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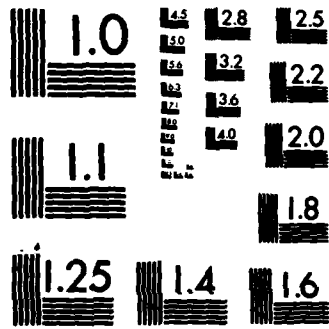
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MENTAL HEALTH LIAISON ABOARD SHIP

F. D. GLOGOWER
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REPORT NO. 84-5

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Mental Health Liaison Aboard Ship

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Report No. 84-5, supported by Naval Medical Research and Development Command, Department of the Navy, under research Work Unit M0933-PN.004-0003. The views presented in this paper are those of the authors. No endorsement by the Department of the Navy has been given or should be inferred.

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Summary

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Navy psychologists and psychiatrists assigned to a fleet setting encounter difficulties in attempting to provide meaningful mental health services. Many clinic referrals reflect organizational, occupational, operational, and environmental conditions aboard ship. Without an appreciation of these factors, clinicians are hampered in their efforts to fully understand the Navy members' difficulties, to coordinate effective intervention strategies, and to make valid recommendations. Furthermore, most problems involving shipboard circumstances do not lend themselves to the traditional psychiatric model of evaluation and treatment in the office. Interface and communication with line commands typically is minimal. Misconceptions, unreasonable expectations, and mistrust hinder the development of a mutually beneficial working relationship.

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In an effort to address these concerns, the staff at Fleet Mental Health Support Unit, Naval Station, San Diego, California, initiated a program of shipboard liaison visits. Meeting with key ship personnel provided an opportunity to enhance communication, coordinate efforts, and develop compatible expectations and goals. A primary objective was to stress the importance of viewing people's problems and their solutions as integral to the shipboard community. A mental health model that emphasized consultative, educational, and preventive services, and attempted to mobilize and augment resources that already existed within the shipboard organization, was promoted. This proved to be an effective and viable approach toward providing meaningful service to the fleet.
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Mental Health Liaison Aboard Ship

Mental health professionals stationed in a fleet setting face a unique set of problems. The shipboard population that we serve functions under a confusing array of organizational, occupational, operational, and environmental conditions. Typically, however, Navy psychologists and psychiatrists work within the confines of the clinic without an appreciation of these factors. This situation hampers their ability to fully understand the Navy members' difficulties, to coordinate effective intervention strategies, and to make valid recommendations.

Interface with ship command personnel is generally minimal, which contributes to the difficulty. Just as clinicians are often unfamiliar with the realities and priorities of the sea-going Navy, the line and their medical department representatives frequently have little understanding of our profession or role. Poor communication and minimal feedback perpetuate misconceptions and unreasonable expectations resulting in inappropriate referrals, mistrust and reduced credibility. Referral sources are numerous, distant, and ever-changing, further hindering the development of responsive and mutually beneficial relationships.

The staff at Fleet Mental Health Support Unit, Naval Station, San Diego, California, is well acquainted with these circumstances. Naval Station is homeport to over 100 surface ships which account for the majority of our caseload. Many clinic referrals reflect shipboard concerns that are work-related, environmental, interpersonal, and disciplinary in nature. However, most such difficulties do not lend themselves to the traditional psychiatric approach of evaluation and treatment in the office. A mental health model that emphasizes consultative, educational, and preventive services provides a more meaningful approach for addressing such problems within the context of the shipboard community. Toward this end, it is essential that open communication, coordination of effort, and compatible expectations and goals exist with fleet commands.

In an effort to promote this model, we initiated shipboard liaison visits. A referral that seemed to reflect ship-related or managerial concerns was selected as a focus of contact with a command's Senior Medical Department Representative (SMDR). Via telephone, we offered to visit the ship, talk with MDR's, and conduct the evaluation on board. Hopefully we could meet the Commanding Officer (CO) and Executive Officer (XO) and also tour the ship. Typically, this was perceived as a helpful and supportive gesture and our offer was accepted enthusiastically. In a tangible way, it underscored our commitment to work closely with fleet commands. Interviewing the referral on the ship focused attention on community factors that may have contributed to presenting complaints. Difficulties often reflect shipboard issues such as morale, leadership, workload, and operating schedule. Frequently, concerns about relationships, finances, career, drugs, or alcohol are involved. We emphasized to the MDR's that many of these problems are most accurately assessed and addressed on the ship. Division Officers, Leading Petty Officers, the Command Master Chief, and the command substance abuse advisor, for example, are in strategic positions to anticipate and identify difficulties of the crew. They can frequently provide advice, emotional support, and counseling and stimulate change when necessary. We indicated to the MDR's that our clinic and a host of other resources in the network are available to lend assistance. When difficulties are psychological in nature, we are the appropriate primary provider of services. In most cases,

however, we can be helpful by augmenting and coordinating resources that already exist within the shipboard community and the Navy organization.

