

**PUBLIC HEALTH NURSES IN THE HOME CARE OF
PSYCHIATRIC OUTPATIENTS AND THEIR FAMILIES**

- Anita Gilbert, M.S.W. - Instructor in Psychiatric Research,
University of Maryland Psychiatric Institute,
Baltimore, Maryland
- Gerald D. Klee, M. D. - Director of Out-Patient Services,
University of Maryland Psychiatric Institute,
Baltimore, Maryland.
- Anna Scholl, R. N. - Supervisor of Nurses,
Baltimore City Health Department.

This project was supported by Grant #OM-356-RI of the National
Institute of Mental Health.

**Public Health Nurses in the Home Care of
Psychiatric Outpatients and Their Families**

Historical Development

During the past decade the discrepancy between the small group of psychiatric personnel and the ever increasing number of troubled persons who seek treatment has become a primary concern. The challenge of providing extended service is being met in a variety of ways throughout the world. In several European countries great success has been reported through the integration of the mental hospitals and the communities they serve.¹

In the United States in July, 1955 the Joint Commission on Mental Illness and Health received a Congressional mandate to survey psychiatric resources and make recommendations for combating mental illness. The findings of this professional group clearly pointed up the inadequacy of facilities throughout the country. With recognition that psychiatrically trained personnel are all too few, the Committee notes, "A host of persons untrained or partially trained in mental health principles and practices -- clergymen, family physicians, teachers, probation officers, public health nurses, sheriffs, judges, public welfare workers, scoutmasters, county farm agents and others -- are already trying to help and to treat the mentally ill in the absence of professional resources. With a moderate amount of training through short courses and consultation on the job, such persons can be fully equipped with an additional skill as mental health counsellors."²

¹Barton, W., Farrell, M., Tenehan, F., McLaughlin, W., Impressions of European Psychiatry, American Psychiatric Association, Washington, D. C., 1961.

²Joint Commission on Mental Illness and Health, Action for Mental Health, Final Report, Basic Books, Inc., New York, 1961, p. XII.

Up until the present time little has been written about public health nurse activities in adult psychiatric outpatient programs. Spohn and Warinner describe one program in Topeka, Kansas, in which public health nurses play a prominent role in the country psychiatric outpatient services.³ In Maryland, as must be the case elsewhere, some of the county clinics are beginning to proclaim enthusiastically that collaboration between psychiatric and public health nursing staffs is greatly increasing mental health services.⁴ Reports from child guidance clinics also mention public health nurses as effective people in the mental health program. With very few exceptions, however, these programs are poorly planned and haphazardly organized.

Rationale

In Baltimore City, adult outpatient psychiatric services are limited to the departments in two teaching hospitals which are neither designed nor equipped to treat large numbers of disturbed people. The need for increased psychiatric services is acute. With the concern for developing and organizing community resources in this urban community where facilities lag far behind the need, a pilot program was set up in July, 1960 to study the effectiveness of a collaborative effort between The University of Maryland Outpatient Psychiatric Clinic and The Public Health Nursing Division of the Western Health District of The Baltimore City Health Department. The project was organized to examine the nurse's contribution in the care of psychiatric outpatients and their families and to observe role differentiation in a multi-disciplinary group. Directly involved in the program during the first year were two psychiatrists, available part time, a social worker, available full time, a public health nursing supervisor and four public health nurses also available part time.

³Spohn, Eula, and Warinner, Alice, "The Public Health Nurse in Preventive and Therapeutic Psychiatry", American Journal of Orthopsychiatry, 1951, Vol 21, pp 285

⁴Davidson, David, et al, Unpublished material.

The program has been in a continuous state of evolution since its inception and has had many facets. This paper will deal with only a circumscribed part of the total program.

This project was based on the belief that the public health nurse is in an excellent position to be an effective mental hygiene worker and to offer invaluable aid to emotionally disturbed individuals and their families. It was presumed at the outset that the nurse would be most effective working with individuals in their own homes, and that emphasis should be placed on the entire family rather than the individual patient. Inherent in this approach was the premise that when an individual is a member of a family group, there is a certain balance of forces within the family which contributes to the emotional disturbance of the individual. A redirection of these family forces can lead to greater psychological growth as well as relief of symptomatology of its members. It was also believed that the public health nurse in the course of her duties frequently acquires a position of trust and influence with families through which she may alter the balance of forces in a critical direction.

