EVALUATING THE EFFECTIVENESS OF TEAMS IN THE DELIVERY OF MENTAL HEALTH IN JAMAICA.

Robertson-Hickling HA, Abel WD, Hickling FW,

Introduction

Research and interest in teams is growing in a variety of organizational settings. In the business world there is talk about autonomous work teams; self managed teams, empowerment, team work and being a team player (Ancona et al 1999). Thompson and Wallace (1996) point out that the ways by which groups of people work together has been of interest in organizational and management thought for a considerable period. Health organizations have had a long history of using teams and this paper evaluates the effectiveness of mental health teams in the delivery of mental health services in Jamaica.

The Concept of Teams

A team is defined as a group of interdependent people who share a common purpose, have common work methods, and hold each other accountable (Bourgeois 1985). There are also many models of teams but for the purposes of this paper we will focus on the teams operating within mental institutions and those operating within the community, both teams have traditionally been multidisciplinary.

Ovretveit divides models of multidisciplinary mental health team management and organization (Ovretveit, 1993). He describes teams in terms of structure, process and integration. Structure describes the composition of the team and its management. Process describes how referrals are
received by the team and how the team works with patients over time. Integration describes how team members work with each other.

Evaluating the Effectiveness of Teams

Sundstrom and McIntyre (1984) have proposed a model for team effectiveness which includes four components by which teams can be evaluated. These include:

- **Performance** – how well team members produce output, measured in terms of quality, quantity, timeliness, efficiency and innovation
- **Member satisfaction** – how well team members create a positive experience through commitment, trust and meeting individual needs
- **Team learning** - how well team members acquire new skills, perspectives and behaviours as needed by changing circumstances
- **Outsider satisfaction** - describes how well team members meet the needs of outside constituencies such as customers and suppliers.

This model will provide the basis for the evaluation of the teams described in this paper.

Development and policy concerns have required even more focus on the provision of teams for the delivery of mental health care. The paper will also describe the reform and development of mental health services, and the role played by various teams in the direction and shape of the reform. The types of reform and the nature of the teams that have shaped this reform in the UK and Jamaica are described and contrasted, as well as the efficacy of the services provided by these teams.

Development of Mental Health Teams in the USA and UK

The evolution of teams in the delivery of mental health has paralleled the major shifts in service delivery worldwide. William Caudill and his colleagues (1951) clearly established the role of the
team in the lunatic asylum. Caudill, led a team of psychiatrist’s and psychologists to study the Chestnut Lodge Asylum in 1950. They concluded that the role of the mental health team was the provision of custody and control of the patients. This is consistent with observations made by Scull (1993), who indicated that before the nineteenth century,

"...the overwhelming majority of insane people were still to be found at large in the community...
but by the mid-nineteenth century the mentally ill found themselves incarcerated in a specialized, bureaucratically organized, state supported asylum system which isolated them both physically and symbolically from the larger society..." (p. 1)

Stanton and Schwartz (1954), Barton (1959), Goffman (1961) continued to document the dehumanizing and depersonalizing atmosphere of huge state mental hospitals, the convincing trend for the establishment of major rehabilitation and deinstitutionalization programs in large mental hospitals has influenced the development of community mental health worldwide (Tooth and Brooke 1961, and Scull 1977). Not all of the community mental health programs in North America and the United Kingdom have been successful (Scherle and Macht, 1979, Halpern et al 1978, Torrey, 1988, and Jamelka et al 1989), but significant success stories have been reported in Australia by Andrews and his colleagues (1990).

Peck described the appearance in the late 1970s, the early Community Mental Health Teams (CMHTs) in the United Kingdom, which were initiated and led by consultant psychiatrists. He suggested that their development was influenced by the enthusiasm of these clinicians for aspects of the American experience (e.g. Mosher & Burti, 1989). He stated that by 1995, the Department of Health in the UK had decreed CMHTs to be one of the foundations of local, comprehensive mental health services (Department of Health, 1995). Most importantly, he suggested that the
enthusiasm for creating CMHTs passed from consultants to managers in both the health and social services, an example of one of the trends identifiable in the 1979-98 period.

