US VIRGIN ISLANDS FIVE YEAR MENTAL HEALTH STRATEGIC PLAN 2014-2019

Prepared by Professor Christopher Heginbotham OBE FRSPH on behalf of Synaptic Healthcare and Athena Consulting

Prepared for the VI Mental Health Consent Decree Commission, September 2014

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Acknowledgments

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1. Introduction

This Five Year Mental Health Strategic Plan is based (i) on papers supplied by the US VI and annotated and amended by the Consultant; (ii) on interviews and group sessions with stakeholders held mainly between 15 and 24 August 2013; and (iii) importantly, a revised draft strategy paper prepared by the Consent Decree Commission on proposed draft Strategy, dated July 2014. A draft Final Report was issued in December 20, 2013 which in turn led to the Consent Decree Commission issuing the revised Five Year Strategic Plan Comprehensive Proposal on 17th July 2014. This report does not specify the additional financial resources required. This is a matter for the DOH and DHS once the proposals are accepted. This entire process was mandated under the Consent Decree issued by the U.S. District, Division of St. Croix Court on July 31, 2009 under the case name of V.I. Alliance for Mental Health Consumers v. Government of the Virgin Islands Case 1:03-cv-182.

The Vision, Mission and Values are crucial to achieving a strategy acceptable to all.

1.1 Vision

To create a comprehensive, integrated mental health system in which all the parts of the system serve each other and the system as a whole in order to create an array of services that optimally provides support for consumers (service users, patients) of mental health services on the United States Virgin Islands, their families and all the citizens of the Territory.

1.2 Mission

To create a system of care that meets the community integration standards as set forth in the 1999 United States Supreme Court's mandate under Olmstead v. L.C., 527 U.S. 581, which affirms the rights of individuals with disabilities to live in their community, supports communication, cognitive skills, resilience to problems and self-sufficiency for individuals who have mental health issues administered through the Division of Mental Health, Alcoholism and, Drug Dependency Services under the aegis of the Virgin Island's Department of Health, and those provided by the Virgin Islands Department of Human Services especially for children and adolescents, hospitals and community organizations. This is supplemented by the Recommendations of the report dated July 18 2013 entitled, 'Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act'.

1.3 Previous commentaries, present arrangements and opportunities for change

Some problems with the present services

At present duplicate or multiple costs are incurred because patients are not case managed *through* the system. Each element of the mental health service appears to operate more-or-less independently. For example, multiple admissions and discharges means that the same patient is often discharged to the street, to inadequate home care or to a variety of homeless situations. This places pressure on families that are ill-equipped to cope and in turn leads to offending behaviour, the involvement of the police and criminal justice agencies, to appearances in court and so on. By streamlining the patients' (or consumers') pathways it may be possible to reduce duplicate effort.

In 2011, the Virgin Islands Alliance Commission noted serious problems with the VI mental health services. They concluded that the service was seriously inadequate, that community based support services (by that is meant the health related elements rather than the housing, family support and employment provision offered by the not-for profit sector) was 'virtually non-existent', and there was poor coordination between hospitals and the DOH. Their assessment was that there were delays in the ERs, a confusing, inconsistent, and tedious commitment process and a lack of professional staff, as well as poor data on psychosocial matters. Their solution was to suggest a fully integrated health care delivery system with:

- Partial hospitalisation with high quality day hospital and out-patient treatment functions;

- Home treatment with carer and home support;
- Assertive community involvement.

Assertive community involvement requires two separate functions side by side: assertive outreach support and assertive engagement of the community as volunteers and voluntary organisations – in other words, professional community support teams, and mobilised communities working with clients. These ideas suggest the need for inpatient criteria that reflect the goals of an integrated system, regular reviews of admission and discharges through a case management system, multi-disciplinary teams of nurses, family practitioners, social workers, case managers, psychiatrists and psychologists, strong efforts to prevent suicides and appropriate follow-up in a seamless in-patient-out-patient system. Another matter not considered here in detail is the importance of amending the law on civil commitment and as a minimum preparing Code of Practice on psychiatric law that would govern best practice.

Consent Decree Commission SWOT analysis

The Consent Decree Commission undertook a SWOT analysis in 2013. The results demonstrate the areas in which change is needed and where there are problems at present.

Strengths	Weaknesses
Dedicated and professional staff despite limited resources	No day hospital for adults and children
Support from Central Government	No 'clubhouses'/drop-in centres
Small community makes it easier to address consumers' needs	Inadequately trained and insufficient staff
	High staff turnover leading to inconsistent care
Some degree of infrastructure exists	Lack of funding
Acute in-patient facilities in St Thomas	Poor dissemination of information on mental health
Long term residential facility on St Thomas	Lack of early intervention services
Collaboration between stakeholders	Lack of treatment for chronically mentally ill
Growing Community and national interest in the needs of mentally ill people	Lack of psychosocial rehabilitation
	Regulatory vulnerabilities
	Lack of overall territorial entity to oversee and regulate mental health service
Opportunities	**Threats**
New models of mental health treatment	Cost of new models especially atypical antipsychotics
Mental health foster care	High staff turnover
Community collaboration in improvements	Politics and bureaucracy
Well organised programs for children	Regulatory sanctions
Patients returning from off island	Patients returning from off island

Could better assess and utilise existing expertise	Working in silos
Recruit and retain highly trained professional staff as VI is a positive destination	Aversion to change
Better assess and utilise existing expertise, funding and facilities	Stigma and discrimination
	Culture and religion
	Growing number of mentally ill patients
	Increased substance misuse
	Pervasive negativity, failure to act and lack of trust in government

SWOT Analysis. Amended from a paper prepared by the Consent Decree Commission.

From this it can be seen that there are opportunities if an asset-based approach is taken, with an emphasis placed on the strengths and the opportunities. This will enable the development of an integrated mental health system, under a Mental Health Policy Task Force that will oversee mental health service delivery.

Opportunities for improvement

The Virgin Islands mental health service (or system) requires a community-oriented early intervention service that is part of a broader stigma reduction program, linked to a prevention program that ensures primary, secondary and tertiary prevention are coherent, and will ensure that patients/consumers self-refer or are referred by primary care much earlier than at present. This will take some time to achieve but even in the interim developing services that offer community-oriented care with an early intervention/crisis team (that can divert patients away from hospital wherever possible) will improve services and begin the long haul to cost- and clinically- effective care.

The present VI services need to be made fully cost-effective and meet the legal, human and civil rights of patients/consumers. Arrangements need to move away from emergency room presentation as first contact, offer adequate integrated outpatient support, and provide an adequate level of home support and housing required. Additional counselling and psychological therapy provision is required. It is tempting to suggest simply starting over; but that would not solve the problem. Nor, however would yet more small not-for-profit organisations being set up to fill yet another gap in care. There is a need to reduce complexity and bring all providers together into more cohesive working relationships whilst at the same time supporting not-for-profit and small private providers.

Additional resources should, if available, be put into:

- Effective primary care assessment and early intervention, with a narrative approach to diagnosis rather than applying a simplistic labels, minimises the numbers of patients in assertive community outreach or secondary in-patient care.

- Reducing stigma which will be a critically important factor in encouraging patients to self-refer as early as possible.
- Specialist community-oriented services, such as crisis resolution and home treatment, appear from the literature to be well received by patients/consumers and may help reduce rates of hospital admissions;
- Alternatives to traditional inpatient mental healthcare, such as 'crisis houses', can provide a useful part of local acute care systems, possibly leading to cost savings;
- New technologies and initiatives, such as peer group workers, can help in supporting self-care and keeping people out of hospital.
- Developing a formal stepped care system (increasing levels of intensity of care for differing presentations). Stepped care ensures that the least restrictive environment and the least resource-intensive treatment is delivered first and escalated when necessary to allow for more efficient use of resources.

Ideal service components

The table below suggests the components of an ideal service extracted and amended form the literature and especially on Thornicroft and Tansella (2004)[1]. It can be seen that the many of the components shown in the table are available in the Virgin Islands, but are not linked systematically, but that there are components such as primary care that need strengthening.

A comprehensive, integrated mental health and system should be developed where all parts of the system serve each other and the system as a whole in order to create an array of services that optimally provide support for consumers of mental health services and their families. The purpose of the system will be to maintain the rights of individuals with disabilities to live in their communities and support communication, cognitive skills, resilience to problems, and self-sufficiency. Hospitalisation should be undertaken on the basis of the least restrictive environment necessary to offer effective care and patients discharged as soon as they are able to be cared for tin community settings. All this demands an improvement in the way that in-patient and out-patients services work together with an effective case management arrangement supporting all consumers (patients).

In summary, an effective integrated system is required that brings together the in-patient care with day hospital and outpatient care, all supported by one or more early intervention teams and assertive outreach teams supported and held together by a substantial case management team.

[1] Thornicroft, G. and Tansella, M. (2004) Components of a modern mental health service: a pragmatic balance of community and hospital care: Overview of systematic evidence. British Journal of Psychiatry (2004) 185: 283-290

Mental health service components: 'in principle' stages in service design

First consideration is to establish a primary care led service[2]	Second consideration is to add ambulatory and in-patient care	Third consideration is to add components which may will include:	Commentary about the Virgin Islands Service
Primary care with specialist back-up	*Mainstream mental health care*	*Specialised/differentiated mental health services*	
Screening and assessment by primary care staff Case Management for all patients throughout their involvement with services	Out-patient/ambulatory clinics	Specialised clinics for specific disorders or patient groups, including: • eating disorders • dual diagnosis • treatment-resistant affective disorders • adolescent services	
Talking treatments, including counselling and advice			Talking treatments are one of the important first components of any service
Pharmacological treatment			
Liaison and training with mental health specialist staff	Community mental health teams	Specialised community mental health teams, including: • early intervention teams • assertive community treatment	Community oriented teams are required covering the components of all three columns.. Although shown as tertiary considerations these features need to be provided early
Limited specialist back-up available for: • training • consultation for complex cases • in-patient assessment and treatment for cases that cannot be managed in	Acute in-patient care	Alternatives to acute hospital admission, including: • home treatment/crisis resolution teams • crisis/respite houses • acute day hospital	Good training for all staff is essential followed by some in-patient care, but the most effective service is one that includes alll those components in column 3

[2] This is one of the most significant problems in the USVI. The best funded component is the secondary in-patient services, when what is needed are good quality primary care services.

First consideration is to establish a primary care led service[2]	Second consideration is to add ambulatory and in-patient care	Third consideration is to add components which may will include:	Commentary about the Virgin Islands Service
primary care, for example in general hospitals			
	Long-term community-based residential care	Alternative types of long-stay community residential care, including: • intensive 24 h staffed residential provision • less intensively staffed accommodation • independent accommodation	Residential care and housing are essential components, especially less intensively staffed accommodation
	Employment and occupation	Alternative forms of occupation and vocational rehabilitation: • sheltered workshops • supervised work placements • cooperative work schemes • self-help and user groups • club houses/transitional employment programmes • vocational rehabilitation • individual placement and support service	

NB: To this model will be added measures to protect and enhance the human and civil rights of service users, improve staff and carer training, consider funding mechanisms, and improve management and governance arrangements.

