

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.

A VA Health Care System Two Years After September 11, 2001

The two years that have passed since September 11, 2001, have demonstrated that mental health care workers play a critical role in disaster response. Future challenges for health care systems that respond to disasters include meeting the needs of a traumatized community, maintaining an educated and able workforce, and developing long-range plans.

The Veterans Integrated Service Network for New York and New Jersey (VISN 3) has remained actively engaged in emergency planning since September 11. The Mental Health Executive Board (MHEB) has implemented a mental health emergency preparedness team to integrate services with hospitalwide emergency preparedness practices. In the immediate aftermath of September 11, the MHEB identified populations most likely to need enhanced services, including known veteran patients, veterans in the community who were not currently receiving Department of Veterans Affairs (VA) services (particularly first responders), and medical center staff. We identified veterans with histories of posttraumatic stress disorder, depression, or suicide attempts as high-risk individuals.

We developed and mailed educational brochures to more than 10,000 veterans with these disorders. Staff

telephoned high-risk veterans on their caseloads, provided psychoeducational and support groups in psychiatric inpatient and outpatient settings, and distributed informational flyers to veterans in medical settings and the community about how to gain access to VA services. We are continuing to develop services and strategies to educate these populations about obtaining care.

The MHEB identified staff as a group that needed support to help them cope with fears and uncertainty during a disaster period. In the event of a chemical or biological incident, stress may be increased as a result of extended operational periods and fear of hazardous exposure. Frontline medical response staff may need support to alleviate the psychological impact of their experiences. Support should be offered in a nonstigmatizing manner so that participation does not imply inability to perform duties. If staff feel that their participation communicates emotional fragility to management, they may decline services. In addition, incident review, education, and personal safety training can help staff cope with the stress of a traumatic event and enable them to master increased job demands.

Immediately after the September 11 attacks, each facility in VISN 3 implemented psychoeducational and supportive services for staff. At one site, leadership requested the assistance of experienced debriefing counselors through the VA Readjustment Counseling Service (RCS). The evidence base for the effectiveness of debriefing is mixed. Studies suggest that in some cases critical incident stress debriefing may be more harmful than helpful. The value of psychoeducational debriefings, which teach participants about normal reactions to stressful events and healthy coping skills, has not been established. However, anecdotal evidence suggests that employees find these debriefings beneficial. Below we describe the debriefings conducted by RCS and results of a postdebriefing survey.

RCS staff met with groups of em-

ployees during two weeks in November 2001. Employees were invited to voluntarily meet with "stress teams" available during each shift. Groups were as large as 80 participants. A psychoeducational format was used. We conducted a survey during March 2002 to evaluate the debriefings. Because of a low response rate (77 of approximately 700 attendees, or 11 percent) and a delay in implementing the survey, the results must be interpreted cautiously. However, the findings were consistent with those reported for a non-VA site in New York by Herman and colleagues in the Frontline Reports column in the April 2002 issue.

Among the 77 respondents, 56 (73 percent) said that they watched the events of September 11 on television, 51 (66 percent) reported feeling emotionally affected, 21 (27 percent) had a friend or relative who was near the World Trade Center at the time of the attacks, six (8 percent) knew someone close to them who was killed, and five (7 percent) witnessed the events in person. A majority (52 respondents, or 68 percent) said that they felt better after attending the debriefing, 23 (30 percent) that they felt the same, and two (3 percent) that they felt worse. Most participants attended the debriefings because they wanted to attend (59 respondents, or 77 percent) rather than because they felt pressured to. Participants rated the content of the debriefings as "good" (a mean score of 3.14 on a scale of 1, poor, to 4, excellent). Ways in which respondents reported that the sessions were helpful included "learning I was not alone," "sharing experiences," "better understanding of how events affected self," "learning ways to speed recovery," and "receiving support." The vast majority of respondents (more than 90 percent) said that they would attend a session in the future and would recommend debriefings to others.

