*This is a report on the use of public health nurses for follow-up care of patients from a state mental hospital. Significant is the evaluation of the value of nursing service.*

# A COOPERATIVE PROGRAM BETWEEN STATE HOSPITAL AND PUBLIC HEALTH NURSING AGENCY FOR PSYCHIATRIC AFTERCARE

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THERE is a division of opinion whether home care for posthospitalized psychiatric patients is or is not a legitimate or profitable area of activity for the public health nurse While the number of nursing agencies providing some sort of aftercare for these people is growing, there are agencies that are reluctant to establish formalized programs of public health nursing service to diagnosed psychiatric patients. In some instances hospital personnel particularly refer psychiatric patients who have physical conditions requiring nursing "hand care" services.[1] The questioning of the usefulness of aftercare services may well be related to lack of factual information about this type of program.

Most reports on existing nursing programs have been confined to the analysis and presentation of qualitative, descriptive materials.[2,3] Quantitative studies have been limited for purposes of generalization either by use of a highly selected patient population or by the use of specially prepared or selected nurses.[1,3,4] The time and cost studies that have been done are further limited in usefulness because nonstandardized methods of accounting were used by the agencies involved.[1]

This study attempts to overcome some of these problems by use of the following tactics. The patient sample includes all patients who returned to the geographic area served by the visiting nurse agency. The nurse sample consists of all nurses who had a patient residing in their area of work. The time and cost involved in rendering the nursing service was computed by standardized methods of accounting.[5] In addition, the procedures used to collect data were devised before the inception of the formalized program of psychiatric nursing service and particular efforts were made not to disturb the pattern of customary nurse activity.

This paper, the second in a series of reports of an evaluative and descriptive study of public health nursing aftercare services for psychiatric patients, is limited to consideration of the following problems: (1) What administrative policies and tools proved effective for facilitating the operation of the cooperative program between the state hospital and the public health nursing agency? (2) What were the time and cost of the nurse's visit? (3) What were some of the effects of the psychiatric program on the existing nursing programs? (4)

What was the immediate outcome of the offer of public health nursing services to posthospital psychiatric patients?

## Description of the Setting

The Visiting Nurse Association of Hartford, Inc., has, for the past 60 years, offered a generalized program of nursing care, with the exception of school nursing, in the Greater Hartford area. The Greater Hartford area includes the city of Hartford and five surrounding suburban communities with a total population of about 300,000. The nursing staff consists of 44 field nurses, five generalized supervisors, and four administrative nurses. The nurses work in five district offices and customarily gain medical guidance from health directors, as well as work under the direction of private physicians and within the framework of the policies of the Medical Advisory Committee.

Norwich Hospital, with a patient population of 3,000, is one of three psychiatric hospitals of the Connecticut State Department of Mental Health. It is located 45 miles from Hartford and fortunately serves all areas of the districts included by the Hartford Visiting Nurse Association, with the exception of one small town. Two days a week the hospital operates an outpatient clinic located in one of the Hartford general hospitals. Discharged patients, as well as those on extended leave, may use this clinic on an appointment basis, but emergency visits are also possible. Patients on leaves of absence of less than one year customarily return to the hospital for their medical supervision.

## Operation of the Cooperative Program

Encouraged by the Greater Hartford Mental Health Association, the Visiting Nurse Association of Hartford, Inc., approached the commissioner of mental health and the superintendent of Norwich Hospital about their interest in developing a cooperative program of community nursing care for psychiatric patients. The details of the planning aspects of this program have been reported.[6] An agreement was reached that the nursing service would be offered to posthospital patients for a year's period and that in addition to the service program efforts would be made to evaluate the success of the program.

One of the major questions that the administrator faces in determining the form of a new service is the definition of the population to be served. Rather than making an a priori decision about which groups of patients might best be served by the public health nurse, it was hoped that this information would be gained from the results of the operative program. Thus, the potential sample of psychiatric patients included all patients who "left-bed" to reside in the Greater Hartford area served by the Hartford Visiting Nurse Association during the 12-month period, October 1, 1960, through September 30, 1961. "Left-bed" was defined as (1) a second 14-day leave of absence uninterrupted by a return to the hospital of 12 days or more; (2) a leave of absence of 28 days or more; (3) extended visit (a leave of one year's duration); and (4) discharged—not preceded by a leave of absence of 28 days or more.

