Interagency Planning for Aftercare of Mental Patients in the Community

R. W. MOSELEY, M.D., M.P.H.

REPEATED OBSERVATIONS have shown that many mentally ill persons can be adequately maintained outside a mental hospital when continual supervision is provided. A program of aftercare in the community for selected persons released from mental hospitals is thus feasible. As with many other new public health programs, however, the administrator must find ways to implement it in the face of extreme shortages of professionally trained health personnel.

In a recent article, Duval and Venable presented the rationale for, and the organization of, a single combined health and mental health agency (*1*). Since, however, such a single agency is the exception, it may be of value to illustrate how a cooperative agreement between independent agencies—in this case, agencies of a State government—may afford a comprehensive, coordinated aftercare program for mental patients.

Aftercare in Virginia

The administrators of the departments of health and of mental hygiene and hospitals in Virginia initiated a coordinated aftercare program in 1967 because they faced the necessity of alleviating the growing costs of hospital care for mental patients while still providing adequate treatment. Attempts to offer aftercare programs to this group were not new in the State. As long as 20 years ago, mental hygiene clinics, jointly sponsored by the State and locality, had been established in some parts of Virginia to afford care to furloughed mental patients, and by 1965, these clinics were serving more than half of the counties in the State (fig. 1). Because of the pressure of local needs, however, most of these clinics became overloaded with local, not furloughed patients. Then, too, the distance between the clinics and the outlying areas they served made it difficult for many ex-hospital patients to obtain aftercare. Also, many patients had been hospitalized for years so that they had lost all contact with the community. Their referring physicians were no longer familiar with them and, in any event, could not give the time for adequate followup. Personnel of the mental hospitals could provide only limited outpatient care, and social workers did not have the time to make field visits. All these problems were more acute in the regions with the highest rates of admissions to mental institutions.

A few local health departments had also initiated aftercare programs for the mentally ill—as early as 1962. These programs were successful, but they served only limited numbers of patients.

Some home health care programs had also been established in Virginia as early as 1962, and they provided some aftercare services, including services to some mental patients. The

Dr. Moseley is regional director of the division of local health services, Virginia State Department of Health, Richmond.

advent of Title XVIII of the Social Security Act Amendments of 1965 permitted a great expansion of home health care programs. As soon as appropriate personnel could be recruited, trained, and put to work, the division of local health services and its various local health districts (administrative combinations of counties and small cities) were certified as home health agencies. Licensed practical nurses and home health aides were among the new personnel who could assume some of the duties of the public health nurses in the local health districts.

The experience of the department of mental hygiene and hospitals with releases from mental hospitals and returns during fiscal year 1965 shows the need for an adequate aftercare program (see table, page 697). The first three categories of released patients listed in the table would be suitable for aftercare in the community. Among these three categories, the highest rate of return was among patients released without specific referral. Although additional supervision was not considered necessary for many of these patients at the time of release, the failure to refer in many instances undoubtedly represented a lack of available services in the community. The referrals that probably would have been made had an aftercare program been operating in Virginia in fiscal year 1965 are as follows, by health regions:

Health region	*Total releases*	*Potential referrals*
1	330	188
2	823	469
3	544	310
4	427	243
5	802	457
6	363	207
7	153	87
8	80	46
9	93	53
10	826	471
11	754	430
12	729	416
Not determined	54	----------
Total	5, 924	3, 377

State Health Administrative Structure

In Virginia, the department of health and the department of mental hygiene and hospitals are separate agencies, operating under the Governor of the State and responsible to him for those aspects of the health of the citizens denoted by their designations.

The State department of health, through the division of local health services, has established full-time health departments in all counties and cities of the State, a total of 126. Although these local departments may formulate programs to meet specific needs, overall policymaking and administration is strongly centralized. To facilitate supervision, the State is divided into a number of administrative regions (fig. 2).