Following our session in sickbay, we usually had an opportunity to meet with the CO and XO. Using the case we had just evaluated to illustrate our approach, we conveyed the importance of viewing problems and their solutions as integral to the shipboard community. We emphasized the influence of occupational, organizational, operational and environmental conditions. Additionally, crewmembers are typically young and attempting to cope with a myriad of maturational and situational issues. If such factors are recognized as potentially stressful, then difficulties can be minimized or even prevented. In our experience, many cases referred to mental health facilities as "psych problems" actually reflect shipboard conditions. As such, they can be handled more effectively onboard, utilizing resources available in the command. We can offer a meaningful service by providing consultative and educational resources. Going aboard ship heightened our visibility and showed the command we were accessible. Navy psychologists and psychiatrists can assist in identifying problem areas, designing interventions, mobilizing resources, and coordinating efforts. Providing MDR's with additional training in diagnostics or the assessment of suicide potential can increase their effectiveness. Preventive measures, such as stress reduction workshops and pre-deployment seminars for officers and crewmembers, can enhance the overall well being of the shipboard community. We encouraged the command to utilize us in this capacity.

By initiating a shipboard liaison program, our clinic operation was greatly enhanced. We visited nearly every ship at Naval Station, San Diego, meeting face-to-face with medical and line personnel. We maintained a close working relationship with commands and established open lines of communication. As a result, efforts between clinic and ship personnel were well-coordinated and feedback was frequent. There was an awareness of priorities and administrative procedures, which contributed to realistic expectations and efficient clinic operation. Requests for consultation to our clinic were more appropriate and showed an increased understanding of our role. Our manpower was utilized effectively. The staff was viewed by commands as a credible and trusted resource, which contributed to everyone's morale. Our increased knowledge of shipboard factors enhanced our ability to understand presenting problems and to respond accordingly. On several occasions patterns and trends of referrals signalled shipboard problems. By alerting commands, these circumstances were addressed quickly and effectively on board.

Our emphasis on consultation resulted in frequent calls from medical and senior line personnel to discuss a variety of issues. This enabled us to tailor our services to meet the specific needs of a particular command. Requests often reflected an increased command awareness of the complex interaction between shipboard conditions and personnel effectiveness. Many individual cases that previously would have been sent to us were redirected through the command and handled on the ship. MDR's indicated that the community approach was very helpful in providing a perspective from which to view presenting problems. Commands were increasingly likely to utilize other appropriate resources in the network, such as the Family Service Center, the Counseling and Assistance Center, or Navy Relief. This allowed for direct and meaningful delivery of

service and permitted our clinic staff more time to provide therapy for those who needed it. Occasional command requests suggested a desire to adopt preventive measures, such as stress reduction workshops for key personnel. The positive impact of these interventions can radiate throughout the shipboard organization. We were also invited to participate in inservice training programs. Other calls demonstrated that commands were anticipating potential difficulties and planning accordingly. An example might be a Commanding Officer who, aware that one of his crew had recently lost a child, wanted to know what the command could do, what to be alert for, and when psychological intervention might be warranted. Our goal in all instances was to provide support, reassurance, and to-the-point helpfulness.

The shipboard liaison program contributed significantly to our ability to provide meaningful service to the fleet. This approach and the community perspective it embodies not only improves the direct delivery of psychological services but also facilitates the command's ability to cope with, minimize, or prevent, mental health-related problems. Line commanders and their medical department representatives have commended our efforts as promoting positive mental health and operational readiness. It seems clear that this is an effective and viable model for psychologists and psychiatrists assigned in a fleet setting.

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REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER 84-5	2. GOVT ACCESSION NO. AD-A139898	3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle) MENTAL HEALTH LIAISON ABOARD SHIP		5. TYPE OF REPORT & PERIOD COVERED Interim
		6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s) Frederic D. Glogower Martha Callaghan-Chaffee		8. CONTRACT OR GRANT NUMBER(s)
9. PERFORMING ORGANIZATION NAME AND ADDRESS Naval Health Research Center P. O. Box 85122 San Diego, CA 92138		10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS M0933-PN.004-0003
11. CONTROLLING OFFICE NAME AND ADDRESS Naval Medical Research & Development Command Naval Medical Command, National Capital Region Bethesda, MD 20814		12. REPORT DATE February 1984
		13. NUMBER OF PAGES
14. MONITORING AGENCY NAME & ADDRESS (if different from Controlling Office) Commander, Naval Medical Command Department of the Navy Washington, DC 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) Approved for public release; distribution unlimited.		
18. SUPPLEMENTARY NOTES		
19. KEY WORDS (Continue on reverse side if necessary and identify by block number) Community Mental Health Fleet Psychiatry Fleet Navy Ships Consultation Psychology		
20. ABSTRACT (Continue on reverse side if necessary and identify by block number) Navy psychologists and psychiatrists assigned to a fleet setting encounter difficulties in attempting to provide meaningful mental health services. Many clinic referrals reflect organizational, occupational, operational, and environmental conditions aboard ship. Without an appreciation of these factors, clinicians are hampered in their efforts to fully understand the patients' difficulties, to coordinate effective intervention strategies, and to make valid recommendations. Furthermore, most problems involving shipboard circumstances		

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