A study is reported on the response of several hundred psychiatric patients to offered public health nursing service. The characteristics of the patients who accepted the service are compared with those who did not, and the reasons why patients did not accept or continue with nursing service are examined. The utility of the results in development of policies by a Visiting Nurse Association are stated.

CHARACTERISTICS OF PSYCHIATRIC PATIENTS WHO UTILIZE PUBLIC HEALTH NURSING SERVICES

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IN RECENT years there has been increased interest on the part of psychiatric hospital and public health nursing agency personnel in defining and expanding the role of the public health nurse as an aid to the discharged psychiatric patient. This expansion produces two problems often found in service programs. The first is how to select patients most likely to be helped. The second is how to expand service so that those patients difficult to serve but needing help can be reached and kept on service. This paper is designed to provide data relevant to both of these problems.

In order to meet the need for a concrete basis on which to decide which patients should be selected for service, a study was made of 13 sociomedical characteristics of 312 unselected discharged psychiatric patients from Norwich Hospital, all of whom were offered nursing care by the Visiting Nurse Association of Hartford, Inc. Two questions were asked of the data:

1. Is there a difference between the sociomedical characteristics of patients who accept nursing service versus patients who refuse?

2. Is there a difference between patients who are maintained (completed at least three visits) and patients who are not maintained (received less than three visits) in terms of their sociomedical characteristics?

The variables studied were race, sex, age, religion, marital status, education, occupation, social class, diagnosis, type of household released to, previous hospitalization, status of nursing service (active or not active at the time of referral), status of hospital discharge (leave of absence, extended visit, discharge).

It is clear that no patient can be helped by the public health nurse unless he accepts her service and is maintained. This, then, is just a first step in seeking the answer to "Who can be helped?"

To those who feel that continuity of nursing care is important for these patients it is most important to examine the characteristics of those who refuse service and those who are not maintained. We hope that such an examination will lead to increased understanding of reasons for refusal or nonmaintenance and then to some notions about how to expand the program or change

the approach in order to encompass more fully those groups of people that are now found difficult to serve.

Procedure

The potential sample of 312 patients who could have received nursing service included all patients of Norwich Hospital who "left-bed" during the period, October 1, 1960, through September 30, 1961, to reside in the geographic area served by the Visiting Nurse Association of Hartford, Inc. Upon the patient's leaving the hospital a letter was sent to him by the superintendent of the hospital offering public health nursing service. If no letter or call refusing the offer was received by the fifth day after the patient left the hospital a referral was made by the hospital liaison nurse to the public health nurse.[1]

For the "Accept-Refuse Study" the potential sample of 312 patients was reduced to 276. Patients who returned to the hospital before the letter could be sent or who could not be located or contacted were eliminated because they had no opportunity to accept or refuse service. A patient was considered to have refused service if he or a member of his family indicated that the service was definitely unwanted, either in a letter or by a call prior to the nurse's visit or in person during the nurse's first or second visit. All other patients who could be contacted were considered to have accepted the service.

In the "Maintained-Not Maintained Study" the sample was reduced to 244 by the elimination of the 68 patients who refused service. A patient was considered to have been maintained if the nurse made three or more visits either to or in behalf of the patient. Alternatively, a patient was considered maintained if the nurse made less than three visits but discharged the patient because she felt he did not need further help and she considered her job with him completed. All other patients (except those who refused the service) were considered not maintained.

The basic sociomedical information on each patient was gathered from patient interviews and from hospital records abstracted by the research staff. Most of the variables need no explanation, i.e., race, sex, religion, and marital status. Those that require explanation follow:

1. Education is scaled from one to seven, according to Hollingshead's procedure.[2]
2. Occupation is the patient's own with the exception of most females and those in school, where the occupation of the social head of the household is ascribed to the patient.
3. Social Class is computed in the manner designated by Hollingshead[2] and in the case of women and those in school is ascribed.
4. Diagnosis refers to the primary diagnosis as it appears on hospital records.
5. Type of household refers to the household the patient was released to at the time of discharge.
6. Previous hospitalization refers to the presence or absence of a previous psychiatric hospitalization.
7. Status of nursing service refers to whether or not the patient or some member of his family was active with the nursing service at the time of referral.

