties propagated itself through the forties, there were fewer children in our elementary schools; during the fifties there were fewer high school and college students; and during the sixties, fewer candidates for the professions. But there was no dearth of schizophrenics—in fact, their first-admission rate increased! The only explanation that can be offered is that when there are not enough frank psychoses, milder cases take their place. Milder cases also improve in greater numbers. This improvement adds to the reputation of psychiatric treatment, bringing even milder cases to the hospitals and clinics, and community tolerance for former patients climbs. While before 1930 only one-third of the patients were released, one-third improved but remained in the hospitals, and one-third remained in statu quo or deteriorated, now the middle third is also pushed out of the hospital, bringing the proportion of released up to 70 per cent or more. The presence in the community of the middle one-third
constitutes the source of our high readmission rate and has forced the community to pay attention to their needs. Furthermore, the uncovering of untreated cases in the community by such efforts as the Midtown Study again forced the community into action.

How can we make certain that the current effort in dealing with mental health will not come a cropper, as some of the earlier movements did? The first soul-searching that needs to be done concerns the goals of the movement. No matter how well intended our efforts may be, it is clear that without goals there can be no evaluation. And without evaluation all our work will come to nought, because only built-in evaluation can provide the self-correcting checks by which progress is made. Without goal-directed evaluation, the heavy hand of bureaucracy descends to hamper any change. But what should evaluation consist of? This raises again the question of the goals of the comprehensive mental health movement.

In a recent paper, Morton Kramer reminds us that the Kennedy message on Mental Health and Retardation and the Community Mental Health Centers Act of 1963 specify the following goals: 1) reduction of the number of mentally ill patients by half in two decades, 2) development of co-ordinated and integrated services that will assure patients continuity of care and assist in maintaining them in their own homes without hardship to themselves and their families, and 3) saving of public funds and conservation of our manpower resources (4). Before any of these steps can be taken, we must first know and assess the nature of the population coming for help. The assessment of this population is the chief burden of this paper. Once this is known, the amount and type of help required can be determined.

It is clear that community mental health facilities cannot take care of the entire spectrum of problems that are brought to them. To return to the 1930's when psychiatry felt itself omnipotent to tackle all of man's ailments—social and economic, as well as psychopathological—would be foolhardy. Consequently assessment should provide screening devices to separate the mentally ill from those who suffer from social, cultural, occupational, marital, or economic difficulties, but who do not suffer from psychopathology. Perhaps the future will bring community health and welfare
centers that will cater to all of man’s ills, but meantime a more modest approach limited to psychopathology is called for with referral of the nonpsychopathological to other facilities. Special methods for separating the sheep from the goats are needed. Once the applicant is regarded as a “case,” an evaluation of the severity of the illness, the type of illness, and the selection of proper treatment should follow.

It is interesting to compare the screening for community mental health with screening for the armed services during World War II. In the armed services, the false negatives were the chief concern, since the introduction of a potential psychiatric casualty into a critical post in warfare might endanger many individuals or the success of a maneuver. The false positives, if they were excluded, could do no harm, except insofar as an attenuation of the manpower potential resulted.

In community mental health screening, on the other hand, it is the false positives who are of chief concern, since only troubled people will come, some of whom may not have any basic psychopathology underlying their complaints (self-selected false positives). Those who have psychopathologically based problems but who do not come for help (self-selected false negatives) need not concern us unless a community study is undertaken to detect them. The false positives, however, are essentially “normal” people who think they have mental problems. For them, the screening devices like the MMPI, vocational inventories, attitude scales, can be wisely applied since their essential normality is presumptive evidence that the results of self-administered inventories are trustworthy. This assumption is not always tenable in the case of the mentally ill. Thus, the patterns of performance over these self-administered inventories can provide an assessment of both liabilities and assets which can distinguish the essentially normal from the psychopathological and those found to be “normal” can be referred elsewhere for the solution of their social, marital, vocational, or welfare problems.

The second goal, that of the evaluation of the course of treatment and its outcome, is perhaps even more difficult than the first, but unless tools for evaluation are provided, we will continue to be merely empirical and practical, that is, practicing the errors of our forefathers.
The third goal, that of detection of the sources of illness and their consequent elimination, is the hardest of the lot. A careful history of the development of the illness in individuals and epidemiological investigation of the underlying factors must be undertaken if the goal is to be achieved. This is the area that promises the most good but demands the greatest effort and where the least is now known.