2. Virgin Islands Strategic Plan

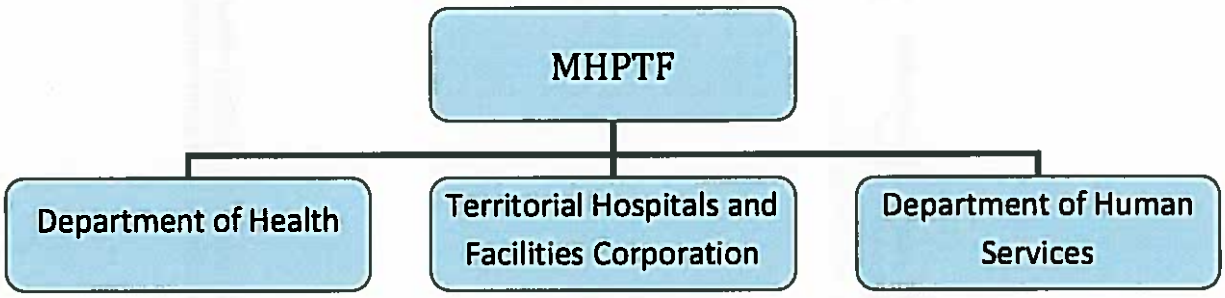
Following consultation on the opportunities and threats faced by the VI mental health services, a strategic plan has been developed which is set out more fully in the following paragraphs. The Strategy includes seven major components of service delivery:

(a) Development of the overarching entity – the Mental Health Policy Task Force;
(b) Regulation of Mental Health Services
(c) Assurer of Quality of Care
(d) Coordination of Community/Outpatient Mental Health Services
(e) Professional Service Contractual Relationships
(f) Assure the availability of Acute Care/Inpatient Treatment Services
(g) Purchaser and provider of Mental Health Services

2.1(a) Development of a Mental Health Policy Task Force

It is proposed that the Consent Decree Commission accept in principle the details of the Five Year Strategic Mental Health Plan set out in Appendixes to this report with an agreement to incorporate into the plan an *overarching entity* to be designated the **Mental Health Policy Task Force** (MHPTF) as shown in the diagram below. This *overarching entity* will manage and deploy the entire scope of mental health services. The MHPTF will oversee the mental health services funded by and provided by the DOH, DHS and Hospital Corporations, and work in partnership with an **independent monitoring body (IMB)**, either an appointed or selected independent individual or organization [the 'Monitor'] to assure compliance with the Five Year Strategic Plan. The anticipated starting date for implementation of the Plan will be after this Report is executed by the representatives of the Commission and after the dissemination of the Strategic Plan to the parties set forth in the V.I. Alliance Consent Decree by the established commission. The Monitoring body shall have access to the Mental Health Policy Task Force and will be able to report on progress on implementing the 5 year plan to the court, governor, media and Senate.

Development of the proposed Mental Health Policy Task Force



The MHPTF will enable representation of a combination of public and private representatives. The suggested membership is shown at Appendix 1.

The purpose of the Mental Health Policy Task Force (MHPTF) is to oversee and create a single cohesive mental health delivery service streamlining the disparate elements offered by providers to ensure the best use of resources and to build strong local partnerships. The MHPTF should take full responsibility for the VI mental health system - for planning, advocacy, and monitoring of care provided – and will have the following goals and objectives, to facilitate:

1. cross-system collaboration and coordination of services, including ensuring a continuum of care in which staff from the hospitals work in community settings and vice versa;[3]
2. resource sharing - promoting collaboration through funding and developing innovative ways to fund services;
3. information sharing and knowledge - using community data and training opportunities to strengthen collaboration;
4. the development of behavioural health advocates - encouraging professionals, consumers, and family members to advocate for high quality behavioural healthcare; and
5. multiple systems working together - collaborating to increase communication and create efficiencies that will improve processes and limit costs for the full and equal delivery of Mental Health Services, within the local community, as anticipated under the mandates of the Supreme Court Olmstead decision.

The specific responsibilities proposed for the Department of Health and the Department of Human Services are shown in Appendix 2.

2.1 (b) Regulation and Monitoring of Mental Health Services

Regulation of the mental health system by an independent body is an important part of the transparency necessary to ensure high quality care and responsiveness to patient/consumer needs. The separation of regulation and monitoring from (i) responsibility for delivery and (ii) from the 'purchaser' arrangements is a necessary feature of provision and governance. The MHPTF should appoint a body to undertake regular audits of the mental health system, to ensure effective independent monitoring of the mental health system, and to include with the audits discussion with patients/consumers and their caregivers about the way the service provides care for them as individuals.

2.1 (c) Assurer of Quality of Care

Standardized Policies and Procedures

The MHPTF must establish appropriate standard polices and protocols to guide services before, during and after hospitalization and between the mental health service-providers. These will include revised and

[3] It cannot be stressed how essential this is. Only by ensuring a continuum of care in which patients/consumers are offered continuous integrated care will the changes proposed be effective.

improved standards on non-consenting detention of mentally ill people, basing revisions on good practice form elsewhere. Additionally the MHPTF should ensure that such policies and procedures are made available widely and are followed by all staff.

2.1 (d) Case Management program and improved Coordination of Community, Crisis and Outpatient Mental Health Services

(a) A **case (or care) management program** is needed that assists and tracks consumers in their mental health treatment and recovery by offering practical assistance and resource advocacy. Support should be accessible 7 days a week with access to a hotline. Case Managers will ensure that clients in the program receive comprehensive, well-coordinated care that is easy to access, recovery oriented, and flexible to meet the needs of the individuals. This includes regular assessment for co-occurring disorders, health issues and access to services. Inpatient and outpatient service coordination should be established to provide an improved system of care coordination between inpatient units and community based service providers. This model views treatment (both inpatient and outpatient) as multi-tiered integrated continuous interventions that engage the consumer as a full partner in directing their care with the goal of building a life in recovery. Increasing linkages to supportive services - providing holistic and comprehensive services to the community by ensuring that consumers have access to case management and can be linked to the appropriate supportive services. Case (or Care) Management with an integrated care approach should include cross-disciplinary case conferencing, co-management of care and forms of care coordination.

(b) **It is essential that all agencies that provide elements of the patients'/consumers' pathway support the process and work together collaboratively. Staff from the hospital corporations must be prepared to work within community services and vice versa.**

(c) It is proposed that a **recovery coach** assists with the development of a recovery plan that incorporates steps toward recovery from substance abuse and/or mental illness (including treatment),living with financial independence, employment and education, relationships and social supports, medical and physical health, recreation, independence from legal problems and institutions, and mental wellness. **Clinical coordinators and health coaches** in primary care practices can reach out to patients in hospitals and the community. The Case Management and Care Transitions Programs should be able to rely on data from the community's Health Information Exchange (HIE).

(d) **Coordinating crisis services** with increasing outreach to the community about ways to access behavioral health services in crisis situations should be part of efforts to streamline crisis services. Establishing a communication plan about the available crisis response and counseling services will help reduce stigma about seeking treatment and will inform consumers and family members about available resources.

(e) **Coordinating with managed behavioral health care**: the mental health system should ensure coordination of services across the behavioral health system, including strengthening the planning

for supports and services that are essential to the overall system but outside of Medicaid funded services.

(f) The MHBP should develop a network of available **data and data sharing agreements** to support decisions on what services need to be coordinated and how to coordinate them, and set up an **Electronic Data Collection System** for the USVI mental health services. This will ensure that all persons entering the system will be documented and can be followed throughout their journey within the system.

(g) Care Managers & System Navigators are critical to providing care for individuals with multiple chronic conditions or who are frequent users of health services. Care managers support integrated care by **managing care coordination** ensuring appropriate care is available when it is needed, increasing self-efficacy in patients, tracking patients on a registry, linking patients with needed resources and providing consultation with other health professionals. [4]

(h) **Transportation:** Coordinating transportation for individuals who cannot afford transportation to and from medical appointments requires careful consideration and a further feasibility study on cost and effectiveness of transport provision.

2.1 (e) Professional Service-Contractual Relationships

The MHPTF, along with the V.I. Government should ensure that each Hospital under the V.I. Government Hospitals and Health Facilities Corporation (HHFC) have professional contracts in place with the V.I. Government that specify the staffing levels, dimensions of the services to be provided, the process of care and outcomes to be achieved. Further the MHPTF shall ensure that all staff have appropriate professional contracts in place that specify the hours available for services, standards of care and all the necessary mandates to assure that the staff at said Hospitals are fully integrated into the case management system, which is to provide full coordinated care for patients with Mental Health Issues.

2.1 (f) Assure the availability of Acute Care/Inpatient Treatment Services

Identified Gaps in the VI Mental Health Services System

The following components of an ideal service require attention.

Post-Hospitalization Transitional Housing Services

Transitional Housing Programs are intended to assist residents with stabilization and acquisition of skills necessary to transition to an independent living situation. Additional transitional housing is needed with the following services and considerations:

[4] SAMHSA has supported the use of Behavioral Health Peer Navigators who offer support to individuals, family members and care givers in order to successfully connect them to culturally relevant health services, including prevention, diagnosis, treatment, recovery management and follow-up.

a. Sufficient number of beds to accommodate consumers for 30 days or longer;
b. Behavioral Health Rehabilitation;
c. Counselling and Therapy;
d. Medication Management;
e. Assistance with long-term disposition (i.e. housing plans) and residential living;
f. Case Workers working closely with Case Management Programs.

Club House, Drop-In Centers, and Wellness Centers

The MHPTF should explore ways in which to provide cost-effective, Club House programs for clients: Club house programs are inexpensive to run, operate with para-professional staff and volunteers (with access to professional backup), are easily managed by not-for-profit organisations with low overheads and access to donations, community support and volunteers. The Division of Mental Health Alcoholism and Drug Dependency Services should operate and partner with private providers to operate Club House operations on all three islands. Club House and Wellness center programs are designed to provide a less intensive level of care. Drop-in Centers can offer group and individual counseling by MH professionals, plus a variety skill building activities.

a. Individual work towards rehabilitation goals (such as, learning to pay rent);
b. Class instruction in rehabilitative topics (such as, health & social skills);
c. Fun classes, activities, and fieldtrips (which are also rehabilitative for clients suffering social skills deficits or depression).

Acute Care-Day Treatment Hospital (Partial Hospital Program)

The focus of Acute Care Day Treatment / Partial Hospital Program is to provide an intermediate level of care that offers the intensity and structure of an inpatient acute program, with the less restrictive environment of outpatient care. Treatment during a typical day may include group therapy, psychological-educational groups, skill building, individual therapy, and psychopharmacological assessments with daily check-ins. Acute Care Day treatment centers should provide:

1. Day Treatment Facility with 24 hour, 7 day per week services.
2. Crisis Intervention Mobilization Unit and Mobile Van.
3. Daily Intervention and Treatment.
4. Case Workers working closely with Case Management Programs.

2.1 (g) Long Term Care for Adolescent and Adults

Investigate and research by developing a **feasibility study** on the possibility of returning all Adolescents and Adults to the Territory so that they may be housed and treated in facilities within the V.I. Community. This should include appropriate forensic (medium secure) mental health services.

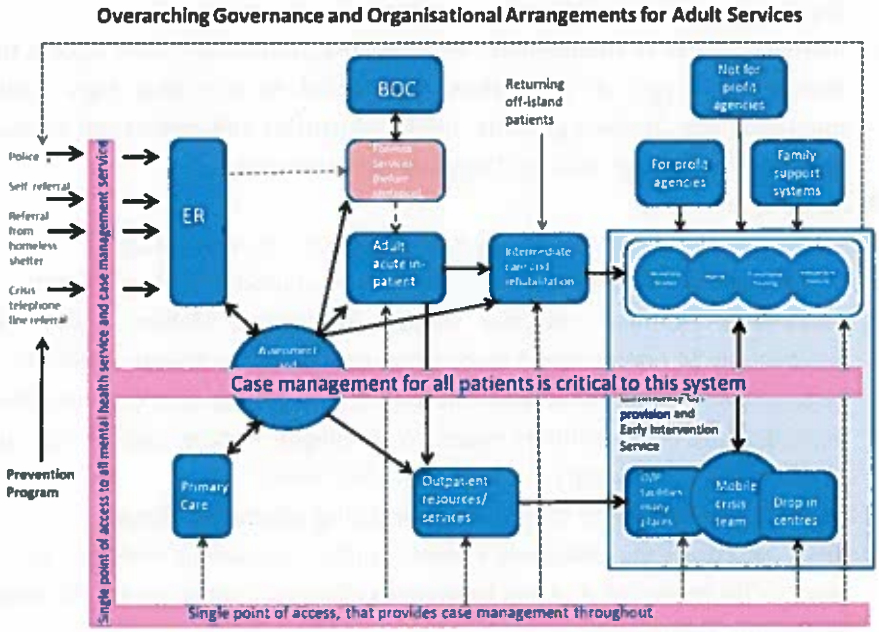
2.1 (h) Purchaser and provider of Mental Health Services

The MHPTF is an overarching body that represents all government agencies. It thus has (at least initially) a largely 'purchaser' role, although some aspects of the mental health system's functions are performed by the DOH and DHS directly. It is recommended that the MHPTF establish a clear purchaser-provider separation internally and that the purchaser functions (i.e. the buyer and 'specifier' of services) is kept separate from the provider functions. This will avoid the tendency for the provider side to influence the purchaser side to the potential detriment of patients'/consumers' care.

