A review is presented of the use of public health nurses in aftercare programs for mental patients. The conditions for optimal use of nursing service are explored, and the elements of a proper program are stated.

THE PUBLIC HEALTH NURSE IN AFTERCARE PROGRAMS FOR THE MENTALLY ILL: THE PRESENT STATUS

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THE term "aftercare" has a wide range of definitions when used in public health and psychiatric literature. Since a common frame of reference is essential to effective communication, and since it is customary to begin with a definition of terms, I shall start by defining "aftercare." The use of the word "after" presupposes that something has gone on before—in this instance a period of hospitalization for a mental illness. "Care" is defined by Webster as "a painstaking or watchful attention; to be concerned."[29]

We are talking, then, about people who have experienced a period of hospitalization for mental illness, from a few weeks to several years, and have need of someone who will be concerned and give watchful attention to their needs. The "someone" is the public health nurse, a professional person trained to give attention to the health needs of patients and their families. She may be functioning as a representative of an official or voluntary public health agency. The service she provides is an all-important one, for it has been said that "the most difficult period we have in treating the psychiatric patient, especially one who has suffered a serious illness which has resulted in a period of time in the hospital, is the period immediately following his discharge, during which he must relocate himself in society and work."[22] The goals of aftercare are to enhance the patient's opportunities for maximum rehabilitation and reintegration into the larger community outside the hospital. To be most effective, these services should begin before the patient leaves the hospital.

A Backward Look

Before a discussion of the present status of aftercare services can be meaningful, a brief look at the past will be helpful. Aftercare services are not really new. As early as 1800 an Aftercare Association was formed to assist the transition of indigent poor from the asylum to the community.[18] In 1906, the New York Charities Aid Society employed the first paid professional worker for aftercare services; and in 1913, New York and New England state hospitals began to employ social workers. Development of aftercare services was slow, however, and we find no mention of nurses being involved. Usually after-

care services were provided by the hospital in which the patient had been a resident.

There is frequent reference in the literature to the need for public health nurses to understand and be aware of emotional factors in illness, but no mention could be found of a possible role in caring for the mentally ill until 1940. In that year, Ruth Gilbert wrote:

> We forget that these (mentally ill) individuals come from the community and, if their condition permits, will return to it. As a matter of fact, the public health nurse apparently has a grave responsibility for helping such patients. . . . Hospitals for mental disease which are placing certain types of chronic and convalescent patients in homes and various communities for 'family care,' have so far supervised this care through the hospital and have in most cases not had recourse to the local public health nurse. Since hospitals for mental disease may not be able to employ a large staff for follow-up of patients returned to the community on parole or discharge, the nurse may find this to be a part of her responsibility in homes which she visits whether or not any cooperative arrangement has been planned by the hospital and nursing organization. . . . It seems obvious that the public health nurse must at least be familiar with symptoms of mental disease and must know community resources for help of such patients.[12 (p. 110)]

In 1944, Clare Rue wrote:

> The overcrowding of institutions and the growing concern for more adequate care of all persons with these conditions (psychoses) have created interest in the promotion of a program of family care, where feasible, instead of hospitalization for patients with mental disorders. If this program develops throughout the country, which is very likely, the public health nurse will find that her responsibilities as a psychiatric public health nurse are just around the corner.[24 (p. 147)]

The "corner" to which Miss Rue referred was still several years away. What we now consider modern public health nursing aftercare programs are only a decade old. While aftercare services are considered established elements of generalized public health nursing programs in many states, there are still a few states in which the public health nurse is not used as a resource in the continuing care of posthospitalized patients. The care of mentally ill patients as a formal program is one of the more recent developments in public health.

Programs of aftercare are as diversified as the states themselves. In 12 states there is a state-wide program, and in 8 states public health nurses are not involved at all in aftercare programs.* The programs themselves range from some which routinely accept referrals on all patients returning from mental hospitals to a given community, to ones in which only a select group of patients are referred. The selection of patients may be on the basis of age, diagnosis, or size of public health agency caseload at a given point in time, and may be at the discretion of hospital staff or community agency staff. Some agencies accept no alcoholic patients, while one apparently accepts only alcoholic patients. Neither a consistent pattern of aftercare services nor an ideal pattern exists.