What is the assessment process?

As far as the individual is concerned, it consists essentially of determining by means of suitable instruments the nature of the present illness and its sources or concomitant factors in the family and in the patient's milieu. These instruments can be observational techniques, interviews, questionnaires, tests, and other devices which yield measures suitable for the classification of the patient, for selection of therapy, and for evaluation of outcome.

From the point of view of the center, assessment consists of suitable arrangements for gauging the efficacy of its various interactions with the patient, its effectiveness in maintaining contact with him, his family, and the community, and its public relations with the community as a whole, its leaders, and other social agencies. The development of suitable instruments for assessing the center's effectiveness in these areas demands the attention of administrators concerned with this problem.

The assessment of the patient himself and the center is not enough. The assessment of his family and milieu is not enough. We must give up the retail attitude of looking only at the individual and adopt the wholesale attitude of looking at the totality of his situation. Here is where the social scientist must be brought in. For example, not all poverty-stricken and deprived individuals need mental health care. In Wisconsin there are some fifteen-hundred Winnebago Indians living in poverty on scrub land, with high unemployment, poor schooling and housing, high infant mortality, endemic tuberculosis, disorganized tribal life, and unstable marital ties, but who, because of personal pride, strongly entrenched kinship ties and extended family organization, and a tradition of stoic fortitude, have little if any mental disorder—according to the reports of anthropologists who have lived with the tribe. In fact, Leo Srole, who reports on this group, feels that early exposure to adversity may serve to immunize the individual
to subsequent crises (9). This principle operates in early animal experience, in immunity to physical illness, and may also be an important factor in mental health.

It is clear that for an assessment center to do a complete job it must also extend itself into the community and assess and evaluate its assets and liabilities, but a consideration of the epidemiological aspects of the work is beyond the compass of this paper.

There is, however, still another facet of assessment, namely, the impact of the community mental health center in bringing about changes in the epidemiological aspects of the community it is serving. This impact can be measured by means of a population study of the community through such instruments as mental health registers in the catchment area served by the center. Admission rates, discharge rates, age, sex, household size and socioeconomic rates, and a variety of other indices have been developed for this purpose (6).

Among some of the more promising techniques are the adaptation of life-table techniques to the evaluation of duration of treatment and the application of the outcome index developed by Biometrics Research (1).

We have been forced to recognize that assessment of the behavior of mental patients cannot be done in the abstract but must arise from some scientific model based on the causes of mental illness. Without such models, science functions in a vacuum. In other words, measurement that is worth while has to be based on some underlying scientific model for encompassing the data which measurement would yield.

For this reason it is important at least to catalogue the variety of models that are now available in the field of psychopathology and to note the type of measurement each might give rise to. I have discussed this problem elsewhere (11). A quick review of the field indicates that the following models are extant: 1) the social-cultural model, 2) the developmental model, 3) the learning-theory model, 4) the hereditary model, 5) the internal environment model, and 6) the neurophysiological or brain model.

The social-cultural model is built on the assumption that all mankind is vulnerable to mental disorders. Given sufficient deprivation and stress-producing loads or other alterations in our environment, our behavior would be altered to the point where the ability to continue to live normally as independent individuals in
society is endangered. Under this model certain expectancies exist with regard to social-cultural norms, and an individual who deviates from these social-cultural norms is regarded as potentially, or actually, mentally ill. The techniques needed to determine the presence of such deviation are primarily culture-dependent techniques, and we shall turn to them when we discuss the tools that have been developed for this purpose.

The second model, the developmental model, and the third, the learning-theory model, are built on the assumption that mental illness develops as a result of some specific deprivation or interference during the critical period of development or that the source of the mental patient's deviant behavior is to be sought in his reinforcement history. In contrast with the social-cultural model, which looks for deviations from expected social-cultural norms that may be indigenous to each culture, the expectancies derived from the developmental model and from the learning-theory model are not culture-bound in the same sense, and may be regarded as culture-fair. By this we mean that various expected behaviors from which the person deviates have transcultural translations or equivalents, so that we can thus speak of greeting behavior and its deviations, or of bereavement behavior and its deviations, or of the responses to reinforcement and its deviations. While the actual response to these forms of stimulation are not identical from culture to culture, it is possible to establish the correspondences across cultures, and hence we can call them culture-fair.