Each sociomedical characteristic was tabulated against each of the two dichotomous variables studied, i.e., accept-refuse, maintained-not maintained. The resulting 2xn tables were tested by means of chi-square (with Yates correction where appropriate).[3] Regression analysis was done on the tables involving age. All tests were two-tailed and only differences with p equal to or smaller than 0.05 were considered significant.[3] The total number of the cases in each table varies slightly because, where information was lacking on a specific variable, the case was removed from the analysis.

Results

Major tables are included in this paper (Tables 1-3). Subsidiary investigations of cross-tabulated data are avail-

Table 1—Responses of Psychiatric Patients to Public Health Nursing Service as Differentiated by Sex, Race, Marital Status, Type of Household, Age, and Religion*,†

Sociomedical Characteristics Variable and Category	Sample–Accept Study (N-276)			Sample–Maintain Study (N-244)		
	Accept (208)	Refuse (68)	Per cent Accept	Maintain (183)	Not Maintain (61)	Per cent Maintain
Sex						
male	86	33	72.27	71	41	63.39§
female	122	35	77.71	112	20	84.85
Race						
white	162	62	72.32¶	142	48	74.74
nonwhite	46	6	88.46	41	13	75.93
Marital Status						
married	90	27	76.92	79	15	84.04‖
single	66	27	70.97	61	16	79.22
divorced	19	6	76.00	16	11	59.26
separated	27	5	84.38	21	16	56.76
widowed	6	3	66.67	6	3	66.67
Type of Household						
family	165	55	75.00	146	31	82.49§
nonfamily	43	13	76.79	37	30	55.22
Age‡						
10–19	11	2	84.62	10	1	90.91
20–29	39	7	84.78	37	11	77.08
30–39	56	14	80.00	49	20	71.01
40–49	58	19	75.32	50	14	78.13
50–59	30	19	61.22	24	12	66.67
60+	14	7	66.67	13	3	81.25
Religion						
Catholic	117	32	78.52	103	34	75.18
Protestant	77	28	73.33	67	26	72.04
Jewish	8	7	53.33	8	0	100.00

* All tests of significance are two-tailed.
† Where information was lacking, the case was removed from the analysis.
‡ Regression analysis—five degrees of freedom: χ^2 9.74, $0.01>p>0.001$.
§ $0.001>p$.
‖ $0.01>p>0.001$.
¶ $0.025>p>0.01$.

able upon request. Only a summary of the results is presented here.

Accept-Refuse Findings

The following four characteristics significantly differentiated the group of patients who accepted from those who refused service.

1. Patients with brain syndrome, addictive disorders, or personality disturbance were more likely to accept nursing service than patients with schizophrenia, affective disorders, or psychoneurosis (p less than 0.01).

2. Patients who were active or whose families were active with the Visiting Nurse Association at the time the patient was referred to the nursing agency were more likely to accept service than patients who were not active at that time (p less than 0.05).

3. A greater percentage of nonwhites accepted service compared to whites (p less than 0.025).

4. A regression of acceptance rate on age shows that as age increased the proportion of patients who accepted service decreased (p less than 0.01).

The rate of acceptance did not vary significantly with the following charac-

teristics: sex, religion, marital status, education, occupation, social class, type of household, previous hospitalization, and discharge status.

Maintained versus Not Maintained Findings

1. A greater proportion of patients living in a family setting were maintained than patients living in a nonfamily setting (alone or with nonrelatives) (p less than 0.001).
2. Married and single patients were maintained at a higher rate than widowed, separated, or divorced patients (p less than 0.01).
3. A greater proportion of females than males were maintained (p less than 0.001).
4. Those who had completed 7 to 12 years of school but did not go to college were maintained at a higher rate than patients who did not complete 7 years or more of school or who went to college (p less than 0.05).
5. Patients with schizophrenia, affective disorders, or brain syndrome were maintained at a higher rate than patients with addictive disorders, personality disturbance, or psychoneurosis (p less than 0.01). When patients with a secondary diagnosis of addictive disorder were added to the group of patients with a primary diagnosis of addictive disorder, the same differences in maintenance rates pertained between the diagnostic groups, but the contrasts were more marked (p less than 0.001).
6. Patients with no addictive disorder were maintained at much higher rates than addicted (alcohol and drugs primary diagnosis only) patients (p less than 0.001).