The department of mental hygiene and hospitals provides central administrative services for State mental institutions and mental hygiene clinics throughout the State. Each mental hospital has a specific service area (fig. 2). Patients furloughed from a given hospital remain the responsibility of that hospital. Both the mental hospitals and the mental hygiene clinics provide outpatient services. Each hospital and clinic is allowed a great degree of local autonomy, a fact which makes it difficult to set up a uniform program.

Implementing an Aftercare Program

The method used to implement an aftercare program obviously must suit the particular situation. Therefore, in 1966, when we began considering how to set up such a program in Virginia, my first step was to eliminate plainly inappropriate solutions, such as the creation of an entirely new program staffed by new personnel. This method would have entailed the procurement of 78 public health nurses to serve a projected patient load of 3,716 at an estimated cost of $475,000 annually. Shortages of nurses and limited funds made this method unfeasible. Nevertheless, consideration of it prompted me to study the feasibility of pooling the resources of the two State departments concerned with health and the practicability of assigning the existing staffs of public health nurses joint responsibility for the program of aftercare of mental patients.

Time and activity studies in fiscal years 1964 and 1965, conversations, and my personal observations suggested that the approximately 500 State public health nurses serving in local health departments could probably provide aftercare for mental patients along with the other diversified services they already were supplying. In fact, the time and activity studies revealed that most of the nurses were already providing such services under a different name. The practical

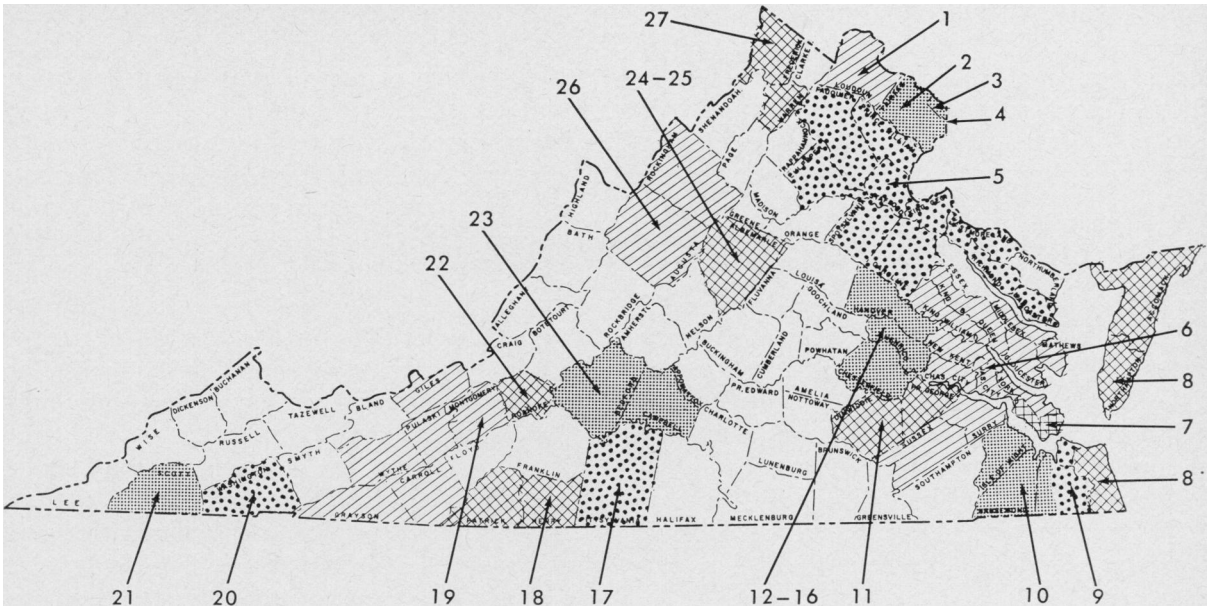

Figure 1. Service areas of mental hygiene clinics in Virginia

nurses, home health aides, and other personnel of the newly established home health agencies helped extend the professional nurses' capabilities. Assignment of this ancillary personnel to each health department relieved the public health nurses of certain activities not requiring their specialized training. I believed that the nurses would therefore have time available for supervising the aftercare of mental patients.