2.2 Outline pathway for service users/consumers through the service

The diagrams below show the present pathways through the service (Diagram 1) and the proposed case management arrangements proposed.

Diagram 1: the proposed case management arrangements for the consumer/patient/service user.



2.3 Outline detailed year by year description of the Five Year Strategic Plan

Appendix 3 provides a detailed timeline for the year by year investment in service and personnel development.

2.4 Opportunities for Improvements in System Coordination and Care

The following opportunities were identified to establish better coordination and care.

1. **Develop and adopt universal standardized protocols:** promoting standards of care that are used widely across the community to streamline information collected and promote best practices.
   (a) The involuntary commitment process will be revised and standardized so that it is understood by everyone
   (b) The protocols which lead to the release of an involuntary commitment patient will be clarified and codified.
   (c) Discharges will be planned and coordinated. There will be no more discharges to the 'street'.
2. **Increase access to services:**
   (a) establish a "**no-wrong door**" approach to better coordinate available resources.
   (b) **Open the in-patient unit** at JFLH on St Croix or set up a temporary alternative on St. Croix, as soon as possible, appropriate to the needs of the consumers and caregivers. The in-patient psych unit at JFLH should be the correct size for the community.
   (c) **Increase access to medication:** ensuring that individuals have access to the appropriate dosage and types of medication is essential to providing high quality treatment for mental illness. Tracking patients' medical histories and medication through technology will also improve through managed behavioral health care.
3. **Reduce Stigma**

   The better informed the community is, the easier it is to reduce stigma.
   (a) Provide **Mental Health First Aid** training with an appropriate group of staff;
   (b) Establish a 24 hour consumer support **Telephone Hotline**. This will provide an inexpensive 24 hour support to give consumers and caregivers a place to talk, provides instant knowledge about and referrals to all existing services, and provides instant intervention in emotional crises. A Telephone Hotline can be run on a mixed professional and para-professional volunteers.
   (c) Continue providing and strengthen **parenting education classes**.
   (d) Create **relationship education** classes, couples counseling retreats, etc. These do not have to be expensive and can be done as easily as a public access TV show that focuses on healthy relationships.
4. **Develop the Workforce**
   (a) Strengthened primary care behavioral health integration should be achieved

through development of new types of workers to deliver behavior change services.

(b) **Behavioral Health Specialists** based in the primary care setting can perform assessments, brief treatment, service planning, consultation and communication with the care management team and possess an understanding of self-care requirements for individuals with chronic diseases.

(c) It is proposed that the MHPTF seek to **increase the numbers of staff undertaking Master level counseling programs** at UVI. The MHPTF and relevant agencies should consider training local counsellors and therapists through the UVI.[5] The Virgin Islands has always had a deficit of psychologists and psychiatrists and PhD level social workers and therapists, because the VI is too small and salaries are insufficiently competitive to attract such professionals. UVIs counseling master's degree program could be expanded beyond school age settings and include concentrations in adult and family counseling.

(d) UVI could be requested to **provide courses** in working with trouble teenagers, working in residential care settings, working in correctional settings, working with people with autism, working with people with dementia and similar progams.[6]

5. **Residential Facilities**

(a) Both sites at Eldra Shulterbrant, the original facility and the Appendix, should be fully utilized for the long term chronically mentally ill. The original facility should include some segregated rooms that house a step-down program for integrating clients back into their home community. An older citizens (geriatric) residential unit for older chronically mentally ill persons should be established.

(b) Local youth residential facilities should increase their capacity to take higher needs consumers thus reducing the number of youths sent for long term treatment off-'island'. Step-Down/Transitional Care Facility (for youth) should be established.

6. **Provide Family Support**

(a) Family support efforts increase knowledge and strengthen family member's ability to care for mentally ill family members and go a long way towards extending the services of the government. These services are inexpensive and cost effective and fairly easy to provide.

(b) Family Education group training should be regularly available-such as Mental Health First Aid or the 12 session caregivers training provided by ARC.

(c) A family caregiver's support group should be established if not in operation on each island with weekly meetings, occasional trainings, resource library and if possible some baby sitting

[5] Thirty years ago most teachers were recruited from the mainland and we turned that around by teaching locals. UVI already has a MA counseling level program in their graduate school of Education. There are therapists in the VI who received their MA from UVI and then their PhD from an online program.

[6] These can be taken for degree credit in the MA program or taken alone outside of a degree track by persons working with those populations or just interested in the subject.

or respite care services.[7]

(d) Parent Cafés and other family strengthening activities will regularly occur that promote the 5 protective factors that support optimal family functioning.

7. **Housing**

(a) The MHPTF should make improved coordination between housing and behavioral health services a priority. Promoting recovery for individuals with mental illness and substance use disorders is highly dependent on the availability of a stable living environment. As a social determinant of health, poor housing is frequently associated with poor health. Housing is a large obstacle for people living with mental illness and substance use disorders as many are at risk for homelessness or have bounced between multiple unstable living environments.

(b) **Develop strategies for diversifying housing options in the community.** Although some housing options exist for individuals in recovery, there are very few options accessible. In order to meet the substantial need for housing, more resources are needed to establish a continuum of varied types of housing that will best meet the needs of individuals who are living with, or in recovery from, mental illness and substance use.

3. Synthesis

The Departments of Health and Human Services must be committed to the establishment of a comprehensive, integrated mental health and substance abuse system where all parts of the system serve each other and the system as a whole in order to create an array of services that optimally provides support for consumers of mentalhealth services and their families and are convinced that this can be achieved through the combined efforts of all parties, recognizing economic constraints and being dedicated to maximizing effectively all funding dedicated to the improving the mental health services delivery system.

September 2014

[7] The support group leaders function as an early warning system when a family member is going into crisis. While the family support programs can be operated mostly with a lower level of mental health professional - at Masters or possibly Bachelors level, it is good to have a higher level professional as a support to the group on an as needed basis.

The following individuals were members of the Consent Decree Commission who were instrumental in the creation of the Five Year Strategic Plan:

MEMBERS OF THE PLAINTIFFS' CLASS

BY: _____
David L. Pendergast, Ph.D., M.P.A
Expert Witness

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BY: _____
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Deputy Commissioner of Health, Lynette George, Co-Chair

Judy Bain, Ten Thousand Helpers, Co-Chair

Ms. Yvonne Woods, Assistant Director, Division of Mental Health, ESF

Mr. Jesse Forte, Unit Leader, Division of Mental Health, Christiansted Mental Health Clinic

Tina Blue, Occupational Therapist, St. Thomas

Sub-Committee on Clinical Services:

David Pendergast, Ph.D., Expert Witness for the Plaintiffs, Co-Chair

Doris Farrington-Hepburn, Director, Division of Mental Health, Co-Chair

Elsie DeNova, Assistant Director, Division of Mental Health

Dr. Brent Woodward, Ed.D., Psychologist, Division of Mental Health

Carnell Troutman, Unit Leader, Division of Mental Health, Frederiksted

Sub-Committee on Housing:

Commissioner of Human Services, Christopher Finch, Co-Chair

Sonia Aubrey, NAMI, Co-Chair

Sub Committee on Hospitals:

Atty. Royette Russell

Dr. Derek Spencer, Psychiatrist, St. Thomas

Dr. Olaf Hendricks, Psychiatrist, St. Croix

Ddr. Evadne Sang, Psychiatrist, St. Croix

St. Thomas Hospital

Mr. William McKenzie

Contributors to the Sub-Committees

Dr. Olaf Hendricks, Psychiatrist, St. Croix

Sedonie Halbert, Director of Adolescent Unit, Sea View Nursing Home

Contractor:

Bert Powell of Athena Consulting Services of St. Thomas

Non Profit Organizations

Chairman Liston Davis

NAMI St. Thomas

*Rooney "Buckey" Rhymer

NAMI St. Croix

10,000 Helpers

PAIMI Council Members for the years 2002-2014

Dale Garee

Horatio A. Millen, M.D.

Cornel Troutman

Special Thanks to :

Professor Christopher Heginbotham

David Pendergast,Ph.D

Ms. Doris Farrington Hepburn

Appendix 1. Membership of the Mental Health Policy Task Force

Co-Chairs

1) Commissioner of Health – Co-chair
2) Commissioner of Human Services – Co-chair
3) Representative selected from Plaintiff Class-Co-Chair

Government of the Virgin Islands

4) Director, DOH Division of Mental Health
5) Governor's Mental Health Policy Advisor

Semi-Autonomous Agencies

5) UVI designee with mental health/psychology expertise
6) JFLH representative from inpatient psychiatric services
7) RLSMC representative from inpatient psychiatric services

Affinity Groups

8) Two Non-Governmental Representatives from the Continuum of Care on Homelessness Advocacy Groups
9) Representative from VI Psychological Association

In time, advocacy groups can be included as independent watchdogs or monitors once the tasks outlined under the strategic plan have been completed.

Public Mandates

Four of the Mental Health Policy Task Force's membership are organizations that have a public mental health mandate. They are:

- JFLH – In–patient acute mental health care services
- RLSMC – In-patient acute mental health care services
- Department of Human Services – residential mental health services to children and adolescents, emergency and ongoing services to senior citizens, adults with disabilities and the homeless.
- Department of Health – overall GVI responsibility for mental health and substance abuse services with special responsibility for adult mental health services.

Appendix 2. Timeline of activities required to implement the five year strategic plan

See the tables below.

	Year/ Quarter	Start dates for headline activities within the overall timeline	Notes
	Start Year 1	**Begin implementation of the Plan**	
1	**Q1**	1. Establish as soon as possible a new Mental Health Policy Task Force to oversee the development of the five year strategic plan and to tackle the seven key points in section 2 of the main report above. 2. Seek funding for the proposals outlined here from the Legislature	Involve the Governor's Office, DOH, DHS, DOJ, private hospitals, professional groups, and other staff.
		3. Begin process of improving primary care provision and develop screening and assessment by primary care staff 4. Begin establishing a case management system as soon as possible with a 24 hour/7 day single point of access into the mental health system for both of St Thomas and St Croix (and with appropriate arrangements on St John) serving consumers, families and the general public by facilitating access to the system and making available information in regard to services throughout the involvement of an individual patient with services. 5. Link the case management system to a 24-hour emergency mental health services contact through both outpatient services and hospital emergency rooms. 6. Link Emergency room triage to the two (STT and STX) single points of access (and vice versa). 7. Assist Juan F. Luis Hospital on St Croix to re-establish an acute in-patient unit	Start immediately. The establishment will take approximately one year and should be done hand in hand with the discussions on the proposed new Mental Health Policy Task Force. These four areas are linked as they form the backbone of a new cohesive service. This will also assist in developing a prevention Program (secondary prevention)
		8. Begin process of improving the continuum of substance misuse services 9. Continue rehabilitation provision at Eldra Schulterbrant facilities.	VDC Environmental Scan Priority 3
2	**Q2**	1. Continue to augment staffing in DOH DMHADDS 2. Promote training and on-going professional development through development of UVI relations by • Establishing and appointing a senior Training Officer to develop and and/or purchase appropriate training for staff. 3. Aim for inclusion and representation on behalf of the mentally-ill patient population by: • Establishing and appointing a Complaints Officer to assist in resolution of disputes and responsible for: • conducting an annual survey of consumer attitudes; • setting-up mechanisms for obtaining feedback and suggestions from consumers.	DOH
3	**Q3**	1. Continue with negotiations on the case-management	