The rationale for the use of these "left-bed" categories was based on the wish to include all patients who conceivably could be reached and served by the community nurse. For this reason brief leaves of absence or temporary visits were not included in the definition of the patient study group. As the research efforts were to measure the nurse's effectiveness, those patients who had made their adjustment to community living prior to the offer of nursing service were excluded, i.e., patients on leaves of absence of 28 days or more prior to the study period. Marginal

leaves of absence (categories 1 and 2) were included, as there was interest in determining whether these leave designations would permit the public health nurse to maintain sufficient contact with the patient to be of service, as well as to determine whether these patients would be interested in receiving community nursing services when there were hospital-based medical and nursing services readily available.

A total of 312 patients "left-bed" during the period of study. Patients had the opportunity to refuse the community nursing service, as, traditionally, the visiting nurse agency offers care only to those patients who request or approve of their services. The superintendent of the hospital sent a letter to each patient upon discharge, offering the service and requesting the patient to notify his office if community nursing care were not desired. Those patients who refused within five days of receipt of the superintendent's letter were not referred to the visiting nurse agency. This brief period for refusal was set due to the need to refer patients as soon as possible after leaving the hospital. Twenty-two per cent of the patients refused the offer of nursing service. Some of the findings regarding patients' refusal of service will be discussed in greater detail in a later section of this paper.

Three staff additions were made in order to put the cooperative psychiatric service program into action. Two staff nurse positions were established and filled. The agency director had calculated, by the armchair method, that with this staff increase the additional number of referred patients, an estimated increase of 300, could be absorbed into the ongoing program. A position of liaison nurse was created with the title of administrative assistant to the director of nursing service of Norwich Hospital. The liaison nurse has the sole responsibility of referral of the patients to the visiting nurse agency and the channeling of communications between the hospital and agency personnel. It should be clearly stated that the liaison nurse has no case management responsibilities. It is believed that, for psychiatric home care, this is the first instance where the liaison person has been a nurse. The reason for this decision was to put into effect the conviction that community nursing services represent continuity of nursing care for the psychiatric patient and his family. An additional conviction was that the liaison nurse had to be versed in both psychiatric and public health nursing.

Medical policies were developed by the hospital medical staff and the agency's Medical Policy Committee.* These policies are similar to those established for the other nursing services. Arrangements were made to have a psychiatric consultant available to the nurses day and night for assistance with any emergency situation that might occur in the conduct of their work. During 12 months of service there has not been one instance in which this resource was used. Emergencies have been handled through customary channels as outlined in the medical policies —the most frequent medical resource used was the health officer of the community where the patient resided.

The liaison nurse, as well as the agency's nurses, is responsible for seeing that the medical policies are carried out. Signed medical orders accompany all patient referrals, except for those patients who are on discharge status. In these cases it is necessary that local medical supervision be obtained by the patients who continue to be cared for in the psychiatric nursing program. These orders are renewed or changed as the patient attends the outpatient clinic or private physician.

Special referral forms were developed to accomplish two purposes: (1) to ob-

* Copies available upon request.

tain information not usually found on a patient's record summary but critical to the nurse's work in the community, and (2) to provide a means of recording needed information with a minimum of effort. To accomplish the second objective, 50 per cent of the information is given in check-list form or brief sentences.*

Referral Form A is initiated by the hospital at the time the patient leaves bed. This form routinely records the presence or absence of handicapping conditions, occupational history, recommendations for employment, vocational skills, ward and work performance, family interest while the patient was in the hospital, discharge planning, the presence or absence of activity of other community agencies, as well as a brief résumé of the patient's psychiatric history and the current medical orders. The liaison nurse is responsible for determining the patient's changed status and is responsible for obtaining the required information from the patient's records and from consultation with concerned staff. If the patient has not refused the service during the five-day period, the referral is sent directly to the nursing agency and the visit is made within 48 hours of receipt of the referral form.

Referral Form B is completed within one month of receipt of Referral Form A by the public health nurse who cares for the patient. These replies may be discussed with the supervisor, but the main onus of responsibility for the exchange of information is the staff nurse's. Some doctors request a more prompt reply and such referrals are flagged for a reply within one or two weeks. Returned Form B's are circulated to concerned hospital staff by the liaison nurse.

Referral Form C differs from A and B as it is completed in narrative form. It may be initiated by hospital or agency personnel. This form is used for continuing communication, such as, outpatient visit summaries, the provision of new or important information, requests for clarification, or for new orders. It is also used as a continuation sheet for either Referral Form A or B.