Finally we have the genetic model, the internal-environment model, and the brain-function model, which indicate that something is awry either genetically, internally, or in the brain functioning of the mentally ill person. These deviations may be in a sense culture-independent insofar as an individual who is vulnerable to an illness may give indications that he is deviant in regard to his functioning in one or more of these three areas, regardless of his social-cultural milieu. These give rise to culture-free indicators.*

* It should be borne in mind that the culture-free indicators may differ from the culture-fair and culture-dependent insofar as the latter generally indicate the actual presence of psychopathology. In the case of the culture-free indicators, no psychopathology need be present. These indicators may merely reflect the presence of vulnerability. If the environment is sufficiently benign, the vulnerability may remain latent, for example, PKU in an environment free of phenylalanine.
As a result of a decade of work in our Biometrics laboratory, we have begun to implement a three-pronged attack on the problem of assessing mental patients by using culture-dependent, culture-fair, and culture-free techniques. The culture-bound techniques are most commonly in use today. Their popularity stems from the fact that the detection and diagnosis of mental disorders depend primarily on the occurrence of behaviors that deviate from social-cultural norms. Since the subcultures in our population, especially those which are now receiving little or no mental health care, show such tremendous variation in their norms, it becomes essential to prepare tools and techniques that will be sensitive to the various types of normative behaviors in the various subcultures and not mistake them for deviations, but will not overlook deviations from local norms when they do occur. Even when two patients report an identical bit of behavior, such as guilt for having committed a grievous sin, the evaluation of this behavior with regard to the presence or absence of psychopathology will be quite different if the report comes from a farmer in a rural area or from a college professor.

The culture-fair techniques differ from the culture-dependent techniques insofar as they deal with equivalent deviant behaviors cross-culturally. Thus, deviations from greeting behaviors, grieving behavior, communicability, response to reinforcement, and so on, can occur in all cultures and may have the same value, psychopathologically speaking. However, the normative forms for each of these behaviors vary from culture to culture, so that translations have to be made cross-culturally. Thus, greeting behavior, though occurring in all cultures, varies from culture to culture, for example, shaking hands in our culture, rubbing noses in another, and profuse weeping in still another. Deviations from the expected in any of these cultures, though taking different forms, may nevertheless represent similar degrees of psychopathology.

The culture-free techniques are aimed at detecting the presence of psychopathology by measuring behaviors that are either completely independent of culture or are relatively free of its influence. A good example of such an indicator, though perhaps not behavioral in kind, is the presence of a high level of phenylalanine in the blood of a PKU patient. A vulnerable individual will have this indicator regardless of the social-cultural environment he
lives in, unless it happens to be one in which phenylalanine is missing from the diet. We have recently been able to develop certain behavioral indicators occurring during the first 1,000 milliseconds following stimulation that differentiate patients from normals. Presumably the processing of information in the brain of patients is different.

The culture-fair and culture-free indicators have been described in detail elsewhere (10). Here we shall limit ourselves to the presentation of the culture-dependent techniques.

**Culture-Dependent Techniques**

Space permits the detailed presentation of only two techniques of assessment, one psychological and the other psychiatric, but other techniques developed by our group will be introduced briefly. The psychological technique known as the Structured Clinical Interview, or SCI, was designed to serve as an individual test of social and psychological adjustment (2). It contains a fixed input of somewhat neutral open-ended questions that set a relatively mild tone of inquiry, but which nevertheless provide the subject with an opportunity to express ideation and behavior from which the psychologist can judge the presence or absence of psychopathology. The SCI is intended for use as both a screening instrument (in the community as well as in admission services of hospitals and clinics) and an assessment tool for determination of changes in psychopathology with passage of time.

The SCI consists of an interview schedule together with an inventory of 179 items, incorporated as an integral part of the protocol, to be marked true or not true by the examiner during the interview on the basis of the subject's answers. The interview usually takes about twenty minutes. Since the examiner records his judgments during the interview, no additional time is required for completion of the inventory after the subject has departed. Figure 8.1 shows a typical section of the interview schedule. In order to facilitate the examiner's task, the items of the inventory have been printed opposite those interview questions that experience with the technique has shown to be most likely to elicit the relevant behavior.

