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DELIVERY OF MENTAL HEALTH SERVICES IN ST. THOMAS: AN INVESTIGATION OF POLICY AND SERVICE NEEDS AS EXPRESSED THROUGH PRACTICE

by

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INTRODUCTION

This paper seeks to examine the defacto system of mental health services delivery in St. Thomas, USVI, with particular attention to the interface between policy and practice -- 1) the gaps between expressed policy and actual service delivery, with a discussion of potential causes and remedies, and 2) how policy can be informed by the examination of existing documentation on service delivery.

A word must be said about the historical context for the study and the organization of mental health services in the US Virgin Islands. A separate Division of Mental Health Services was first formally established in the VI Department of Health in 1952, and was given charge of outpatient care for mental patients. A mental health program had been in place since 1949. However custodial care for the mentally ill had been under the umbrella of the St. Thomas hospital since at least the transfer of the islands from Denmark to the United States in 1917, and perhaps before. Consequently, the organization of acute inpatient and outpatient services has remained administratively divided into separate divisions of the Department of Health, although Mental Health Act 4039 instituted in 1977 as Title 19, Chapter 31 of the VI Code, gives legal oversight and responsibility for mentally ill persons, as well as substance abusers, to the Division of Mental Health, Alcoholism and Drug Dependency Services. A further complicating factor is the responsibility of the Mental Health Division as the designated 'state' agency and primary provider of mental health services, for longterm inpatient care, and for services for special groups such as dually diagnosed mental ill/mentally retarded individuals, and criminally insane persons. Thus patients with serious and persistent mental disorders or special needs are required to move back and forth between the two agencies as necessary given

their current level of functioning, and patients with acute or less dramatic problems (such as suicidal behavior!, or anxiety disorders) often never progress past the first point of contact with the system to receive adequate services. The result is an uneasy, fragmented, sometime faltering relationship between the hospital and the Division, that leaves considerable room for patients to fall through the cracks.

Notwithstanding the historical and administrative divisions, this research looks at the mental health system as a unitary one, from the point of view of the patients who enter it, and seeks to answer the question of whether entry into and treatment in that system benefits patients and produces desirable outcomes for patients and for the community. Nevertheless a starting point must be chosen, and given the history of divisions, as well as strong remnants of fear and stigmatization of mental illness and the mentally ill in the community, the locus of contact with the mental health system was designated as the emergency room, the first point of contact with the St. Thomas Hospital Neuropsychiatric Unit. Most persons who become ill in the Virgin Islands, either physically or mentally, do not go a private doctor or public outpatient clinic, they go to the emergency room. Hence the ER serves as a vital point of triage for the mentally ill, and was included in the study as a distinct component of the mental health system in its own right.

Mental Health Policy

Under the impetus of federal PL. 99-660, Title V, of 1986, the Comprehensive Mental Health Services Plan Act, the Virgin Islands State Mental Health Agency in 1988 and early 1989 developed a three-year state plan for comprehensive community-based mental health services for the seriously mentally ill. The preparation of this document, while spearheaded

by the Division of Mental Health, was supported by a newly formed, federally-mandated Mental Health Planning Council, composed of consumers, governmental and non-governmental agency personnel, community leaders, legislators, business persons and family members of consumers. Administrators from the inpatient psychiatric services were invited to sit as guests on the Planning Council. This document, entitled Visions, critiques the existing service delivery system and sets forth the ideal design and components of a service delivery system for the Virgin Islands. Because Visions represents the best consensus of a broad-based spectrum of the community and sets goals for the period from 1989 - 1991, which coincides with the research period, it was selected to be the source document for policy on mental health needs and services.

Philosophy and Identified Problems of the Mental Health Agency

While all the goals of this plan cannot be evaluated in this paper, certain aspects of the plan have been highlighted for examination in light of the data collected. Among other elements, the philosophy of the Virgin Islands Mental Health System includes the following values and goals whose practical effects will be examined.

1. "Inpatient treatment should be used only when community-based treatment options are not available or appropriate, and all treatment activities should be geared toward return of the individual to his or her own community when inpatient treatment goals have been met."

