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Chapter XVI

PUTTING EPIDEMIOLOGY TO WORK IN COMMUNITY MENTAL HEALTH

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THE READER who has made his way this far will have found many of his questions unanswered while discovering answers to many other questions he hadn't asked. At this point he should be asking "What are the significance and implications of the material in this volume?", and, "How much will epidemiological data ever be put to 'practical' use?" The reader will be left to decide for himself the answers to the first and broader question, while we consider the second.

Biometric data have long been used in psychiatry, but not always for scientific purposes. Perhaps the most common use of such data has been to impress legislators with the large numbers of mentally ill so that more funds could be obtained for their care. Despite rising budgets for mental health, funds allocated have never been sufficient. The public and government alike have now been largely persuaded, however, and mental health has entered into a period of undreamed of affluence with the passage of Community Mental health legislation. With this affluence goes a proportionate degree of responsibility. Effective services must be provided for many who now receive inadequate care and for still larger numbers who have not been hitherto reached. When compared with the magnitude of the problem, our affluence is soon recognized to be only relative to what has been known. Osterweil mentions that the planner is soon faced with the problem of "allocating scarce resources." As emphasized repeatedly by Kramer and other participants, it is of paramount importance that adequate information be available for planning the type, location, and scope of new programs, while established programs require a flow of data for continuing modification to meet changing needs. The supply of mental health manpower is

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insufficient and will become increasingly scarce as new tasks are undertaken. Adequate planning is thus necessary not only to provide optimum care and to avoid unnecessary costs, but also to make the best use of available manpower.

Epidemiological and other types of biometric data are essential for meeting these aims. This is not to say that decisions will be reached on the basis of such data alone. Finances, clinical considerations, value systems, community readiness, political factors, *etc.* will all have their influence. Biometric data sensitively adapted to each situation, however, can provide guide lines for arriving at rational decisions.

The major goal of this conference was to highlight the importance of epidemiological data in community mental health planning and to give some illustrations of its potential. As one might have expected and, indeed, as one would have hoped, the conference also brings out some of the difficulties in the application of such data. The papers presented deal with the subject from a variety of viewpoints and at differing levels of abstraction. While an impressive array of valuable information is marshaled, much of the material is presented at levels of abstraction which do not readily admit direct application. While the pure scientist, having other goals, may be unconcerned or even pleased with this state of affairs, those concerned with providing care would be interested in seeing more studies directly related to service programs. The problem also reflects the usual division between the research worker and the administrator. Because of this division in communication and power there has been little opportunity thus far to demonstrate the full value of biometric methods in program planning. Downing's and Goldfarb's paper is a promising exception. It illustrates the use of biometric data in the planning operations of an ongoing mental health program. It reflects what we hope is a growing trend, in which the program director wears another hat for research. Perlin's paper is another example of this type of relationship between research and operations.

Despite these small hopeful signs, there is no assurance that adequate use will be made of biometric data in the current expansion of mental health services. Research workers in this field are few. Administrators and clinicians are overwhelmed

with their new responsibilities and are likely to attend to other matters which scream more loudly for their attention. Without their participation, the necessary research won't be carried out, or perhaps worse, it will be done, but will not be designed to meet planning and evaluation of program needs. As Lemkau reminds us in a different context, "Art is long and time is fleeting!" Psychiatry is facing a great challenge and is undertaking a vast and bold experiment. And it is, indeed, an experiment since the effectiveness of much of what is being done remains to be demonstrated. In the excitement of getting things done, research may go out the window; yet unless valid research for planning and evaluation is included on a commensurate scale we stand to learn little from these grand experiments.

What steps can be taken to see that the necessary research is conducted and applied? This question is bound to have many answers each adapted to specific local conditions throughout the country. A few general answers are possible, however. Since qualified researchers are scarce, more people must be trained for these functions. Each program should have an associated research team. In the case of smaller programs, research teams could be shared among several within an area. Research workers should enjoy status and rewards at least comparable to those in clinical and administrative functions.

The fulfillment of these conditions is necessary, but not sufficient to achieve our research goals. The greatest obstacle is the division of communication and power between research and administration, which has been mentioned. It is too Utopian to expect to find or to create an abundant supply of "universal men," each possessing a balance of administrative, clinical, and research abilities and interests. What then? Traditional administrative structures need to be altered to remove the isolation of research workers in community mental health. The research person must share some of the power, the responsibilities, and the headaches of the administrator. He should have a place near the fire where he can be warmed and also share the risks of getting burned. To put it more prosaically, he must be a full member of the team. Such a rearrangement of working relationships will permit the development of common perceptions and language which are the beginnings of communication.

In the current spirit of innovation and experimentation in social organization, this does not seem to be an unrealistic goal. There will, of course, be resistance from administrators and clinicians. The greatest resistance, however, may come from research people themselves, who tend to cherish their isolation, and usually consider it a necessary condition for their work. This argument has some validity, especially in the case of pure research, but in applied research, isolation has more drawbacks than advantages.

In conclusion, though this conference illustrates the value of epidemiological research for community psychiatry; we believe that it also reveals some of the current deficiencies of this research, in particular, the gulf that usually exists between research and operations. While continued refinements in research methodology offer theoretical promise, operational usefulness will depend upon the extent to which the gulf is narrowed. This returns us to our second question, "How much will epidemiological data ever be put to 'practical' use?" This question, too, must be turned back to the reader, since the answer is still forthcoming and he will be instrumental in determining what the answer is to be.