	Year/ Quarter	Start dates for headline activities within the overall timeline	Notes
		arrangements integrating and improving coordination of primary, community and in-patient care and bring forward draft legislation if needed. 2. Begin development of a comprehensive prevention program working with primary care. Develop a primary care strategy and consider establishing primary care as first line service 3. Begin development of an outpatient program as the heart of the service on St Thomas, St John and St Croix 4. Develop a plan for improved tendering and contractual arrangements with NGOs[8]	DOH initially but becomes responsibility of new agency depending on whether one of the restructuring options is chosen.
4	**Q4**	1. Plan the establishment of day hospital treatment program on St Thomas and St Croix. 2. Consider additional staffing based on the mobile units. 3. Review data and record keeping (report in time to start comprehensive data from the beginning of Year 3) 4. Review Billing staff availability	
	Year 2		
5	**Q1**	1. Undertake a feasibility study on providing additional beds for youth and adults to enable repatriation of off-island consumers. (Follow through Y2Q1-1) 2. Obtain an auditing agency to perform regulatory oversight.	Important function (see section 2.1(b) above).
6	**Q2**	1. Establish and make operational a telephone helpline, 2. Establish an Early Intervention Team on St Croix. 3. Ensure that UVI is offering specialised counseling courses form August 2016	VDC Environmental Scan Summary Table.
7	**Q3**	1. Ensure that JLFH in-patient unit is functioning. 2. Ensure that the Transitional Home is operational. 3. Ensure the Eldra Schulterbrant facility is fully operational and can relocate off-island consumers/patients. 4. Initiate collaboration with UVI/Medical School to develop courses to serve the development of improved mental health care with the VI. 5. Ensure Mental Health First Aid courses are being offered	Essential to bring the services together, to save money and to integrate primary, community and hospital care in a seamless service.
8	**Q4**	1. Review the functions of all community support and home care services. 2. Develop transitional living arrangements and provide transitional and step down services. 3. Ensure that Family Caregivers Support Groups are established	See VDC Environmental Scan (Behavioural Health Continuum of Care, Priority 1) Need to negotiate cost control

[8] NGO – non-governmental organisation

	Year/ Quarter	Start dates for headline activities within the overall timeline	Notes
		and operating on all three islands. Establish Family Strengthening services and provide access to free prescriptions for patients/consumers.	with Medicaid and Medicare
	Year 3		
9	**Q1**	1. Establish one Day Treatment Hospital centres on St Thomas and two centres on St Croix initially, with a fourth on St John. 2. Ensure that UVI is offering Counseling courses 3. Begin data and record keeping on new format	Relate to Y2Q1 feasibility study.
10	**Q2**	1. Establish a further Assertive Outreach Team (AOT) on St Thomas and an additional EIT on St Croix. 2. Ensure that all local residential programs are certified by CMS and other federal agency	Important to ensure that all local residential agencies are eligible for grants to increase their capacity especially to care for the harder to manage patients/consumers
11	**Q3**	1. Begin planning specialty units for children's services and geriatric services.	
12	**Q4**	1. Review and begin improvements in employment services via not-for profits and private providers. 2. Ensure regulatory audit is operational and providing independent oversight of the delivery of the mental health services.	
	Year 4		
13	**Q1**	• Begin planning for a nursing home for elderly chronically mentally ill patients/consumers.	
14	**Q2**	• Specialty units for Children, and Geriatric outreach in place and operational.	
15	**Q3**	• Establish further collaboration and partnership with local residential providers to increase capacity.	
16	**Q4**		
	Year 5		
17	**Q1**	1. A robust mixture of prevention, education and family strengthening programs will be operational,	

	Year/ Quarter	Start dates for headline activities within the overall timeline	Notes
		including: • A telephone hotline • Day Hospital Treatment programs on each island • Family Caregiver support programs on each island • Mental Health First Aid and other educational programs offered regularly Parenting education and parent support programs regularly available	
18 – 20	Q2-Q4	2. Either a NGO or the Division of Mental Health shall be operating at least two clinics on St Croix and St Thomas and one clinic on St John. 3. Specialty units of children services and geriatric services are in operation. 4. An ongoing Educational Program and Behavioral Health on local radio and television networks. 5. Both hospitals have fully functioning in-patient units. Discharge planning is working well. 6. Both Eldra Shulterbrant facilities are being fully utilized. 7. Local residential programs have begun to increase capacity. Fewer clients are being sent for off-island treatment and some stateside placed clients have been transferred home. 8. UVI's Counselling MA degree program is graduating students prepared to work in these new services. Other program staff is increasing their skills through taking counselling classes. 9. Nursing home units are established to care for patients and chronic geriatric mental illness.	

Appendix 3. Goals and Activities

The goals listed here are those set out in the Clinical Services Sub Committee Report 2011. Please see that report for further detail.

Goal 1: Quality Care. Includes parallel activity to the implementation process, and obtaining and ensuring practices are of high quality.

Goal 2: Access to Care/Services. This goal is focussed largely but exclusively on systems development

Goal 3: Provide intake screening and assessment. This goal must be a linked development to Goal 11

Goal 4: Evidence treatment modalities. This goal is focussed largely on early intervention and outpatient service development, which is one of the foci of Appendix 2.

Goal 5: Professional development. This goal focusses on high quality mandatory training and must be a requirement of the program.

Goal 6: Family support. This goal should be read as offering family and community support and is related to Goal 11 on community oriented service development. Link to Goal 4 and see Appendix 2.

Goal 7: Program governance. This goal is essential but is not part of the initial program plan.

Goal 8: Financing. This goal must be integrated with the developing model of care and is an essential prerequisite to any investment.

Goal 9: Program monitoring and evaluation. This is related to Goal 7 and must be built in to the later program plan.

Goal 10: Client Dispute Resolution Procedure. This goal is essential and will be included on a second cut of the program plan. However a Complaints Office post is included in the early program development (see Appendix 2, Y1Q2).

Goal 11: Continuum of care: the overall model of care must be specified clearly. This is the remit of Appendix 2 which includes all the service development proposals in a single table.

Appendix 4. DOH Mental Supplemental Budget Request FY'15

U.S. VIRGIN ISLANDS DEPARTMENT OF HEALTH

Mental Health Supplemental Budget Request
Fiscal Year 2015

EXECUTIVE SUMMARY

In 2006, a class action suit was filed for declaratory and injunctive relief brought under the American and Disability Act. It was stipulated and agreed that a Commission comprising of members of the Defendant and Plaintiff class would be established to develop a comprehensive strategic five year plan for the prevention and treatment of mental illness.

The mission of the strategic plan is to create a system of that meets the United States Supreme Court's Olmstead case standard which affirms the right of individuals with disabilities to live in their community, supports communication, cognitive skills, resilience to problems and self sufficiency for individuals who have mental health issues through the Division of Mental Health, Alcoholism and Drug dependency under aegis of the Virgin Island's Department of Health, the Hospitals and those provided by the Department of Human Services .

A number of possible models were canvassed in the interim report and were considered and debated at the Consent Decree Commission meetings. Recently, the Defendants developed and proposed as an option, the development of an **Integrated Mental Health System.** The proposal includes the reestablishment of a *Behavioral Health Interagency Council/Board* to build strong local partnerships and a better integrated and coordinated with other service systems. It is important to leverage local resources and develop partnerships to change service delivery and coordinate

community efforts. The advantages of this option are:

- Collaboration is mandated by statute
- Each agency would not make major changes to its structure or organization
- The duplication of services would be avoided
- A continuum of patient care would be ensured

The five year strategic plan outlines yearly goal and objectives. The following is a supplemental budget request and cost estimate of the goals and objectives outlined in the ***first year*** of the **Integrated Mental Health System Proposal:**

I. Re-established of DOH's Day Treatment Centers /Services on each island.St. Croix, St. Thomas and St. John.
II. Creation of Case management Program-DOH
III. Re-established JFLH Behavioral Health Unit.

Mental Health Consent Decree: Year One Goals and FY'15 Proposed Budget

Virgin Islands Department of Health: Mental Health Services

I. **DOH's Day Treatment Centers /Club House Services:**

A. District: St. Croix

Site: Re-opened/Renovated Club House

Service-delivery Paradigm: Provision of rehabilitative and occupational therapeutic services for behavioral health clients.

Client Population: Adult

Program Capacity: 25 Clients

Staff per Program

Administrator	$65,000:
Occupational Therapist	$37,571
Social Worker	$45,222
Cook-II	$25,254
Total	**$173,047**

Fringe Benefits: **$36,936**

Supplies

Food	$40,000
Rehab Supplies	$15,000

Other

A/ C Units	$7,000
Improvements	$5,000

B. District: St. Thomas
Program Site #1: Clear Blue Sky, Inc. (Executed Professional Service Contract)

Service-delivery Paradigm: Managed-Care & Step-Down Services

Client Population: Adult

Agency Capacity: 20 participants

Referral Source(s):

Barbel Plaza South Mental Health Outpatient Clinic

St. Thomas East End Health Center

Morris de Castro Clinic

Estimated cost: $1700 p/m *12 = $20,400

Program Site #2: Karen House (Executed Professional Service Contract)

Service-delivery Paradigm: Residential services

Client Population: Adult

Agency Capacity: 10 participants

Referral Source(s):

Barbel Plaza South Mental Health Outpatient Clinic

St. Thomas East End Health Center

Morris de Castro Clinic

Estimated cost: $2000.00 p/m x 12 = $24,000

C. **District:** **St. John**:
Site: Morris de Castro Clinic

Service-delivery Paradigm: Managed Care

Client Population: Adult

Program Capacity: 20 Clients

Estimated cost: $1500 p/m x 12 = $18,000

Administrator	$65,000
Occupational Therapist	$37,571
Social Worker	$45,222
Cook-II	$25,254
Total	**$173,047**
Fringe Benefits (total):	**$36,936**
Supplies	
Food	$40,000
Rehab Supplies	$15,000
Total	**$55,000**

Other	
Retrofitting	$45,000
Total	**$45,000**

II. **Provision of case management services.**

(2) Case Managers @ $45,000.00 ea. = $90,000.00 per annum

Fringe Benefits: $18,734

Governor Juan F. Luis Hospital and Medical Center

Inpatient acute care behavioral health services are a critical component of any Mental Health System. The Inpatient behavioral health services at the Gov. Juan F. Luis Hospital and Medical Center was suspended for various reported challenges. JFLH Administration has expressed plans and interest in re-establishing its inpatient mental health services. The following is a projected cost analysis to re-establish the services within 90 days.

III. **JFLH Behavioral Health Unit**

- Unit is under a construction zone and will it will cost about $750,000- $1million; can be completed in 90days.
- Building spec will have to be in compliance with CMS, Staffing and clearance from CMS to reopen.
- FTE requirements- 9RNs and 4tech-$850,000 for a 4-5 bed unit

In summary, the Department of Health is facing its opportunities for improvement with a renewed sense of optimism and determination to enhance and build sustainability systems to improve the infrastructure of the USVI Department of Health. Enclosed, is the Divisions' 2013 Annual Reports.

The Mental Health Consent Decree Commission members are committed to the establishment of a comprehensive, integrated mental health and substance abuse system where all parts of the system serve each other and the system as a whole in order to create an array of services that optimally provides support for consumers of mental health services and their families. However, funding and resources are essential investments needed to achieve and successfully implement the proposed **Integrated Mental Health System** and the prevention of another class action claim against the Government of the Virgin Islands.

Appendix 5. Retro Claim Proposal and Bill No. 30-0501

THE UNITED STATES VIRGIN ISLANDS

OFFICE OF THE GOVERNOR
GOVERNMENT HOUSE

Charlotte Amalie, V.I. 00802
340-774-0001

September 12, 2014

VIA HAND DELIVERY

The Honorable Shawn Michael Malone
President
30th Legislature of the Virgin Islands
Capitol Building
St. Thomas, V.I. 00802

Re: Legislative Proposal to provide appropriations in FY 2015 to be apportioned Between the Department of Health, Department of Human Services, Health Partners and Affiliated Health Agencies Funding Initiatives

Dear Senator Malone:

In accordance with Section 11 of the Revised Organic Act of the Virgin Islands of 1954, as amended, I submit to the Thirtieth Legislature the enclosed proposed measure to partition the use of $19,941,076.50 million received as part of services paid by the Government of the Virgin Islands in fiscal years 2009 through 2012.