All forms have proved effective for continuous communication between hospital and agency personnel. After one year's use, the hospital and agency staffs have recommended that these forms continue to be used.

* Copies available upon request.

## Time and Cost Study

During the 12 months of study, 269 patients were referred for public health nursing service by Norwich Hospital. Four of these referrals were inappropriate as the patients did not return to the defined geographic area. The data on the time and cost of this program concern the referral of 258 patients who received service during the 12-month period, October 1, 1960, through September 30, 1961. Additional referrals were received during the first week of October for patients who "left-bed" the latter part of September; however, these patients were not included in this analysis of time and cost.

There were 1,507 "visits" made to or in behalf of these patients by 41 nurses. A visit is defined as any contact with the patient or in behalf of the patient and includes "unable to locate" visits. The number of visits to a patient ranged from 0 to 32. The mean number of visits to a psychiatric service case was 5.84 with a standard deviation of 5.35. The median number of visits was 5 and the mode was 2 (from ungrouped data). Fifty-seven per cent of the cases received from 1 to 4 visits.

There were 1,166 "seen" visits made to or in behalf of 232 patients. These visits included only direct patient or family member contacts. The range of

"seen" visits was 1 to 32. The mean for "seen" visits to a psychiatric case was 5.03 with a standard deviation of 4.53. The median was 4 visits and the mode was 1 (from ungrouped data). Both of these distributions are skewed in a positive direction.

It should be clearly stated that the time period studied varied from patient to patient, since some patients left the hospital at the beginning of the 12 months studied and some at the end of this period. As a result a large proportion (63 per cent) of the 312 patients are still receiving nursing service. After another year of study it will be possible to change the focus of the analysis so that the data concern a cohort of patients, all of whom have been studied for 12 months.

The length of the nurse's visit to all referred study patients was computed by two methods. One, the actual "door-to-door" time spent with the patient, averaged 42 minutes, with a range of 5 minutes to 3½ hours. Thirty-two per cent of all these visits took between 30 and 35 minutes and 15 per cent lasted 45 to 60 minutes. The second method used followed the National League for Nursing cost accounting directives, wherein the visit time included pre- and postpreparation, travel, as well as the "door-to-door" visit time. On this basis, the average length of the nurse's visit was 66 minutes, with a range of 29 minutes to 3 hours and 54 minutes. Visits in which the nurse was unable to locate the patient or a family member were not included in either method of determining the length of the nurse's visit.

Based on the theory of Method II, a standard method of cost accounting devised by the National League for Nursing, the average cost of a nurse's visit to a psychiatric case for the study period here reported (12 months) was $5.96. It is of interest to compare this cost with the costs of several of the more traditional services—Cancer Visit, $5.88, Cardio-Vascular Arteriosclerosis Visit, $6.55 and Post-partum Visit, $3.82.

At the inception of the formalized psychiatric service program many of the supervisors and staff nurses expressed concern that the ongoing service programs would suffer due not only to the increased number of referrals, but they also expected that the psychiatric service visits would take longer than visits to other service cases. After the referrals began to be received the staff expressed surprise that the case load was not heavier and they observed that many nurses were still anticipating their first patient. In districts where there were few referrals the nurses expressed disappointment that so few patients were under care, stating that, with all the inservice preparation for the new program, they felt a little "let down." As nurses cared for only those patients living in their geographic district, some nurses had a heavier case load of psychiatric patients than did others. The average number of cases per nurse was 7, with a range of 0 to 17. Fifty-two per cent of the nurses had 4 to 7 cases during the 12-month study period. The greater number of referrals occurred in the downtown, semislum areas of Hartford where the population is highly transient. Several low-income housing project areas with a less transient population where heavy case referrals were expected had fewer referrals. Also, there were substantially fewer patients referred to nurses serving suburban districts. When the residence of patients discharged in the last two years was studied, the same pattern was found.

An agency time and cost study was completed six months before the inception of the formalized psychiatric program and was repeated after six months of referrals for service. The number of visits per staff nurse per day rose from 6.96 to 7.34. The number of visits to each of the other service category

cases remained the same. The agency director observed that the increased number of visits per nurse is not an infrequent result of additional case load pressure applied under conditions of high morale and high nurse interest. From these remarks, it was felt that the study activities did act as a biasing factor in these findings of increased nurse visiting.

Independent of the category of service, the average length of visit was consistently reduced by 3⅓ minutes (from 64.7 minutes to 61.3 minutes). The average length of time of a visit to patients referred from Norwich Hospital was 4⅔ minutes longer than the above over-all average.