The two departments readily agreed to joint participation in the aftercare program—an agreeable surprise. The next step was to evaluate the resources and capabilities of the departments to determine what additional staff would be needed for the new program.

Fortified with the information about manpower resources and the knowledge that the few aftercare programs for mental patients established in local health departments had been successful, I began preliminary discussions with officials of the department of mental hygiene and hospitals about the design and implementation of the aftercare program.

Since, in the aftercare project, we proposed to use all appropriate resources of both State departments working cooperatively, there were many potential problems. Each department had certain organizational patterns which could not be changed. Thus, we had to formulate procedures which took these different patterns into account but still allowed the program objectives to be met. Commitment to "old line" public

Releases from State mental hospitals in Virginia, fiscal year 1965

Type of release	Number of releases	Percent of total	Number of returns	Percent of total	Return rate
Without specific referral	2, 593	43. 4	1, 594	45. 5	61. 5
Referral to mental health service	1, 667	27. 9	658	18. 8	39. 5
Referral to other agency	412	6. 9	174	5. 0	42. 2
Placement in nursing home	23	. 4	2	. 1	8. 7
Placement in family care	12	. 2	8	. 2	66. 6
Return date specified	421	7. 0	331	9. 4	78. 6
Medical-surgical leave	98	1. 6	98	2. 8	100. 0
Escape	752	12. 6	638	18. 2	84. 8
Total	5, 978	100. 0	3, 503	100. 0	58. 6

health programs made the staffs reluctant to accept responsibility for new ones.

The personnel of each department had to be shown that this cooperative program would not weaken or threaten their perceived roles. Certain conflicts about the perceived roles arose and had to be clarified. Guidelines which would be workable and yet flexible had to be set up so that a program could be established which would be uniform and yet allow local modification when necessary for increased efficiency. Personnel of each department had to receive orientation and training not only as to their own functions, but also as to the responsibilities and activities of the other department. As a better understanding was achieved of the capabilities of the various disciplines which would participate in the project, conflicts were rapidly resolved.

An advisory committee, composed of all hospital disciplines, regional health officers, and public health nurses, planned an appropriate inservice training program. The resources of both departments were used to provide combined training for personnel of both departments.

Guidelines and training plans were completed in the fall of 1966.

Orientation of Public Health Workers

Initially, the regional and local health directors and regional public health nurses received orientation on the administrative aspects of the aftercare program. Next, the bureau of staff development of the division of local health services, in cooperation with the area mental hospital, set up an inservice training program for the nurses in the local health departments who were to provide the aftercare services.

Although all the nurses of the State health department had had some training in the care of psychiatric patients, in many instances the training had been many years before and they felt uncomfortable in handling mental patients. Since both the instructors for the inservice program and the nurse trainees were fully occupied, an orientation schedule was worked out which allows a phased expansion of the aftercare project throughout the State.

The nurses' inservice training consisted of a series of lectures as well as on-the-job training at the State mental hospital caring for patients from their specific areas. A 2-day lecture session covered the purpose of the aftercare program, various commitment procedures, psychiatric conditions and treatment, drug therapy, general considerations in meeting patients' needs, and various aspects of the family and community situation as it would relate to patient care. This 2-day session was followed by a 1-day visit to a hospital, where the nurses observed admission procedures and patient care so that they would be in a better position to provide information to patients and families. After this initial orientation, conferences with hospital personnel, local health directors, and public health nurses are planned at intervals of approximately 1 month to provide ongoing training. The purpose of these conferences, which are scheduled by the local health director, is to provide a means of answering the questions that are sure to arise concerning newer methods of patient care, interpretations of patients' actions, and so forth.

