

# Recommendations for Inpatient Psychiatric Treatment for Suicidal Adolescents

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There is a great need for research that would provide empirical support for interventions and approaches to acute care that reduce the morbidity and mortality of suicide-related thoughts and behaviors in adolescents (Corcoran et al., 2011). The treatment adolescents currently receive on inpatient psychiatric units is sub-par, and this is not due to the experience and skills of clinicians, but rather, the larger system of psychiatric care in the United States. When parents agree to psychiatric hospitalization for their adolescents, they typically believe their adolescents will receive treatment at these units. However, rather than receive the active treatment they need on these units, they are essentially held there until they are "stable enough" to receive community-based residential treatment or outpatient treatment. This is an extremely ineffective way to treat adolescents with active suicide-related thoughts and behaviors. Why not take advantage of the time when they are in crisis to deliver evidence-based treatments in brief formats but intensive doses? Currently, there are no evidence-based psychiatric inpatient treatments that have been found to reduce the frequency of suicide-related behaviors or suicide attempts subsequent to discharge (Knesper, 2010). Therefore, there is a critical need for the development and testing of brief, but intensive, treatments that can be delivered in acute psychiatric care settings (Knesper, 2010).

Importantly, brief treatments implemented on psychiatric units must emphasize the involvement and accountability of parents. Family conflict or acute crises often precipitate suicidal events in adolescents (Pineda & Dadds, 2013), yet, the adolescent typically only has two or three family sessions in the context of their one to two week inpatient stay. How can we expect to help the adolescent to heal in this time after a suicidal crisis when their family is sent away from them to leave them alone to cope except for the one-hour session every few days that they have with a therapist? Also posing a challenge to inpatient psychiatric treatment is that family sessions frequently only minimally address the suicidal crisis in part because the therapist does not want the adolescent and parents to unearth a conflict that will disrupt the milieu. Sometimes the chaos of the inpatient environment can cause clinicians to neglect the individual functional assessment of the adolescent's suicidal event, which is integral to understanding what the adolescent is trying to communicate (Brent et al., 2011). Despite these obstacles of time and acuity, it is necessary that we find comprehensive ways to incorporate parents into the adolescent's inpatient psychiatric treatment, as research consistently demonstrates the critical role of family in the effectiveness of interventions with suicidal adolescents (Brent et al., 2013).

Instead of treating adolescents in a suicidal crisis as if they are in a holding ground while they are hospitalized, they inpatient settings need to use this time to work intensively (multiple hours per day) with a therapist to work through the suicidal crisis and potential family rupture implement evidence-based practices in brief formats but concentrated doses and to plan extensively for returning home. Parents need intensive cognitive behavioral training in the context of their adolescent's suicidal crisis (Asarnow et al., 2011; Pineda

& Dadds, 2013; Stanley et al., 2009). Additionally, parents need emotion coaching so that they can be better prepared to listen and be emotionally attuned to their suicidal adolescent (Diamond et al., 2010). More research is needed for development of family-based treatment modalities for suicidal adolescents (e.g., Huey et al., 2004) to be implemented as intensive brief treatments in psychiatric hospitalizations. These efforts are increasing in Emergency Departments (Asarnow et al., 2011; Asarnow, Berk, Hughes & Anderson, 2015; Wharff, Ginnis & Ross, 2012), but are completely lacking in inpatient settings.

We are missing chances of when and how to effectively engage suicidal adolescents. Arguably the best time to engage suicidal adolescents is in the time immediately following a suicidal event, as the event often can represent a "teachable moment" where they may consider change that may lead to reductions in suicide-related thoughts and behaviors. Motivational Interviewing (MI; Miller & Rollnick, 2013), defined as a collaborative, goal-oriented style of communication with particular attention to the language of change, should be considered as a potential therapeutic modality to implement with adolescents and their families in the midst of a suicidal crisis. When adolescents are psychiatrically hospitalized, they often feel the hospitalization is something that is being done to them against their will. Psychiatrically hospitalized adolescents need to have a choice in their treatment. MI techniques can be used to give adolescents some feeling of control in a treatment environment where they often feel it has been taken away from them. During psychiatric hospitalizations adolescents often feel forced to do things that they have not bought into yet. More research developing and testing short-term intensive MI interventions for suicide (e.g., Britton, Conner & Maisto, 2012), specifically for adolescents at risk for suicide (O'Brien, 2013), is therefore warranted.

Unfortunately, the current payer system limits the types of active and intensive treatments that would be most useful for adolescents in a suicidal crisis. Many adolescents feel like they are in a bubble while they are hospitalized, and the treatment they receive on the unit often does not help prepare them to get themselves safely back to reality. We are missing crucial opportunities to help psychiatrically hospitalized adolescents learn to cope with prospective stressful situations that may be associated with the presence of suicide-related thoughts and behaviors when they return home, causing many to reattempt or to be readmitted to the hospital in impending weeks. In fact, we do not even know what safety planning protocol is best practice with suicidal adolescents returning home from the hospital since none have been tested for effectiveness in a clinical trial. Although safety planning has been rolled out routinely in clinical trials (e.g., TORDIA, Asarnow et al., 2011), it has not been tested for effectiveness in preventing repeat suicide-related behaviors on its own. As of now, we are not clear on what the critical components of safety planning with suicidal adolescents and families actually are. More research is needed to determine the active ingredients of an effective safety plan, and voices of lived experience (i.e., the suicidal adolescent and parents) must play a role in their development (National Action Alliance for Suicide Prevention, 2014).

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There must be a continuity of care post-discharge from Emergency Departments and inpatient psychiatric units (Knesper, 2010). Unfortunately this will likely not occur until there are better payer rates for managing acutely suicidal adolescents. There do appear to be low cost options to maintain continuity of care. For instance, technological interventions, such as web-based, text-based, or smartphone application modalities, should be developed and tested as a standard of care at time of discharge for suicidal adolescents, and possibly as booster sessions in to be implemented in the weeks following discharge. Such interventions are suitable for adolescents and have the potential to be equally or more cost-effective than in-person interventions, in part because the likelihood of treatment adherence may be higher with technology modalities because of easy access for adolescents. Therefore, additional research and development in this area are necessary (Reyes-Portillo et al., 2014).

The system within which we provide psychiatric care is broken. We need to break this chain of “not-so-good” systems and find out what really works. The only way to do that is to take innovative risks in intervention development and implementation that combine cost benefit analyses (e.g., Sheidow et al., 2014) in order to demonstrate to payers that more intensive short term treatments may actually save money in the long run. These risks must be taken in order to witness real change in inpatient psychiatric treatment effectiveness with adolescents at risk for suicide. We must focus suicide prevention efforts on periods of high risk (Olfson, Marcus & Bridge, 2014). Although psychiatric hospitalization is not the ideal treatment modality for all suicidal adolescents, there are times when an adolescent’s imminent risk to self makes hospitalization necessary, even after a thorough evaluation and brief intervention by an Emergency Department or mobile crisis team. Since psychiatric hospitalization will always exist for suicidal adolescents, we must put our energy and resources into the development and testing of innovative intensivecost-effective treatments that reduce suicide-related outcomes for this high risk population and setting.

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