Role of the Public Health Nurse in Alcoholic Rehabilitation

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IT has been estimated that in 1955 more than 4½ million persons in this country were experiencing severe difficulties related to the excessive use of alcoholic beverages (*1*). It seems apparent that a community needs multiple rehabilitative resources to control this problem. Unfortunately, key services for the alcoholic, such as hospitals, private physicians, and social agencies, do not readily open their doors to these patients (*2*). Alcoholism has become a matter of major concern for public health authorities.

In recognition of the problem the State of Maryland instituted an alcoholic rehabilitation program in 1952. Within the division of mental health of the Maryland State Department of Health, a section on alcohol studies was established and a clinic program started. By 1955, six of the counties in the State had part-time clinics modeled on the traditional psychiatric outpatient clinic. Five operated after daytime hours, one evening a week, and the other worked on Saturdays. In addition to the usual psychiatric team of psychiatrist, psychiatric social worker, and psychologist, a public health nurse was included as a staff member at these clinics.

Five of these original alcoholic rehabilitation clinics have since been combined with existing health department mental health clinics, and today patients with alcoholism are accepted in all of the 22 county mental health clinics operating in Maryland. This study presents data on the attitudes and reactions of public health nurses to the alcoholic rehabilitation program in its early stages.

The nurses employed by Maryland county health departments provide the full range of public health nursing services including health guidance and counseling, care of the sick, school and occupational health nursing, and the management and staffing of the various public health clinics. Although the role and functions of public health nurses in the nonpsychiatric clinics of health departments are well established through long experience, there has been some uncertainty about nursing responsibilities in clinics concerned with mental health and alcoholism. In an effort to clarify nursing responsibilities in the alcoholic rehabilitation clinics, the functions of public health nurses assigned part time to these clinics were described in an unpublished memorandum prepared by the division of public health nursing, Maryland State Department of Health, in 1956.

Nurses were assigned to the clinics to carry out the following activities:

1. To interpret the philosophy and objectives of the overall county health department

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program. (The nurse was usually the only member of the team who was a full-time employee of the county health department.)

2. To emphasize the integral relationship between the physical and emotional aspects of the patient's problems and the familial and community background of the patient.

3. To serve as a resource in relation to local living conditions, customs, and community services.

4. To facilitate the work of the clinic staff through management of clinic quarters, care of equipment and supplies, recordkeeping, and appointment schedules.

5. To represent health department and nursing services in the clinic setting to patients and their families.

6. To participate in interviewing patients and family members in the clinic, coordinating this service with that given by other team members.

7. To participate in clinic staff conferences.

8. To interpret the alcoholic clinic to the health department and the community in general.

9. To encourage and support the clinic staff in their work in public health.

For the purpose of determining the effectiveness of the program and to assist in future planning, the division of mental health conducted an assessment of the county alcoholic rehabilitation clinics in 1956. An evaluation of the general program based on the survey has been published (*3*). This paper reports on the part of the survey which focused on the role of the public health nurse in relation to alcoholism, both as a team member within the clinic setting and as a full-time employee of the county health department outside the clinic.

The term "clinic nurse" refers to a public health nurse assigned to the clinic part time as one of her activities in the generalized family-centered public health nursing service.

A team of research consultants (Gliedman, Imber, and Stone of Johns Hopkins Universersity) planned and conducted the survey. Two forms were developed for recording the data, which were to be supplied in retrospect for the 3-month period immediately preceding completion of the forms. One form was a questionnaire, and the other, a checklist.

The questionnaires were sent to the health officer in each of the six counties maintaining a clinic for alcoholics with the request that they be distributed to a representative sample of nurses performing various types of service for the county. This form was designed to obtain from nurses information on alcoholism in relation to current community preventive activities, education and training, and research in their respective county health department programs. Its purpose was to provide a basis for evaluation of the current status of these activities, the assistance received from the State division of mental health in carrying them out, and the extent and nature of further assistance desired from the division. Though the questionnaire included a number of specific questions, it was open-ended to encourage free expression of opinion on the part of the respondents.

The checklist was designed to gather information concerning the specific tasks performed by each member of the alcoholic rehabilitation clinic staffs. Only the replies obtained from the nurses assigned as clinic team members are reported here. The checklist included such items as number of patients seen by the staff member, amount and type of treatment performed, and variety of contacts with community agencies.