Role of Public Health Nurse

Just as the public health nurse helps people to use other health resources, so can she help them to meet their mental health needs. Every nursing activity offers her an opportunity to promote mental health. Being a frequent visitor in the home, she can provide anticipatory guidance during the critical formative years of childhood. As she guides people in the establishment of good health habits, she is laying the foundation of good mental health.

The public health nurse provides a sounding board for the patient and the family, for she allows each person to express his feeling freely. When she is an understanding listener, she eases stress; when she encourages self-help, she strengthens self-confidence. The nurse is in a position to emphasize the importance to the family and the mental patient of adhering to an established drug regimen and can be alert for adverse reactions to drugs. She is also able to observe whether any unfavorable changes take place in a patient's behavior and to report them to the appropriate authority. Her encouragement makes patients and families more likely to return for followup clinic appointments.

The following excerpts from the records of nurses in our newly established aftercare pro-

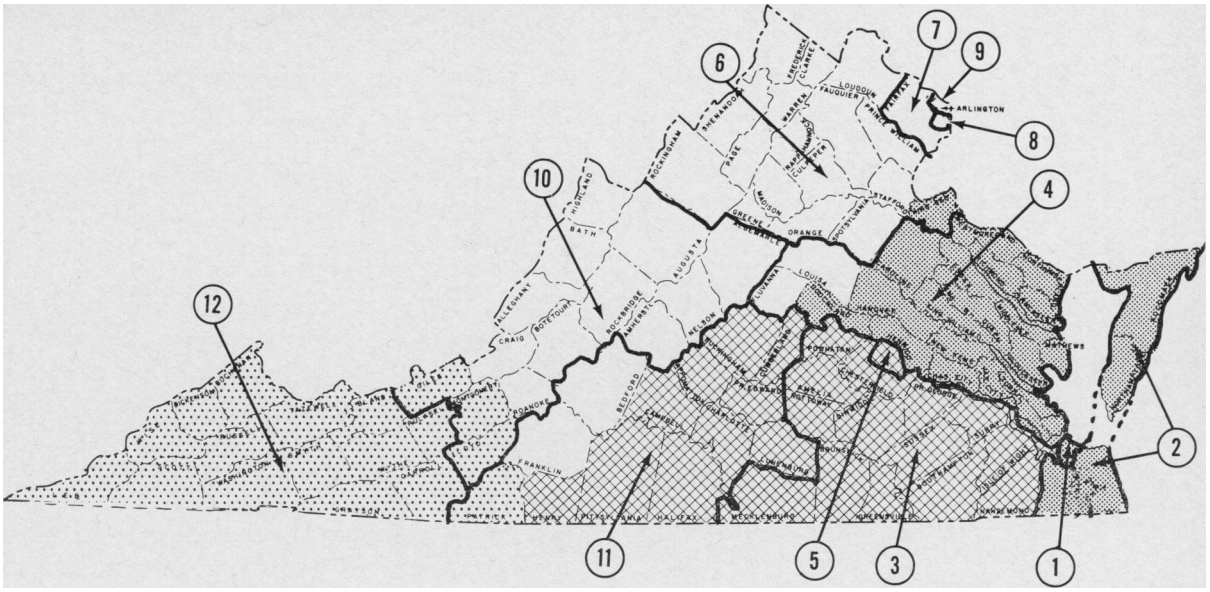

Figure 2. Administrative regions of the division of local health services, Virginia State Department of Health, and service areas of State mental hospitals

NOTE: The heavy lines denote the boundaries of the 12 administrative regions; the service areas of the four State mental hospitals are denoted by separate tones.

gram show the nurse's role in it. One of the patients described in the first excerpt, Esther Mae, was referred to the program with a diagnosis of schizophrenia. In the course of a visit to check on Esther Mae, the nurse discovered that Esther Mae's sister Margaret, home from a mental hospital, also needed help.