As a member of the local health department and public health nurse is available to all families living within her assigned area. She is readily accessible through participation in clinics, schools and within the neighborhood. She is accustomed to visit in homes where families are most at ease and where she can observe the family group within its own unique environment. She is helped by her acquaintance with the resources within her community, not only within health agencies, but those concerned with social welfare, religion, education and recreation.

In an area of specialization the public health nurse has retained her concern with total health. In the course of her daily duties she is constantly faced with the interrelationship between physical and emotional well-being. She is aware of the epidemiology of emotional disturbance and the growing closeness of psychiatry

4

with other areas of medicine. Moreover, much of her activity is with the hard-to-reach, multiple problem families who rarely seek out psychiatric help and who are, in turn, considered poor candidates for the current methods of psychiatric treatment.

Method

During the first year, ten cases were randomly selected for intensive care from among applicants to the psychiatric outpatient department. Many other families already known to the Public Health Nursing Division were also treated by the collaborative team. Only the results with families who were referred from the clinic are being reported, but the impressions and conclusions are based on the total experience. The only criteria for inclusion were that they be residents of Western Health District; and that they be members of a family as defined by the presence of two or more persons living together who are related by blood or marriage. Thus, the impact of public health nursing activities could be observed on a variety of psychiatric symptoms and syndromes. With no more information than that obtained from an initial telephone call, a nurse was assigned to visit the family. It was decided that the nurse would make the first contact in order that the patient and his family would establish a primary relationship with her rather than the clinic. Moreover, a clinic visit could interfere with nurse-family relationships in the home.

Since primary concern of the project was to enable clinic and nursing staffs to learn as much as possible from each other and to enable a working relationship to evolve, flexibility was of the utmost importance. Conferences were held frequently. Procedures were examined and modified whenever indicated. In the initial phases of such a program, uniformity in gathering data and measurements of change could not be considered. All effort was directed at removing barriers and restrictions which might hamper or endanger the ability to change any procedures or to test any new ideas.

Initially the staff was concerned that some individuals would object to being visited by a nurse after requesting a psychiatric appointment. At first, the social worker phoned to introduce the nurse, adopting the attitude that this was the usual course of events whenever possible. The procedure was so readily acceptable that the nurses voluntarily assumed the responsibility of making the initial contact themselves. Despite one or two expressions of surprise from persons who had had previous psychiatric experiences, there was very little resistance to having the nurse visit and in most instances she was actually welcomed eagerly.

Already outside the realm of orthodox psychiatric treatment, the staff immediately became aware of the need to assist the nurse in describing the kind of information she could obtain in the initial interviews which would establish a specific role for her in the family and enable her, together with clinic staff, to set up specific goals for future contacts. She ultimately limited herself to the following area of inquiry:

1. Statement of problem and symptoms as presented by the family member who requested help.
2. Family expectations of the clinic and of treatment outcome.
3. Community resources used by family members in the past and present.
4. Description of the home environment and observations about the socio-economic and cultural background of the family and the neighborhood.
5. Observations and descriptions of family interaction.

The nurse did not inquire about past history in these early interviews, but recorded any pertinent data which was spontaneously given.

After the nurse discussed the initial interviews and the data obtained with her supervisor, joint conferences with psychiatrist and social worker were held. Initially these conferences could scarcely be differentiated from the usual psychiatric case discussions of individual psycho-dynamics. Gradually, however, focus shifted to consideration of family interaction patterns and their effect

on the family members.

As soon as the initial home interviews were discussed, the nurse arranged for clinic visits with the individual and if possible the family member most involved in his problems. The symptomatic member was interviewed by the psychiatrist with the nurse, nursing supervisor and social worker present. Family members were usually seen by the social worker and nurse.