The rate of maintenance did not vary significantly with the following characteristics: race, age, religion, occupation, social class, previous hospitalization, status of nursing service, or status of discharge.

Table 2—Responses of Psychiatric Patients to Public Health Nursing Service as Differentiated by Education, Occupation, and Social Class*,†

Sociomedical Characteristics Variable and Category	Sample–Accept Study (N-276)			Sample–Maintain Study (N-244)		
	Accept (208)	Refuse (68)	Per cent Accept	Maintain (183)	Not Maintain (61)	Per cent Maintain
Education						
postgraduate	4	0	100.00	3	1	75.00¶
college graduate and some college	20	8	71.43	16	9	64.00
high school	45	15	75.00	41	12	77.36
some high school	37	20	64.91	32	7	82.05
grammar	74	19	79.57	70	14	83.33
some grammar	28	3	90.32	21	16	56.76
Occupation						
Class 1	4	0	100.00	3	1	75.00
Class 2 and 3	6	5	54.55	5	2	71.43
Class 4	61	26	70.11	51	17	75.00
Class 5	23	8	74.19	19	10	65.52
Class 6	44	12	78.57	42	10	80.77
Class 7	69	13	84.15	62	22	73.81
Social Class						
I and II	6	1	85.71	4	2	66.67
III	15	9	62.50	13	5	72.22
IV	79	28	73.83	67	23	74.44
V	107	24	81.68	98	29	77.17

* All tests of significance are two-tailed.
† Where information was lacking, the case was removed from the analysis.
¶ $0.05 > p > 0.025$.

Table 3—Responses of Psychiatric Patients to Public Health Nursing Service as Differentiated by Diagnosis, Status of Nursing Service, Previous Hospitalization, and Leave Status*,†

Sociomedical Characteristics Variable and Category	Sample–Accept Study (N-276)			Sample–Maintain Study (N-244)		
	Accept (208)	Refuse (68)	Per cent Accept	Maintain (183)	Not Maintain (61)	Per cent Maintain
Diagnosis‡						
schizophrenia	107	40	72.79‖	98	22	81.67‖
affective disorder	13	7	65.00	12	2	85.71
chronic brain syndrome	19	3	86.36	16	4	80.00
addictive disorder	26	3	89.66	19	21	47.50
personality trait disturbance	19	1	95.00	18	6	75.00
psychoneurosis	20	14	58.82	17	5	77.27
Diagnosis‡ schizophrenia + chronic brain syndrome affective disorder				113	22	83.70§
psychoneurosis personality trait disturbance				29	8	78.38
addictive disorder first and second diagnosis				38	30	55.88
Status of Nursing Service						
active	23	1	95.83£	22	2	91.67
not active	185	67	73.41	161	59	73.18
Previous Hospitalization						
yes	144	47	75.39	127	42	75.15
no	64	21	75.29	56	19	74.67
Leave Status						
leave of absence	30	8	78.95	27	7	79.41
extended leave	88	33	72.73	77	21	78.57
discharge	90	27	76.92	79	33	70.54

* All tests of significance are two-tailed.
† Where information was lacking, the case was removed from the analysis.
‡ Four cases of Mental Deficiency Diagnosis were removed from the analysis.
§ $0.001 > p$.
‖ $0.01 > p > 0.001$.
£ $0.05 > p > 0.025$.

Discussion

In order to more fully examine the findings, the various sociomedical characteristics investigated need further explanation.

Sex

The fact that there was no significant difference in the acceptance rate of males (72 per cent) and females (77 per cent) was quite surprising in view of the fact that much of the nurse's usual work is done with women and children. It was felt that the male patient would tend to refuse because of an inability to perceive that nursing service was relevant to his problems. It became clear, however, that once the nurse became active in the case it was much easier for her to maintain females. This was illustrated by the fact that only 63 per cent of the males were

maintained whereas 85 per cent of the females were seen for three or more visits.

