The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to the column editor, Francine Cournos, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032.

Psychoeducational Debriefings After the September 11 Disaster

After the World Trade Center disaster on September 11, a group of clinicians, educators, and administrators from New York State Psychiatric Institute responded to requests, mostly from government and nonprofit agencies, to provide mental health debriefings to persons affected by the disaster. Our group was aware of the controversy about the effectiveness of one-session debriefings, but the pressure to offer this service, from both administrators and employees, convinced us that a response was needed.

Between September 26, 2001, and November 6, 2001, our group facilitated 12 debriefings, using a psychoeducational model. Each session lasted 90 minutes to two hours. The facilitators remained on-site for about half an hour after the presentation to answer questions. Attendance was voluntary, a point that was emphasized at the beginning of each session. We provided information about emotional responses to disaster, both normal and traumatic; advice for helping children who have been exposed to trauma; and practical steps that participants might take to feel safer.

The group of facilitators usually included a psychiatrist, a psychologist, and a social worker. All facilitators had prior training. The program was flexible and allowed time for questions. The sessions emphasized resilience and recovery but included a discussion of the types of problems that might suggest that a participant would benefit from mental health services. We developed a referral list, which included over 100 mental health professionals who were willing to donate treatment time.

In early November, we distributed evaluation forms by contacting the employee who had organized the session at each site, usually the employee assistance coordinator. This person distributed the anonymous questionnaires along with stamped, self-addressed envelopes to employees who had attended the sessions. Of 203 surveys distributed, 129 (64 percent) were returned. The 13-item questionnaire covered demographic characteristics, level of exposure, perceived impact of the September 11 events, and an evaluation of the debriefing.

Our survey included only one individual who was actually in the World Trade Center on September 11. Most participants had lost someone they knew or had been indirectly affected.

Eighty-two percent of the respondents found the intervention helpful, 10 percent did not find it helpful, and 8 percent had no opinion. Eighty-six percent did not find the session harmful, but 3 percent (four participants) did find it harmful.

Sixty-eight percent felt better after the session, but 22 percent did not. Ninety-one percent found the session informative. Forty-seven percent felt more comfortable discussing the disaster, 43 percent were already comfortable, and 10 percent did not feel more comfortable. Among respondents with children, 74 percent said the session helped them talk to their children, and 22 percent said it was not helpful. For the subgroup with the highest level of exposure, 92 percent of those who lost someone found the session helpful, and one participant (3 percent) did not. Two percent (13 respondents) of this subgroup had been within five blocks of the World Trade Center at the time of the disaster, and all of them found the session helpful. Ninety-seven percent of the respondents who said that they were "having symptoms" found the session helpful, and one participant did not.

The last part of the survey asked participants to check all applicable statements. Sixty-eight percent of the respondents indicated that they would recommend the sessions to others, 39 percent felt they would benefit from additional sessions, and 48 percent indicated that they used information from the sessions to help coworkers, friends, or family. Thirty-six percent said that as a result of this session they had a clearer idea of how to handle a disaster. About a dozen persons received a referral after these sessions, but in some cases the person who needed the referral was not a participant but a friend or coworker of a participant. Only 3 participants (2 percent) indicated that they sought mental health services after the session.

After a disaster, people often have a desire to process the event. Most participants who answered our survey indicated that the debriefing sessions that were held for this purpose were helpful and positively received.

More research on debriefings is needed. Regardless of experts' concerns, there is a great demand for them, and many participants feel that they have been helped by debriefing. Debriefings also create an opportunity for case finding. Four participants found the session harmful, one of whom had had significant exposure to the events. A better understanding of adverse responses is essential.

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A Second Chance for People With "Treatment-Refractory" Psychosis

Despite advances in psychopharmacology, many patients remain too impaired to be discharged from state hospitals. One response to this problem in New York State was the development of a partnership among a private hospital, the New York Presbyterian Hospital–Weill Medical College of Cornell University–Westchester Division (NYPH-WD), the New York State Office of Mental Health, and four community residence providers in New York City. The goal of this partnership was to develop an alternative treatment model for "untreatable" patients who had been in state hospitals for more than three years. Such patients would be placed in the Second Chance Program, a new, specialized 30-bed inpatient unit at NYPH-WD. The program opened in the winter of 1998.

Patients in the program receive aggressive pharmacotherapy in addition to milieu management, group skills training, and individualized interventions to address their behavioral excesses and deficits. A point system based on comprehensive observational ratings is used for determining on-ward and off-ward privileges. Patients receive daily ratings on ten criteria each for appearance and grooming, room cleanliness, behavior at meals, and preparation for sleep. Points are given for each criterion met, and extra points are given to patients who reach the targets set for them on the basis of their performance during the previous two weeks. In addition, patients receive daily ratings on 20 inappropriate behaviors and four classes of socially appropriate behaviors. The total number of points earned and lost is computed at the end of the week to determine each patient's level of on-ward and off-ward privileges for the next seven days.

All of these data are entered into a software application developed for the Second Chance Program, and individual patient reports are produced. The reports include frequency counts of each behavior during the previous week, the week before that, and the first week the patient was on the unit. Patients receive a copy of their own report each week, and clinical staff receive reports on all patients. The reports are reviewed at weekly staff meetings. The data in the reports are used not only for setting privilege levels but also for treatment planning and for informing patients about progress in the program and behaviors that need further change.

The program also uses a token economy, which can be thought of as a prosthetic environment for people with severe cognitive deficits. Patients earn tokens for meeting specific behavioral targets; such targets may be for the behaviors noted above or for aspects of behavior at group sessions, including arriving on time, participating, and staying for the entire session. An important feature of the system is that as a patient's behavior begins to approach community standards, external reinforcers are used less, and social and internal controls are relied on more.

Within the milieu, feedback for appropriate and inappropriate behaviors is given through a specific form of prompting that highlights consequences of behavior and, for inappropriate behavior, assists the patient in choosing a better alternative. In addition to these milieu management systems, the program offers a full range of skills training, cognitive rehabilitation, and recreational groups.

By April 2001, a total of 181 patients had been admitted to the program, 30 of whom were in the program at that time. The average length of stay for the current state hospital admission for the 181 patients was seven years. Of the 151 patients who had left the program, 116 (77 percent) had been discharged directly to the community, most to one of the program's four residence provider partners, and some to other housing providers or to live with family members. The other 23 percent had been readmitted to the state hospital.

The median length of stay in the program for first admissions for the 151 patients was 87 days; the mean was 145 days. Of the 116 discharged patients, 63 (54 percent) had not yet required readmission to the program. Among those who did, the mean length of community tenure before readmission was 176 days, and the mean length of stay in the program during the readmission was 67 days.

Data on patients' behavior change while in the program indicate large improvements in nearly all areas relevant to effective functioning in the community. In addition, rates of aggressive behavior dropped significantly. For example, before the introduction of behavioral interventions, the frequency of the use of seclusion and restraint for all patients combined was 9.3 per month, and 17.9 incidents occurred per month. With the program of behavioral interventions, both of these rates dropped below two per month.

The Second Chance Program model has proved to be effective for treating patients who were considered unlikely to be discharged from state hospitals. The program provides further evidence that when intensive behavioral treatment is combined with appropriate psychopharmacology, the number of patients deemed to have treatment-refractory psychosis is far lower than when medication alone or medication plus inpatient treatment-as-usual are used.

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