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The Process of Establishing a Collaborative Program between a Mental Health Center and a Public Health Nursing Division

A Case Study

M. B. AHMED, MD
ESTELLE L. YOUNG, RN, MS

The development of a coordinated program utilizing a team approach to care of discharged psychiatric patients is described.

Introduction

In developing genuine continuity of care in the mental health center, administrators often have to establish collaborative efforts with community agencies for selected aspects of their program. This is true even in centers with large trained staffs, but is particularly so in facilities with limited staffing funds. A community agency especially equipped to work collaboratively with a community mental health center is the nursing division of a public health department. The public health nurses have already had considerable experience in working in the community with individual families and with other agencies; they are socially and psychologically close to patients and their families; they have already established their importance in health delivery, particularly in rural, urban-rural, and center city areas.

At the time that this study was performed, Dr. Ahmed was Director, Department of Psychiatry, St. Louis County Hospital, St. Louis, Missouri. He is presently Assistant Professor of Psychiatry and Director of Sound View-Throgs Neck Community Mental Health Center, Albert Einstein College of Medicine, Bronx, New York. Ms. Young is Assistant Director, Nursing for Education, St. Louis County Health Department, St. Louis, Missouri.

Although public health nurses have had mental health education in their training for many years, only in the last two decades have they begun increasing their participation in the field of psychiatry. For example, in Boston, both public health nurses and visiting nurses participate in community mental health programs. In the Boston State Hospital "home treatment service" program, psychiatric and public health nurses work closely with the psychiatrist and social worker. They plan for and provide aftercare services to a large number of patients.[1]

In Michigan, a state hospital and a county health department developed a joint program to facilitate discharged patients' return to the community. The nurses interpreted patients' needs to their families, administered medication when necessary, and were active in the total rehabilitative program.[2]

It is precisely in the area of home visiting aftercare that public health nurses can be effective allies of a community mental health service. This team system is not uncommon in European countries. For example, two American psychiatrists and a psychiatric nurse traveled to Moscow and Amsterdam to study outpatient treatment, with their primary focus of interest centered on home care and the functions of a psychiatrist-psychiatric nurse team. In both cities, they report, the salient feature of delivery techniques

is the team approach and heavy reliance on the ability and judgment of the nurse, who is assigned much greater responsibilities than her American counterpart.[3]*

The increasing involvement of public health nurses in mental health care is reflected in the professional nursing and psychiatric literature. Leonard and King report on the work of public health nurses with psychiatric patients and their families before and after discharge in California, under a statewide program.[4] MacKay and Serrano describe a program in Galveston, Texas, in which public health nurses practice crisis intervention with troubled families.[5] Nevertheless, Elwell, writing in 1970 about community mental health centers and the implications for nurses of this method of health delivery, mentions that in a sample of 12 proposals for new centers which he reviewed, most references to nurses in the staffing patterns indicated that they were to be employed in traditional roles. Only three references were made to responsibility for consultation to and liaison with public health nurses.[6]

In 1971, the Division of Psychiatric and Mental Health Nursing of the American Nursing Association circulated a questionnaire to its 50 state chapters, as well as their chapters in Guam, Puerto Rico, and Washington, DC, aimed at determining the readiness of nurses to become involved in community mental health programs. Twenty-nine chapters responded. Significantly, most indicated that their nurses were minimally or not at all ready for such involvement. Where the chapters indicated some degree of willingness, it was in areas where community mental health centers had been established.†

The Process of Developing Collaboration Between Agencies

It is easy enough to prescribe collaborative relationships and joint programs between relatively autonomous agencies. It is more difficult to establish them, primarily because agencies tend to protect their autonomy and collaboration involves some blurring of lines of authority. Nevertheless, it is possible to establish effective working relationships once key agency personnel can see that a program will enhance the functioning and the total service commitment of each agency.

The St. Louis County Program

In July, 1967, the St. Louis State Hospital Complex was reorganized into a unit system consisting of four units, each with the responsibility for phasing out traditional state hospital practice then in existence and for developing acute, rehabilitative, and preventive services in their respective catchment areas. The catchment area of Unit I lay in St. Louis County; it included suburban and urban-rural sections, the latter close to the city without being part of it. Approximately 500,000 persons resided in the catchment area.

One year after the initial reorganization began, this unit discharged a large number of chronic patients and concentrated on providing intensive care to the newly admitted patients in order to prevent prolonged hospitalization. By then, the traditional ward system had been replaced by the team treatment approach within a therapeutic milieu. During this period, we encountered two major problems. First, discharged patients were readmitted too frequently, usually because the patients and their families had little understanding of how mental illness precipitated environmental problems in a family. The resultant tensions undermined patients' willingness to continue medication, creating a particularly serious problem with chronic schizophrenic patients. The second problem we faced was that patients appeared in the emergency room for admission at a relatively late stage of emotional disturbance, with markedly disorganized behavior patterns and prognoses of long periods of hospitalization—precisely the pattern we were trying to eliminate.