Responses to the Questionnaire

Fifty-three public health nurses, constituting 35 percent of all nurses employed in the health departments of the six counties with alcoholic rehabilitation clinics, completed and returned the questionnaire on their participation in activities concerned with alcoholism. Their responses are summarized below.

Approximately half the nurses indicated they did not participate in any community programs of prevention, education, or public relations focused on alcoholism. Where there was participation, the amount varied considerably from county to county. In some, only a few nurses took part, while in others, apparently, most nurses were involved to some degree. Their activities included distribution of literature, participation in television and radio programs, personal contacts with community agen-

cies, and casefinding. Except for occasional consultation and conferences provided by the State division of mental health, these activities were planned and executed at the local county level. Although slightly more than half the nurses in the sample indicated some need for help (for example, assistance with publicity, program planning, and speakers' bureau), more than 40 percent indicated no desire for assistance. The latter group was comprised primarily of nurses currently not working with families in which there were alcoholic members nor in community projects dealing with alcoholism.

The responding nurses had little understanding or even awareness of the clinic services offered to alcoholics in their counties. They indicated that in general they knew of no specific kinds of help available to them from the division of mental health, and they expressed no interest in obtaining assistance from the division for their own work in this field.

Inservice education and training activities were reported as intermittent and relatively unorganized. No intensive program was mentioned at either the local or State level. There were indications, however, of satisfaction with occasional State-sponsored institutes and conferences and with opportunities to attend the Yale Summer School of Alcohol Studies on scholarships provided by the division of mental health. A few nurses requested further lectures, workshops, and case presentations. Nevertheless, with rare exceptions, nurses indicated no particular desire for division help with respect to inservice education and training.

The responding nurses did not participate in any of the research then in progress, nor were they aware of proffered help from the division in this activity. However, several felt that research should be encouraged.

The nurses were asked in the questionnaire to rank the types of activities with respect to the priority of importance that should be accorded them. They ranked community performance in prevention, education, and public relations as first in significance. Inservice training was given second priority, followed by clinic services and, finally, research.

In addition, the nurses offered general comments and recommendations in the space provided at the end of the questionnaire. A large number reported that they felt isolated from the activities surrounding the alcohol programs in their counties. They requested wider dissemination of information about alcoholism and the rehabilitation programs in their geographic areas. Several of these nurses, none of whom served in the alcoholic rehabilitation clinics, commented on what they considered insufficient and ineffective communication with the staff members of the clinics, including the nurses.

Responses to the Checklist

The five nurses assigned during the sampling period to the alcoholic rehabilitation clinics completed the checklist on tasks performed by clinic staff members. A summary of their responses follows:

Although the nurse working in the clinic saw, for the purpose of nursing service, as many patients on the average as other members of the clinic treatment staff, the extent of her contact with patients varied considerably from clinic to clinic. For example, in one clinic, the nurse apparently saw every patient and provided nursing service for each. In another clinic, however, the nurse did not see a single patient, even though the caseload for other staff members was fairly high.

The nurses serving in clinics reported little difficulty in maintaining contact with other services in and outside the health department, including community resource agencies. Their full-time employment as generalized public health nurses presumably facilitated such communication.

Most nurses believed they were inadequately trained for some of their clinic functions such as skilled interviewing and counseling of psychiatric patients. Some felt they were not performing functions for which they had received special preparation. They were not applying their knowledge of local families and their skill in helping families improve their nutritional and general health status (*4,5*). Another area of nursing competence not fully utilized, according to the respondents, was the nurse's knowledge and experience in the use of the community resources.

Most of the nurses desired more time for pre-

ventive and educational activities, which were allotted only a small part of their scheduled working hours.

Discussion

The potential of public health nurses as participants in alcoholic rehabilitation was for the most part not realized. There was discouragement almost to the point of indifference with regard to participation in the rehabilitative efforts. Even where there was recognized need for further training or expert assistance nurses generally seemed reluctant to request such help. Also, the feelings of isolation from clinic services expressed by those nurses not engaged in actual clinic operations tended to limit further their involvement in the program. Unfortunately, neither they nor the members of the clinic staffs seemed to have made any special effort to improve their distant relationships through more effective communication.