There are several possible reasons for the longer length of the average psychiatric visit; one, the psychiatric visit requires more time; two, the nurses were in the process of defining their role—learning to set limits; or three, the nurses were especially careful in the conduct of their work, as they appreciated that this group of patients was under study. The nurses were unaware of the specific items of study interest and, until now, there has been no feedback of the research findings. It is possible, however, that this knowledge has affected the quality of the service. The length of the study period (12 months) offers one safeguard as it is conceivable that usual patterns of nursing behavior would be reinstated if biasing effects were active. Also, the patients with psychiatric disorders who were not study cases were clearly designated, and time and cost studies for this group of patients will be available for comparison with the study cases at the close of the agency's calendar year.

## Effects on Other Service Programs

It is important to emphasize that this was not a "new" service for the visiting nurse agency, but a newly formalized program. A 1957 review of the total active case load revealed that 65 patients with psychiatric diagnoses or severe symptomatology were currently under care.[7] A review of the 1959 case load showed that this number had increased to 140. Formerly these patients were given care under morbidity, adult or child health supervision service categories. With the advent of the cooperative program with Norwich Hospital, all new, nonstudy cases and many of these older cases were transferred from their old service category to a "Psychiatric, Other" category. At the present time there are 208 active cases of "Psychiatric, Other." These cases were not included in this study.

One of the more novel changes that affected the agency was the occurrence of "afterhours" nursing service. "Afterhours" service includes visiting before 8:00 a.m. and after 4:00 p.m., as well as weekend and holiday visiting. The nurses had spontaneously begun afterhours visiting and this action required the establishment of directives concerning uniforms (optional), the use of agency cars and the reimbursement for time. The agency administrators did not believe that the need for afterhours service was necessarily unique to the psychiatric service program. They believed that a number of patients and family members carried under more traditional service categories, who were inaccessible during the nurse's customary hours of visiting, would gain from her visit and the nurse would be able to increase the effectiveness of her total family service.

Several possibilities suggest themselves as reasons for this voluntary scheduling of afterhours service. One is the fact that the patients referred from Norwich Hospital were under study. Second, the answers requested on Referral Form B concern actions and attitudes of family members as well as the patient, and the nurse was implicitly

obliged to visit afterhours to encounter persons otherwise unavailable. Third, the sample of patients referred from Norwich Hospital was not typical of the nurse's usual case load as there were an increased number of male patients and of patients who were employed during the nurse's customary hours of work. Fourth, the psychiatric consultant consistently asked questions about all family members, particularly the role of the father in the family situation. Early in the study, the nurses reported a lack of knowledge of family members absent from the home during the day. Later, following several group sessions wherein the same questions were always raised, the nurse obtained the information prior to the consultation and in doing so had often arranged to see the "missing" family members.

Because the question is raised whether the phenomenon of afterhours service is restricted to study patients or to psychiatric service patients, a check was made of afterhours care to other than study patients. The supervisors reported that this type of visiting was restricted to the patient group referred from Norwich Hospital. Rare exceptions, once in every several years, had been encountered in giving morbidity care. Nurses do schedule visits to see "missing" family members when they are working over the week end. However, this type of activity was not included in the definition of afterhours service, as the nurses were then working on a "during-hours" schedule.

Another aspect of change in the agency's program has been in the area of inservice education. These activities will be discussed in detail in a forthcoming paper. Briefly, however, they include orientation programs for both agency and hospital nursing personnel and monthly psychiatric consultation for the nurses in each of the five district offices. These consultations are, by choice of the staff, case-centered group discussions. The patients/families that are discussed are not limited to the psychiatric service. In fact, over a 15-month period of psychiatric consultation, 15 per cent of the presentations involved study case referrals; 29 per cent involved a "Psychiatric, Other" case, and 56 per cent of the 75 presentations concerned patients in other (nonpsychiatric) service categories.

A method of tapping information that arises spontaneously and unpredictably from the work situation regarding the cooperative program has been the use of Form E and Form F. Form E may be completed by either agency administrator, consultant, supervisor, or staff nurse and Form F by personnel of the hospital or State Department of Mental Health. The identity of the writer remains confidential to the research workers. These forms provide much information regarding the impact on and meaning of this service to the staffs and patients who are served.