Since Unit I was responsible for developing mental health services for its community, we had to find, with limited staff, some way to solve these problems. It was obviously essential to find ways of providing additional care and support in the community for these discharged patients. One of the first steps taken was to explore community agencies with which the hospital unit could collaborate and/or coordinate services, and which in turn could benefit by consultation from the unit's professional team. The Director and senior staff members of the unit approached the Medical Director and the Nursing Director of the St. Louis County Department of Public Health. We explained that we were in the process of opening an outpatient clinic at County Hospital (a general hospital) and were interested in developing a collaborative program with the nursing staff of the county health department.

The First Stages

In the course of six preliminary meetings, the Nursing Director and Assistant Nursing Director of the department first explored with us the possibility of such involvement and then began actually planning its development. These six sessions were quite informal, but vital to the establishment of a joint program. Plummer and Maney note that nursing directors in the public health field are the professionalizers of public health nursing, "more concerned with the general and ideal aspects of public health nursing. More specifically, . . . most concerned with program developmment."[7] The Nursing Director indicated that the staff field nurses were already interested in community psychiatry and eager to participate in our program.

The program we jointly planned evolved in a number of steps. In the early stages, Unit I staff concentrated on exploring the attitudes and perceived needs of the nursing division with respect to their involvement with psychiatric patients. It became obvious that a number of tensions existed.

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* Author's personal observation on his visit to Moscow, May, 1971.

†Personal communication.

By tradition, community health nurses are familiar with community resources and the process that relates one to another. This was especially true in this health department, where a particularly good relationship existed between the nursing service and the social service division. Through the years, the health department nurses had practiced prevention, health promotion, and cure of family health problems in the home. But in spite of the many already changed and changing concepts in health care, the field nurses were utilized predominantly in a physical health program. Although the nurses had been coming into contact with persons suffering from emotional problems in their day-to-day nursing activities, their mental health training had emphasized practices promoting mental health but had not stressed the problems of mental illness.

As a group, therefore, the nurses felt they had gaps in training for work in community mental health, despite the fact that in recent years they had had various in-service sessions and psychiatric consultation available to them. They wanted to update their basic psychiatric nursing education. We also found that they had some difficulty in accepting the community mental health care concept; they were confused about the apparent blurring of members' roles inherent in the operation of a mental health team; they felt that including a field nurse in this team would result in duplication of effort.

The nurses also expressed some frustration with their regular work schedules, because they frequently were unable to contact a patient's physician directly in order to discuss the family or to get prompt and adequate direction. They suffered, too, from inadequate feedback about a patient's progress. These communications problems were probably inherent in the size and complexity of the St. Louis County Health Department, which is charged with developing policies and procedures to facilitate collaboration and coordination among the divisions within the department as well as with other agencies in the community.

Initial Implementation of Training

With these concerns in the forefront, the unit staff and the nursing division then designed a training program to meet the specific educational needs of the field nurses. The teaching staff included psychiatrists, a psychiatric nurse, a social worker, and a psychologist. The program was intended to help the nurses recognize, accept, and deal appropriately with the problems they encountered in the families with which they worked. The format consisted of 20 training sessions, 10 of them didactic lectures and 10 of them group sessions. The training period ran from October, 1968, to April, 1969.

The lectures and group sessions focused on problems raised by the nurses; they were also designed to increase their understanding and utilization of crisis intervention techniques. The topics explored under this heading included how to make efficient use of community resources, a review of family dynamics and the effects of emotional and social disturbances on family life, a review of the basic stages of child development, and the relationship of developmental sequences to social and emotional problems of children and youth. Three sessions were devoted to a general discussion of the symptomatology of major psychiatric illness, diagnosis and prognosis, techniques of supportive therapy, physical methods of treatment, and side effects of drugs. Vocational rehabilitation and nursing home problems were discussed by specialists in these fields.

The group discussion program was divided into two subgroups. Each subgroup had a psychologist leader and a co-leader—a psychiatric nurse with experience in hospital and community psychiatry. Twelve to 14 public health nurses participated in each subgroup. The main objective of these group sessions was to provide opportunities for the public health nurse to define and cope with her own role and organizational problems, to develop skills in interview techniques, and to learn how to manage emotional problems more effectively. Cases the nurses had encountered were presented in some sessions, followed by discussions that focused on factors underlying the problem being presented, appropriate crisis intervention techniques for each case, the family dynamics involved and the most effective methods or support to be offered, exploration of community agency resources which might offer supplemental help, and the devising of concrete plans for the future management of the case under discussion.