This legislation provides for an appropriation of retro claim funds, which we are able to access after an exhaustive audit, targeted to the health centers, hospitals, and affiliated partners as a one-time grant funding to specific projects and initiatives. As these funds are essentially a one-time occurrence based on an audit, it is important that these amounts are not incorporated into the base funding of each entity or become a part of the Government's annual budget whether

Transmittal to Senate President Malone
Legislative Proposal to provide appropriations in FY 2015to be apportioned Between the Department of Health, Department of Human Services, Health Partners and Affiliated Health Agencies Funding Initiatives Proposal

September 12, 2014

Page 12

outright or as matching funds except where funds are already earmarked for other health initiatives.

The apportionment of these funds takes into account the critical need in our community to address the interlocking relationships of critical healthcare coverage, mental health needs, our seniors, early childhood efforts and our juvenile rehabilitation requirements. Also, the measure will provide funding for Ingeborg Nesbitt Health Clinic and the East End Health Clinic initiatives in partnership with the Department of Human Services ("DHS") and the Department of Health's ("DOH") current plan for the Patient Centered Medical Home model in which DHS will refer new and existing Medicaid beneficiaries to them for primary care services. These funds will also provide additional medical and case management staffing needed to support new medical expansion enrollees and will constitute a portion of local matching Medicaid funds required on an annual basis to draw-down designated Medicaid and Affordable Care Act funds for the Territory.

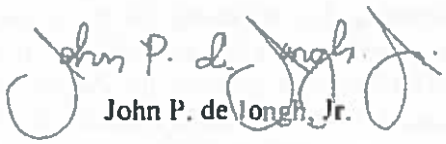
This proposed use of funds follows deeply set priorities of the Government to provide access to healthcare coverage on a consistent basis to those most in need, while achieving the shared goal of reducing our uncompensated health care costs and thereby allowing us to better allocate our limited resources. The framework provides additional funding to the Governor Juan F. Luis Hospital and Medical Center, to Schneider Regional Medical Center and DOH to address areas of the Territory's mental health inpatient and outpatient care improvement initiatives. Other uses address a pressing elder care need and assist the hospitals by reducing the incidence of senior citizen boarders at their facilities. Instead, a home-based alternative Jong term care program will be developed allowing our elders to spend more quality time with their families and in familiar surroundings as they advance in age. The measure also allows for the completion of a variety of early childhood projects enabling us to meet federal regulations and to construct new buildings at the Youth Rehabilitation Center in St. Croix.

Finally, the measure allows for payments to be made to the Virgin Islands Water and Power Authority ("Authority") on behalf of both hospitals in order to further

reduce their severely past due accounts. Please note that the Fiscal Year 2015 appropriations for the Territory's hospitals in the attached draft legislation combined with the Fiscal Year 2014 supplemental appropriations provided to the Territory's hospitals for payroll, capital improvements, accounts payable and outstanding obligations owed to the Authority are combined but a fraction of what is required to ensure that we have a core healthcare system that provides quality patient care. We are at a critical stage with both hospitals and this funding and investment go a long way towards this goal.

I look forward to working with you and other members of the 30th Legislature in the prompt consideration and approval of this important and timely measure.

Sincerely,



John P. de Jongh, Jr.

Governor

Enclosure

BILL NO. 30-0501

THIRTIETH LEGISLATURE OF THE VIRGIN ISLANDS

Regular Session

2014

An Act appropriating retro claim funding to the Department of Health, the Department of Human Services, Schneider Regional Medical Center, Governor Juan F. Luis Hospital & Medical Center, St. Thomas East End Medical Center Corporation, Frederiksted Health Care, Inc. and for other health care and social welfare services and for other related purposes

---0--

Be it enacted by the Legislature of the Virgin Islands:

WHEREAS, the Virgin Islands Medical Assistance Program (VIMAP) was able to claim retroactive federal funds as a result of a multi-year account reconciliation and review from several of the territory's health care agencies that participate in the Medicaid Program resulting in $15,893,727.50 for services and administration; and

WHEREAS, the VIMAP was additionally able to retro claim for services provided specifically to the beneficiaries of the Children's Health Insurance Program (CHIP) in the amount of $4,047,349 for the years 2007-2012; and

WHEREAS, the VIMAP also retro claimed funds from the July 1, 2011 Affordable Care Act adjusted rate in federal match rate for the territory's from 50% to 55% for medical services; and

WHEREAS, the distribution of the Virgin Islands Medical retro claim funds will occur as a "one time" payment to specified agencies and will remain available until expended. These funds will be utilized to increase the quality of health care and social services offered to the residents of the Virgin Islands territory; Now, Therefore,

Be it enacted by the Legislature of the Virgin Islands:

2

SECTION 1. The sum of $19,141,076.50 from retro claim funding received in September 2014 from the reimbursement of federal Medicaid funding for the fiscal years 2009, 2010, 2011 and 2012 is appropriated for the fiscal year ending September 30, 2015 as follows:

(1) $4,000,000.00 to the Governor Juan F. Luis Hospital & Medical Center, as set forth below:

(A) $2,500,000.00 for general purposes;

(B) $1,500,000.00 to be paid directly to the Virgin Islands Water and Power Authority on behalf of the hospital.

(2) $4,000,000.00 to the Schneider Regional Medical Center, as set forth below:

(A) $ 5 2,500,000.00 for general purposes;
2 0
, 2

(B) $1,500,000.00 to be paid directly to the Virgin Islands Water and Power Authority on behalf of the hospital.

(3) $1,000,000.00 to the Virgin Islands Department of Health - For mental health programs to include: care coordination, completion of the Eldra Schulterbrant residential facility renovations and clubhouse programs and for the implementation of care coordination services for the Enhanced Medicaid Program via a patient centered medical home.

(4) $250,000.00 to the Frederiksted Health Center for implementation of care coordination services for the Enhanced Medicaid Program via a patient centered medical home.

(5) $250,000.00 to the St. Thomas East End Medical Center for implementation of care coordination services for the Enhanced Medicaid Program via a patient centered medical home.

(6) $7,941,076.50 to the Virgin Islands Department of Human Services, as set forth below:

(A) $72,600.00 to construct four (4) buildings at the Youth Rehabilitation Center in St. Croix, as set forth below:

(i) $729,300.00 for one (1) administration/intake /clinic building;

(ii) $598,500.00 for one (1) classroom; and

(iii) $1,744,800.00 for two (2) living pods of 10 cells each.

(B) $1,360,000 for a pilot home based program for frail senior citizens.

(C) $2,618,476.50 for the Government of the Virgin Islands' Matching Funds to the various Medical Assistance Program initiatives:

(i) Expansion of recipients and to provide the general fund portion of required match to cover the health care costs to expanded beneficiaries;

(ii) The Integrated Eligibility and Enrollment System; and

(iii) The consolidation of all family assistance programs.

(D) $150,000.00 to finish the new Claude O'Marko Head Start site with a playground and to renovate or replace playgrounds at other Head Start sites, as determined by the Department of Human Services.

(7) $6,240,000.00 to assist in covering the anticipated increased cost of the Government's health insurance.

SECTION 2. Any refund from CIGNA to the Government of the Virgin Islands as reimbursement for overpayment of premiums must be paid into the General Fund, with the sum appropriated in Section 1, paragraph 7, $6,240,000.00 to be first allocated as follow:

(1) $1,000,000.00 to the Governor Juan F. Luis Hospital and Medical Center to rebuild and restore the acute care inpatient psychiatric unit;

(2) $1,000,000.00 to the Schneider Regional Medical Center to be used as follows:

(A) $400,000.00 for the development of a pilot day hospital program for adults with mental illness; and

(B) $600,000 for general purposes;

(3) $500,000.00 to the Virgin Islands Department of Health - For mental health programs to include: care coordination, completion of the Eldra Schulterbrant residential facility renovations and clubhouse programs and for the implementation of care

coordination services for the Enhanced Medicaid Program via a patient centered medical home; and

$3,740,000.00 to the Virgin Island Department of Human Services to be used as follows:

(A) $3,000,000.00 to construct four buildings at the Youth Rehabilitation Center in St. Croix;

(B) $640,000.00 for the pilot home based program for frail senior citizens;and

(C) $100,000.00 to finish the new Claude O'Marko Head Start site with a playground and to renovate or replace playgrounds at other Head Start sites, as determined by the Department of Human Services."

SECTION 3. The sums appropriated in Section 1 remain available until expended and are "one time," non-recurring awards.

Thus passed by the Legislature of the Virgin Islands on September 30, 2014. Witness our Hands and Seal of the Legislature of the Virgin Islands this 2nd Day of October, A.D., 2014.

Shawn-Michael Malone
President

Janette Millin Young
Legislative Secretary

Appendix 6. Consent Decree Clinical Services Report 11-29-2011

CONSENT DECREE - MENTAL HEALTH SERVICES

Five Year Strategic Plan: Clinical Services (Children & Adolescent Services)

Vision Statement: To provide comprehensive Mental Health, Substance Abuse and Prevention Services to the residents of the U S Virgin Islands.

Mission Statement: The mission of the Division of Mental Health, Alcoholism & Drug Dependency Services is to provide hope and help to all persons in the U.S. Virgin Islands who strive to overcome the disabilities and problems associated with mental illness, alcoholism and/or drug dependency.

GOALS

GOAL #1:	*GOAL #2*:	GOAL #3:	GOAL #4:	GOAL #5:
QUALITY CARE **Provide and increase access to quality mental health care for Families, Children and Adolescents in the Virgin Islands**	**INTAKE ASSESSMENT/SCREENING AND CASE MANAGEMENT** **Provide Intake, Screening and case management services to children & Adolescents**	**STANDARDIZED ASSESSMENT INSTRUMENTS** **Provide standardized assessment instruments for Children & Adolescent that are evidence-based**	**TREATMENT MODALITIES** **Provide an individualized Plan of Care for each child and adolescent with Serious Emotional**	**STAFF TRAINING AND DEVELOPMENT** **Ensure that all staff working with Children & Adolescents receives training that's evidence**

OBJECTIVES					
	1.To establish a separate building/facility for Children and Adolescents 2. To develop MOU's with Mainland Universities, University of the Virgin Islands (UVI) and PR to provide students who need internships in clinical training 3. To increase services to children and their families to include evening hours. 4. To strictly adhere to HIPAA guidelines 5. To provide a 24 hour 7 days a week Children & Adolescent emergency services	1.To provide a complete Intake & Assessment including Mental status Examinations. 2. To utilize projective tests and Personality Inventories. 3. To use cognitive/Behavioral Instruments. 4.To utilize Neuropyschological Instruments 5. To Provide Case management/Outreach Services 6. To utilize the WISC-IV and other standardized Intelligence Tests.	1.To provide Behavioral and Focal Assessment Instruments. 2. To provide and conduct Computer- Assisted Assessments. 3. To provide Assessment of Anxiety and its Disorders in Children and Adolescent. 4. To provide Assessment of Hyperactivity/Attention Deficit Disorders	1. To develop treatment plans that include individual, group and/or family therapy. 2. To provide Problem-specific group therapy. 3. To provide Family-focus treatment 4. To provide Multi-Systemic Therapy 5. To provide Family Functional Therapy Programs. 6. To provide Hyperactivity/Attention Deficit Disorder Treatment including Pharmacological interventions. 7. To provide Day Treatment programs for children & adolescents	1. To develop staff training in the implementation of evidenced-based treatment programs. 2. To Provide training in Cognitive Behavioral Therapy 3. To Provide training in the treatment of Co. occurring Disorders in Adolescents 4. To Provide training in Brief Strategic Family Therapy 5. To provide training in Grief, Loss and Trauma counseling.