Following the clinic visit concrete treatment goals were defined and a tentative treatment plan agreed upon. In most cases the nurse was designated as the primary person to continue working with the family. Medication was prescribed when needed and was supervised through the clinic emergency service. The project psychiatrist and social worker were available to see any members of the family as indicated. Use was made of other community resources and the nurse interpreted and facilitated the referrals.

A period of six months was arbitrarily chosen for families to remain in the program. The staff felt that within this time interval, change within families could become evident, and that the nurse-family relationship could be defined. Furthermore, by limiting the duration of treatment per family, a larger series could be accumulated. At the end of the six month period, each case was evaluated in relation to the original goals set, and impressions of any changes were noted. Consideration was given to the initial symptoms presented by the family member who first sought help and to the current status of the family as a whole. Much time was invested in examining the role of the nurse, as well as in exploring her subjective reactions to these experiences. This is a crucial area which has been largely neglected and will be the subject of a subsequent paper.

Results:

The ten cases randomly selected from the clinic represented a wide range of psychiatric syndromes and family problems. The nurses encountered chronic

schizophrenia, acute anxiety, epilepsy, psychopathy, delinquency and severe family relationship problems. The families were young and old, negro and white, and represented a variety of cultural backgrounds.

In every instance nurses found easy access into the homes. In only one home did the welcome ultimately wane. Although in most cases visits were more immediately acceptable to the persons who called for help, they were actively helpful to other members of seven families. Equally free to call nurse, psychiatrist or social worker at any time, the families always contacted nurses to report both discomfort and pleasant events, indicating that the major relationship was with the nurse.

Although the clinic retained medical responsibility for the patient, nurses maintained the primary contact with families. Their chief concern was always with the present and the future; their emphasis on the mitigation of discomfort of day-to-day living. Many kinds of interpersonal and relationship problems were presented to the nurses along with practical questions of financial planning, child management, and medical concerns. In the course of their services the nurses referred families to a variety of community resources including the many medical clinics, Department of Welfare, Vocational Rehabilitation, Volunteer organizations and camp facilities. They talked with doctors, social workers, ministers, teachers, other nurses, who had been or might be interested in the families.

Of the ten individuals who initially sought outpatient psychiatric treatment, three were ultimately institutionalized, three remained essentially unchanged and four indicated appreciable alleviation of early symptoms. It should be emphasized that these were cases who began with a poor prognosis and for whom clinic help probably would not have been available.

During the course of their activities with the project, all the nurses at times experienced considerable anxiety, which was not related to the degree of family disturbance. Although unable to define their relationships with the project

families precisely, the nurses felt that these were more intense than those usually encountered, and they found this intensity disquieting. Where heretofore they had maintained emotional distance with families by limiting the frequency and duration of visits, they were now unable to use this defense.

The nurses felt that they had been taught to deal with concrete issues and were now faced with abstract and nebulous concepts. They wanted to think in terms of disease - specific treatment - cure, and the inability to define psychiatric problems in concrete terms provoked discernible anxiety. Moreover, the nurses felt that they did not fully understand the nature of the nurse-family relationship per se and were therefore unable to appreciate the therapeutic value of the relationship itself.

As nurse-family relationships developed, the nurses' emotional investment often tended to become greater and they identified with the disturbed individuals in their care. They expressed personal frustration and dissatisfaction with the clinic staff and with themselves when cases did not go well. When they did go well they were uncomfortable because they did not know why, nor what, if anything, they had contributed. Moreover, because of these uncertainties the nurses, rather than becoming more ingenious and inventive in the use of their skills, have felt themselves more constricted and dependent upon guidance from the psychiatric staff. The complicated area of the nurses' responses to this type of work have merely been touched upon, but as indicated earlier, will be the subject of another paper.

One of the major aspects of the program has been the ready availability of two psychiatrists. Their role has been varied and flexible. As consultants they both have independently sought ways of translating individual and family dynamics into concepts that were familiar to the nurses' own frames of reference.