In order to acquaint the nurses with milieu therapy techniques, nurses paid observation visits to the hospital itself and participated in patients' meetings and staff team meetings.

After the training program, but before the nurses actually began to participate in the team effort, another series of meetings was held in August-September, 1969, between the hospital executive staff and the health department administrative and supervisory nurses. The field nurses' prescribed role in public health had been primarily preventive, and this model was retained for the mental health program. With their enhanced background in psychiatric principles, we anticipated that the nurses would enrich the mental health preventive services for persons not mentally ill, for example, in their contacts with patients at common times of crisis, such as a child entering school, a couple entering marriage, a woman entering her first pregnancy, as well as in situations of financial stress or marital conflict.

We also assumed that the training program would alert the nurses to early signs of emotional problems and make them feel more secure in referring patients for evaluation and treatment. The nurses' role in the rehabilitation and aftercare program also focused primarily on prevention. Already accepted and known in the community, they were better able to reach out to patients returned to the community and help them and their families make the adjustment necessary to keep the patient out of the hospital.

The Program in Operation

The field nurses' duties were essentially 2-fold. First, they worked with patients to be discharged from both the crisis intervention unit or admission ward and the long term wards of Unit I. They assessed the family, home, and

community settings while the patient was in the hospital. These evaluations helped the hospital staff comprehend the patient's overall life situation. Second, after a patient was discharged, a nurse followed him home. Of the numerous functions she performed in aftercare, we have chosen only two to mention here. The first concerns her activities in the area of supportive care to the patient and his family; the second concerns her communication with the hospital staff about the patient's adaptation to the home situation. It was especially in the second area, we feel, that the administrative staff developed an unusually free flow of communication between the field nurse and the physician responsible for the overall care of the patient. This was especially rewarding in view of the aforementioned concern on the part of the nurses about the difficulties they would encounter in and around feedback of information.

During the 9-month period between October, 1969, and December, 1970, 66 new patients were referred to the public health nurses, who made 220 home visits in that time. In most of these cases the rehospitalization was prevented by public health nurse follow-up. Furthermore, and perhaps most significant, they referred a substantial number of patients to the hospital staff for diagnosis and care. Of the 54 field nurses in the county health department (all of whom participated in the training program), 19 provided service to psychiatric patients in their respective nursing areas. Undoubtedly, the continuous support from their own supervisory staff as well as from the hospital team members enhanced their effectiveness in this program.

For the nurses who were working with patients, ongoing educational activities were provided. At a weekly meeting, two or three nurses always participated in diagnostic discussions, staffing planning, and discharge planning. At a monthly session, the hospital psychiatric nurse would meet with public health nurses to provide liaison and consultation services. In addition, an ongoing relationship between the nurses and the Unit I staff encouraged the nurses to make referrals, to exchange phone calls about patients, when necessary, and to share ideas about current and future treatment plans.

The meetings and the ongoing relationship made us aware of some basic problems in the program as it was operating. We defined a few we consider of major importance. They are: (1) the adequacy of communication between the hospital staff and the health department staff; (2) the securing and delivery of drugs for patients; (3) problems related to home visits for psychiatric patients; (4) the public health nurses' uncertainty about their ability to handle crisis situations; and (5) their concern about their ability to assess the need for hospitalization or rehospitalization of a patient being followed in home care. Becoming aware of and defining problem areas led us to explore some possible solutions and to formulate certain proposals and suggestions.

The Communication Problem

From the inception of the program, we worked on the communication problem. It was clear that the Unit Director and the Public Health Nursing Director had to allow physicians and field nurses the freedom to telephone, visit, and make personal contact without going through formal channels. Nurses were encouraged to call hospital personnel directly in order to get necessary information about a patient referred or to discuss a crisis situation or an immediate problem. On occasion, when a nurse felt she had encountered a problem too complex for a resident to handle, she was—but, more important, felt—free to call the Unit Director and request consultation with him.

We devised a referral form to provide brief but essential information about the patient, his diagnosis, and treatment and management plans. Although we revised this form as need indicated, we still faced problems arising out of the fact that referring personnel provided inadequate background information. Physicians and nurses, hard pressed by the immediate demands of their case loads, are naturally reluctant to write detailed notes after a follow-up visit. But these documents are key elements in successful continuity of care programs, particularly because the turnover of physicians in community care programs is rapid, nurses are occasionally transferred from one district to another, and patients move from one nursing area to another.

Again, in the general area of communication, it is obvious that the psychiatric nurse coordinator's role must be redefined to permit her to give full time to liaison activities between the hospital unit and the health department.