TWO SISTERS

Esther Mae, lying in bed fully dressed, with long stringy hair, dipping snuff and watching TV. She was very pleasant and talked quite intelligently. States that she does not have any pain—just nervous and does not feel like getting up. She has a few friends who visit occasionally, but she does not want to go anywhere—seems to enjoy company.

States she does not have any boy friends, although she used to have. I advised patient to try and get up and out in the air—go to the beauty shop and have the long hair cut; she stated when she worked she kept herself neat. Neighbors state this girl is very intelligent and both she and her sister are well thought of in the community.

On this home visit regarding Esther Mae, her parents informed me about Margaret, her sister, who is home now. About a year ago, Margaret was a patient in Southwestern State Hospital for 6 weeks. She took her medication for about 6 months after discharge; then quit. Family is unable to purchase these drugs. She stays in bed all day and watches TV. Will not take a bath or clean up unless forced to. She does not sleep well.

The reason I am sending this report is that I wonder if you have any suggestions to offer so that it will not be necessary for Margaret to return to the hospital.

The home situation not too good. The father has a small store. Family eats in store building as there is an electric range in it. Am sure diets are inadequate. Mr. and Mrs. ——— both are diabetics.

MRS. E

The diagnosis of Mrs. E's case was schizophrenic reaction, schizo-affective type. She was hospitalized in 1964 with complaints of "morbid fears, refuses to eat and sleep, and believes that someone is going to kill her," specifically indicating fears of her husband. Over the next 4 years she had 11 furloughs, returning each time after 3 to 4 months with similar complaints. On several occasions she returned with relatively minor injuries. Upon referral to our aftercare program, the public health nurse made an initial visit to assess the home situation and reported as follows:

After inquiring the whereabouts of the patient's residence, I drove as far as possible by car and continued to walk up the side of the mountain to the house. I was met at the door by Mr. E who very politely invited

me into the house. Mrs. E was lying on the bed, but sat up on the side of the bed. Her eyes were black and swollen and her face and nose had dark splotches that were badly swollen. I ignored this and proceeded with the routine interview concerning her illness, medication, and progress.

Mr. E answered most of the interrogations, and when the medication was discussed he took a key from his pocket and unlocked a metal strongbox and handed the medication to me. The medication was counted and there was an 18-day supply still on hand so I did not replenish the supply. After it was counted he returned it to the box and locked it, returned the key to his pocket and continued the conversation. I asked Mrs. E what happened to her face and she replied, "He did it." Mr. E lost some of his good-natured disposition he had displayed earlier and retorted, "Yes, I hit her. She was wanting to go to her son's house and I kept her in the house all day Sunday."

This is a very sorry home situation. This couple have no interests in common and apparently have agreed to disagree continually. They are not members of any church and they have no common social interests. Insofar as I am able to conclude, there is no immediate solution in view. My impression in this case is as follows: This woman's mental and physical health is in jeopardy as long as she remains in this situation.

Role of Psychiatric Social Worker

The department of mental hygiene and hospitals had planned to assign one or more psychiatric social workers to each health region of the State. Shortage of qualified personnel, however, prevented such assignments. The service of psychiatric social workers is nevertheless available statewide in the aftercare program, but hospital-based social workers have had to assume most of the added responsibility. The psychiatric social worker assists in coordinating services between the hospital and the mental hygiene clinic and the public health department.

Psychiatric social workers in the mental hygiene clinic and hospital notify the public health nurse of a patient's admission to either facility and keep her informed of his progress and the expected time of his trial visit. They help prepare the patient while he is still in the hospital for referral for aftercare to the nursing service.

The social worker may also function as a resource person to the public health nurse when the nurse encounters problems of social adjustment in the family settings. The social worker is responsible for coordinating referrals of patients between the health department and psychiatric clinics.

The public health nurse, on the other hand, keeps the social worker informed about the family's progress toward accepting the patient's illness and about the family's needs. She also coordinates the services being provided to the patient, once he has been referred to the local health department's aftercare program.