The reasons for this situation are probably numerous. Males tend to be out of the home during the nurse's customary working hours and also tend to have more transitory residences than females. Our data confirm these assumptions. When the patients who were not maintained because they could not be located or kept in contact (52 per cent of the nonmaintained group) were removed from the sample, the percentage of males maintained was raised 19 points to 82 per cent. Under these conditions the difference in maintenance rates between males and females was not significant. Thus a large share of the difference in maintenance rates of males and females seemed to be accounted for by the fact that males were harder to find and keep in contact. This difference in maintenance rates was not affected by the removal of the nonmaintained patients who had returned to the hospital (37 per cent of the nonmaintained group).

The poor maintenance of male patients is a difficult situation to correct. If contact with males is desired it would seem advised to test out the advantage of formal arrangements for "after-hours" visiting of working men. Another approach would be to orient the patient while he was in the hospital to the potential usefulness of the community nursing services.*

Some of the cases lost because of inability to keep in contact might be maintained if the nurse could increase her ability to interpret as well as to demonstrate her usefulness to the patient, thus motivating him to keep appointments as well as to keep her appraised of his residence changes. Since the bulk of the nurse's work is with female patients, inservice education dealing specifically with her role in relation to male psychiatric patients might be expected to aid her in keeping male patients under care. In our own experience the nurses have requested additional help in working with male patients as they chose the subjects for psychiatric consultation.

* Design requirements of this study did not permit such orientation.

Race

The data demonstrate that a greater proportion of nonwhites (88 per cent) accepted service than whites (72 per cent).

The case load of the Visiting Nurse Association of Hartford is disproportionately high in nonwhite patients, 37 per cent, while the proportion of nonwhites in the community is 5.6 per cent. This fact has a number of implications that support our findings. First, that it is likely that the members of the nonwhite community are more intimately aware of the nurse and the services she has to offer, making it easier for them to accept service. Second, it appears that nonwhites either have greater need for the nurse's care or are more inclined than whites to accept her care when the service is offered.

Under these circumstances it seemed possible that, if patients active in nursing service at time of referral were subtracted from the sample, nonwhites who accepted service would be differentially subtracted, leaving a nonsignificant difference between whites and nonwhites in rate of acceptance. The subtraction did not substantially affect the percentage of whites or nonwhites accepting. Apparently being active at the time of referral is not a factor crucial to the greater acceptance rate of nonwhites.

It was found, however, that, if those patients who had completed less than seven years of school were removed from the sample, the percentage of whites accepting remained 72 per cent, but the percentage of nonwhites ac-

cepting was lowered to 85 per cent. This measure eliminated the significant difference between the two groups, although it still left a sizable numerical difference. This result indicates that there is some relationship between the high acceptance rate of nonwhites and their lack of education. This is not surprising, since those with low educational achievement usually have a low income which could make their actual need for public health services greater. Such low income families are also more likely to live in the type of cultural milieu that makes receipt of community services socially acceptable.

It seems feasible that the factors discussed above, although having their major impact on acceptance rate, would also have some effect on maintenance rate. This was not so; almost exactly the same percentage of whites (75 per cent) as nonwhites (76 per cent) were maintained. At least two factors may have entered into this finding. One is that the patients left—after refusals were subtracted—were equally motivated and had equal need for service; the other is that once white patients were in contact with the nurse she was able to demonstrate to their satisfaction their need for service and to allay their anxieties about accepting an unfamiliar community agency.

If it is believed that many of the white patients lost have need for continuity of nursing care, then it may be important to increase their knowledge about the services of the public health nursing agency, and it may also be helpful to allay any anxieties they may have about utilization of community facilities. The best place for this might be at the hospital, before the patient is released.

Education

There was no significant difference in the acceptance rate of patients with different levels of educational achievement. In spite of the lack of significance, the high acceptance of nursing service (100 per cent) by the admittedly small sample of patients with postgraduate education gives pause for consideration. It might be thought that this group of patients has less need for community nursing service.