   This value should result in fewer inpatient admissions and readmissions as community-bases services are developed.

2. "Mentally ill people should be treated with the expectation that they have the capacity for self-direction and that they can live

satisfactory and productive lives in the community."

The practical implications of this value would be services oriented toward enhancing the capacity of the client for productive activity, through vocational training, work placement and sheltered workshop programs.

3. "The best environment for growth and nurturing is within one's own family whenever feasible, and when necessary, services to families should be provided to enhance their capacity for this role."

   The outcome of this value is explicitly directed towards the development of family services for the seriously mentally ill.

4. "Mentally ill persons should be offered all opportunities, without prejudice, to live and participate in a normal environment in the community, and with the least restrictions possible."

   The practical implementation of this would be efforts to plan and develop housing and placement alternatives for mentally ill persons in the community.

Existing gaps in services to the severely mentally ill were also identified in all of the above areas of need: inadequate rehabilitation programs; the lack of 24 hour crisis services staffed by trained mental health personnel, which would include evaluation and non-hospital stabilization services; a dearth of alternative living or residential care options; a dearth of supportive employment opportunities; inadequate delivery and coordination of services through outreach and early intervention and case management services; and the lack of effective client and family involvement in treatment planning and service delivery. Additional, substantial deficits were identified

in the areas of organizational structure, inter-agency communication and coordination, including within the Department of Health, the allocation of financial resources within the system of care, human resources development, and adequate data collection and processing for evaluation purposes.

In setting goals and objectives to begin to remedy the problems identified, Visions made a serious effort to address root causes. The creation of a separate Department of Mental Health with cabinet status (to include Mental Retardation and Substance Abuse) was recommended to increase the autonomy and priority given to mental health issues. The privatization of mental health services delivery was also recommended to circumvent the barriers artificially created by government bureaucracy which affect the judicious use of human, material and financial resources required to support effective services.

Prior to even the publication of the document however, the current Administration went on record as opposing cabinet level status for Mental Health. Support was pledged for other goals and objectives expressed in the document however, and many of the objectives were deemed to be realistic and feasible in spite of anticipated difficulties in funding and implementation, including the contracting out of some ancillary and supportive services as a first step towards privatization. Hence it is appropriate to evaluate the degree to which movement in the desired direction of patient outcomes was achieved in the three years to which the report applies.

DATA COLLECTION AND ANALYSIS

The data for this study comprises archival inpatient medical and outpatient mental health clinic records on every emergency room patient who presented with psychiatric symptoms during the three year period from

January 1989 through December 1991, on whom a medical record could be found. Five hundred seventy-seven persons were recorded as having visited the emergency room for psychiatric reason during the research period and were eligible for inclusion in the study, however records could not be located on 176 persons, due to misfiling, misplacement, current use on a hospital ward, or other unknown reasons. An additional 10 cases were eliminated as a result of either duplicate listings under different names or medical record numbers, or because they did not meet the minimum age of 16 for inclusion in the study.

Data was collected on every Emergency Room (ER) and Neuro-Psychiatric (NP) unit admission during the three year research period, as well as on every outpatient clinic admission through 1992. In approximately 22% of cases, the medical record was incomplete, in that information was not available on all admissions during the research period.

Variables defined were grouped into demographic patient variables, measures of emergency room procedures and decision-making, measures of inpatient treatment and patient characteristics recorded on the inpatient unit, and measures of outpatient treatment. The data were analyzed using descriptive and non-parametric statistics.

A methodological comment is appropriate here: research that relies on the collection of archival data of necessity makes the assumption that what is recorded in the file is an accurate representation of what actually took place. While it can be fairly argued that events which occur routinely are not always properly documented since they are taken for granted, in the case of medical records, much rests on having an accurate description of the patient's condition, and account of services rendered. Internal quality assurance and peer review procedures, and external certification review and malpractice

considerations are examples of critical processes which utilize these documents. Accordingly, it is a matter for concern and rectification when there is inadequate documentation in the medical record of normal and expectable procedures.