In 24 of the 53 states and territories of this country the state department of health is the state mental health authority. The public health nurse is involved in aftercare programs to some degree or other in 17 of these. Public health nurses participate in aftercare programs in 18 of the 29 states and territories in which some agency other than the health departments is the mental health authority. While this is not a significant difference, it was noted that in those states in which there is a formalized, state-wide program of aftercare involving public health nurses, there are eight in which the health department is the mental health authority and four in which it is not. In addition, in those states which do not involve the public health nurse in aftercare programs, one is a state in which the health department is the mental health authority.

* For a summary of services by states, see Appendix.

In seven of the states, the health department is not the mental health authority.

While the latter differences approach significance, there are so many variables that we cannot draw any conclusions from these figures. I call attention to them only to suggest that in those states in which some agency other than the health department is responsible for the community mental health program; i.e., the mental health authority, it appears that public health nurses need to do a more concerted job of demonstrating the contributions which they can make in community care of the mentally ill.

Basic Needs

The most successful programs, and the most satisfying to all concerned, are those in which a period of extensive planning has occurred, and policies and procedures for referrals and communication have been jointly decided upon by the hospitals and community agencies concerned. Orientation and inservice education programs have been conducted by and for both hospital and public health nursing agency staff, and continuing psychiatric and mental health nursing consultation are provided to the public health nurses. New Jersey's experience has led to a definition of three basic needs for successful aftercare programs:

1. Need for a definite procedure, including statement of responsibilities of agencies and institutions concerned;
2. Need for qualified consultation and guidance for public health nurses; and
3. Need for orientation to hospital resources and current psychiatric practices for public health nurses.[28 (p. 71)]

Experience thus far has shown that in order for an aftercare service to be truly effective, it must be a continuing, integral part of the patient's treatment program. An aftercare program cannot be an afterthought if it is to fulfill its goals. Several studies have indicated that to be most effective, efforts at rehabilitation and plans for the patient to leave the hospital must be initiated at the time of admission. It is really too late to begin when the patient is ready for discharge.[26] In order to emphasize its role in the total treatment of the patient, the Mississippi Department of Health program is called Continued Care rather than aftercare, or follow-up, another term frequently used.

Programs in which referrals have been just routine, that is, an automatic communication from a hospital to a community agency on a standardized form, have proved to be generally unsatisfactory. One reason is that this ignores the community agency's role in joint planning for the patient's return, preparing the family and assisting them in making necessary arrangements. These forms frequently do not contain all the information necessary for the public health nurse to do an adequate job on behalf of the patient. The most successful aftercare programs are those in which the community agency participates in selection of patients to be served by the public health nurse based upon patient and family needs and agency resources. For example, in the District of Columbia, a full-time mental health liaison nurse is assigned to the psychiatric hospital by the Department of Public Health. She has the opportunity to get to know the patients, evaluate their posthospital needs, orient the public health nurse to these needs, and interpret to the hospital the services available from the nurse within the framework of the generalized nursing program.[23] The study conducted by the Hartford Visiting Nurse Association also pointed out the need for an established liaison person and clear channels of communication between hospital and community agency.[4]

In many instances it is noted that the patient's needs are not primarily

related to health, but perhaps to welfare or vocational rehabilitation. The public health nurse recognizes these needs, but is frustrated in meeting them unless there is some formalized system of interagency cooperation and cross-referral at the community level. The public health nurse cannot function in isolation as the sole community resource for the discharged psychiatric patient. Many of the projects in aftercare which have been conducted by public health agencies across the country have served to demonstrate that the community at large has a responsibility to the patient and his family. Initially the nurse was the sole resource and was able to define what were appropriate nursing activities and where other resources were needed. Through community education —and sometimes coercion—the public health nurse has demonstrated that other agencies also have a responsibility and has initiated cooperative programs with them. These foresighted public health agencies are to be commended for their leadership in initiating community action on behalf of patients.

In still other programs the public health nurse does not receive the referral directly from the hospital, but serves rather as a resource to another community agency which does receive the referral. For example, in California the Department of Mental Hygiene maintains responsibility for community care of the patient after discharge through an aftercare service which is a part of the state mental hospital system, but separate from the administrative structure of the hospitals. This service makes referrals to other community agencies, including the health department, based on needs of individual patients. The aftercare service also provides coordination of services and psychiatric consultation to the staffs of these agencies.

