AD-A134 801 MENTAL HEALTH CARE IN A FLEET MENTAL HEALTH SUPPORT UNIT(U) NAVAL HEALTH RESEARCH CENTER SAN DIEGO CA R B CHAFFEE ET AL. JUL 82 NAVHLTHRSCHC-82-14 1/1

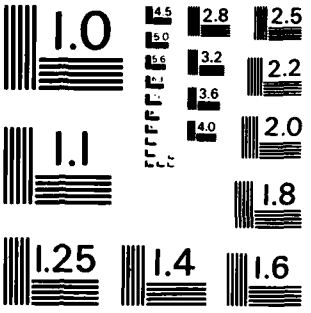
UNCLASSIFIED F/G 5/10 NL

END

DATE FILMED

12 82

DTIC



MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS - 1963 - A

AD-A134 801

MENTAL HEALTH CARE IN A FLEET [illegible]

R. B. CHAFFEE
R. E. BALLY

REPORT NO. 82-14

[illegible]

Mental Health Care in a Fleet Mental Health Support Unit

LT R. Blake Chaffee, MSC, USNR*

LT Ralph E. Bally, MSC, USNR**

Naval Health Research Center

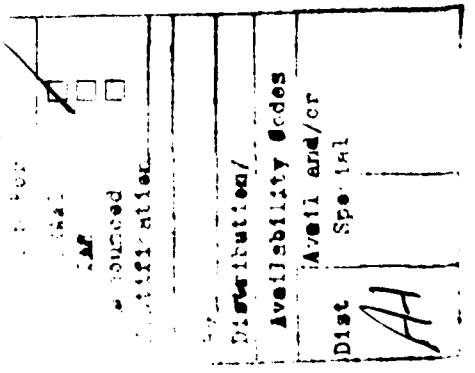
P. O. Box 85122

San Diego, California 92138

Report Number 82-14, supported by Naval Medical Research and Development Command, Department of the Navy, under Research Work Unit MF58.527.1C2-0002. The views presented in this paper are those of the authors. No endorsement by the Department of the Navy has been given nor should it be inferred.

*Environmental Medicine Department

**LT Bally has a Ph.D. and is assigned as a psychologist at the Navy Regional Medical Center, San Diego, California.



SUMMARY

The present study sought to describe the patient population and service delivery at a single small Navy outpatient mental health clinic by collecting data directly from patient/clinician encounters. The total sample included 248 Navy officers and enlisted personnel and 6 Marine Corps service members seen during a 9-month period. Major findings were that most patients were referred from the base dispensary's sick call, that services provided consisted almost exclusively of evaluation and individual psychotherapy, and that a large proportion of patients seen (56.3%) received no psychiatric diagnosis. Further, the problems presented by patients seen reflected difficulties specific to career and emotional developmental levels. The findings are discussed in terms of their implications for the delivery of outpatient mental health services in the Navy.

Mental Health Care in a Fleet Mental Health Support Unit

Research in Navy mental health has focused primarily upon the epidemiology, diagnosis, disposition, and subsequent service effectiveness of personnel admitted for psychiatric hospitalization. (1-8) Relatively little attention has been devoted to studies of mental health outpatients despite the fact that outpatients represent a far larger proportion of the total Navy population receiving mental health services. Follow-up studies have investigated the disposition and subsequent service effectiveness of military personnel seen in outpatient mental health facilities, (6,9-11) and one study has described referral patterns, demography, and service status of mental health outpatients. (12) The latter represents the first attempt to determine the patient characteristics and clinical procedures involved in Navy outpatient mental health services. In this study, Bailey found that Navy outpatient mental health clinicians were primarily involved in triage, brief assessment, and crisis intervention. Patients were disporportionately younger, unmarried, with less time in service, and working in Deck or Engineering and Hull occupations when compared with the entire Navy enlisted population.

The present study, based upon data collected at a single small facility, was designed to detail the delivery of outpatient mental health services, that is, patient populations served and reasons for referral, diagnosis, and disposition. It was hoped that these data would provide insight into mental health care needs and practices at the small clinic level. The study reported here also was the pilot project for a large-scale data collection effort involving four Fleet Mental Health Support Units (FMHSUs) within the San Diego region to design and test the feasibility of a standard outpatient mental health reporting system. (13)

METHOD

The FMHSU studied was selected because it was a relatively small unit staffed by one Hospital Corpsman and a single full-time clinician (in this instance a clinical psychologist) and because its catchment population was limited to a small aviation community and the relatively few fleet sailors stationed within it.