The liaison function of the public health nurses assigned part time to the clinics was not adequately fulfilled, perhaps because the health department administrative structure did not provide a way to accomplish this. Communication usually proceeds from staff nurse to supervisor and through the latter to other members of the nursing staff and the health officer, to whom the psychiatrist-director of the clinic was administratively responsible. Although inservice education and training might have helped to bridge the gap between the public health nursing staffs and the clinics, this activity was not consistently promoted within the county health departments.

The clinic nurses, more than any other team members, felt they were not performing certain functions for which they were specifically trained and which presumably would have contributed to the program goals. Among these functions, several of which were mentioned specifically by the nurses in the survey, the following appeared to be important: providing health guidance to patients and their families and information to other members of the psychiatric team about community resources; concern with and activities related to the general physical and nutritional condition of patients; accumulating data concerning specific familial problems pertinent to the treatment through contact with nursing colleagues and home and school visiting; integrating clinic facilities and activities such as recordkeeping and maintaining appointment schedules; providing the clinic teams with liaison and information related to other health department facilities of potential use in dealing with the clinic caseload.

In summary, three separate (although not necessarily independent) factors seemed to limit the contribution of the nurses to the rehabilitation program:

1. For the nurses serving on the clinic teams, there was a certain misuse or failure to use public health nursing skills.
2. For the nurses not working in the clinics, there was inadequate liaison with the clinics.
3. For the latter group of nurses, there was an apparent lack of interest in and insufficient information concerning the general program.

Some possible explanations for these limiting factors are described below.

The rehabilitation program itself was quite new in the health departments, and guidelines for specific organizational procedures were not available. The clinic staff personnel, recruited almost exclusively from psychiatric settings, quite naturally patterned their new service after the traditional psychiatric outpatient facility. This probably led to the impression that alcoholism is exclusively a psychiatric problem, best left to the special skills of the "experts" who, incidentally, worked after regular health department hours and behind "closed doors." In addition, these new part-time mental health personnel were not well acquainted with other health department programs and practices, including public health nursing services. It seems likely that these clinicians, by virtue of their special training and experience, which focuses on the individual patient, found it difficult to accept the public health nursing approach, which focuses on the family as the unit of treatment. On the other hand, the nurse probably expected her work in these clinics to be much like that in other health department clinics where her duties and responsibilities are clearly delineated and accepted.

The apparent divergence between the basic approach of the nurse and the therapeutic philosophy of the other members of the clinic

team was an especially puzzling problem for the nurse. The traditional psychodynamically oriented techniques utilized by other team members tended to emphasize particularly the confidential nature of information divulged by the patient to the therapist. This special emphasis might easily have aroused feelings of mistrust and rejection on the nurse's part when she found she was seemingly denied access to certain patient data routinely available to her in other health department clincs. The situation posed a dilemma for the nurse. If she adopted the special confidential framework of her new colleagues, she would tend to isolate herself from her own nursing co-workers and seriously hamper her liaison functions with them. If she did not adopt this framework, she could easily find herself excluded from full membership in the clinic team.

Other special problems contributed to the difficulties in liaison between the public health nurses not working in the clinics and the clinic staffs. The typically small caseloads in the clinics (*3*), plus operation of the clinics only in the evening or on Saturday severely restricted opportunities for communication and coordination of services. For the nurse who did not have the experience of working in one of the clinics, there was an additional problem. Generally, she was accustomed to dealing with well-defined disease entities and therapeutic procedures (*6*). Alcoholism, however, presented a symptomatology not easily recognized as a disease entity and for which treatment procedures remained rather unspecific, prolonged, and in many cases, seemingly ineffective. Nevertheless, she recognized the considerable influence of alcoholism on the other health problems requiring her attention and the difficulties in motivating alcoholic patients to seek assistance. It would not be surprising, therefore, if the nurse felt quite powerless because of the limited consultation resources available to her.

Finally, the nurse, like other professional persons, is not entirely immune to the common moralistic and hostile attitudes evoked by the alcoholic and his problems (*6*). This also may have handicapped the nurse in her efforts to orient herself to this illness, whether seen in the clinic or in the community.