The multidisciplinary team in UK has now been criticized as being unfocussed inefficient and result in low quality service (Galvin & McCarthy 1994).

**Mental Health Teams in Jamaica**

Robertson-Hickling and Hickling (2002) identified that the mental health services in Jamaica have made significant advances in the latter half of the twentieth century. Asylum custodialization of the mid nineteenth century was replaced in the post-independence period with decentralization and community mental health care. The mental health issues in Jamaica represent manifestations that are present also in large developed countries like the USA with a shared history of British colonization and African slavery. They concluded that individuals and organizations were already working together to provide high quality mental health care in Jamaica. Robertson-Hickling and Hickling also suggested that the provision of mental health care in the Jamaica provides many lessons about the need for the new partnerships within what Kleinman (1978) describes as the tripartite model. This model suggests that there are three interconnecting sectors that provide health care, the popular, the folk and the professional sectors.

**Development of Mental Health Teams in Jamaica**

In Jamaica, The Lunatic Asylum was built in 1862, mainly from the efforts of Dr Lewis Quier Bowerbank, grandson of English physician John Quier who had settled in Jamaica one hundred years previously. Bowerbank was sent to the UK at age 7 for schooling, and returned to Jamaica years later as a private medical practitioner (McNeil 1987).

The Lunatic Asylum Law of 1874 institutionalized the system whereby `insane' people, so adjudged by the police could be arrested and charged for lunacy, taken before a magistrate and sentenced to
incarceration at H.M’s Lunatic Asylum. Two general practitioner's certificates attesting to the patients’ state of ‘unsound mind’ were also necessary to legitimize the process within the bounds of medicine (Hickling 1975).

The concept of compulsory detention for patients with acute mental illness is a product of modern European civilization (Scull, 1993), first making its appearance in mental health legislation in Europe, America and their colonies in the nineteenth century. John Conolly (1849) makes it clear that the same architectural plan for custodial mental hospitals was used by the British all across the British Empire, spreading the philosophy of custodialization for the treatment of mental illness across the globe. Initially, compulsory detention was linked legally with the power of arrest by the police for lunacy. For example, the 1873 Lunatic Asylum Law in Jamaica (subsequently renamed as the 1873 Mental Hospital Law), which was based on the British Law of a few decades earlier, placed the onus of recognition of mental illness and the first act of “treatment” on compulsory arrest by the police, and the power of incarceration by the Justice of the Peace and the Court, in specially designed institutions for their custody called Lunatic Asylums.

By the early 1930's the population of the Lunatic Asylum had quadrupled, staffing was minimal and inadequately trained, supervision was lacking, therapeutic programs were absent, and sanitation and overcrowding were deplorable (Beaubrun et al 1976). Increasing numbers of black Jamaicans were trained in medicine and psychiatry at British Universities in the first decades of the 20th century. By the mid 1950's the fledgling Jamaican Government had turned to the Pan American Health Organization for assistance with the seemingly insoluble mental health problems. The first PAHO consultant (Roberts 1958), after lengthy discussions with Cooke and Royes and other health professionals in the region, recommended to the Jamaican Government that psychiatric facilities be established on an islandwide basis, to serve the needs of the people, and to reduce the emphasis on Bellevue Hospital. His recommendations were confirmed and re-stated by Richman (1965). The next
PAHO psychiatrist spent nearly nine years in Jamaica assisting the Jamaican psychiatrists of the time to establish a new mental health service.

Collis & Green (1975) described the major tenets of the program outlined by PAHO, bringing a global perspective to Jamaican psychiatric public policy: a) the training of mental health personnel and public education; b) redistribution of psychiatric services; c) building new facilities; d) development of a new administrative structure, and, e) drafting new mental health legislation. PAHO brought five senior psychiatric consultants from the UK, America, Canada and Africa over a 25 year period to work with the Jamaican psychiatrists and other members of the Health Team in Jamaica to conceptualize, create, and implement a plan for mental health in Jamaica. The Jamaican psychiatrists identified the priorities as training, deinstitutionalization, and implementation of the Community Psychiatric Services as the immediate first steps.