Central Coordination

Early in our consideration of a joint aftercare program we discovered that central coordination would be necessary to settle differences in philosophy and concepts and to prevent too much diversification. Specialized assistance was needed to coordinate the planning, training, and evaluation required in such a joint endeavor. The necessity for continuous contact and discussion between the parts of the two departments providing direct service to the patient was apparent. After considerable effort, the division of local health services was finally able in December 1966 to recruit a nurse with training and experience in psychiatric nursing, and the aftercare program got underway in January 1967. As medical coordinator for the aftercare project, this nurse participated in the following activities.

Joint planning sessions between department representatives.

Selection and development of visual and other training aids and selection of reference materials for the educational program for staff nurses of the local health departments.

Orientation of the public health nurses of the local health departments.

Establishing criteria for evaluation of the program.

Developing records and reports for evaluating the performance of public health nurses.

Consultation with regional and local health departments about program implementation.

Consultation with the bureau of public health nursing about the organizational needs of the aftercare program.

Operating Procedures

Referral procedure. As soon as possible after the patient's initial admission to a mental hospital, a report indicating his tentative diagnosis and possible disposition is made to the local health department. The public health nurse then makes a visit to evaluate the home situation. This visit lays the groundwork for future followup when the patient returns home. Any

information obtained which is believed to be of value in the management of the patient is transmitted to the mental institution.

Before the patient's scheduled trial visit home, a referral summary and plan of treatment is sent to the local health department with information copies to the appropriate regional personnel. The plan includes recommendations as to the frequency of nursing visits, the date of return to the hospital outpatient clinic or mental hygiene clinic, and the dosage of drugs to be used, as well as any other information needed for proper followup care. Public health nurses visit the home of the patient as soon as possible after his return and at intervals thereafter as indicated.

Psychiatric consultation. The department of mental hygiene and hospitals provides for, or arranges, all psychiatric consultations. The department provides such support in the following clinics:

1. An aftercare clinic located at the mental hospital or mental hygiene clinic. In many instances the patient is able to return to the hospital or to the area mental hygiene clinic for followup and may require no nursing visits.

2. An aftercare clinic in the local health department. In areas remote from mental hospitals or mental hygiene clinics, provisions have been made for psychiatric teams to meet patients at the local health department offices in order to provide followup for patients on trial visits. At this time, the public health nurse consults with the psychiatrist regarding nursing care for these patients.

3. A consultation clinic at the health department. In the event that patients return to the mental hospital or mental hygiene clinic for psychiatric followup, members of the psychiatric staff meet with local health department personnel to discuss the individual cases under supervision and to provide any supportive consultation that the staff nurses consider necessary.

Requirements for local health departments. A local health department has to meet the following requirements before it can participate in the aftercare program for mental patients:

1. It must have received certification as a home health agency.

2. Its nursing personnel must have received orientation.

3. The department of mental hygiene and hospitals must have provided for psychiatric consultation.

Preliminary Results

The aftercare program for mental patients is gradually being phased in throughout the State. Twelve months after initiation of the project, 120 of the 126 local health units throughout the State were accepting referrals for such aftercare. By the end of 1967, a total of 1,096 patients had been referred to the program; of these, 137 had to be readmitted to the hospital—a return rate of 12.5 percent. There was considerable variation among hospitals in return rates; the rate ranged from 7.6 percent for one hospital to 14.4 percent for another. A study is underway to seek the reasons for this variation. Statistics are also being accumulated for an annual tabulation of nurse-patient contacts and hospital returns which will be used in evaluating the effectiveness of the program.

Summary

When responsibility for health services is divided between two or more State departments, cooperative working agreements can provide better and more economical service to the public. In 1967, the Virginia departments of mental hygiene and hospitals and of health mutually initiated a program providing statewide supervision of mental patients on trial visits.