As the nurses anticipated the formalized psychiatric program, comments were not infrequent regarding their fear of saying the wrong thing and thereby harming the patients or thereby upsetting the patients so the patients would harm them. Also, they frequently asked for directions on how to behave with the patient and how to evaluate the adjustment the patient was making in the community. After one year's experience in the program, they have expressed feelings of greater confidence in what they can do and a greater appreciation of their personal and professional limitations. These gains have been reported to influence not only the conduct of care of psychiatric patients, but much that has been learned has improved the nursing care of patients carried in other service categories.

In the hospital setting, one year ago, many of the staff had never worked with a public health nurse. This was particularly true of the medical staff. The personnel who had some knowledge of visiting nurse services expressed

puzzlement as to what the nurse would do or expressed concern about what she should be doing for patients who did not have need of direct "hand care" nursing services. Exposure has provided at least partial answers to many of these questions.

A changed situation that has consistently been reported is the increase in direct, effective communication between hospital and agency personnel, and a new feeling of mutual concern on the part of the staffs for the welfare of patients leaving the hospital. In fact, one of the most serious problems that arose in carrying out this cooperative program was the tie-up of hospital and clinic telephone lines as hospital and agency personnel discussed mutual concerns.

## What Was the Immediate Outcome of the Offer of Public Health Nursing Aftercare Service to Psychiatric Patients?

Two of the basic necessities for the provision of a nursing service are a consent for service and contact with the patient. As previously stated, no a priori decision was made about which patients could be helped by the public health nurse. Therefore all study patients were to be offered the nursing service and were studied in terms of (1) their acceptance or refusal of the nursing service; and (2) their maintenance or nonmaintenance in the nursing service program.

Table 1 presents the findings on the patients' acceptance or refusal of the

**Table 1—Acceptance or Refusal of Public Health Nursing Aftercare Services Offered to 312 Psychiatric Patients**

| Patient Group | | | Number | Per cent |
|---|---|---|---|---|
| Accepted | | | 208 | 67 |
| | N-Subgroup | Per cent | | |
| Accepted—hospital | 9 | 4 | | |
| Accepted—at time of nurse contact | 199 | 96 | | |
| Total | 208 | 100 | | |
| Refused | | | 68 | 22 |
| | N-Subgroup | Per cent | | |
| Refused—hospital | (53)* 40 | 59 | | |
| Refused—at time of nurse contact | 28 | 41 | | |
| Total | 68 | 100 | | |
| Undetermined | | | 36 | 11 |
| | N-Subgroup | Per cent | | |
| Unable to locate or to contact | 22 | 61 | | |
| Returned to hospital prior to offer of service | 14 | 39 | | |
| Total | 36 | 100 | | |
| Grand total | | | 312 | 100 |

* Thirteen patients who refused by letter were referred for service.

**Table 2—Patient Reasons for Refusal of Public Health Nursing Aftercare Service**

| Reasons for Refusal of Service | | | Number | Per cent |
|---|---|---|---|---|
| No need or wish for service | | | 63 | 93.0 |
| | N-Subgroup | Per cent | | |
| Doing well, feel fine | 14 | 22 | | |
| Other therapeutic care | 21 | 33 | | |
| Mixed reasons and not further specified | 28 | 45 | | |
| Total | 63 | 100 | | |
| Scheduling difficulties | | | 5 | 7.0 |
| Grand total | | | 68 | 100.0 |

offer of public health nursing aftercare services. Three hundred and twelve study patients "left-bed" during the 12-month study period. The response of acceptance or refusal of the service could not be determined for 36 (11 per cent) of the total patient group.

Of this group, 14 patients returned to the hospital before the service could be offered to the patient.* An additional 22 patients (7 per cent) were not located or were not contacted by the nurse, although family members or friends may have been seen in the nurse's search to contact the patients. It was of interest that 23 letters of the service offer were returned to the hospital by the post office, marked "address unknown." Referrals for nursing service were made for this group of patients. Six of these patients were not located, one refused service, nine were not maintained under care beyond the initial visit period (two visits) and seven were maintained for nursing service. Due to these results the administrators have decided to continue to refer for nursing service those patients who cannot be contacted by mail.

Sixty-eight patients (22 per cent) refused the offer of aftercare nursing service. Fifty-three patients or a family member wrote to the superintendent of the hospital. Although no referral for service was to be made for patients who refused the service, 13 of these patients' letters were received after the five-day waiting period and the referral to the nursing agency had been made. At the time of the initial contact with the nurse, 5 of the 13 patients accepted the offer of additional visits. Twenty-eight patients refused the offer of service when the nurse contacted the referred patient. The refusal of service, whether by letter or upon community nurse contact, was made by the patient himself in three-fourths of the cases. The remaining refusals were made by a family member in behalf of the patient.