The Community Mental Health Service was established by the development of a pilot project in the Eastern three parishes of Jamaica supervised by the University Department of Psychiatry (Ottery 1973), and the appointment of the first two Mental Health Officers - specially trained psychiatric nurses. By 1969 their numbers were increased to five, and by 1975 there were 19 mental Health Officers practicing at the community level in all parishes in Jamaica. The numbers have now increased to 40 mental health officers. These nurses have been working in primary and secondary care facilities across the island, and have become the backbone of the community psychiatric service islandwide, with caseloads of over 500 patients. Working with regional psychiatrists and district medical officers, the community psychiatric service presently manages over 10,000 patients annually, in clinics across the island.

In 1974, the Mental Hospital Act of 1873 was amended to authorize mental health officers to enter the home of any mentally ill person, and to take that person to a clinic or hospital for evaluation and
treatment by authorized medical practitioners under the system of common law which governs the treatment of physically ill people who suffer from incapacity (e.g., patients with diabetic coma, hepatic encephalopathy or unconsciousness from any cause). This amendment removed the powers of arrest for lunacy by the police as was entrenched in the 1876 Act, and put the responsibility by law of persons living with the mentally ill person to assist the mental health officer. It formed the legal basis around which the community psychiatric service was established.

**The Mental Health Officer as the Link**

The placement of MHO’s in the community as the link between the primary care team, the public health team, the secondary care team and the patient with mental illness has been the single most important strategy in the development of the community mental health services in Jamaica. This link has provided a high level of integration of the community mental health service with the primary and secondary care services in the country, especially in the rural parishes.

Hickling (1991) in the Situational Needs Analysis has reported that these (LINK) teams appear highly organised and extremely efficient, highly motivated and with high levels of job fulfillment. He also noted that where the antecedent history of the service had started with committed general medical practitioners, the success of the community mental health service was virtually assured. He cited the parish of St. Thomas in which Dr. Ronald Lampart, a general surgeon with public health background had made a tremendous impact on the establishment of a community psychiatric service in this region even before the mental health officers were appointed.

In all parishes except Manchester, Clarendon, and St. Catherine, Kingston, and St. Andrew, the mental health officers function as a part of the public health team in the parish and they work well in conjunction with the public health nurses who are mobile and are found all over the parish and are able to provide a higher degree of support for the mental health officers in regards to
transportation, communication and information technology. In addition, they attend the senior staff meeting in the public health service, presenting regular reports on the patients in the mental health service similar to patients of other medical illnesses.

**Caseload of Mental Health Officers**

Table 1 compares the clinical caseload of the Service in 1975 and 1990. Over this fifteen-year period, there were 10% more patients seen at the clinic level in 1990 as compared with 1975 although the rate had fallen from 628 per 100,000 in 1975 to 590 per 100,000 in 1990. There were nearly three times as many patients seen as home visits in 1990. Fewer patients (79%) were transferred to Bellevue Hospital, and there were 9% fewer admissions to the parish general hospitals, in 1990.

**TABLE 1: Caseload of Mental Health Officers 1975-1990 (Source Ministry of Health)**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>CLINIC PATIENTS</th>
<th>HOME VISITS</th>
<th>PARISH HOSPITAL</th>
<th>REFERRALS TO BELLEVUE HOSPITAL</th>
<th>ADMISSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>12,817</td>
<td>2,955</td>
<td>606</td>
<td>139</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>14,149</td>
<td>10,546</td>
<td>551</td>
<td>29</td>
<td></td>
</tr>
</tbody>
</table>

Chi squared = 2582.746 p > 0.00001

**General hospital psychiatric units**

Since the onset of the community psychiatric movement in the early 1950's, the general hospital psychiatric unit has become the main flagship of acute treatment, (Hoenig & Hamilton 1966, Downham 1967, Freeman 1983) and the 20-bed psychiatric unit in the general hospital has been replicated widely (like the asylum in the 19th century) across the globe. There is no doubt that
this model has significantly reduced the dependency on long stay treatment for the mentally ill, but in a very real sense has created almost more problems that it solved. In almost every location worldwide it has become a 'custodial mini-mental hospital' on the grounds of a general hospital. The attendant problems of violence, institutionalization, stigma and alienation in these units are almost as great as in the monoliths, which they replaced.