The data collection instruments employed were designed and developed by the first author at the Naval Health Research Center in San Diego after a review of existing military and civilian mental health intake and reporting instruments (see Figures 1 and 2). The remainder of the 5-page Encounter Form consisted of a diagnosis checklist from the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). As the data collection occurred during the time of transition to DSM-III, the checklist was intended as a training aid to reduce confusion between the DSM-II and DSM-III diagnostic systems.

The data collection instruments and procedures were integrated into the FMHSU's customary check-in and evaluation pocedures. Initially, patients were asked to fill out the Mental Health Care Information Form (see Figure 1) upon arrival, but because of

excessive errors and omissions in the data submitted, this information was subsequently obtained in separate interviews by the Hospital Corpsman and the clinician. The Hospital Corpsman briefly explained the purposes of the study and obtained consent, emphasizing that participation was voluntary and that only routinely collected medical information would be utilized. The Hospital Corpsman then obtained identification and demographic information on the Mental Health Care Information Form and the clinician recorded service delivery data on the Encounter Form.

When preliminary examination of the data revealed that a large proportion of patients seen received no formal psychiatric diagnosis, the FMHSU's records for the study period were reviewed in order to obtain information on the reasons for referral in all cases. Data on 156 cases of the original total sample were obtained, and the major reason for referral in each case was classified into one of 10 discrete categories. Classifications were based on agreement between two judges on the rationale for referral presented in the consultation which included the impressions of both the referral source and the FMHSU clinician.

RESULTS

Types of Patients Seen. The total sample included 240 Navy officer and enlisted personnel and 6 Marine Corps members seen during a 9-month period from 1 August 1980 to 30 April 1981. There were 19 warrant officers or officers and the remaining 227 were enlisted patients. The sample was predominantly male, although females were overrepresented compared with the overall Navy sex ratio: 201 patients were male and 45 female. Patients ranged in age from 17 to 46. The mean age for males was 25.2 years and for females 23.1 years. Of the total patients, 94 (38.2%) were 21 years old or younger; 46 (18.7%) were 22-24, and 106 (43.1%) were 25 or older. The racial distribution was consistent with other samples of Navy mental health patients: 198 patients (81%) were Caucasian; 32 (13%) were Black, and 14 (6%) were of other racial origins. Of the total, 96 patients (39.0%) were married while 148 (60.2%) were single at the time of consultation. Marital status was unknown for two patients. The majority of patients (N = 213) were referred to the FMHSU from the base dispensary's sick call. Other referral sources were: 10 patients from medical services, 15 from other sources including the brig, emergency room, or the command, and 6 patients were self-referred.

Presenting Problems Preliminary examination of the data revealed that many patients had not received a psychiatric diagnosis. Review of the FMHSU records yielded data on the reasons for referral for 156 cases of the original sample. Table 1 presents the problem category by pay grade frequencies and percentages. These data clearly indicated that service members in different pay grades are referred to the FMHSU for different resons. Chi-square analysis of the pay grade by problem category distribution revealed that it differed significantly from that which would be expected by chance at the .05 level (X^2 = 86.25, df = 63). Junior or nonrated enlisted personnel (pay grades E-1 through E-3)

accounted for most of the cases that involved wanting out of the service (82%), suicidal ideation or behavior (73%), depression (67%), alcohol or drug abuse (57%), and interpersonal problems (55%). As would be expected, analysis by age yields a similar pattern. Younger patients (22 years old or younger) represented the majority of patients wanting out of the service (76%), presenting with suicidal ideation or behavior (73%), or with interpersonal difficulties (50%).

Petty officers (E-4 through E-6) tended to present distinctly different types of difficulties. Petty officers accounted for most of the referrals for marital problems (71%), general fitness for duty evaluations (53%), and physical complaints (55%). They also accounted for large proportions of the referrals for anxiety (44%) and job stress (43%). Again, the age data paralleled the results of pay grade: 70% of service members presenting with marital problems were in the 23- to 30-year-old age group. Petty officers, therefore, reflect difficulties associated with marriage and career progression.

Senior enlisted personnel (E-7 and E-8) and officers (including warrant officers comprised relatively small proportions of the total sample and their data were considered separately. Anxiety accounted for three of the five referrals for E-7s and E-8s. Further, anxiety and job stress accounted for 43% of all referrals for officers. In general, senior enlisted personnel and officers were referred for stress-related difficulties including anxiety, job stress, physical complaints, interpersonal difficulties, and marital problems.

Service Provided. The services provided to patients consisted almost entirely of evaluation (N = 210) and individual psychotherapy (N = 29). In addition, 9 patients were seen for psychological testing, 5 for screening for special programs, e.g., submarine service, and 11 for other forms of psychotherapy, e.g., group therapy, relaxation training, etc. (Note that the total number of services provided exceeds the total number of patients because a patient could have received more than one type of service).

