

Moving Beyond Crisis Stabilization: Clinician Recommendations and Patient Perspectives for Improving Youth Psychiatric Hospitalization

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ABSTRACT

Inpatient psychiatric hospitalization is often considered the “default” solution for youth at risk for suicide, but these services have not been shaped by the voices of youth or families or by strong research support. To address these gaps, we sought to provide recommendations on improving care based on our clinical teams’ diverse experiences working in inpatient settings in Rhode Island, enhanced by interviews with youth in psychiatric care and their caregivers about their experiences. We highlight the need for stronger family involvement, better transition planning, personalized safety strategies, and culturally responsive care. These improvements could reduce readmissions and support long-term recovery.

INTRODUCTION

Inpatient psychiatric hospitalization is often considered the “default” response for youth at risk for suicide.¹ Psychiatric hospitalization is intended to provide immediate safety and stabilization through individual, family, group, and milieu treatments.²⁻⁴ Despite its widespread use, inpatient care for youth is not guided by an empirically informed or standardized model of care, and practices vary across units.⁵ Furthermore, inpatient care has primarily been developed without input from critical parties, including the impacted youth and their families.^{6,7} Consequently, there is a pressing need for an evidence-based care framework that integrates this input, to enhance treatment efficacy and promote long-term outcomes.

Drawing on our team’s multidisciplinary expertise in pediatric inpatient settings, we sought to address this gap. To enrich our clinical insights, we invited youth (n=10; age range: 12–17, M=14.4) receiving psychiatric care at an adolescent inpatient unit in Rhode Island and their caregivers (n=17) to share reflections through open-ended conversations regarding their expectations about inpatient psychiatric hospitalization. These interviews were conducted with approval from our hospital’s Institutional Review Board, with all participants providing informed consent and assent. Through this commentary, we seek to share key insights and recommendations based on our frontline professional experience and the lived experiences of these critical parties.

A NEED TO MOVE BEYOND CRISIS STABILIZATION

While psychiatric hospitalization is largely viewed as effective in providing immediate safety and stabilization, there is a need for enhanced transition planning, increased family involvement, and attention to cultural considerations to enhance overall treatment efficacy and promote more long-term safety for at-risk youth. To that end, the following recommendations are presented.

THOROUGH SCHOOL TRANSITION PLANNING

Returning to the home and school environment is often one of the most significant sources of stress following an inpatient hospitalization. In particular, youth-caregiver dyads frequently highlight an overall lack of coordination between the hospital and the school, impacting the development of a clear and supportive reintegration plan. Inpatient units may want to include designated social workers or other clinical team members who could serve as liaisons between the hospital, the school, and the family in the youth’s treatment team. Specific tasks for these liaisons may include ensuring that there is signed consent for the clinical team to talk with the school, communicating diagnostic impressions and treatment courses throughout the hospitalization and beyond, organizing and facilitating plans to address missed assignments or other academic expectations, and providing robust recommendations to relevant parties (e.g., teachers, guidance counselors, school administration, support staff).

CAREGIVER SUPPORT AND GUIDANCE

While inpatient care is understandably centered on the hospitalized youth, the support offered to caregivers and broader systems often falls short of meeting their needs. Caregivers frequently report wanting greater inclusion and support throughout their youth’s hospitalization. Caregivers note that they often feel unprepared and too overwhelmed to support their youth effectively during hospitalization and following discharge. Inpatient units should consider incorporating caregivers within the treatment plan from the start of hospitalization to address these concerns. This can be achieved via the development of formal caregiver training and educational sessions conducted throughout the hospitalization, either through single- or multi-family therapy

sessions. These sessions should focus on providing psychoeducation regarding specific coping skills that the youth are learning and on disseminating practical tools (e.g., communication strategies, emotion regulation practices) that the caregivers can utilize to support their youth as they transition back home. Given the competing demands of many caregivers (e.g., caring for other children, balancing the demands of work, home, and the treatment of their hospitalized youth), making sessions available “on demand,” such as through pre-recorded training videos, would alleviate some of the time burden not only for caregivers, but also clinical staff. Further, inpatient units should implement early and collaborative discharge planning with the family to provide caregivers with the support and confidence needed to manage their youth’s transition home, and should include specifics on which providers will be involved in the youth’s treatment team post-discharge, identifying potential barriers and collaborative problem-solving to attend appointments and sessions, and creating a visual schedule (when possible) so that expectations are clear for both the youth and the caregiver.

Finally, some caregivers describe the hospitalization as a temporary, but significant, relief from the emotional and logistical strain of caring for their child at home. Inpatient units may want to address and validate these feelings openly and perhaps even prescribe that caregivers utilize their youth’s hospitalization to learn new supportive strategies and skills and engage in respite and self-care activities.

PERSONALIZATION OF SAFETY PLANS

Safety planning has become a standard component of inpatient hospitalization and is typically completed by the youth shortly prior to discharge. While many caregivers note that their youth had developed a safety plan before their hospital discharge, some caregivers may perceive these safety plans as hastily developed, with inadequate input from the family. As a result, youth and caregivers often feel that their safety plans are generic, impersonal, and difficult to implement within their home environments. Further, caregivers often express uncertainty in their specific role within their youth’s safety plans. This is consistent with the literature that shows caregivers often do not know the details of their child’s safety plan⁸; yet, when caregivers are involved in safety planning, the plans are deemed more effective.⁹

Inpatient units should focus on training and role-playing safety planning with staff to enhance personalization of the plans. This should be in tandem with implementing early and collaborative safety planning discussions with youth and their caregivers. These plans should be tailored to fit the family’s unique environments. Further, inpatient units may consider expanding safety planning to include direct, clear instructions for caregivers on responding to challenging moments or supporting their youth during a crisis. Providing

opportunities for caregivers to practice these responses while their child remains hospitalized could enhance their confidence and preparedness to respond following discharge. Brief, post-discharge check-ins with families could further support effective implementation.

INTEGRATION OF CULTURAL FACTORS

Currently, there are no cultural guidelines specific to inpatient care, potentially leaving important aspects of culture overlooked and inadequately addressed. Youth and their caregivers often endorse wanting a greater emphasis on cultural considerations within treatment plans during hospitalization. For example, religious or familial beliefs around suicide may need to be more thoroughly assessed. To address these concerns, inpatient psychiatric units should provide ongoing, consistent cultural competency training for clinical team members and unit staff. This training should focus on understanding the diverse backgrounds, strengths, and challenges of the youth in their care and integrating these considerations into treatment.

Further, on a practical note, inpatient psychiatric units may want to develop processes that ensure access to critical materials (e.g., safety plans, psychoeducation documents) in the family’s preferred language, and ensure access to culturally informed personal hygiene products.

CONCLUSION

While psychiatric hospitalization remains a critical component of intervention for high-risk youth, it is essential that care evolves to reflect the needs and voices of the families it serves. By integrating our clinical expertise with direct feedback from youth and their caregivers, we offer a set of recommendations to guide improvements in inpatient care beyond short-term crisis stabilization toward a more family-centered and culturally responsive approach. Inpatient units may wish to address these areas of improvement via the recommendations provided or through their own efforts to understand their communities, ensuring hospitalization effectively meets the immediate and long-term needs of the families served.

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