Suitable patients on trial visits are referred to local health departments for supervision by public health nurses. Outpatient psychiatric services are provided by mental hygiene clinics or hospitals and by special aftercare clinics held at local health departments.

Formulation of the program required evaluation of the capabilities of both departments, orientation of personnel, and close supervision during the early phases. Early review of the program reveals that, of a total of 1,096 patients referred to the program, 137 had to be readmitted to the hospital. This return rate of 12.5 percent contrasts with a preprogram rate of 40 to 67 percent.

REFERENCE

(*1*) Duval, A. M., and Venable, J. H.: Mental health and public health—Organization of State services. Amer J Public Health 57: 878–882, May 1967.

phr synopses

JEKEL, JAMES F. (Yale University School of Medicine): *Role of acquired immunity to* T. pallidum *in the control of syphilis. Public Health Reports, Vol. 83, August 1968, pp. 627–632.*

Hypothetically, an important contributing factor in the marked resurgence of infectious syphilis during the past decade is that a decline has occurred in acquired immunity among the populations at high risk for spreading the disease. Evidence from clinical, epidemiologic, and laboratory studies indicates that a true acquired immunity to *Treponema pallidum* develops in rabbits and man if the infection is not treated for several months. The primary effect of this immunity is to prevent the development of infectious skin lesions, thus interrupting the spread of syphilis—herd immunity.

Data for the United States indicate that acquired immunity to syphilis among young men has fallen to approximately one-fifth of pre-World War II levels. This decline in herd immunity may have contributed to the recent resurgence of the disease. In countries where yaws eradication campaigns have been conducted, declining levels of antitreponemal immunity seem to be permitting a more rapid spread of syphilis.

A vaccine against *T. pallidum* may be needed to eradicate syphilis worldwide. The primary effect of such a vaccine would be production of herd immunity, which would slow the spread of syphilis through a population and enable casefinding and treatment programs to eradicate the disease. To have a major effect, the vaccine need be used only in promiscuous populations.

GERRIE, NORMAN F. (Tufts School of Dental Medicine), and FERRARO, RICHARD H.: *Organizing a program for dental care in a neighborhood health center. Public Health Reports, Vol. 83, August 1968, pp. 633–638.*

Some of the preventive features and behavioral patterns frequently overlooked in public dental programs will be emphasized in the dental services which will be a component of the Tufts-Columbia Point health services program. This joint project of the Tufts Schools of Medicine and Dental Medicine and the Office of Economic Opportunity serves low-income families in a Boston, Mass., housing project. By the fall of 1968 its staff will give restorative treatment to Columbia Point residents of all ages as well as employing maximum preventive measures.

Most persons seek dental care only after self-diagnosis and in emergencies. Two educational projects are planned to replace this prevalent pattern with a pattern of regularly seeking examination for preventive and restorative treatment. The first project stresses the favorable conditioning influence of the mother on the child's attitudes toward dentistry. Mothers will be cautioned to speak positively about their dental experiences and to demonstrate by example that regular dental visits are the accepted pattern of good health behavior in the family.

The second project is arranging supervised visits to the clinic by small groups of 3-year-olds to acquaint them with the dentist and his equipment before they need treatment. Efforts will be made to instill in the children a strong sense of personal responsibility for voluntarily seeking regular examinations so that they will continue this pattern when they are no longer eligible for care at a public clinic.

Quality of care will be insured by careful recruitment of staff and periodic evaluation of dentists' clinical performance by faculty members from the Tufts School of Dental Medicine. Each dentist will have two chairside assistants to insure maximum use of his skills. Six to eight Columbia Point residents will be recruited and trained as chairside assistants. After a period of experience, they will be encouraged to seek employment elsewhere to promote mobility from Columbia Point and to permit a continuing training program. This vocational training is expected to contribute to the general objective of the health services program of breaking the cycle of poverty-illness-unemployment.