The SCI yields a total score that provides an over-all measure
of severity of symptoms. The items have also been clustered into ten non-overlapping subtests that describe areas of potential psychopathology in psychological terms.

65. "Tell me something about your imagination."

"What kinds of things have you been thinking about?"

65. Reports that he engages in wishful thinking instead of working.

66. Reports that he broods over a certain unpleasant thought or feeling.

67. Reports or expresses weird or bizarre thought.

68. Reports that a certain irrelevant thought intrudes on his consciousness.

69. Reports that things seem unreal or dreamlike.

70. Says that he feels as if he is outside of his body, or as if his body does not belong to him.

Figure 8.1. Typical section from The Structured Clinic Interview (revised). Copyright Eugene I. Burdock, Anne S. Hardesty, and Biometrics Research, 1966.

Figure 8.2 illustrates certain systematic differences among normals, outpatients, and inpatients in the proportions of items indicative of psychopathology. In general, the three groups are arranged in order of increasing pathology, from normals to outpatients to inpatients. The outpatients score higher than the inpatients on Fear-Worry, Physical Complaints, and Self Depreciation. Since the outpatients are preponderantly neurotics, while the inpatients are mostly psychotics, it is not surprising that the latter show more Conceptual Dysfunction, Incongruous Behavior, Incongruous Ideation, Lethargy-Dejection, and Perceptual Dysfunction.
Figure 8.2. Differences among normals, outpatients and inpatients in per cent of items indicative of psychopathology. (From unpublished data by Eugene I. Burdock, Ph.D., and Anne S. Hardesty, Ph.D., Biometrics Research.)

Figure 8.3 illustrates how the technique can be used to compare individual subjects. The base line represents the mean scores of a norm group of nonpsychiatric subjects. The two patients represented here were interviewed at time of admission to hospital. The over-all level of pathology is about the same for both patients, nearly two sigmas above the mean of the normals. However, the profiles show that the respective totals are compounded of different ingredients. The manic patient greatly exceeds the depressive in Incongruous Ideation and Sexual Problems, while the depressive shows extreme elevation on Physical Complaints, which are absent in the manic. The depressive shows considerably more Fear-Worries than the manic, although both are high. The two patients show about equal elevation on Anger-Hostility, Conceptual Dysfunction, Lethargy-Depression, and Self Depreciation. Neither patient shows any Incongruous Behavior or Perceptual Dysfunction.
Figure 8.3. Comparison of profiles of a depressive and of a manic patient. (From unpublished data by Eugene I. Burdock, Ph.D., and Anne S. Hardesty, Ph.D., Biometrics Research.)

Figure 8.4 presents successive profiles of a patient who was interviewed three times at intervals of two months. The first interview took place on admission to the hospital, and the second at the request of the psychiatrist because of a marked change in her behavior. The third interview was held on a follow-up visit to the hospital after the patient’s release. The three total scores show a progressive decline in over-all level of psychopathology from a high of two sigmas above normal to less than one sigma above. The profile of subtest scores shows two features that remain relatively high on all three occasions, Anger-Hostility and Self Depreciation. In her manic phase at the time of admission the patient showed extreme Incongruous Ideation and had numerous Physical Complaints. She also manifested considerable Conceptual Dysfunction, Incongruous Behavior, and Fear-Worry. Two months later, in a depressed phase, Incongruous Ideation, Conceptual
Dysfunction, and Incongruous Behavior, together with Physical Complaints, had declined to normal, but Lethargy-Dejection had risen. By the time of the follow-up interview, Fear-Worry had returned to normal, but Conceptual Dysfunction had increased again to a significant extent and, together with Anger-Hostility and Self Depreciation, reflects the persistence of deviation from the normal reference group.

![Clinical Profile Graph]

Figure 8.4. Successive profiles of a manic-depressive patient interviewed three times at intervals of two months. (Published in E. I. Burdock and Anne S. Hardesty, Psychological tests for psychopathology. J. abnorm. Psychol. 73: 62–69, 1968.)