The difference in rate of maintenance for the various educational groups was significant. The most dramatic result is the low maintenance rate (57 per cent) of those with the least education (less than seven years). This provides a startling contrast to their high acceptance rate (90 per cent). This difference was not affected either by the removal of the group of patients not located or kept in contact or by the removal of the group of patients who returned to the hospital. Why should these particular patients, apparently so willing to be served, be so difficult to maintain? One reason may be that the nurse herself usually comes from a background with higher education than this particular group of patients represents.[4] The nurse's usual health-care role is a widely known and well established one. This fact undoubtedly enhances her ability to function with and be understood by those people with whom she has little in common and whose mores and values may not be well understood by her.

In entering the situation as an aid to the psychiatric patient, the nurse probably loses to a certain extent the advantage of a well defined role and must establish a new, more personal level of communication than is usual in her health-supervision work. This may be especially difficult for her to do with patients so different from the people in her own background. Perhaps she cannot understand their problems; perhaps she is too impatient with the differences in their values and hers; and, finally, perhaps she cannot establish satisfactorily verbal communication with

these patients. If this discussion has any validity, then it would seem very important that further research on the interaction of the nurse and the poorly educated patient be done, with an eye to discovering areas of difficulty that would eventually be overcome by special education for the nurse.

We must also appreciate that the group with least education is most frequently the nucleus of "hard-core" families. This group is most difficult to assist by motivating them to help themselves. They often have frequent contacts with social and health agencies and may look suspiciously at the authority inherent in the role of the public health nurse.

In any case, this result brings into question whether or not the nurse is functioning as effectively as we like to think she is with poorly educated patients in her traditional health-supervision role. Also, this finding gives impetus to efforts to give prior orientation to the patient about public health nursing services.

Occupation and Social Class

There were no significant differences in either acceptance or maintenance rates of patients in different occupational groups or social classes. This finding is of special interest in view of the fact that educational groups did differ in maintenance rates.

If it is the relationship between the patient's sociocultural level and the nurse's that is important in determining whether the patient is maintained, then of the three indicators—education, occupation, and social class—occupation and social class are probably less effective indicators of sociocultural level for the mental patient. The reason for this is twofold. First, and probably most important, is that the mental patient often does not function at the occupational level his background and education might imply. He often finds it difficult to maintain this optimum level of functioning and, in addition, attitudes in the community make it difficult for him to move ahead in the occupational scale. Thus we have a doctor working as a janitor, or an unemployed college professor. This tends to obscure the usual relationship between the patient's sociocultural level and occupational level. Second, for women and persons still in school, both occupation and social class were ascribed to the patient on the basis of the occupation and social class of the social head of the patient's household, if the patient was not head of the household. This ascription was done to make possible categorization of patients who otherwise would be occupation-less and, more importantly, to reflect the actual social class background of the patient's household. There is, however, some possibility that this process moves patients up in social class and occupation compared to their "own" situation and that their "own" situation is what is important in patient-nurse interaction.

Education indicates achievement by the individual and is acknowledged by Hollingshead to "reflect cultural tastes."[2] It is never ascribed and does not change as a correlate of a patient's stay in a mental institution.

Marital Status

There was no significant difference in the acceptance rate between patients with differing marital status. It was thought by the experimenters that married patients would be more likely to accept nursing service because of the community's stereotype of the nurse as a "family" helper, but this notion was clearly not upheld.