At present, it appears that there are some aftercare programs in which the expectations of the public health nurse are so broad that they are totally unrealistic, but many others in which they are so narrow that the full potential of the nurse is not being realized. It is very unsatisfactory, from the point of view of benefit to the patient, to expect the public health nurse to be the sole resource for aftercare services. It is just as unsatisfactory for her role to be only one of making home visits to see why a patient did not return to the hospital for a follow-up interview. Both situations, unfortunately, exist today.

As the system of comprehensive community mental health services, now being developed, spreads across the country, it is hoped that the public health nurse will more and more be functioning as an integral part of a complete complex of mental health services. She will be able to utilize her unique skills as a professional nurse while, at the same time, function as a member of a professional team in meeting the needs of the mentally ill. Establishment of effective public health nursing aftercare programs will lead to the involvement of the nurse in precare services. As the public health nurse is recognized by the community as a mental health resource, she will be called upon by families for guidance and assistance in recognizing emotional illness and obtaining necessary services. She will become more involved in the preventive and primary treatment aspects of mental health programs, as well as the restorative and rehabilitative aspects. She will thus fulfill her traditional role as a provider of comprehensive, family-centered health care.

Summary

We have seen that a wide variety of patterns of public health nursing participation in aftercare programs for the mentally ill exist throughout this country today. There is no question in my mind, based upon personal experience

and a review of the literature, that there is a very definite role the public health nurse can and does play in providing aftercare services. If an agency is committed to comprehensive preventive and therapeutic family health care, then it cannot overlook this vulnerable and needy group. The specific activities in which the nurse engages are being continually evaluated and reported in the literature.

There is need for continued demonstration and evaluation of the most appropriate and effective administrative systems for provision of aftercare services. Each state and each agency must define for itself the most effective mechanism based upon individual patient and family need and other available community resources. Where resources are lacking, public health nursing has a responsibility to stimulate community action for development of needed resources and to cooperate in the coordination of the services thus developed. Then, perhaps, the full potential of joint planning, agreement on common goals and methods, discriminate use of services, and individualization of each patient will be realized.

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APPENDIX

Current Status of Aftercare Programs Including Public Health Nursing Services by States*

Public health nurse involved to some degree or other 35
Formalized state-wide program 12
Aftercare program involving public health nurse under discussion or in planning stages 7
No formalized aftercare program involving public health nurses 7
No recent information available 4
(Above includes 50 states, the District of Columbia, Puerto Rico, and the U. S. Virgin Islands.)

Alabama†—Formalized program in 60 counties. Brochure designed to show progress made in follow-up program from its development in 1957 through 1962. (Available from Mrs. Louise Cady, Mental Health Nurse Consultant, Division of Mental Hygiene, Department of Public Health, Montgomery, Ala.)

Alaska†—Public health nurse is the official representative of the Department of Mental Health in her district, and participates in the care of the patients before, during, and after hospitalization.

Arizona†—No information.

Arkansas†—No program involving public health nurses.

California—Cooperative program between Department of Mental Hygiene and Department of Public Health. Referrals are made to the public health nurse by a community-based hospital follow-up service based upon patient need.

Colorado—NIMH-sponsored project was conducted in several counties. Role of public health nurse now being re-evaluated in light of the shift of the mental health authority from the Department of Public Health to the Department of Institutions and development of community clinics.

Connecticut—Following the success of a visiting nurse service project, state-wide planning is going on for cooperative services between Department of Public Health and Department of Mental Health.

Delaware—No program involving public health nurse.

District of Columbia†—NIMH-sponsored project completed in 1962. Aftercare service is now a part of generalized nursing service, liaison nurse assigned to St. Elizabeths Hospital. (See copy of "Report of the Mental Health Follow-up Project.")

Florida†—All 67 counties report activities in the area of mental health and psychiatric nursing services by county public health nurses, including aftercare.

Georgia†—Public health nurse aftercare services were initiated in Georgia, and all local health departments offer supportive services to mentally ill patients and their families as part of a generalized program.

Hawaii†—Preparation for more active public health nursing activity in mental health programs now ongoing. Inservice education, establishing of policies and procedures is under way.

Idaho†—NIMH-sponsored pilot project in aftercare has been completed and a report was published in May, 1963. (Available from Idaho Department of Public Health, Boise, Idaho)

Illinois—No program involving public health nurse, but discussions of possible role are now being held.

Indiana—Three-year plan developed in 1963 to place a public health nurse in one state hospital to demonstrate role of a full-time public health nursing coordinator in developing a family-centered aftercare program.