The psychiatric interviews of the patients in the presence of the group became an integral part of the program. In addition to providing direct medical evaluation of the cases, these interviews added a new dimension to the nurses' understanding of the individuals. Moreover, the collaborative relationship among nurse,

psychiatrist and social worker was underlined. The existence of positive nurse-patient relationships were demonstrated when the patients frequently directed glances, questions and answers to the nurses.

In a project involving many persons and activities, it was essential to have one individual in touch with all facets of the total operation. The social worker, whose training and full-time availability prepared her for such a role, assumed the responsibility for maintaining the flow of communication and coordinating the over-all program.

The supervisor of nurses was the primary spokesman for her profession. It was she who was available for consultation when the nurses anxiously returned from interviews with families and helped them sort out and evaluate their impressions. She was also instrumental in helping the nurses verbalize the problems they encountered both with families and with their own subjective reactions. Moreover, she was concerned at all times with the problem of translating patient and family dynamics into appropriate nursing activity.

Discussion

Experiences in the program support the belief that Public Health Nurses can be developed into effective members of the group directly concerned with mental health. The ready welcome they received in the ten homes indicates that the communities they serve are ready to recognize them in this role. Moreover, it was the strong impression of the clinic staff that the families involved in the program, with one possible exception, were not likely to have been selected nor to have remained involved in therapy in this clinic. It must be pointed out that none of these families were representatives of upper-middle class or upper class groups. There may be some question as to whether the nurses could function as effectively among those groups where they are not already well known in other capacities.

Without discussing improvement in the classical sense there was nevertheless strong evidence that the impact of nurses on families visited proved useful in a variety of ways. In most instances there was involvement of other members of

the family with recognition that the problem of a patient seeking psychiatric help is of concern to the whole family. During the six-month period when the nurses visited in homes, significant changes in interaction between the family members were noted and amelioration of symptoms was reported.

With emphasis on reorganization of psychiatric services to provide help for larger numbers of people, programs including public health nurses are bound to expand. It is, therefore, essential to consider some of the problems that as yet remain unresolved in a collaborative effort of this type. The anxiety reported by the nurses in the program needs further understanding and clarification. There is need for a great deal of exploration of the skills and techniques already being used by the nurses in their day to day activities and the translation of these procedures into mental health practice.

Communication among the disciplines directly involved in the program has also presented difficulty. It took time for the clinic staff to learn to translate patient dynamics into behavior patterns and to recognize that many phrases used so glibly and comfortably in psychiatric clinic settings were unknown to the nurses. It took time also to explore the skills of the various team members, to develop respect for the contributions possible from each, and then to mesh these into one plan of help for families. Another barrier existed in the inability of the team members to express any disagreements with each other, a problem reported by others who have attempted to establish similar programs.⁵

Because of the difficulties discussed, it has not yet been possible to determine the type of training needed by public health nurses to enable them to be as

⁵Schlossman, Howard N., "Transference in Medical Team-Family Research: The Family Health Maintenance Demonstration", American Journal of Orthopsychiatry, July, 1961, pp. 612-620.

effective as possible. Thus, the statement of the joint commission that "with a moderate amount of training through short courses and consultation on the job such persons (public health nurses) can be fully equipped with an additional skill as mental health counsellors" is not as simple as it sounds. Such persons are and can be effective mental health counsellors, but the determination of what it is they already bring into this work and the type of training required to make full use of the skills they already possess required a great deal of additional exploration.

Summary

The implications for expanded mental health programs with the inclusion of public health nurses as members of the mental health professions are far reaching. A project was established to investigate the effectiveness of public health nurses as mental health workers through collaboration of a university psychiatric out-patient clinic with a public health nursing division of the city health department. Public health nurses visited in families of ten applicants to the Psychiatric Out-patient Department for individual treatment of emotion problems. Nurses were readily accepted as mental health workers, dealt effectively with a variety of family problems, and were able to note change in some patterns of family interaction.

One important aim of the program was to reveal the problems inherent in such a collaboration. These included the anxiety of the nurses who participated in the project, barriers in communication among the multi-disciplinary staff, and question concerning the training and orientation of the public health nurses. Further exploration and understanding of these areas are essential so that the liaison between psychiatry and public health nursing may be most useful and effective.