CONSENT DECREE - MENTAL HEALTH SERVICES

Five Year Strategic Plan: Clinical Services (Children & Adolescent Services)

Vision Statement: To provide comprehensive Mental Health, Substance Abuse and Prevention Services to the residents of the U S Virgin Islands.

Mission Statement: The mission of the Division of Mental Health, Alcoholism & Drug Dependency Services is to provide hope and help to all persons in the U.S. Virgin Islands who strive to overcome the disabilities and problems associated with mental illness, alcoholism and/or drug dependency.

GOALS

GOAL #1;6:

FAMILY SUPPORT

Families have intensive networks and resources that support the overall well being of our patients.

***GOAL #7*:**

PROGRAM GOVERNACE

Operation of DMHADDS in accordance with established law, executive orders and funding mandates.

GOAL #8:

FINANCING

Expenditure of all awarded monies, federal and general fund, In accordance with established VI Government systems of accountability.

OBJECTIVES			
	1. To encourage family's involvement in treatment planning. 2.To develop Wrap-around services. 3. To Provide Family Support Education 4. To Organize Parents Support Groups. 5. To Provide Technical Assistant Training for Family Members. 6. To advocate for families with other agencies who provide assistance. 7. To encourage families to be involved in all levels of care.	1. To deliver mental health services to children & adolescents in accordance with stated goals and objectives proffered and so accepted within the approved respective grant application(s). 2. To provide mental health services guided by the stated terms and conditions stipulated in the Notice of Grant Award	1.To expend awarded funding pursuant to required stipulations of the funding grantor at the local and federal levels. 2. To provide funding by the USVI Government for the treatment of children & adolescent with serious emotional disturbances. 3. To seek funding outside of the Territory via public and grant sources.

Mental Health Screening for Children

Since the establishment of the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit in 1967, federal Medicaid law has provided for coverage of regular well-child visits to assess both physical and mental health in children enrolled in Medicaid. The Omnibus Reconciliation Act (OBRA) of 1989 strengthened this benefit by establishing participation goals and reporting requirements. These two statutes have directed state Medicaid programs to offer regular well-child screenings, diagnostic and assessment services, and any medically necessary care, services, or treatment to correct or ameliorate problems uncovered in the course of screening and diagnosed through a clinical assessment.

In 2006, in the U.S. District Court case of Rosie 0. v Patrick, the court ruled that the Commonwealth of Massachusetts must use standardized evidence-based screening tools in the enforcement of the federal Medicaid directive to provide mental health screening at well-child visits.

The complaint also asked that the that all children covered by the Massachusetts Medicaid program have access to medically necessary mental health services in the home and community-based settings, in addition to the inpatient, outpatient, emergency and diversionary mental health services that were available. In regard to this aspect of the complaint, the court required that Massachusetts Medicaid must offer a specific set of home and community-based services for children with serious mental illness.

The court also ruled that mental health specialists must use a standardized assessment tool to assist with diagnosis and treatment planning.

The Value of Mental Health Screening

Up to 20% of young people suffer from a diagnosable mental disorder and one in ten suffers significant impairment due to mental illness. Epidemiological research has found the three-quarters of all lifetime mental illness begin by age 24, with half beginning by age 14. Yet in the United States today only 20 percent of all youth with a diagnosable mental disorder receive evaluation or treatment services.

The costs of this failure are substantial. According to a 2009 report from the Institute of Medicine (IOM), the annual quantifiable cost of mental illness among young people is more than $247 billion annually. While the financial toll is staggering, the human toll is worse. Suicide is the third leading cause of death for

youth ages 10 to 24, and mental illness accounted for more hospitalizations among young people ages 13 to 17 than any other condition in 2000. Mental illness in adolescence also has been demonstrated to result in significantly poorer long –term outcomes across a range of quality of life indicators, including physical health educational attainment and socio-economic status.

Mental health screening using validated tools provides an effective, evidence-based approach to increasing early identification and intervention, which can both improve outcomes and reduce the cost of mental illness. The IOM and the World Health Organization hold that early intervention in adolescence can reduce or even eliminate the manifestation of some mental disorders. Studies have also shown that treatment of mental health disorders in youth to be effective at reducing rates of substance abuse; improving school performance; decreasing physical or somatic complaints; and reducing morbidity and mortality. According to data cited by the National Institute of Mental Health, covering mental illness on the same basis as medical illness would cost $6.5, but this spending would result in savings of $8.7 billion to U.S. taxpayers. By expanding access to mental health screening as a routine component of preventative care, the United States could significantly improve access to early intervention and reduce both the human and financial toll exacted by mental illness.

In Massachusetts, a small pilot program that used a comprehensive integrated system of care including community based services for children and adolescents showed a threefold reduction in hospital inpatient days among Medicaid managed care patients and also a three fold reduction in residential stays.

After decades of research, we now know that there is a window of opportunity of two to four years between the first symptoms and the onset of the full-blown diagnosable disorder, when treatment is most effective at reducing the severity of specific disorders. Mental health screening holds the potential to intervene early, and in some cases, to prevent fully developed mental, emotional and behavioural disorders. If all children were given the opportunity to have a mental health check up at the yearly well-child exam, the identification of mental illness at its earliest stages would be greatly increased and the cost to the individual and society - an estimated $47 billion annually - would be greatly reduced.

*** Data in this report is condensed from Julianna Belelieu's report from TeenScreen National Center for Mental Health Checkups at Columbia University including direct quotations from the report.**

Mental Health Screening for Children on the United States Virgin Islands and the Pediatric Symptom Checklist

Pediatric Symptom Checklist

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional and behavioral problems in order that interventions can be initiated as early as possible. Parents, primary care doctors, pediatricians, nurses, teachers and mental health professionals can administer the PSC. It also can be self- administered by children from the ages of 11 to 16.

The PSC consists of 35 items that are rated as "Never," "Sometimes," or "Often" present and scored 0, 1, and 2 respectively. The total score is calculated by adding together the score for each of the thirty-five items. For children and adolescents ages 6 to 16, a cutoff score of 28 or higher indicates psychological impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher. The PSC has been found to be 95% accurate in identifying children having moderate to severe impairment in psychosocial function. The PSC has been studied and found valid and reliable with children from pre-school through age 16 with slightly higher validity rates for children over 6 years of age as compared to children less than 6 years of age (95% as compared to 85%). It has also been found valid and reliable in research for English-speaking, Spanish-speaking and Dutch-speaking populations of children. The PSC finds evidence of psychosocial impairment in approximately 30% of the population. **A positive score on the PSC suggests a need for further evaluation by a qualified health or mental health professional.** Finally, the PSC can be used as a screening tool and can also be used as an evidence-based outcome measure to measure outcomes post identification and treatment when compared to pre- treatment PSC scores.

Pediatric Mental Health Screening on the United States Virgin Islands

The Clinical Services Committee has recommended the use of the Pediatric Symptom Checklist, specifically and mental health screening in general as an effective means to identify children with psychosocial issues in order to recognize potential cognitive, emotional and behavioral problems at an early stage in life and intervene with the appropriate treatment. It has been shown that early identification and intervention with children may mitigate and even reverse symptoms in some forms of mental illness and in certain emotional disorders and ultimately result in cost savings to a society. It has also been show to greatly improve the quality of an individual's life. The PSC has proven to be a valid reliable method for increasing awareness of behavioral health problems across a variety of settings. It has also been shown to be a quick, easy, and effective way to screen large numbers of children and adolescents in resource-challenged, ethnically diverse areas. In a study conducted by Navon et al. reported in Psychiatric Services published by the American Psychiatric Association in 2000, about two-thirds of the children identified as having significant behavioral problems by the PSC were not receiving mental health services and one-half of the group identified as having severe to very severe emotional disturbance were not receiving mental health services. In the same study, the group of children and adolescence who received a positive score indicating psychosocial dysfunction on the PSC had an average of 25% more medical visits than children and adolescents who received a negative score. The costs of lack of treatment to an individual and society both in direct costs, lack of productivity and quality of life are dire.

The challenge for the USVIs is to administer the PSC to as many children and adolescents as possible in the Territories. The required medical screening for beginning school on the Virgin Islands might be one very powerful avenue to get this task accomplished. In Massachusetts, the mental health screening process for children and adolescents was endorsed and promoted by the Massachusetts Pediatric Association, as were trainings and psychiatric consultations. Medicaid in Massachusetts also promoted it. Beyond screening for the general pediatric population, screening for particularly vulnerable children in the USVIs, such as children of addicts and children whose families had been reported for child abuse are important to access in terms of identifying children in high risk of psychosocial impairment.

The ultimate goal is to identify those children and adolescents with the greatest needs and to develop a strengths-based comprehensive individualized plan of care for them.

Identification is the first step leading into an effective, coordinated treatment plan and subsequent measurable positive outcomes. The results of taking these steps in an integrated coordinated mental health system in the United States Virgin Islands will pay dividends across generations of people in the Territories.

DATE _____

CPLETED BY _____

NAME _____

RECORD# _____

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

	NEVER (0)	SOMETIMES (1)	OFTEN (2)

1. Complains of aches and pains	
2. Spends more time alone	
3. Tires easily, has little energy	3.
4. Fidgety, unable to sit still	
5. Has trouble with teacher	5.
6. Less interested in school	
7. Acts as if driven by a motor	7.
8. Daydreams too much	
9. Distracted easily	9.
10. Is afraid of new situations	
11. Feels sad, unhappy	11.
12. Is irritable, angry	
13. Feels hopeless	13.
14. Has trouble concentrating	
15. Less interested in friends	15.
16. Fights with other children	
17. Absent from school	17.
18. School grades dropping	
19. Is down on him or herself	19.
20. Visits the doctor with doctor finding nothing wrong	
21. Has trouble sleeping	21.
22. Worries a lot	
23. Wants to be with you more than before	23.
24. Feels he or she is bad	
25. Takes unnecessary risks	25.
26. Gets hurt frequently	
27. Seems to be having less fun	27.
28. Acts younger than children his or her age	
29. Does not listen to rules	29.
30. Does not show feelings	
31. Does not understand other people's feelings	31.
32. Teases others	
33. Blames others for his or her troubles	33.
34. Takes things that do not belong to him/her	
35. Refuses to share	35.

Total score_____

Doe' your d l ld haw any emotional or behavioral problems for which she/he needs help"---------- No Yes
Are there any services that you would like your child to receive for these problems? ---------- No Yes

If yes, what type of services?-----

"CMS Jellinek and J.M. Murthy Massachusetts General Hospital (http://psc.partners.org)

English PSC Gouverneur Revision OI -06-03

RESPONSE TO THE CONSENT DECREE, CIVIL #2003/182

CLINICAL SERVICES SUB-COMMITTEE

5-YEAR MENTAL HEALTH STRATEGIC PLAN

ADULT SERVICES/CARE

VISION:

To create a comprehensive, integrated mental health system where all the parts of the system serve each other and the system as a whole in order to create an array of services that optimally provides support for consumers of mental health services on the United States Virgin Islands, their families and all the citizens of the Territories.

MISSION:

To create a system of care that meets the United States Supreme Court's Olmstead case standard which affirms the rights of individual's with disabilities to live in their community, supports communication, cognitive skills, resilience to problems and self-sufficiency for individuals who have mental health issues administered through the Division of Mental Health, Alcoholism and Drug Dependency Services under the aegis of the Virgin Island's Division of Health.

GOAL #1: QUALITY CARE:

To insure provision of and access to comprehensive and integrated mental healthcare services for adults resident in the U.S. Virgin Islands.