Figure 8.5 illustrates the potential of the SCI for screening. Profiles of two normals are shown side by side. One of these, a relatively low normal, has some elevation on Anger-Hostility and Lethargy-Dejection. The other subject has a total score more than one and one-half standard deviations above the mean. His profile shows extremely elevated scores on Anger-Hostility, Fear-Worry, Self Depreciation and Lethargy-Dejection, together with suspi-
ciously high amounts of Conceptual Dysfunction and Incongruous Behavior. In any screening program the latter subject might well be referred for a detailed psychiatric evaluation.

In summary, the SCI has been designed to serve as an individual test for manifest psychopathology. It is a psychometric instrument that can provide reliable scores when it is administered and evaluated by a specially trained clinical psychologist. It may be used to compare patients with one another, to follow

![CLINICAL PROFILE](image)

Figure 8.5. Profiles of a “high” and a “low” normal. (Published in E. I. Burdock and Anne S. Hardesty, Psychological tests for psychopathology. *J. abnorm. Psychol.* 73: 62–69, 1968.)

up changes in individual patients, or to detect subjects with potential pathology in the community. Because of its comparatively neutral tone, the SCI is usually given before certain other schedules are administered. If the subject reveals considerable psychopathology under these relatively neutral conditions, it may be desirable to follow it with a more probing instrument, such as the Mental Status Schedule which will now be described (8).

The MSS is primarily designed for use with psychiatric patients
and focuses upon signs and symptoms associated with neurotic, psychotic, and organic disorders. The instrument is similar in structure to the SCI and consists of a booklet containing an interview schedule and a matching inventory of 248 dichotomous items descriptive of small units of pathological behavior. The interview schedule is a series of questions and statements covering a wide range of psychopathology which the interviewer uses to elicit information from the patient. The interviewer records his judgments as to the presence or absence of the pathology described in each dichotomous item by marking it on an answer sheet as either True or False. The interviewer is permitted to make general probes for more information and may select from the schedule alternative phrasing of questions, as well as optional but specific follow-up questions. Thus, while standarized, the procedure has enough flexibility so that, properly administered, it has the feel of a clinical interview, allowing good rapport between interviewer and patient. At the conclusion of the standardized evaluation, the interviewer may, if he wishes, conduct an unstructured interview to obtain additional information. All of the data are obtained and recorded while the patient is being examined, so that the evaluation is completed at the same time as the standardized interview. The entire evaluation generally takes from twenty to fifty minutes, depending upon the patient’s verbal productivity and co-operation.

There are two major sections in the schedule: the interview section and the observation section. In Figure 8.6, the left side shows the questions which the examiner asks, and on the right hand side are the precoded answers which the examiner marks True or False in conformity with the response given by the patient. Figure 8.7 demonstrates another representative portion of the schedule, which shows examples of the behavioral items which the examiner observes during the interview; these are also marked True or False depending upon whether the patient exhibited the behavior in question.

An MSS scoring system has been developed, based on a series of factor analyses of 2000 MSS protocols. An over-all factor analysis yielded three independent macroscales which have been designated by the following names: 1) Feelings-Concerns; 2) Confusion-Retardation; and 3) Delusions-Hallucinations. In addition, a combination of clinical judgments and factor analytic
How are you getting along with people?

What kinds of trouble do you have with people?

Whom do you feel you can trust most?

27. Complains about the way peers or strangers treat him.

28. Complains extensively about the way people in positions of authority or power treat him (e.g. staff members, police, employer).

29. Complains extensively about members of family, friend or associate.

30. Indicates he cannot trust other people or that he is unduly suspicious of their intent.

Figure 8.6. Portion of page 2 of the Mental Status Schedule.

RATE OF SPEECH

211. Speaks extremely rapidly and with infrequent pauses.

212. Speaks extremely slowly.

EMOTION

213. Has a sad expression or holds his body in a dejected or despondent posture.

214. Talks of his problem with no outward sign of emotion.

215. Laughs inappropriately during discussion of a serious topic (do not include simple embarrassment).

QUANTITY OF SPEECH

207. Makes no answer to most or all questions.

208. Answers questions with single words or brief phrases only.

209. Talks on and on and keeps resisting interruption.

Figure 8.7. Observation items of the Mental Status Schedule.
rotation yielded thirteen other specific factors. The three macroscales and the thirteen specific scales are shown in Figure 8.8.