In summary, debriefings based on a psychoeducational model were well received and were generally experienced as helpful. Future research should examine what elements of the

sessions are most efficacious, and integration of these elements in an employee assistance plan during and after a disaster should be considered. It can be difficult to perform rigorous studies at the time of an emergency, but, to the extent possible, agencies should document interventions and conduct assessments of what works so that we can build on experience.

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Measuring Patient Satisfaction

It is very difficult to measure patient satisfaction on acute inpatient psychiatric units. The traditional method of using written surveys has a number of weaknesses. Cognitive impairment associated with acute exacerbations of schizophrenia, schizoaffective disorder, and severe depression can substantially influence patients' ability to complete these surveys, leading to inaccurate results. Unless surveys are conducted daily, a problem that can diminish patient satisfaction may persist for days before coming to the attention of staff. In many general hospitals, inpatient psychiatry is excluded from written patient satisfaction surveys, and thus the issue is ignored altogether. Yet the need to measure patient satisfaction in an accurate and timely manner persists.

After examining a number of instruments to address the measurement of patient satisfaction, Bridgeport Hospital adopted an innovative method of tracking patient satisfaction in the department of psychiatry. Our goals were to measure satisfaction on a daily basis, to use a simple and understandable method so that even impaired psychiatric patients

could participate in the process, and to use an existing forum—the community meeting, which is a staple of many inpatient psychiatric units.

A meter was developed consisting of a “satisfaction board,” which includes an arrow that can be used to point to any of five levels of patient satisfaction: outstanding, almost perfect, okay, could be better, and “the pits.” The board is permanently mounted in the room where the community meeting takes place. As a regular part of the meeting, patients are asked to reflect on the factors that have influenced their satisfaction for the previous 24 hours. Patients are provided with some examples of such factors, such as the friendliness of staff, the quality of the group sessions they have attended, their feeling of safety while on the unit, the quality of meals and snacks, and patients' involvement in their own treatment plans. To ensure comparability from one day to the next, care is taken to repeat the instructions in the same manner each time. All patients are asked to indicate their level of satisfaction by raising their hands as each of the five levels of satisfaction is identified. A consensus level of satisfaction is then determined, and the arrow is moved to point to that level.

Patients are then asked to identify specific areas that have had a positive or a negative impact on their satisfaction. Care is taken to assure patients that their opinions and feedback are important. Examples of the changes made as a result of this process are cited to reinforce for patients that this is an open and nonpunitive process. Such changes include more consistent implementation of individual sessions with assigned staff, greater choice in meal selections, the development of a more efficient method of storing patients' personal belongings, and improved timeliness of staff response to patients' needs throughout the day.

Negative ratings are reviewed by the treatment team after the community meeting. Corrective action taken in response to these ratings is reported to the patients at the next day's meeting. Positive ratings are also reviewed by the treatment team and

serve as reinforcement for staff, which enhances staff morale.

Patients have told us that the process of being asked for their opinions is as important to them as is the eventual resolution of their concerns. In many ways, measuring and responding to patient satisfaction has become a therapeutic process in itself.

The hospital's leadership has recognized that this process allows for accurate and immediate feedback on a daily basis, provides a method for correcting problems quickly, offers feedback to patients about corrective actions taken, and assures patients that their satisfaction is genuinely important, a concept that is too often overlooked in inpatient psychiatry.

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The Bridge Program: A Model for Reaching Asian Americans

Although Asian Americans represent one of the fastest growing populations in the United States, they have the lowest use of mental health services. Asian Americans with mental illness are often severely ill or in crisis by the time they receive a psychiatric diagnosis. As a result, this patient population is more costly to treat, frequently requiring lengthy inpatient hospitalization.

In an attempt to address these salient mental health issues, the Charles B. Wang Community Health Center in New York City developed the Primary Care and Mental Health Services Bridge Program in 1997. Asian Americans generally have very little awareness of mental health issues, and having a mental illness and seeking psychiatric services are profoundly stigmatized. The stigma is typically heightened by Asian culture, which puts tremendous emphasis on familial identity and honor, often preventing persons with mental illness from referring themselves or family