OBJECTIVE(S):

1. To standardize and insure uniformity in out-patient services, policies, procedures and practices.

2. To insure complete and applicable therapeutic intervention in patients' treatment protocols.
3. To insure replication of services delivered pursuant to established standards of care viz. patients' diagnosis.
4. To identify standards of mental health protocols in programs nationwide towards possible adaption within DMHADDS.
5. To conduct ongoing needs assessments of mental healthcare services in regard to inclusion, accessibility and quality.
6. To collect data tracking services provided in order to monitor the effectiveness of the Mental Health Strategic Plan.
7. To monitor the operations of duly established mental health agencies/programs
8. To establish operating standards of care, insure compliance and patient's rights.
9. To insure adherence to patient's confidentiality and privacy consistent with HIPPA regulations.
10. To develop outcome indicators and generate data based on established mental health services data infrastructure.
11. To establish electronic data linkages amongst key agencies.
12. To offer clinicians opportunities for consultation, through electronic linkages (i.e., teleconference) with off-island mental health experts.
13. To insure routine bio-medical laboratory testing.
14. To insure admission, bi-annual and annual physical examinations.

GOAL #2: ACCESS TO CARE/SERVICES:

To eliminate barriers to service and/or gaps in care or treatment for people with mental illness.

OBJECTIVE(S):

1. To render billable to Medicaid, Medicare or other third-party payers for mental health services.
2. To offer a sliding-fee-scale as a viable option of payment for mental health services.
3. To increase mobility through coordination of ground transportation utilizing VI Trans & Dial-a-Ride, or such services.

4. To insure continuity in service delivery through appointment-scheduling.
5. To utilize the Clinicians-on-Call when assessing prospective clients.
6. To establish satellite mental health stations within public housing communities.
7. To deploy a mobile van in the performance of outreach services to mentally-ill persons, inclusive of referral to DMHADDS.
8. To establish and electronically link patient's treatment record consistent with HIPPA regulations; thus insuring access to and continuity of care throughout DMHADDS.

Goal #3: TO PROVIDE INTAKE, SCREENING AND ASSESSMENT OBJECTIVE(S):

1. To provide a complete screening and assessment of each consumer upon entry into the mental health system.
2. To provide a diagnostic evaluation making use of all tools appropriate to the refinement of the diagnosis including the use of evidence-based evaluation instruments such as neuropsychological evaluation instruments, cognitive developmental assessment scales such as the WAIS and other standardized intelligence and developmental scales and projective tests and personality inventories.
3. To provide a treatment plan based on the clinical assessment, diagnostic evaluation and bio-medical laboratory test results.

GOAL #4: EVIDENCE BASED TREATMENT MODALITIES:

To utilize clinical services for mental illness and substance abuse that reflect scientific research and "best practices" standards in the diagnosis, treatment, and prevention of mental illness in order to mitigate relapse, aid resilience to problems, self- sufficiency and assist with recovery.

OBJECTIVE(S):

1. To provide evidence-based treatment that will provide real and measurable outcomes for consumers and their families.
2. To insure that treatment is culturally and linguistically appropriate to serve the needs of consumers and their families on the Territories of the U.S. Virgin Island.
3. To incorporate treatment modalities within an integrated treatment system.

4. To insure age and developmentally appropriate treatment interventions.
5. To establish a 24-hour easily accessible point of access to the mental health system both for access to clinical services and for access to consumer/public educational information.
6. To establish an automated mental health and substance abuse services directory.
7. To establish an outpatient emergent mental health care mechanism on all the islands.
8. To establish a full array of evidence-based treatment modalities available in the outpatient clinics with therapists appropriately trained and credentialed to deliver these services.
9. To insure the availability of psychopharmacological treatment along with monitoring for drug interactions.
10. To establish a drug formulary commensurate with the most current, effective and accessible drugs (pursuant to FDA approval) on the market.
11. To insure for laboratory work and screening for individuals on psychiatric medications.
12. To insure the availability of Psychiatric Day Treatment.
13. To insure the provision of a case management system with an outreach component to adequately serve consumers in the Virgin Islands.

GOAL #5: PROFESSIONAL DEVELOPMENT:

To develop a training calendar for the interdisciplinary treatment team.

OBJECTIVE(S):

1. To ensure that professional staff obtain related mandatory credentials and/or licensure commensurate with their respective professions and/or disciplines and attendant job related functions, duties and responsibilities.
2. To mandate participation, by interdisciplinary treatment staff, in mental health training and development opportunities.
3. To require use of and competence in reading findings of standardized tests and assessment instruments commensurate with corresponding

mental health diagnoses, assessments and prognoses.

4. To avail staff and interns with opportunities for learning through the establishment of DMHADDS as a mental health practicum.
5. To develop a directory of mental health professionals/services within the USVI.
6. To provide mental health staff with the necessary tools with which to expand their competencies and perform their related tasks.
7. To promote cross-training and ongoing professional development through development of UVI relations.
8. To seek and accept opportunities for technical assistance within the area of mental health.
9. To provide incentives to staff for participating in routine training and development.
10. To facilitate opportunities for mental health staff licensure and credentialing.

GOAL #6: FAMILY SUPPORT:

To integrate a wholesome and holistic network and resources supportive of the well-being and wellness for families of mentally-ill persons.

OBJECTIVE(S):

1. To insure the delivery of primary-care and dental healthcare through established partnerships.
2. To execute MOA/MOUs by and between DMHADDS and Public Healthcare and Dental Health Clinics.
3. To promote the medical home model in the service of incapacitated mentally- ill persons.
4. To provide training in Medication Management towards assisting mentally-ill patients in adhering to medication regimen.
5. To offer training opportunities, in associated mental health areas, to care- givers of the mentally-ill.
6. To conduct home visits in observation of severely-mentally ill patients in their routine.
7. To conduct Follow-Up contacts for mentally-ill patients due to

absenteeism and abrupt treatment termination.

8 To develop strategies to reach and engage mentally-ill patients and their families.

9 To incorporate family involvement as an integral part of patient's treatment plans.

10 . To educate families and the community regarding mental health issues and attendant disability rights.

GOAL #7: PROGRAM GOVERNANCE:

To operate DMHADDS in accordance with established law, executive orders and funding mandates.

OBJECTIVE(S):

1. To administer the DMHADDS, in its delivery of mental health services pursuant to Titles 7 and 19, VI Code.
2. To administer the DMHADDS, in its delivery of mental health accordance with applicable Public Health Laws.
3. To deliver mental health services in accordance with DMHADDS' stated Vision, Mission, Goals and Objectives.
4. To deliver mental health services in accordance with terms stipulated in executed Contracts for Professional Services and MOA/MOUs and other contracted party/ies.
5. To provide mental health services guided by the terms and conditions stipulated in the issued federal Notices of Grant Award.
6. To develop inter-agency agreements supportive of Mental Health Strategic Plan Implementation.
7. To provide opportunities for all installations of the VI government to collaborate supportive of territory-wide mental health systems and structures.
8. To enlist proactive involvement of executive and legislative branches of government for the 5-year Mental Health Strategic Plan.
9. To identify and operationalize avenues of support, for the 5-Year Mental Health Strategic Plan, from Community- and Faith-Based organizations.

GOALS #8: FINANCING:

To disburse all expenditure of all awarded monies, federal and general fund, in accordance with established VI Government systems of accountability.

OBJECTIVE(S):

1. To expend awarded funding pursuant to required stipulations of the funding grantor at the local and federal levels.
2. To ensure establishment and incorporation of the requisite accounting checks and balances in the management of funds.
3. To petition the Legislature of the VI for annual supplemental funding to underwrite the un-budgeted expenditures and satisfy the "matching-fund" requirement(s).

GOAL #9: PROGRAM MONITORING AND EVALUATION:

To establishment several meetings designed to assess, monitor and evaluate, for the purpose of insuring the delivery of comprehensive mental health services.

OBJECTIVE(S):

To convene the following meetings:

1. General Staff Meeting-Staff/Clinic operations--focused.
2. Interdisciplinary Team Meeting-Clinician/Expertise/Specialty/Treatment Plan-focused.
3. Case Conference-Patient focused/ Treatment Plan-centered.
4. Group Supervision-Clinical/Staff/Professional behavior-focused/.
5. Clinical Supervision/ I: 1-Clinician/Patient/ Treatment/Relationship- centered.
6. Case Assignment Meeting: Clinician Caseload/Clinic Census-focused.

GOAL #10: CLIENT DISPUTE RESOLUTION PROCEDURE

To establishment a forum responsive to patients' expressed disputes regarding mental health services provided by DMHADDS.

OBJECTIVE(S):

1. To establish, announce and encourage patients to utilize DMHADDS' Complaint Officer in resolution of dispute(s) specific to delivery of mental health services.
2. To conduct an annual "Assessment Survey" regarding mental health services offered and/or received by DMHADDS.
3. To utilize a Suggestion Box, inviting feedback from patients regarding DMHADDS services and its operations.
4. To actively engage the VI Planning and Advisory Council in development of DMHADDS's Strategic Mental Health.
5. To aim for inclusion and representation on behalf of the mentally-ill patient population.

GOAL #11: CONTINUUM OF CARE:

The establishment of a comprehensive, integrative mental health mental health and substance abuse system where all parts of the system serve each other and the system as a whole in order to create an array of services that optimally provides support for consumers of mental health services and their families. The purpose of this system is to support the rights of individual's with disabilities to live in their communities, yet supports communication, cognitive skills, resilience to problems, and self-sufficiency.

OBJECTIVE(S):

1. A 24 hour a day single point of access into the mental health system serving consumers, families and the general public by facilitating access to the system and making available information in regard to services.
2. 24-hour emergent mental health services through both outpatient

services and hospital emergency rooms.

3. Emergency Room triage
4. Emergency Commitments
5. Inpatient mental health services appropriate to all age groups and developmental issues.
6. Day Treatment programs
7. Forensic Mental Health Services
8. A full range of outpatient services including psychopharmacological treatment, evidence-based individual, group therapy and family therapy.
9. Case Management and Outreach Services capable of serving consumers throughout the U.S. Virgin Islands.
10. Co-morbidity Groups (mental illness and Substance Abuse).
11. Residential Treatment programs appropriate to the age and developmental needs of the consumers.
12. Psycho-Social Rehabilitation Programs such as Clubhouses for Consumers.
13. Integrative treatment planning between all levels of care within the system.
14. Acute Care Services
15. Chronic Care Services
16. Off-island placement (goal: to eliminate within 5 years)
17. Coordination between the mental health system and the primary care system for the purpose of consumers having access to non-psychiatric medical care.
18. Hospitalization

Staffing Proposal for United States Virgin Island's Mental Health Services

Staffing on Saint Thomas

2 Full time Psychiatrists with one with a specialty in Child Psychiatry (shared between St. Thomas and St. John)
1 Full time Nurse Practitioner (licensed to prescribe and act as back-up to psychiatrists)
1 Full time Psychiatric Nurse
1 Full time Clinical Supervisor (Master's Degree)
3 Full time Mental Health Workers (Bachelor's Degree) - one of which would be in a case manager's role
1 Full time Psychologist (Doctoral Degree) (shared between St. Thomas and St. John) – in aggregate in the island-wide staff of psychologists there is a need for the sub- specialties of child psychology and neuro-psychological testing to be present on staff.
1 Full time administrative personnel

Mobile Outreach Unit (St. Thomas)
1 Full time Driver (Bachelor's Degree) - outreach worker
1 Full time Mental Health Worker (Bachelor's Degree) - outreach worker
1 Full time Psychiatric Nurse

Adult Psychiatric Day Treatment
(standards based on Psychiatric Day Treatment Regulations from the Division of Medical Assistance, Commonwealth of Massachusetts)

1 Full time Program Director (Master's or Doctoral Degree) 1 Full time Professional Staff member (Master's Degree)
1 Full time or 2 Part time professional staff (Bachelor's or Master's Degree)

Minimum Staffing Requirements

(1) A psychiatric day treatment program with fewer than 28 participants must be staffed at a minimum by a treatment team of three qualified professionals. At least two of the treatment team members must be employed full-time by the program. The third team member may be two part-time or one full-time employee.

(2) Programs with 28 participants or more must have one additional full-time professional for every eight additional participants.

Composition of the Treatment Team

(1) Each member of a treatment team must represent a different discipline from the other members of the same treatment team.