Figure 8.8 compares five different groups of patients on the sixteen separate scales.

1) Community Cross Section (32): This group consisted of leaders and a stratified sample of individuals living in the Washington Heights area of New York City.

2) Former Inpatients (225): This group consisted of former psychiatric hospital patients now participating in a rehabilitation program (Fountain House).

3) Bowery Men (100): This group consisted of men interviewed at the Municipal Shelter in the Bowery section of New York City.

4) Psychiatric Outpatients (55): This group consisted of patients attending psychiatric outpatient clinics in New York State.

5) New Admissions (1413): This is the group on which the

Figure 8.8. Mean standard scores of five population groups on factor-based scales of the mental status schedule. (After R. L. Spitzer, J. Cohen, J. L. Fleiss, and Jean Endicott, Quantification of agreement in psychiatric diagnosis. Arch. gen. Psychiat. 17: 83–87, 1967.)
scores were standardized (mean of 50, standard deviation of 10).

The left portion of Figure 8.8 contrasts the groups on the three macroscales: Feelings-Concerns, Confusion-Retardation, and Delusions-Hallucinations. The new admissions had the highest score on both Confusion-Retardation and Delusions-Hallucinations, while the psychiatric outpatients had the highest score on Feelings-Concerns. The other groups differ in the expected directions when the nature of the samples is considered. The community cross section has the lowest score on all three macroscales.

The right portion of Figure 8.8 contrasts the groups on the second set of factor-based scales. On nine of the thirteen scales, the new admissions had the highest mean score. The Bowery men had the highest score on the scale Inappropriate or Bizarre Appearance or Behavior. This is not surprising, as many men on the Bowery are seen to be disheveled, dirty, and somewhat bizarrely dressed. The psychiatric outpatients had the highest score on Depression-Anxiety and Suicide-Self Mutilation, while the Bowery group had the highest score on Social Isolation. These differences as well as others shown in the figure demonstrate the power of the Mental Status Schedule scales to differentiate among groups who differ in specific ways.

Audiotape recordings of MSS interviews have been made for training interviewers and for estimating their reliability and bias. A method for estimating accuracy has been developed, whereby a number of experienced clinicians have come to a consensus as to which items are true, false, or "possible" for a number of teaching tapes. A rater listens to and scores a number of recordings, and later notes for each item whether he had a "hit" (he and the experts both agree that the item is either true or false), an "add" (he rated it true, experts rated it false), or a "miss" (he rated it false, experts rate it true). The degree of inaccuracy and the direction and sources of bias are thus indicated to the rater.

The usefulness of these systematic, structured interviews in determining the basis on which diagnoses are arrived at is demonstrated in Figure 8.9, reporting an experiment conducted by Katz et al. (3). One of our structured interviews was videotaped so that it could be presented to groups of psychiatrists for their clinical judgment and diagnosis. In addition to the over-all diagnosis, the psychiatrists were asked to fill out ratings on an inven-
tory for such factors as excitement, paranoid projection, anxious intropunitiveness, perceptual distortion, motor disturbances, hostile belligerence, apathy and retardation, grandiose expansiveness, and thinking disorganization (5). The psychiatrists were all seasoned veterans of psychiatry; nevertheless, of the thirty-

Figure 8.9. Mean symptom profiles of a psychiatric patient as viewed by two groups of clinicians who differed on diagnosis.

five participants, fourteen diagnosed the patient as neurotic and twenty-one as psychotic. An examination of their ratings revealed, however, that the groups differed significantly only in one respect—the rating on apathy. Those who rated the patient high on apathy diagnosed him as psychotic, while those who rated him low on apathy diagnosed him as neurotic. We are planning an
objective approach to the estimation of apathy, one that is independent of the interview.

Recently, one of our biometric teams under the guidance of Dr. Robert L. Spitzer undertook to serve as the research unit for the community mental health service inaugurated at the Psychiatric Institute. In order to provide an evaluation of this unit as a whole, a series of instruments were developed.

The first was an extension of the MSS to include pertinent data regarding the role functioning of the patient at the time of his admission. This developed into the Psychiatric Status Schedule or PSS. Two samples of this Schedule are shown in Figures 8.10 and 8.11.