The reasons for refusal of service are presented in Table 2. The majority of responses (93 per cent) were in the category of "No need or wish." Frequently the reason for this statement was specified as "doing well," "feel fine," or "other therapeutic care." Scheduling difficulties were reported by five (7 per cent) patients.

* Although the writers agree with the opinion that hospital-based preplanning with the patient for this service would be of value in increasing the effectiveness of the use of the service, due to the research requirement that the patient's introduction to the service be consistent, it was not feasible to prepare the patient prior to his leaving the hospital.

The first mentioned or primary reason was used in tabulating the data given in Table 2. Nine of the 68 patients gave more than one reason for the refusal of service. These additional reasons were: other therapeutic care, two; social stigma, four; family objection, one; going out of area, one; and "not physically ill," one.

Of the patients, 208 (67 per cent) accepted the offer of aftercare service. Acceptance was defined as a nurse contact with the patient during which time both planned for an additional visit and this second visit was completed. Patients who expressed question for the need of the service or reluctance for further visits, and who did not complete a planned second visit, were classified as "refused service."

To further narrow the patient population who were carried under nursing service, a study was made of the numbers of patients who could be maintained for service beyond the initial visit period. Visits made to family members "in behalf of" the patient were counted as patient visits.

The initial visit period was defined as a completed second visit and no dis-

**Table 3—Psychiatric Patients Who Were Maintained or Not Maintained for Public Health Nursing Service**

| Patient Group | | | Number | Per cent |
|---|---|---|---|---|
| Maintained (more than two visits) | | | 180 | 74 |
| Not Maintained | | | 64 | 26 |
| | N-Subgroup | Per cent | | |
| Served (one or two visits) | | | | |
| Unable to locate | 1 | 3 | | |
| Died | 2 | 7 | | |
| Out of area (moved, jail, general hospital) | 4 | 13 | | |
| Returned to hospital (psychiatric) | 10 | 32 | | |
| Loss of contact location known | 10 | 32 | | |
| Refused after initial period | 1 | 3 | | |
| Nurse discharged | 3 | 10 | | |
| Total | 31 | 100 | | |
| | N-Subgroup | Per cent | | |
| Not served (no visits) | | | | |
| Out of area prior to visit | 5 | 15 | | |
| Returned to hospital (psychiatric) | 14 | 43 | | |
| Unable to contact location known | 6 | 18 | | |
| Unable to locate | 8 | 24 | | |
| Total | 33 | 100 | | |
| Grand total | | | 244 | 100 |

charge from service prior to the third visit between nurse and patient. Of the patients, 180 (74 per cent) were "maintained for service."

In order to determine the maintained-nonmaintained status of the referred patients, records of patients discharged by the nursing service during October 1, 1960, to November 3, 1961, were independently read and the reasons for discharge were coded by two workers. Prior to the abstracting activity, category definitions had been discussed. The decisions of the coders were consistent for 94 per cent of the discharged cases. Where there were inconsistencies, the final judgment was based on a mutually agreed upon category.

The major reason for nonmaintenance (discharge with less than three visits) of service was return-to-hospital (38 per cent). Loss of contact of the nurse with her patient (ten cases) accounted for 16 per cent of the reasons for nonmaintenance. It was of interest that during the initial visit period the nurse discharged only three cases due to "no present need for service" or "service not appropriate to needs of the patient."

Seventy-four per cent of the patients, excluding all refusals of service, were maintained for service (three visits or more). Of those who initially accepted the service 87 per cent were maintained; and 58 per cent of the potential case load (all patients) were maintained for nursing service.

This analysis has described quantitatively the immediate use made by psychiatric patients to the offer of public health nursing service. In a forthcoming paper data will be presented that indicate there are sociomedical characteristics that distinguished the group of patients who accepted or rejected the service and those who were maintained or nonmaintained.

It must be self-evident from the results of this cooperative program that the administrators in both institutions never waivered in their commitment to the belief in the importance of continuity of nursing care for patients after hospitalization. On the basis of the study findings it may be shown that certain groups of patients would benefit more than others from such aftercare services. However, until the complete findings are made available, the cooperative program will continue in its present form, although the current Norwich Hospital referrals are no longer study patients.

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