ANALYSIS OF RESULTS

Description of the sample

Three hundred and ninety (390) persons who were seen in the Emergency Room of the St. Thomas Hospital from January 1989 through December 1991 were eligible to be included in the study. The sample was equally divided between the sexes with 50.5% females and 49.5% males. Ages ranged from 16 to 86, with a mean age of 37, and a median age of 34. In racial/ethnic groups, 11.5% of the sample was identified as other than Black, either Caucasian, Hispanic, French West Indian, or other. No information was recorded on 137 persons or 35% of the sample, however given other data from census records and outpatient admissions, these persons are presumed to be blacks. Thirty-seven percent (37%) were born in the USVI, 28% were born in other parts of the Caribbean, 10.5% were born in the US, and no information was available on the birthplace of 23% of the sample. Over two-thirds of the sample were single, although nearly 22% were identified as either married or in common-law relationships. Twenty-nine percent (29%) of the sample worked either part-time or full-time, 58% were not working and 13% gave no information.

Sixty-two percent (62%) of those included lived with family or a roommate, 9.5% reportedly lived alone, and only 4% were identified as homeless, however the number of homeless persons in the sample may be considerably larger, since no information was recorded on 21%. Nearly 60%

of the sample were not covered by any form of insurance, 20% were covered under public assistance programs such as Medicare, Medical Assistance, and Hill-Burton, and 21% had private insurance coverage.

The sample accounted for 1009 treatment records, representing at least an emergency room contact over the three year period, and for 925 hospital admissions to the Neuro-Psychiatric ward over the same period. Approximately 47% of patients seen in the ER were not admitted to the Hospital, with 48.5% of the sample admitted to NP from one to 10 times over the three year period. The remaining patients, 3.5% of the sample, were admitted to a medical ward of the hospital. The readmission rate, that is patients with more than one hospital admission from 1989 through 1991, was 20%, a relatively low figure in comparison to earlier data.

Coordination Between Service Components -- Community Reintegration.

Of the 390 emergency room contacts, and 189 NP admissions, only 82 patients were located in the Division of Mental Health outpatient clinics, largely in the Transitional Care Unit which serves the severely mentally ill, with approximately 25% also being seen in the Adult Outpatient Unit, serving acute care cases. This represents a transfer rate from St. Thomas Hospital as a whole to the Division of Mental Health of only 21%, and a slightly better transfer of 43% between the NP Unit and the Division of Mental Health Outpatient Department. The hospital medical records document 135 emergency room referrals to the Division, or approximately 13.5% of all ER cases. In only 31 cases was an actual appointment made for the patient. By contrast, the NP unit noted referrals to Mental Health in 182 of 340 total discharges for a rate of 53.5%, with appointments made in 113 cases.

The most recent needs assessment conducted by the Division in 1986-87 identified 329 seriously mentally ill persons who were receiving services. It is doubtful that a substantial decline in this population occurred over the next two to five years. Some of these persons are likely being served adequately within the outpatient system of care and have not had a need for inpatient treatment. However it is likely that many patients have fallen through the gap between the hospital and mental health. Areas for improved coordination should focus on encouraging referrals to outpatient care from the Emergency Room of patients who do not require hospitalization, and in the NP Unit, the making of actual appointments at Mental Health prior to discharge of the patient.

Enhancing Capacity For Productive Activity.

The emergency room patients are for the most part unemployed, with only 22% recorded as employed. Similarly, twenty-nine percent of patients admitted to the NP unit were recorded as being employed either full or part-time. Once on the inpatient unit however, concern for the productive activity or work status of the patient was limited to the consideration of activities following discharge. Plans for some type of productive activity were noted in the record in only 25 of 190 first admissions, a mere 13% of the total.

In the outpatient services, the proportion of clients engaged in full or part-time work ranged from 8.45% to 12.33%, with no substantial change over the research period. Data was also collected on the degree to which clients were involved with supportive services at other agencies while at Mental Health, and referred to supportive agencies following discharge from the Division.