<table>
<thead>
<tr>
<th>SLEEP</th>
<th>SLEEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>How soundly do you sleep?</td>
<td>122. Indicates he has trouble sleeping.</td>
</tr>
<tr>
<td>What time do you usually go to bed?</td>
<td>123. Indicates that for no good reason either the times that he goes to bed are usually grossly irregular or bizarre, or that he usually does not go to bed before 2 a.m.</td>
</tr>
<tr>
<td>Do you sleep much during the day?</td>
<td>124. Indicates he often spends more than 10 hours out of 24 in bed either resting or sleeping (do not include when due to obvious physical illness).</td>
</tr>
<tr>
<td>How much time would you say you spend in bed?</td>
<td>125. Indicates he often does not arise from sleep or a nap when he intends.</td>
</tr>
<tr>
<td>If more than 10 hours in 24: (Why is that?)</td>
<td>126. Indicates he often takes drugs because he cannot sleep, in the absence of a specific physical illness.</td>
</tr>
<tr>
<td>Do you often find that you can't get up in the morning or from a nap when you want?</td>
<td></td>
</tr>
<tr>
<td>Do you take anything to help you sleep?</td>
<td></td>
</tr>
</tbody>
</table>

Figure 8.10. Example from the general psychopathology section of the Psychiatric Status Schedule.
In order to obtain information about the patient from others significant in his environment, the Informant Form of the PSS was developed. It consists essentially of the same items covered in the PSS, but addressed to the informant. Another recently developed instrument is the Psychiatric History Schedule. There is also a Diagnosis Recording Form, in which the clinician records his diagnostic impressions, and a Social Background Record for recording pertinent background data.

248. Indicates that primarily because of his psychopathology he limits himself to part time, temporary or transient work.

249. Indicates that during the last week because of his psychopathology he was incapable of working some or all of the time expected of him by employer, client, etc. (e.g. skipped work one day because of anxiety).

250. Admits to an unduly strong dislike for the nature of his work.

A Psychiatric Evaluation Form has been developed to serve as a tentative criterion reflecting the treating psychiatric resident’s clinical judgment. Applying this instrument to case history material yielded high correlations between two independent raters.

How can such a multiplicity of data be obtained from the population likely to storm the doors of our community mental health centers? It would be foolhardy to try to obtain the information on all applicants. The wave of applicants that will inundate the community mental health centers once they are opened, with the added load brought on by Medicare and the newly proposed chil-
children's services, will put such a strain on facilities that only a small portion of the effort can be devoted to assessment. Yet without assessment there is a grave danger that the entire effort will be in vain and may produce catastrophic rather than beneficial results. I would be willing to settle for assessment on a sampling basis. Properly selected representative samples of the inflow of patients could give a microcosmic picture of the total population of applicants which could very well serve the purposes of assessment. The Bureau of the Census no longer depends upon total counts for all of its information but instead gets a good deal of its information from properly selected samples. The same can be done for community mental health centers.

The nonsampled part of the population would have to be screened by the best available methods. As our research progresses, we may be able eventually to use screening devices based upon the instruments we have developed but in some more automated form. In order to reduce the number of false positives, the assets as well as the liabilities of each person will have to be determined, and in presumably normal people self-administering instruments can be of great use in eliciting the balance between assets and liabilities.

Summary

In order to prevent the community mental health movement from going the way of all other similar movements, a built-in feedback mechanism must be instituted for evaluating the efficacy of the effort as it develops. For this purpose an assessment center is essential. Without such a center, community mental health cannot help but become stultified, and eventually it will deteriorate for lack of self-validating devices.

Not all applicants coming for help need be evaluated in the assessment center. The bulk of the patients will have to be dealt with by means of the current clinical methods, though attempts at automating some of the objective devices ought to be tried. The assessment center, in its initial stages, will deal with only a small representative sample of the population seeking help—perhaps only 10 per cent. However, the evaluation of the small sample
will be as thorough as present techniques allow and will give a reliable and valid picture of the effectiveness of the community mental health center. Armed with such a yardstick for evaluation, the center can scrutinize its effectiveness continuously and introduce innovations as the need for them arises.

References