Diagnosis. Data on psychiatric diagnosis were available for 245 patients and are presented in Table 2. The number of patients seen at the FMHSU who received no psychiatric diagnosis was striking: 138 (56.3%) had "No diagnosis or condition" on either Axis I or Axis II of DSM-III.

Disposition. Of the 246 patients seen, 159 were returned to full duty after a single visit with no subsequent treatment. An additional 74 were returned to full duty with outpatient treatment provided. During the course of the study, 6 patients were admitted to the hospital psychiatry service. Recommendations for administrative separation were made for 3 patients. Additional "Other" dispositions were made for 10 cases, and 1 patient received an outpatient medical board. (Note that the number of dispositions does not equal the number of patients because the disposition categories were not mutually exclusive.)

Patients' contacts with the FMHSU staff were typically brief. Of the 246 patients seen for initial visits, 74 returned for follow-up. Follow-up visits ranged from 1 to 15 additional visits and totaled 258. Whether or not a patient received a psychiatric diagnosis had no bearing on whether or not he returned for follow-up visits. Patients who recieved diagnoses returned for follow-up visits no more often than patients who were not diagnosed (X^2 = 2.54; df = 1; p = Ø.11): 26 of the 138 patients who received no diagnosis returned for a total of 115 follow-up visits while 38 of the 107 patients who were diagnosed returned for a total of 143 follow-up visits. Further, patients who received psychiatric diagnoses did not differ from patients who were not diagnosed in the total number of follow-up visits for which they were seen (t = Ø.73; df = 72; NS). Certain types of patients were more likely to be seen for follow-up visits. Table 3 shows the distribution of patients' pay grades/rank over the first six follow-up visits. Officers and senior enlisted personnel were more likely to be seen for follow-up visits than service members in lower pay grades.

DISCUSSION

The FMHSU studied serves a command which includes the air squadrons and aircraft carriers based there and occasional visiting ships. Walk-in patients, however, are not accepted at the facility. To be seen, a patient must have a consultation form from a medical officer, indicating that he or she had been seen at sick call aboard ship, by a flight surgeon, or by a staff member at the base dispensary. The only exceptions to this are emergency patients or patients referred from the Navy Regional Medical Center, San Diego. Consequently, the majority of patients seen during the study period were referred from the base dispensary.

In a larger survey, Bailey found that clinicians in Navy outpatient mental health typically engage in triage, brief assessment, and crisis intervention. The results of this study support Bailey's findings. Fewer than one-third of the patients seen returned for follow-up visits. The brevity of outpatient mental health interventions is attributable in part to policy. Long-term psychotherapy is usually not provided because it is not considered the best use of limited resources. Interventions tend to be brief for practical considerations as well. Personnel transfers, deployments, and watch schedules all curtail patients' availablility for extended periods.

The fact that diagnosis was not related to whether or not a patient returned for follow-up or to the number of follow-up visits for which he was seen may have been due to the types of diagnoses included in the analysis and customary procedures for handling them. Individuals who received V Code diagnoses (N = 33), for example, may not have required follow-up as frequently because the difficulties presented may not have been severe or because sufficient progress toward resolution of the difficulty could be made in a single session. Similarly, individuals who received substance use diagnoses (N = 1Ø) might be

referred to the appropriate Navy program, e.g., alcohol rehabilitation or the Counseling and Assistance Program (CAAC), without further contact.

The large proportion of patients seen at the FMHSU who received "No diagnosis or condition" on either Axis I or Axis II was unexpected. Even more surprising and difficult to explain were the facts that these patients did not differ from patients who were diagnosed in whether they returned for follow-up visits or in the total number of visits for which they were seen. These results indicated that there was indeed some problem or concern which brought these patients to the FMHSU and that they were not simply inappropriate referrals. Without a documented diagnosis, however, no information was available concerning the reasons for these referrals. This situation reveled a serious oversight in the content of the data collection instruments, i.e., there was no way to capture data on the reason for referral in cases in which the patient's concern or difficulty was not severe enough to warrant a formal psychiatraic diagnosis. No special provisions had been made for such cases because it was assumed that the DSM-III category of "V Codes" would suffice. In order to rectify this short-coming, the unit's records were reviewed to determine the reasons for referral in all cases. The results of this study, therefore, indicate that a taxonomy of reasons for referral is essential to the adequate clinical description of the Navy outpatient mental health population.