A total of 34 patients were referred for services simultaneously with their treatment in Mental Health, a rate of 41. 5%. The largest number of

these attended Narcotics Anonymous (41%), and the Clubhouse (26.5%), a psychosocial rehabilitation program developed under contract from the Division. However there was virtually no change in the amount of referrals from 1989 to 1992, in fact simultaneous referrals declined over that period. (X^2 = 23.72, df = 24, p = n.s.). There were almost no recorded referrals on discharge, with only one client referred to the Clubhouse in 1991, and another referred to an off-island treatment service. It must be noted in this context that Mental Health clients were rarely discharged, except in cases of non-compliance with treatment plans. Discharge occurred in only 20 of 70 cases where information was available. Clearly there is significant room for a more aggressive approach to interagency coordination, and vocational development for Mental Health clients.

Services To Families

In both the hospital and the Mental Health populations, the large majority of patients reside with family members -- 62% and from 64 to 71% respectively. Several variables were used to measure the involvement of family and the degree of social support available to clients. Data was collected on the degree to which a need for family respite was recorded as a reason for psychiatric admission, however this was mentioned in only 6 emergency room cases. However, family or friends accompanied 47.5% of patients who were admitted to NP, and only 15% of all patients seen in the emergency room, indicating a potential influence on the decision to admit. Once on the NP unit family contacts declined sharply, with 62% of patients receiving no visits at all during the first week after admission, and another 19% receiving only one visit. Only 16% of patients had more that one visitor, with these proportions declining over time in lengthier admissions.

Family supports in Mental Health cases were measured through the counselor's recorded contact with family members in the first month following admission. None were recorded in any client record, and only two telephone contacts to a client's home were recorded in cases requiring follow-up. Again the area of family supports is one where the goals outlined in Visions have not yet been achieved.

Housing and Alternative Placement Development

Types of housing facilities used by patients were not recorded in either hospital or Mental Health records. Some information on aftercare housing arrangements was recorded in 336 NP admissions, if only to report no housing or a lack of information in 48% of these cases. Forty-four percent (44%) were reportedly returning to family, 17 persons were being placed with a social agency such as the Department of Human Services or Mental Health Longterm Care, one person was returning to public housing, and six were living independently.

In Mental Health cases where information on housing was available, homelessness ranged from 9 to 12.5%, from 6 to 10 persons lived alone, and only one person lived in a supported living situation in each year from 1989 to 1991. This situation reflects the critical lack of housing resources noted in Visions, as well as the lack of progress toward remedying the problem.

DISCUSSION AND CONCLUSIONS

The goal of improving coordination between the inpatient and outpatient components of the mental health system is the one which shows the best performance during the period under review. Referrals were made from the NP Unit to Mental Health in approximately 53.5% of cases. However when first admissions for each patient are examined, referrals to

Mental Health declined significantly from 1989 to 1990 and remained steady thereafter. ($X^2 = 20.86$, df = 12, p = .05). Hence it is impossible to conclude that success has been achieved, or even that progress has been made, toward achieving the goals set forth in the mental health planning document for the years 1989 to 1991.

In considering the relative failure in developing the ideal mental health system for the Virgin Islands, there are several issues to keep in mind. Difficulties were candidly anticipated, particularly given the high level opposition to enhanced independence and flexibility for the Division, as well as the near rigor mortis of bureaucratic systems which control essential elements such as hiring of staff and the providing of transportation. Without progress in these structural areas, improvements in service delivery would be difficult at best. Secondly, Hurricane Hugo clearly played a large role in disrupting the momentum that may have been laid earlier in 1989, and recovery to basic infrastructure took several years. Further, goals were diverted towards meeting the needs of disaster victims, many of whom were Mental Health and hospital staff.

Finally, goals such as privatization of services, improved coordination between human service agencies and mental health service components, and the development of vocational and housing alternatives were and continue to be worthwhile and important targets to improve the quality of the mental health system as a whole. However the timetable for achieving them must be considerably extended, not only to allow for intermittent disasters and retrenchment, but also for the natural pace of social evolution, the slow process by which the community eventually catches up to the professionals in its understanding and support for new ideas and ways of doing things. These ideas are particularly new to the Caribbean, including the Virgin Islands,

where old fears and stigma still hold sway over the mind of the public. Change imposed from the metropolitan centers of federal government is unlikely to be successful.