Before these suggestions can be implemented in any such program, it is probably important that both psychiatric and health department staffs be educated to understand what information the other needs. In the light of our experience, at the stage under discussion, we concluded that hospital staff needs to understand more about precisely how the nurse contributes to the treatment program, and also needs to convey more data about the patient to the nurse. Communication may, of course, improve automatically as a team gains experience in working together. The hospital staff may then be more accepting of the nurses' contribution and consequently more willing to share information. The health department staff may also come to feel less threatened by the fact that other professionals are visiting "their" families and will learn more about what to share with the hospital staff.

On a concrete level, we feel that the establishment of a common index or file would give both groups immediate access to information about a family seen in the past or a family already receiving service from one group. Such an index would make the transfer of information faster and therefore more useful in more situations. The existence of the file might make it possible to devise a system whereby recommendations would routinely be sent to the public health nurse after each outpatient clinic visit. Conversely, if the nurse has advance information about the next clinic appointment, she could contact the physician in charge to alert him to any changes in the home situation.

The Problem of Securing Medication

Securing and delivering medication to patients is not an

accepted function for the public health nurse. Yet, in certain cases, she is the only professional person who visits the patient and can deliver the medication recommended, especially when the patient or family is in a crisis situation or temporarily unable to carry on independently. In our program, the distance between the health department and the hospital pharmacy caused many problems. On occasion, the hospital liaison nurse would bridge the gap by regularly getting the medication from the hospital pharmacy and delivering it to the field nurse. It may prove necessary to expand the system, legal in many states, whereby nurses can write prescriptions pre-signed by a physician but given to a nurse orally. The physician retains professional responsibility for recommending kind and dosage of medication, but it is possible for the nurse to obtain it without his presence.

Problems of Home Visits

The problems related to home visits for psychiatric patients have not been simple. These visits usually take more time, and the families seem to seek more support by phone; the nurses therefore had to learn to readjust their work schedules and to set limits. They must learn how to judge when they can adjust the frequency of their visits according to the needs of the patient. Some nurses feel that they may not have enough to offer, especially in the area of supportive care. They seem especially frustrated in the cases of old persons suffering from organic brain syndrome, who often live alone and have few resources. In this situation, we always attempted to get help from other community agencies. On occasion, patients are admitted to the psychiatric unit for evaluation and later referred to geriatric services of the hospital or to a nursing home. But there are few nursing homes and inadequate financial support for indigent patients, many of whom therefore had to be managed in the community.

Coping with people who present extreme behavior problems has sometimes been troublesome. We developed a nursing instruction guide for handling certain behavior patterns, but ongoing consultation on management of such cases is extremely important.

The nurses expressed frustration when they were unable to know a patient's family member who lived outside their nursing district. The nurse then has to communicate with the nurse in whose area the family member lives. This indirect way of getting information about family members often slows the whole process. We have not yet found any suitable alternative.

Anxiety about Crisis Intervention

The field nurse's uncertainty in handling crisis situations, including familial, mental, interpersonal, or situational problems, suggests a need for continued consultation in this area. Ongoing consultation could be made available by frequent meetings and by extending the case discussions already used. The nurses need to learn more about psychiatric nursing, especially such things as what is important to report back and discuss with the physician and psychiatric team. Increased instruction might be accomplished through planning reciprocal combined home visits, combined observations, and meetings. However, the nature of psychiatry lends itself to no definite answers and often the psychiatric personnel also express frustration in handling crises.

As for the community nurse's occasional insecurity about her ability to assess the need for hospitalization of a patient she has been following, continued consultation and education are again the only solution. One method would be to provide a list of certain basic "signals." Another method, probably more specific, would be for the nurse to contact the hospital staff member familiar with the symptoms that precipitated the original hospitalization. This method might be best handled by a coordinator from the hospital staff who is aware of most referrals.

Summary

The effectiveness of enlisting the participation of public health nurses in a community psychiatry program rests heavily on the establishment of certain key inputs: an intensive educational program for the nurses in fundamentals of psychiatric theory; frequent communication between the nurses and the psychiatric staff; ongoing consultation to the nurses by the community psychiatry staff. A psychiatric nurse coordinator is essential in a situation where two separate agencies or departments are involved in a collaborative service program. That nurse's function, which should be on a full-time basis, is to provide the linkages between the two staffs.

Further, to avoid the fragmentation introduced by bureaucratic procedures, the director of the public health nursing staff and the director of the psychiatric facility must be willing to give the public health nurses freedom of communication at any level. The mental health team must be willing to give advice and training, and to relinquish "specialist" attitudes, if they are to help successfully the nursing members of the new team gain the confidence to tackle crisis situations and make on-the-spot decisions.

This kind of interagency collaboration would be a significant addition to the techniques developed—and in development—for maintaining patients in the community, further reducing hospital populations, and expanding the linkages for continuity of care.

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