**The Open Medical Ward**

Jamaica was faced with a number of challenges in the early 1970’s, custodialization for the mentally ill had been significantly reduced, social services for the mentally ill were virtually nonexistent, and the community services were spread extremely thin. This situation presented a situation quite different from that reported in the UK and other parts of the world. Grappling with the dilemma of the worldwide community psychiatry imperative in the absence of money in the 1970’s, the Jamaican psychiatrists approached the medical and nursing staff of the general hospitals of each of the 11 rural parishes for the admission of acutely ill psychiatric patients to the open medical wards of those hospitals (Ottey 1973). These services became an important component of the community mental health services and the mental health officer became an important link, working both in the community and in the open medical ward setting with other health personnel. There was initially marked resistance from the medical and nursing staff to managing acute psychotic patients alongside patients with myocardial infarcts and diabetes. A treatment regime was developed which resulted in the patient's rapid recovery and discharge from hospital within 10-14 days. Non-psychiatric nurses and doctors soon lost their fear of patients with acute psychosis. Family members were overjoyed to witness the speedy recovery of their relatives, and the complete acceptance and integration into the social life of the ward, the hospital and very soon, the community. This formalized the treatment of persons with acute mental illness on open medical wards.
In a study assessing the efficacy of treating acute psychotic illness in open medical wards of general hospitals, Hickling and his colleagues (2000) found that patients admitted to open general medical wards had significantly shorter lengths of stay in hospital and had a superior one year outcome compared with patients admitted to conventional community psychiatric units or patients treated in acute wards of mental hospitals. These patients also exhibited greater outpatient appointment compliance, and significantly greater gainful employment after discharge. Acute psychotic patients treated in general medical wards were considerably less stigmatized and enjoyed greater reentry acceptability in their communities after discharge compared with those admitted to the other facilities. The success of this practice in Jamaica has led to a major reorganization of the psychiatric services under the administrative, clinical and academic rubric of internal and community medicine.

**The role of the family**

Another major factor in the Jamaican success seems to rest with the role that the family plays as caregivers (Hickling 1995), where compulsory detention has been replaced by voluntary and informal admission, with the family taking responsibility hospital admission and therapeutic compliance. The family act as the 'eyes and ears' of the service, reporting the first signs of unusual behavior of their mentally ill relative to the mental health officer or the community psychiatrist, or by initiating attendance of their family member at the community hospital or clinic. Family members provide 'welfare' and rehabilitation services for their relatives by the provision of housing, food and other support, and by the provision and identification of work for recovering patients. The family more often than not provides the services of home treatment teams for their acutely ill relative. Bennett (1991) suggests that there is considerable anxiety in the UK about the burdens of community care on families. In the Jamaican situation family care is not seen as a burden but as a responsibility, and recovery from, not containment of illness seen as the outcome of mental illness.
**Conclusion**

This paper initiates research and discussion about the important issue of the effectiveness of teams in mental health. The evolution of mental health teams has paralleled the major changes occurring in mental health worldwide and in Jamaica. These teams developed within the context of resource constraints, responding to the needs of the client population, the national political agenda, health reform and international trends.

In Jamaica a unique team developed, this team consisted of mental health officers working closely with other health personnel in both primary and secondary health care. Selected performance indicators; number of patients seen, and a comparison of outcome measures in different treatment settings measured team effectiveness. There are implications for small states with limited resources and personnel, which are faced with challenges of developing teams to meet the service needs. This paper has focused only on performance output measures; however research needs to be undertaken on member satisfaction, team learning and outsider satisfaction.
REFERENCES


Hickling F.W. (1975) "The Establishment of a Rehabilitation Service at Bellevue Mental Hospital, Jamaica, and an Analysis of the first six months of that Service.” Thesis: Degree of Doctor of Medicine, (Psychiatry), University of the West Indies.


Hickling, F.W. (1995)"Community psychiatry and Deinstitutionalization in Jamaica". Hospital and Community Psychiatry. 45,1122-1126


Stanton, A. & Schwartz, M. (1954).*The Mental Hospital*. New York; Basic Books,


Torrey E.F( *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill*. New York,