Senior enlisted personnel and officers were most likely to be scheduled for follow-up visits. This practice may reflect a bias among clinicians to expend more effort and attention on career-oriented and senior personnel. On the other hand, this practice may reflect differences in presenting problems. Senior personnel may not seek help and referral sources may not refer more senior service members until their difficulties have clearly become intense and unmanageable and, hence, require more attention. Another possibility is that the small numbers may reflect a tendency among officers and senior enlisted personnel to seek civilian mental health consultation rather than risk any negative impact such treatment might have on their careers. A larger sample of senior enlisted personnel and officers and data on how frequently such personnel seek civilian mental health consultations are necessary to adequately address these issues. Clear differences in the types of problems presented by junior and senior personnel occurred: In general, the younger, inexperienced, junior enlisted personnel presented difficulties that were adjustment-related characterologic, or behavioral while the older, more senior personnel presented with emotional difficulties.

Women were overrepresented in this sample compared to the overall Navy sex ratio (approximately 8% female). This finding that women were referred more often than men for outpatient mental health consultation is consistent with a previous study which found that Navy enlisted women had higher rates of hospitalization for mental disorders than men across all enlisted pay grades. (14) In that study, Hoiberg found that the differences decreased as pay grade increased, i.e., senior women (E-4 and above) had lower

hospitalization rates than junior women although the rates for senior women were still higher than those for senior men. The decreases in rates for senior women were attributed to three factors: "... (1) a steadily increasing ability among women to adapt to Navy life; (2) a higher level of experience and enjoyment of the job; (3) a gradual elimination from service of women who had insurmountable adjustment difficulties." (p.689) The differences observed may reflect different patterns of help-seeking behavior between males and females and/or between other service subgroups. Help-seeking attitudes and behavior may be a productive area for future research, providing a context for the interpretation of these and similar medical consultation findings, and for informed mental health liaison and patient education efforts.

Alternative explanations for the disproportionate number of women in the present sample may include (a) that the command studied had more of the job rates in which women represent higher proportions of the population or (b) that differential attitudes and practices exist for referring men and women for outpatient mental health consultation. Additional data are required before these alternatives can be adequately evaluated.

The fact that only six of the 246 service members seen were hospitalized during the 9-month study period emphasizes the functions of the FMHSUs as screening and evaluation facilities. While this is an important "gate-keeping" function, much of the clinician's valuable time is consumed evaluating individuals who present adjustment-related, characterologic, or behavioral difficulties that may not warrant formal psychiatric diagnoses and that are generally not amenable to psychotherapy. The difficulties of such individuals might be more efficiently resolved administratively, by providing an opportunity to talk to a concerned, parental figure without recourse to mental health referral, or by providing training groups in specific coping skills at the FMHSU. Liaison with referral sources may reduce the numbers of these referrals, but this population continues to consume a large proportion of the Navy outpatient mental health treatment resources.

Generalization of the findings of this study to commands of other types, e.g., the surface fleet or submarine force, should remain tentative until similar data from these communities are available. At present, data collection is under way at four FMHSUs within the San Diego region, and future reports will present the results of these expanded studies.

REFERENCES

1. Arthur RJ: Psychiatric disorders in naval personnel. Milit Med 131:354-361, 1966.

2. Gunderson EKE, Arthur RJ: Demographic factors in the incidence of mental illness. Milit Med 131:429-433, 1966.

3. Gunderson EKE, Arthur RJ, Richardson JW: Military status and mental illness. Milit Med 133:543-549, 1968.

4. Plag JA, Arthur RJ, Goffman JM: Dimensions of psychiatric illness among first-term enlistees in the United States Navy. Milit Med 135:665-673, 1970.

5. Clum GA, Hoiberg A: Biographical variables and post-hospitalization adjustment of psychiatric patients in the naval service. Milit Med 135:177-181, 1970.

6. Gunderson EKE: Epidemiology and prognosis of psychiatric disorders in the naval service, in Spielberger C (ed): Current Topics in Clinical and Community Psychology. New York, Academic Press, 1971, Vol 3, pp 179-210.

7. Berry NH, Edwards D, Iorio V, Gunderson EKE: A study of Navy and Marine Corps personnel admitted to the psychiatric sick list. Report No. 72-1. San Diego, Calif., Naval Health Research Center, 1972.

8. Schuckit MA, Gunderson EKE: Psychiatric incidence rates for Navy women: Implications for an all volunteer force. Milit Med 139:534-536, 1974.

9. Erickson JM, Edwards D, Gunderson EKE: Status congruency and mental health. Psychol Rep 33:395-401, 1973.

10. Erickson JM, Edwards D, Gunderson EKE: Work assignments and disposition in an industrial setting. J Comm Psychol 1:366-368, 1973.