The picture is quite different, however, when we look at this variable in relation to who was maintained. More patients who were married and single were maintained in service than patients who were widowed, separated, or di-

vorced. Since the nurse tends to operate in a family setting, it was expected that a large proportion of the married, "accustomed" type of case load would be maintained. The nurse herself is probably most comfortable with this group of patients. The single person is more often near the age of the nurse than are patients in the other groups. (Average age of a single person is 35; of widowed, separated, or divorced, 44; of nurse, 28.) It seems likely that persons of near age would have common interests and common problems, and Willie has found that public health nurses prefer to work with patients when there is a common bond of interest.[4]

The difference between the two groupings of patients is that both married and single patients have a place in society, are likely to have a circle of friends, and so on, whereas the other three groups have a more marginal social status. The married patient is interacting to a greater or lesser extent with a spouse and perhaps with children. The single person usually establishes relationships with others, and most importantly these are customary, chosen ways of interacting. The widowed, separated, or divorced, by fate or decision, have lost a close relationship and are similar in that they have had severed contacts with a previous intimate. Much has been written on the disturbances of ability to relate caused by isolation, and this may be the factor associated with the nurse's difficulty in maintaining this group of patients.[5,6]

The social instability and isolation of this group is shown by the fact that they were difficult to contact and locate. In fact, when patients who could not be located or contacted were subtracted from the sample, 88 per cent of the married and single patients were maintained and 83 per cent of those widowed, separated, or divorced were maintained. The difference between the two groups was not significant under these circumstances. It might be thought that the low maintenance rate of widowed, separated, or divorced was related to the low maintenance rate of those living in nonfamily household settings, but if patients who live in a nonfamily setting were removed from the sample the difference between marital status groups remained significant.

We wondered whether the low maintenance rate of patients with a disruptive marital status was related to the nonmaintenance rate due to a return to the hospital. When this group was removed, the level of significance of our finding rose (p less than 0.001), indicating that social instability was a more operative factor than that of psychological instability.

If these marginal social groups are to be maintained, greater effort must be expended in locating and keeping in touch with them. Here again, predischarge work with the patients might be of great aid in motivating the patient sufficiently to relieve the nurse of the total responsibility for locating and contacting the patient. The nurse is apparently prepared to meet the problems of these special groups once contact can be established.

Type of Household

Here we see a picture similar to that found for marital status. There was no significant difference between patients who lived in a family setting and those who lived in a nonfamily setting (alone, in voluntary residences, or with nonrelatives) in acceptance rate, but those who lived with their families were maintained at a much higher rate (82 per cent) than those who did not (55 per cent). Here, again, those living in the most socially stable circumstances are more easily maintained. Probably all the explanations given above for differences in maintenance of groups differing in marital status are applicable in this case—with those living in a non-

family setting difficult to maintain for the same reasons as patients who are widowed, separated, or divorced. Again, if patients who cannot be located or contacted were subtracted from the sample, the difference in the maintenance rate disappeared. As for marital status, when patients nonmaintained due to their return to the hospital were removed from the sample, the difference in maintained rate remained.

Age

Although it was believed by the experimenters that the aged would accept service at a high rate because of the trend of increasing utilization of nursing service by this age group, the results clearly contraindicate this notion. While the over-all chi-square is not significant, a highly significant regression exists, demonstrating that as age increases acceptance rate decreases. Eighty-five per cent of those from 10 to 19 years old accepted, whereas only 67 per cent of those 60 years or over accepted. It was thought that perhaps more of the young patients with families were active with the nursing service at the time of referral, therefore increasing their acceptance rate, but when patients active with the Visiting Nurse Association at that time were subtracted from the sample, a significant regression remained. The possibility that older patients were living with their children and thus being taken care of without need for nursing care was tested by subtracting from the sample patients living with their children and retesting for regression. Although the subtraction removed mainly older patients, it did not differentially remove the older patients who refused, and so the significant regression remained.

There are, however, other possible explanations which cannot be checked with the data now available to us. One is that older patients tend to find new relationships more difficult to establish and therefore shy away from having a stranger enter the home. To the extent that this is true, predischarge planning for nursing service with the patient may be helpful. In fact, a predischarge visit at the hospital by the liaison nurse might be the most anxiety-relieving procedure for this group of patients.

Another possibility is that the older patient resents having a young person "meddling" in his personal affairs. The nurse's ceded authority is in physical health care and supervision, and the older person especially may feel the nurse has no place as an aid to a psychiatrically ill patient. If this is the case, then the older patient, especially, should be informed about the more traditional aspects of the nurse's role as they apply to the mental patient, i.e., medication supervision, knowledge of and referral to community resources. This might help the patient to re-establish in his own mind the notion that the nurse is working in her own area of authority for his benefit.