Iowa—No formal program as yet, but discussions are being held between the Department of Public Health and the Board of Control of State Institutions, through nursing leadership, to develop a cooperative program.

Kansas—No program involving public health nurse.

Kentucky—State-wide program of aftercare cooperatively developed between the Department of Public Health and the Department of Mental Health.

Louisiana—No program involving public health nurse.

Maine—No program involving public health nurse.

Maryland—All 23 counties and Baltimore Visiting Nurse Association participate in a cooperative program with the Department of Mental Hygiene to provide aftercare services.

Massachusetts—Mental Health Nurse Consultant employed by Department of Public Health in August, 1963. Apparently no

* Data is current as of July, 1964.
† Indicates Department of Public Health is also State Mental Health Authority.
NOTE: Data Source: "Annual State Summary—Psychiatric and Mental Health Nursing Activities, 1964," compiled by Pearl R. Shalit, chief mental health nurse consultant, Community Research and Services Branch, National Institute of Mental Health.

Involvement of public health nurse in aftercare programs for the mentally ill.

	Public Health Dept. Is Mental Health Authority	Public Health Dept. Is Not Mental Health Authority
Public health nurse involved to some degree or other	17	18
(State-wide program)	(8)	(4)
Program in planning stages	3	4
No program involving public health nurse	1	7
No information	3	—
Total	24	29

formal aftercare program involving the public health nurse exists.

Michigan—No program involving public health nurse.

Minnesota—NIMH-sponsored project was initiated June, 1964, to extend public health nursing services to patients from 26-county receiving area of one hospital on a demonstration basis.

Mississippi†—NIMH-sponsored continued care project was completed in 1963. The program is a part of generalized services in the project counties with extension of services to six additional counties.

Missouri†—There are organized services, varying from county to county depending upon availability of public health nursing services.

Montana—Project on "Family Health Services for the Mentally Ill" has been extended through 1966. Many areas of the state have no public health nurses.

Nebraska†—Only four of 93 counties have public health nurses. One county has an aftercare program.

Nevada†—No formalized program, but plans for development of a state-wide program are under discussion.

New Hampshire†—Program is in the developmental stages, with inservice training for public health nurses being conducted at the state hospital.

New Jersey—Twenty of the 21 counties, including 39 public health nursing agencies, participate in a formalized aftercare program.

New Mexico†—Public health nurses collaborate with state hospital aftercare representatives in several counties.

New York—Public health nurses in two counties and three district areas have been involved in a psychiatric referral project with three state and one Veterans Administration hospitals. This is expected to expand. A special project in one city ended in 1961 and is now a part of services.

North Carolina—Twenty-five of the 99 county health departments have aftercare programs.

North Dakota†—Public health nurses are providing aftercare services to alcoholic patients from the state hospital and their families.

Ohio—No program involving public health nurse.

Oklahoma†—A joint Health Department-Department of Mental Health program involving the public health nurse is under way in eastern Oklahoma.

Oregon—Aftercare services are well organized in some counties, developing in others.

Pennsylvania—Pilot project in one county; no formalized state-wide program.

Puerto Rico†—Selected patients are referred to public health nurses based upon individual need.

Rhode Island—No program involving public health nurse, but conferences are being held to discuss possible role of public health nurse.

South Carolina—Aftercare by public health nurses is in the developmental stages. In-service training is ongoing, and policies and procedures are being tested in pilot counties.

South Dakota†—Formalized program was inaugurated in 1963.

Tennessee—Public health nurses work closely with the mental hospital outpatient service from two state hospitals.

Texas†—Selected counties are participating in a pilot project—concluded in May, 1964; no formalized state program.

Utah†—No information.

Vermont—No formalized program involving the public health nurse, but discussions are being held to investigate ways of promoting aftercare services.

Virginia—No state-wide program, but several counties provide service on independent agreement with the state hospital serving their area.

† Indicates Department of Public Health is also State Mental Health Authority.

Virgin Islands†—Selected patients are referred to public health nurses based upon individual need.

Washington†—A state-wide program is in the process of being formalized and is active in a few areas.

† Indicates Department of Public Health is also State Mental Health Authority.

West Virginia—An aftercare program is gradually being reinstituted after several years of discontinued program. A few counties are now accepting referrals.

Wisconsin—Some counties are participating in aftercare programs and plans are being developed to extend the service.

Wyoming†—No information.

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