11. Fichman JS, Edwards D, Berry NH: Investigation of an industrial psychiatric decision. J Occup Med 15:881-883, 1973.

12. Bailey LW: Outpatient mental health services in the Navy: Referral patterns, demographics, and clinical implications. Milit Med 145:106-110, 1980.

13. Chaffee RB: The development of a standard Navy outpatient mental health reporting system. Report No. 81-31, San Diego, Calif, Naval Health Research Center, 1981.

14. Hoiberg A: Sex and occupational differences in hospitalization rates among Navy enlisted personnel. J Occup Med 22:685-690, 1980.

Table 1

Frequency and Percentage Distributions of Reasons for Referral (Problem Category) by Pay Grade/Rank

Rank/ Pay Grade	PROBLEM CATEGORY: Physical Complaint	Depression	Marital Problem	Suicidal Ideation/Beh	Alc/Drug	Wants Out	Job Stress	Anxiety	Inter-personal	Evaluation	Total
Junior Enlisted	8 (36)*	10 (67)	3 (18)	8 (73)	4 (57)	14 (82)	5 (36)	3 (19)	12 (55)	6 (40)	73
Petty Officers	11 (50)	3 (20)	12 (70)	3 (27)	3 (43)	3 (18)	6 (43)	7 (43)	8 (36)	8 (53)	64
Senior Enlisted	1 (5)	0 (-)	1 (6)	0 (-)	0 (-)	0 (-)	0 (-)	3 (19)	0 (-)	0 (-)	5
Officers	2 (9)	2 (13)	1 (6)	0 (-)	0 (-)	0 (-)	3 (21)	3 (19)	2 (9)	1 (7)	14
Total	22	15	17	11	7	17	14	16	22	15	156

*Percents in parentheses.

Table 2

Diagnostic Distibution for a Fleet Mental Health Support Unit

Diagnosis	Number of Cases
None	138
Substance Use	10
Anxiety Disorders	9
Personality Disorders	6
Adjustment Disorders	32
V Codes	33
Other	17
Total	245

Table 3

Distribution for Follow-Up Visits by Pay Grade/Rank

Follow-up Visit	Pay Grade				
	Junior Enlisted	Petty Officers	Senior Enlisted	Officers	Total
0	93	66	4	9	172
1	23	34	7	10	74
2	14	22	5	5	47
3	10	14	6	3	33
4	8	12	4	1	25
5	5	11	2	1	19
6	4	8	2	1	15

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER 82-14	2. GOVT ACCESSION NO.	3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle) Mental Health Care in a Fleet Mental Health Support Unit		5. TYPE OF REPORT & PERIOD COVERED INTERIM 6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s) Chaffee, R. B. and Bally, R. E.		8. CONTRACT OR GRANT NUMBER(s)
9. PERFORMING ORGANIZATION NAME AND ADDRESS Naval Health Research Center P.O. Box 85122 San Diego, California		10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS MF58.527.1C2-0002
11. CONTROLLING OFFICE NAME AND ADDRESS Naval Medical Research and Development Command National Naval Medical Center Bethesda, Maryland 20814		12. REPORT DATE July 1982 13. NUMBER OF PAGES 11
14. MONITORING AGENCY NAME & ADDRESS(if different from Controlling Office) Bureau of Medicine and Surgery Department of the Navy Washington, D.C. 20372		15. SECURITY CLASS. (of this report) UNCLASSIFIED 15a. DECLASSIFICATION DOWNGRADING SCHEDULE

16. DISTRIBUTION STATEMENT (of this Report)

Approved for public release; distribution unlimited.

17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report)

18. SUPPLEMENTARY NOTES

19. KEY WORDS (Continue on reverse side if necessary and identify by block number)

Outpatient mental health
Mental health services
Mental health services delivery
Outpatient psychiatry
Mental health information systems

20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

The present study sought to describe the patient population and service delivery at a single small Navy outpatient mental health clinic by collecting data directly from patient/clinician encounters. The total sample included 240 Navy officers and enlisted personnel and 6 Marine Corps service members seen during a 9-month period. Major findings were that most patients were referred from the base dispensary's sick call, that services provided consisted almost exclusively of evaluation and individual psychotherapy, and that a large proportion of patients seen (56.3%) received no psychiatric diagnosis. Further,

DD FORM 1 JAN 73 1473 EDITION OF 1 NOV 65 IS OBSOLETE
S/N 0102-LF-014-6601

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

the problems presented by patients seen reflected difficulties specific to career and emotional developmental levels. The findings are discussed in terms of their implications for the delivery of outpatient mental health services in the Navy.