As far as the nurse herself is concerned, our data show that once a patient has accepted service the nurse demonstrates equal facility in maintaining the different age groups. There was no significant difference in maintenance rates for patients in the various age groups.

Religion

There was no significant difference in either the acceptance or maintenance rates for patients with different religions. Nevertheless, there was a tendency for Jewish patients to refuse the service. Interestingly enough, all Jewish patients who accepted the service were maintained under care.

Diagnosis

The data show that schizophrenics, patients with affective disorders, and psychoneurotics have lower acceptance rates (73, 65, and 59 per cent, respec-

tively) than patients with brain syndrome, addictive disorders, or personality disturbance (86, 90, and 95 per cent, respectively).

It seems quite reasonable that the psychoneurotic should consider himself not ill enough to require the services of the public health nurse and in fact might want to divorce himself from all aspects of his illness, but the low acceptance rates of the schizophrenics and patients with affective disorders is quite puzzling. There seems to be nothing inherently predisposing in the disease syndromes themselves that would lead to rejection of nursing service except, of course, that the patient with paranoid tendencies might be suspicious of any new contact.

It was thought that perhaps patients with affective disorders would consist of the older patient group, but examination of the data reveals that when patients 50 years or older were removed from the sample, the proportion of patients with affective disorders who accepted service was raised from 65 per cent to 75 per cent, still quite a low acceptance rate compared to other diagnoses.

When we examined the data for information on diagnosis for patients who have been maintained versus those who were not maintained, the picture was different. Those with schizophrenia, affective disorders, and brain syndrome were maintained at somewhat higher rates (82, 86, and 80 per cent, respectively) than patients with personality disturbances or psychoneuroses (75 and 77 per cent, respectively). The diagnostic group that was dramatically poorly maintained was that of addictive disorders (48 per cent). This was in stark contrast to the high percentage of those patients who accepted service. It should be remembered, however, that acceptance was defined as, "not an overt refusal of service." The group of patients with addictive disorders as well as those with a personality disturbance may have passively accepted but actually rejected the service by not continuing under care. This result may be due to a combination of factors: first, the service was not seen as appropriate to the patient's needs; second, a lack of motivation to change old patterns of behavior; or third, the nurse was not sufficiently comfortable or effective with these specific types of patients whom she often does not perceive as ill.

Subtraction of the group not maintained because of a return to hospital only increased the significance of the difference in maintained rates between patients with addictive disorders and those not addicted (p less than 0.001). Proportionally fewer addicted patients were not maintained due to a return to the hospital. This may be due to the following reasons: fewer addicted patients are readmitted to the state hospital; the period of hospital stay is brief, thus the patient may not be discharged from nursing care; or the nurse discharges the patient prior to any return because of an initial difficulty in contacting the patient.

When those not maintained because they could not be located or contacted were subtracted from the sample, the percentage of those with addictive diagnosis that were maintained was raised from 48 per cent to 83 per cent. Not only is the group difficult to locate and to keep in contact, but this group combines other characteristics that make patients more difficult to maintain. They are predominately male (93 per cent) and they have a greater proportion of widowed, separated, or divorced persons (51 per cent) than any other diagnostic category.

Other workers have also found that patients with addictive disorders are particularly difficult to maintain in service. The alcoholic male is probably especially threatening to the nurse. (The three female patients with a diagnosis of addiction were maintained for service.) Here, more than with any

other group, the question arises as to whether the nurse can help such patients. While there are no data directly bearing on this question, in both agencies where the addicted patient was found to be poorly maintained the decision of the agency was to continue to try to serve these patients, an indication of a belief that the service is needed.[1,7] If the nurse's personal fear, discouragement, or discomfort with this type of patient is a cause of poor maintenance of this group, then inservice education may increase her skills. For example, in Hartford we have found that one of the chief topics requested by the staff was information and discussion about the care of the alcoholic and drug addict, particularly regarding the nurse-patient relationship.