SAPIRA, JOSEPH D. (University of Pittsburgh School of Medicine), BALL, JOHN C., and COTTRELL, EMILY S.: *Addiction to methadone among patients at Lexington and Fort Worth. Public Health Reports, Vol. 83, August 1968, pp. 691–694.*

During fiscal years 1962–66, 214 patients at the Lexington, Ky., and Fort Worth, Tex., Public Health Service Hospitals had a first drug diagnosis of methadone addiction. Compared to all other narcotic addicts, methadone addicts tended to be older, white, and residing in States of the "methadone belt" (Virginia, Tennessee, Georgia, Alabama, Mississippi, Louisiana, Arkansas, Oklahoma, New Mexico, and Nevada).

No evidence was found to support the theory that nonmedical use of methadone decreases drug-seeking or antisocial behavior. Methadone addicts had about twice as many second and third drug diagnoses as the general narcotic addict population.

phr synopses

POLGAR, STEVEN (University of North Carolina), and JAFFE, FREDERICK S.: *Evaluation and recordkeeping for U.S. family planning services. Public Health Reports, Vol. 83, August 1968, pp. 639–651.*

Evaluation techniques to measure the effectiveness of family planning services in the United States must be related to the primary objective of these services—namely, to reduce the discrepancy between desired and experienced pregnancies among families who are unable to obtain family planning care from private physicians. Service statistics, or the measurement of program effort, offer the most rudimentary form of evaluation, but they can be made more meaningful if they are related to a defined universe, for example, to the estimated number of families in a community who need subsidized family planning services. In programs serving circumscribed populations, such as hospitals or welfare departments, yardsticks for program evaluation can be developed which are simple, yet meaningful.

More systematic evaluation techniques can be formulated for the administrators of service programs. The suggested procedures include (*a*) estimates of the size and characteristics of the population in need of services, (*b*) measurements of success in contacting the indicated population, (*c*) measurements of success in enrolling that population, (*d*) measurements of success in providing continuity of service, (*e*) measurements of success in reducing the discrepancy between intended and actual births, and (*f*) measurement of the effect of family planning on its secondary and indirect objectives. Various procedures are currently being used for these measurements, but certain basic information is required for all of them. The Planned Parenthood clinics currently use an automated patient record system.

COLOMBOTOS, JOHN (Columbia University School of Public Health and Administrative Medicine), ELINSON, JACK, and LOEWENSTEIN, REGINA: *Effect of interviewers' sex on interview responses. Public Health Reports, Vol. 83, August 1968, pp. 685–690.*

Arguments for recruiting male or female interviewers in health surveys are based on apparently different, though equally plausible rationales. The selection of female interviewers is based on the assumption that similarities between interviewer and respondent, in this case with respect to their sex, facilitates communication between them. Since the respondent in family health surveys is more often the female head of the family, female interviewers are indicated.

In surveys on certain topics, however, such as sexual behavior and drinking practices, it is often argued that male interviewers are more appropriate. The model for this type of survey is the Kinsey interviewer whose qualities were "a high level of academic interest and an equally high level of personal disinterest" that communicated the impression to the respondent that "they had heard everything, that nothing the respondent might reveal could surprise them."

The effects of the interviewers' sex on the respondents' replies were explored during a health survey of a two-stage, stratified, clustered sample of residents of the Washington Heights Health District in upper Manhattan. Respondents answered eight questions about their emotions and 22 questions designed to distinquish between psychiatrically impaired and well persons.

Analysis of results was confined to the responses obtained from 1,479 persons by 31 white interviewers, of which 10 were female.

There was a tendency for male interviewers on the staff to obtain higher scores on the two measures used—from both male and female respondents—than female interviewers; however, the differences were not statistically significant.

MOSELEY, R. W. (Virginia State Department of Health): *Interagency planning for aftercare of mental patients in the community. Public Health Reports, Vol. 83, August 1968, pp. 695–701.*

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