(2) At least two full-time staff members of the same treatment team must be drawn from the following disciplines: psychiatry, psychology, social work, psychiatric nursing, licensed mental health counseling, occupational therapy, or rehabilitation counseling.

(3) The remaining members of the treatment team may separately represent any disciplines listed in number two or expressive therapy or allied health

submitted by DOH Personnel.

Additional Staff

The program must ensure an overall staff-to-participant ratio of one to six by hiring additional professional or paraprofessional staff from any of the disciplines listed above in numbers two or three.

Children and Adolescent Day Treatment Services
(The same staffing numbers and standards apply as listed above for Adult Psychiatric Day Treatment services)

Staffing on St. John

2 Full time Psychiatrists with one with a specialty in Child Psychiatry (shared between St. Thomas and St. John)
1 Full time Substance Abuse Counselor
1 Full time Psychiatric Nurse
1 Full time Clinician (Master's Degree)
1 Full time Mental Health Worker (Bachelor's Degree) - case manager
1 Full time Mental Health Worker

Staffing on St. Croix Christiansted Clinic

2 Full time Psychiatrists with one with a specialty in Child Psychiatry (shared between Christiansted Clinic and Frederiksted Clinic)
1 Full time Psychologist (Doctoral Degree) – with psychological testing skills for adults, children and adolescents (shared between the clinics on St. Croix)
1 Full time Nurse Practitioner
2 Full time Clinical Supervisors (Master's Degree)
2 Full time Alcohol and Substance Abuse Counselors (Master's Degree) (shared between Christiansted Clinic and Frederiksted Clinic)
1 Full time Mental Health Worker (Bachelor's Degree) – case manager Administrative Personnel (4 already exist)

Adult Day Treatment Services
(The same staffing numbers and standards apply as listed above for Adult Psychiatric Day and Children's services on Saint Thomas)

Children and Adolescent Day Treatment Services
(The same staffing numbers and standards apply as listed above for Adult Psychiatric Day and Children's Services on Saint Thomas)

Frederiksted Clinic

2 Full time Psychiatrists with one with a specialty in Child Psychiatry (shared between Christiansted Clinic and Frederiksted Clinic)
1 Full time Registered Nurse
1 Full time Clinical Supervisor (Master's Degree)
2 Full time Mental Health Workers (Master's Degree)
2 Full time Alcohol and Substance Abuse Counselors (Master's Degree) (shared between Christiansted Clinic and Frederiksted Clinic)
1 Full time Mental Health Worker (Bachelor's Degree) - case manager
1Administrative Personnel
1 Billing Clerk

Mobile Outreach Unit (shared by both clinics on St. Croix)
1 Full time Driver (Bachelor's Degree) -outreach worker
1 Full time Mental Health Worker (Bachelor's Degree) - outreach worker
1 Full time Psychiatric Nurse

Adult Day Treatment Services (staffing estimates to follow)

Children and Adolescent Day Treatment Services (staffing estimates to follow)

United States Virgin Islands

Inpatient Psychiatric Services for both Children and Adolescents on the United States Virgin Islands

CLINICAL SERVICES SUB-COMMITIEE PERSONNEL COST ANALYSIS
CONSENT DECREE

DISTRICT: St. Croix

	Proposed Salary	Sub-Total	Total
E. CHRISTIANSTED: Personnel			
Psychiatrist: two (2), F/T, adult/child, C'sted./F'sted. clinics	$150,000.00 x 2	$300,000.00	$300,000.00
Psychologist (Doctoral Degree): F/T, C'sted./F'sted. clinics	$75,000.00	$75,000.00	$75,000.00
Nurse Practioner (presciption-licensed/psychiatri st back-up) F/T	$65,000.00	$65,000.00	$65,000.00
Clinical Supervisor (Master's Degree): two (2), F/T, 1-SA, 1-MH	$58,000.00 x 2	$116,000.00	$116,000.00
Mental Health Worker/Clinician (Master's Degree) two (2), F/T	$45,000.00 x 2	$90,000.00	$90,000.00
Alcohol and Narcotic Counselor--11 (Master's Degree): F/T, C'sted./F'sted.	$45,000.00	$45,000.00	$45,000.00
Alcohol and Narcotic Counselor--11 (BA Degree): F/T, C'sted.	$30,000.00	$30,000.00	$30,000.00
Billing Clerk: F/T, SA	$27,000.00	$27,000.00	$27,000.00
Sub-total			**$748,000.00**
F. Frederiksted: Personnel			
Psychiatrist: two (2), F/T, adult/child, C'sted./F'sted.	shared w/ C'sted.	shared w/ C'sted.	shared w/C'sted.
Psychologist (Doctoral Degree): F/T, C'sted./F'sted. clinics	shared w/ C'sted.	shared w/ C'sted.	shared w/ C'sted.
Billing Clerk: F/T	$27,000.00	$27,000.00	$27,000.00
Alcohol and Narcotic Counselor--111 (MA Degree): F/T, C'sted./F'sted.	shared w/ C'sted.	shared w/ C'sted.	shared w/C'sted.
Alcohol and Narcotic Counselor--11 (BA Degree): F/T, F'sted.	$30,000.00	$30,000.00	$30,000.00
Mental Health Worker-III, F/T	$45,000.00	$45,000.00	$45,000.00
Sub-total			**$102,000.00**

G. ST. CROIX: Mobile Outreach Unit			
Driver (Bachelor's Degree): F/T, outreach services	$28,000.00	$28,000.00	$28,000.00
Mental Health Worker (Bachelor's Degree): F/T, outreach specialist	$30,000.00	$30,000.00	$30,000.00
Psychiatric Nurse: F/T	$60,000.00	$60,000.00	$60,000.00
Sub-total (salaries)			**$118,000.00**
Sub-total (District)			**$968,000.00**
GRAND TOTAL			**$1,972,000.00**

CLINICAL SERVICES SUB-COMMITIEE PERSONNEL COST ANALYSIS CONSENT DECREE

DMHADDS:DFH/eden:3/8/2011			

DISTRICT: St. Thomas/St. John	Proposed Salary	Sub-Total	Total
A. ST. THOMAS: Personnel			
Psychiatrist: F/T, adult/child, STI/STJ clinics	$150.000.00 x2	$300,000.00	$300,000.00
Nurse Practioner (presciption-licensed/psychiatrist back-up) F/T	$65,000.00	$65,000.00	$65,000.00
Psychiatric Nurse: F/T	$60,000.00	$60,000.00	$60,000.00
Clinical Supervisor (Master's Degree): F/T	$58,000.00	$58,000.00	$58,000.00
Mental Health Worker (Bachelor's Degree): three (3),F/T, -CM/2-SA	$30,000.00 x3	$90,000.00	$90,000.00
Psychologist (Doctoral Degree): F/T, STI/STJ clinics	$75,000.00	$75,000.00	$75,000.00
Administrative Staff: F/T	$38,000.00	$38,000.00	$38,000.00
Sub-total			**$686,000.00**
B. ST. JOHN: Personnel			
Psychiatarist: two (2), F/T, adult/child, STI/STJ clinics	shared with STT	shared with STT	shared with STT
Alcohol and Narcotic Counselor--11 (BA Degree): F/T	$30,000.00	$30,000.00	$30,000.00
Mental Health Worker: F/T	$30,000.00	$30,000.00	$30,000.00
Sub-total			**$60,000.00**
C. ST. THOMAS: Adult Psychiatric Day-Treatment			

Director-Rehabilitation Program (Master's Degree): F/T	$60,000.00	$60,000.00	$60,000.00
Professional Staff (Master's Degree): F/T	$45,000.00	$45,000.00	$45,000.00
Counselor (Bachelor's Degree): F/T	$35,000.00	$35,000.00	$35,000.00
Sub-total			**$140,000.00**
D. ST. THOMAS: Mobile Outreach Unit			
Driver (Bachelor's Degree): F/T, outreach services	$28,000.00	$28,000.00	$28,000.00
Mental Health Worker: F/T, outreach specialist	$30,000.00	$30,000.00	$30,000.00
Psychiatric Nurse: F/T	$60,000.00	$60,000.00	$60,000.00
Sub-total (Salaries)			**$118,000.00**

sub-total (District) **$1,004,000.00**

Appendix 7. Hospital Report-Psychiatric Services Information

Recommendation for improvement of psychiatric services in USVI

Recommendations for Emergency: Department

1. **Establishing psychiatry emergency department:**
   a. This will be part of the emergency room but there will be a separate nurse who can medicate and do the intake for the patient. This nurse will also be in touch with the psychiatrist. Nurse will be provided with a standing order for lab and PRN medications. Patient must be medically cleared before admission to the psychiatric unit. If the patient has medical issues that is causing his psychiatric issue, he will need to be admitted to the appropriate department and psychiatry can act as a consult service.
   b. The advantage: Once identified as an acute psychiatric patient, they will be immediately triaged and worked up for admission to the psychiatric unit. This will minimize the waiting time for psychiatric patients in the ER and facilitate the admission to the psychiatric unit.

Recommendations for Involuntary Commitment

2. **Current 722 grants involuntary admission for 5 days only, which is not enough in most of the cases**
   a. Recommendation: 722 involuntary admission should be extended to 10 days
3. For 723, completing the form should be sufficient for involuntary commitment without physically attending a court hearing
   a. The advantage: This reduces the amount of time wasted at court allowing the physician to provide the best care to inpatients. Additionally, this is the current policy implemented in psychiatry emergency

departments in the US.

Recommendations for Improving InPatient Unit

4. **Establishing Adolescent Psychiatric Unit:**
   a. Currently, only two beds are assigned specifically for acute adolescent (age 12-16)services where a thorough evaluation and stabilization is done before transition to a specialized adolescent facility (usually off island).
5. **Establish an appropriate Seclusion Room:** Current room is not padded and pose a danger to patient's safety. Ideally, The room would be padded.
6. **Establish occupational therapy program and increase the amount of inpatient activities.**
7. **Extra space is needed for acute alcohol/drug rehabilitation patients.**
8. **Extra space and equipment is needed to establish a neuroscience research center.**
   a. Goal: To treat resistant conditions which are not responding to regular medical treatment. Patients who do not improve in the inpatient setting can be referred to the research center to follow treatment with a specific research protocol.
   b. Equipment required:
      i. Imaging: SPECT (Single Photon Emission Computerized Tomography)- this imaging system uses low emission radioactive substance to map the brain activity. It will give invaluable information about WHERE exactly the problem lies. This will assist in choosing the appropriate medication or treatment modality.
      ii. QEEG (Quantitative Electroencephalogram): this system will give information about WHAT is the problem through changes in the electrical activity and its' deviation from normal. This will assist in choosing the appropriate medication or treatment modality.
      iii. Transcranial Magnetic Stimulation (TMS}: this system delivers magnetic field that modulates the activity of the affected area as determined by SPECT and QEEG. TMS is already approved for

treatment of resistant depression and encouraging results were obtained for many other illnesses (ex. schizophrenia and Parkinson's Disease).

c. Estimated total cost for program implementation: $700,000

Recommendations on Discharge

9. **Provide Partial Hospitalization Program (PHP):**
   a The program will be responsible for picking up the patient from their home in the morning and providing transportation to the PHP facility where the patient will be provided with their medications and engage in several activities including group therapy. Additionally, these patients will be provided lunch and will be transported home around 3:00pm.
      i. Advantage:
         1. This program minimizes the burden on the patient's family.
         2. Enhances compliance with medication.
10. **Establish a Rehabilitation Program:**
   a. This program will serve local and off island patients.
   b. Requirements:
      i. Attractive facility Staffing
11. **Establish Permanent Residency for Homeless Individuals with Mental Illness**

US VIRGIN ISLANDS FIVE YEAR MENTAL HEALTH STRATEGIC PLAN 2014-2019

Prepared for the VI Mental Health Consent Decree Commission, September 2014

Consultant Professor Chris Hogwebotham OBE FRSPH

The following individuals were members of the Consent Decree Commission who were instrumental in the creation of the Five Year Strategic Plan:

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