Status of Nursing Service

A significantly greater proportion of patients who were active or who had families who were active with the nursing service at the time of referral (96 per cent) accepted service compared to patients who were not active at time of referral (73 per cent). We believed that contact with the nurse would encourage patients to make use of her services, and these data tend to confirm that belief. Once in the situation, however, the nurse maintains the group of patients who were not active in nursing service at the time of referral equally as well as those who were.

Presence or Absence of Previous Psychiatric Hospitalization

It was originally thought by the experimenters that this factor would weigh heavily on the patient's perception of his own state of illness—those patients having had a previous hospitalization being most likely to regard themselves as "ill" and in need of nursing care. These patients may indeed perceive themselves as more ill than do patients who have not had prior psychiatric hospitalization, but apparently they are no more convinced that they need nursing care. At least both groups tend to accept and be maintained at the same rate.

Leave Status

The fact that leave status did not affect either the acceptance or maintenance rate was rather surprising to us. Patients who were on "Leaves of Absence" continued to receive medical and nursing supervision directly from the hospital. Those on "Extended Visit" and "Discharge" received follow-up care from an outpatient clinic of the psychiatric hospital housed in one of Hartford's general hospitals.

Patients who "left-bed" on "Leaves of Absence" were considered marginal candidates for the service, since we believed that they would tend to refuse the offer of service and that it would be difficult to maintain them as they would be returning to the hospital at regular intervals. One reason for keeping an open mind and accepting this group for referral was that, looking back at the history of patients in previous years, this group tended to remain out of the hospital, and leaves into the community were extended, with most of the group later being transferred to "Extended Visit" or "Discharge Status."

Summary

Findings have been presented and discussed about the response of 312 unselected psychiatric patients to the offer of public health nursing service.

The patients who accepted the nursing service differed significantly from those who refused it, with regard to diagnosis, contact with the nursing agency at the time of psychiatric referral, race, and age.

Maintained (completed at least three visits) versus nonmaintained patients differed significantly for type of household, marital status, sex, education, and diagnosis.

There were two principal reasons for nonmaintenance of patients: (1) the patient was difficult to locate or keep in contact (52 per cent), and (2) the patient returned to the hospital (37 per cent). Subtraction of the patients who returned to the hospital only confirmed or increased the significance of the overall findings for the "Maintained Study." However, removal of the group of patients difficult to contact eliminated significant differences in maintenance rates for the characteristics of sex, marital status, and type of household.

Since the study was conducted in one locale with one Visiting Nurse Association, it is not known to what extent results may be valid for other communities. It is hoped that they may be used as a guide for the offering of public health nursing services to the posthospital psychiatric patient. For example, if service had to be limited, those patients with addictive disorders might be left out of the patient cohort to be served, since the chance of maintaining them in service is under 50 per cent. It should be noted, however, that 47 per cent of those with addictive disorders are maintained in service and that eliminating this group in toto also eliminates those who might have been maintained.

The results of this study have been of value in the development of the following policies for the Visiting Nurse Association of Hartford, Inc., and Norwich Hospital:

1. To retain the liaison nurse as a member of the hospital staff and, in addition to her current work with discharged patients, to have the liaison nurse visit patients prior to their leaving the hospital. This would help to interpret the potential usefulness of the nursing service, answer the patient's questions, as well as gain additional information that may be of value to the public health nurse.

2. To begin referral for service of patients upon their admission to the hospital as well as to continue referrals at the time of leaving the hospital.

3. To accept all patients for referral as now defined, but to limit to one or two visits ineffectual efforts to locate or attempt to reestablish contact with patients. This policy pertains to all patients rather than any specified grouping of patients.

4. To continue the present plan of inservice education by an orientation to Norwich Hospital and by monthly small group psychiatric consultations wherein the nurses select their own topics for discussion and plan the format of the session.

More emphasis has been laid on discussing the data in relation to how it can help improve service rather than how it can be used to limit service. This is in line with our belief that, as nursing aftercare for psychiatric patients becomes more accepted and used, the primary interest will be in how to reach and help more of these patients in their adjustment to community living, thus making practical the concept of continuity of nursing care.

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