With increasing emphasis on psychiatric consultation for public health nurses and more intensive mental health inservice education in some counties, isolation of clinic and nursing services has become a less acute problem. An intensive study of working methods and relationships of public health nurses and psychiatric personnel, begun in 1960 by the Psychiatric Institute of the University of Maryland and the Baltimore City Health Department, Western Health District, should provide more specific information about personnel attitudes that interfere with learning and impede coordination of public health nursing and psychiatric clinic services for the treatment of alcoholism.

Summary

The division of mental health of the Maryland State Department of Health studied the role of the public health nurse assigned part time in alcoholic rehabilitation clinics in six counties and the activities in relation to alcoholism of the other nurses employed by the county health departments in these counties.

Questionnaires concerning pertinent public health nursing activities were completed by 53 nurses who were employed by the counties maintaining alcoholic rehabilitation clinics but who were not themselves attached to one of the clinics. Analysis of the responses to these questionnaires indicates:

1. Approximately half the responding nurses did not participate in community programs of prevention, education, or public relations focused on alcoholism.
2. These nurses had only sparse information about clinic services for the alcoholic offered by their own county health departments.
3. Inservice education and training opportunities concerned with alcoholism were intermittent and relatively unorganized.
4. Nurses expressed strong feelings of isolation from activities surrounding the clinic services for alcoholics.

The nurses serving as part-time members of the treatment teams in the alcoholic rehabilitation clinics felt that they were asked to perform activities for which they were not adequately trained and were not performing

other services for which they were well qualified.

It was concluded that the potential of the public health nurse as a participant in the rehabilitation of alcoholics and their families was being dissipated.

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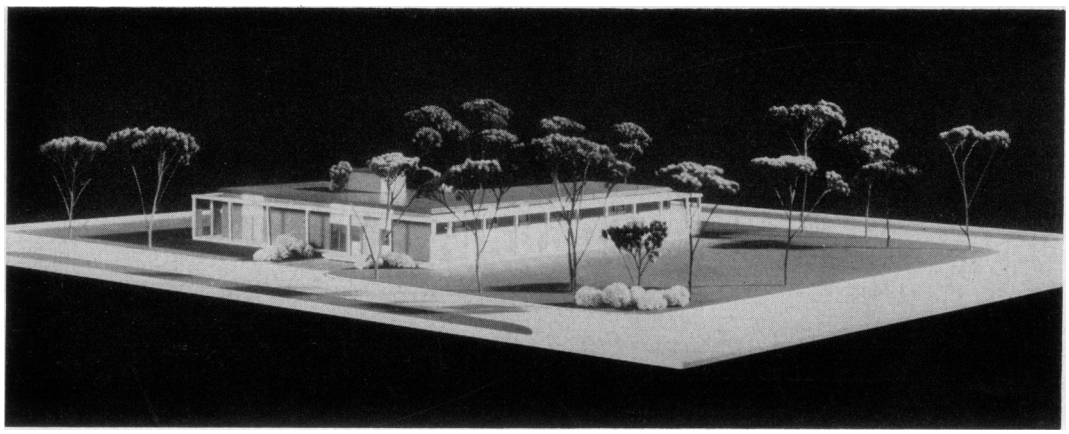

Zoonoses Research Center

The first center dedicated solely to research on the zoonoses has been organized by the University of Illinois. In September 1960, a conference attended by such nationally known medical leaders as Dr. Richard Shope and Dr. Justin Andrews helped formulate plans for the new center. Construction has started on the first of several buildings, a maximally secure research laboratory, an architectural sketch of which is shown above.

The first director of the center is Dr. C. A. Brandly, dean of the College of Veterinary Medicine, University of Illinois. The organization is composed of an executive committee, senior and associate members, and consultants.

The center is organized to further interdisciplinary investigation of the zoonoses. At present, physicians, veterinarians, public health officials, zoologists, parasitologists, epidemiologists, agricultural scientists, microbiologists, and statisticians are members of the center staff.

The emergence of the zoonoses is a fundamental problem to be attacked. For instance, the man-killing influenza pandemic of 1917 is now believed to have entered the swine population as swine influenza, deadly also for that species. Research is underway on parainfluenza, psittacosis, leptospirosis, vibriosis, Q fever, and parasitic zoonoses.

The zoonoses are costly worldwide diseases which have sometimes occupied a no man's land between the professions, especially when the infection in one host has been inapparent. Man as a reservoir host has often been ignored. The center promises to be an effective means of stimulating and promoting research.