The Family Treatment Center Education For Families on What to Expect From the Acute Hospitalization

Purpose Of This Guide

To provide concrete, tangible, and useful information for parents and families. Psychiatric hospitalization can be overwhelming, scary, and worrisome. These feelings often make understanding and retaining all the information provided very difficult.

This guide attempts to encapsulate much of the overall education and information provided to families at admission and throughout hospitalization so it can be referenced at any time.

It is also aimed to increase family engagement in the hospital treatment and follow up care, while hopefully reducing stigma, inaccurate expectations, or assumptions associated with hospitalization

Having a quick reference guide for families allows the providers at FTC more time to address each child's and family's specific clinical needs.

REASON FOR THE ADMISSION

- Children and teenagers are admitted when they are in Crisis
- Crisis: mental health conditions that lead to imminent safety risks to self and/or others, or severe psychosis that poses a risk to safety (eg, paranoia that leads to aggression, walking into traffic).
- Imminent safety: suicidal statements or actions, whether planned or impulsive. Imminent safety can also be violence or threats of violence in the context of a mental health condition

HOW ARE PATIENTS ADMITTED?

- Youth are usually admitted through an emergency room (brought there by the community crisis team or police/emergency services) on a 72 hour involuntary hold. This gives the treating MD up to 72 hours to assess them and determine if they are safe to be discharged

LAWS FOR HOSPITALIZING CHILDREN AND TEENAGERS

- In the emergency room, if an MD determines there are sufficient concerns for imminent safety, they will admit to FTC on a 72 hour hold regardless of whether the parent/guardian agrees. These decisions are unfortunate, but prioritize safety for the youth above all else.
- MD has up to 72 hours (at time of admission) to assess them and determine if they are safe to be discharged.
- In the state of Hawaii, youth ages 15 and older have the right to sign themselves in for treatment
- If the youth declines to sign in but the doctor feels imminent safety concerns are still present, or there remains a condition that requires inpatient care (such as issues that need to be addressed that could result in imminent safety concerns if discharged) they would file for an extended involuntary hold. There often are differing ideas between the youth, parents/guardians, and treatment team, about when a youth should be discharged. Part of the treatment process involves balancing youth's wishes, parents' concerns, and provider recommendations (see Family Treatment for details later in this guide).
- If an extended involuntary hold is placed on a youth, a court hearing would be scheduled on the following Thursday. Parents or guardians would receive a notice in the mail of the court date. At this hearing parents or guardians would need to be present to testify to the danger they are concerned would occur if the youth were discharged. This can be very hard to prove, can be very uncomfortable for youth and family, and should be avoided if at all possible. Youth can sign in at a later date if they initially decline to sign in.

My Child Was Just Admitted, What Can I Expect?

- The purpose of the hospital is to assess, stabilize, and safely discharge (including connecting patients to outpatient treatment resources whenever possible).
- Assessment: involves a child/adolescent psychiatrist interviewing the child, as well as interviewing family or others close to the child/teen. A diagnosis or diagnoses will be given at this time, subject to change as new information comes in (the diagnosis at discharge may be different from the beginning of the hospitalization).
- Stabilization: means the child is no longer in crisis. They are not having thoughts to hurt themselves or others and are thinking about the future. This does not mean they are "fixed", it means they are ready to continue treatment in a setting that is less restrictive.
- A safe discharge plan: involves the child and their family/guardians identifying areas of concern when the child leaves the hospital, and ideally are in agreement on how to best address them. In nearly all cases this includes participation in continued care (going to therapy, medicine compliance if applicable), asking for help when needed (if symptoms worsen and unsafe thoughts return) from parents/responsible adults, and safety proofing the home if the child is returning there (locking up medications to prevent impulsive overdoses, securing firearms and potentially lethal means like knives, ingestible cleaners, obvious ligature risks like ropes). Another essential aspect to safety planning is calling the crisis line (988), EMS/HPD (911), or bringing the child to the nearest Emergency Room to be assessed should imminent safety become a concern.
- For patients from an outer-island who are transported to FTC by air-ambulance, Quest insurance will pay for travel (air and ground) on the day of discharge for an adult (usually a parent/guardian) to travel to FTC and accompany the patient back to their home island. For families with commercial insurance, check benefits for possible reimbursement. Family meetings occur via telehealth (using Webex).

The Nuts and Bolts of Acute Care at FTC

- Medical and Financial implications on Length of Stay: Acute care is the highest level of care possible, the psychiatric equivalent of the Intensive Care Unit (ICU). The average length of a stay in the acute hospital is 2-7 days, but this can vary depending in each case. Insurance companies pay for care based on what is deemed medically necessary, so once the child no longer meets those criteria then discharge should be anticipated.
- Nursing handles the care of the child in the milieu. Upon admission nursing provides information about the unit rules and policies. They provide care throughout the day and night to the child. And upon discharge they go over discharge forms with family/guardians.
- If there are concerns about care, Patient Relations can be contacted at 808-691-2837. Medical records can be reached at 808-691-4361 if families are requesting the child's chart. Be aware there is a fee for records and it takes some time to procure. Assessments can be directly faxed to agencies and schools with guardian consent. Families must go through Medical Records if they request their child's chart and some information may be withheld if deemed therapeutically harmful to the child to have it released.

THE TREATMENT TEAM

- Psychiatrist-in-Charge (Attending M.D.) and Fellow/Resident: It is the responsibility of this psychiatrist to plan, direct, and coordinate each individual patient's treatment program. The psychiatrist meets with patients individually for an initial assessment, continues to meet with them daily, and conducts rounds to review each patient's progress. There may be a psychiatry fellow or resident assigned to a patient as well. This person is a doctor who is receiving specialized training in child psychiatry and is supervised by the attending physician.
- Nurses, Behavioral Health Aide, and Psychiatric Assistant: Nurses provide 24/7 care to patients on FTC. They administer medications, treatments, provide individual counseling, provide and maintain a safe environment, encourage participation in group activities, and communicate relevant information to other team members as needed. Nurses work in collaboration with other team members to provide a comprehensive assessment. The goal is to preserve dignity, promote independence, and identify and build on existing strengths. Nursing care also focuses on promoting Recovery Principles, and optimizing psychological and physical well-being. Behavioral Health Aides facilitate the majority of the programming on the unit. They run psychoeducational groups and provide supportive individual counseling and safety planning. Psychiatric assistants help nursing with supervising patients and milieu management.

TREATMENT TEAM CONTINUED

- Clinical Social Worker: This is an LCSW who will coordinate with the patient, their family, and the interdisciplinary treatment team to provide information and education regarding understanding and managing the psychiatric condition, mobilizing resources, improving interpersonal relationships, decision-making related to discharge and continuity of care, and locating appropriate post-discharge services. Clinical Social Work services may include individual and group counseling, family meetings or family therapy.
- Pharmacist: Although you may not meet with this person individually, the pharmacist is a specialist in psychiatric medications who provides consultation and education to clinical staff. The pharmacist reviews all medication orders before being carried out.

Family Treatment at FTC

- Family meetings are usually held with doctors and a social worker to share the findings of the assessment and educate families. Recommendations are provided on treatment in the hospital and when the child leaves. The child is often included to formulate a discharge plan. Sometimes conflicts and concerns need therapeutic intervention in these meetings, and at times a second or third meeting is required to sort through issues, let feelings calm down, and arrive at a plan on which everyone can agree. Usually compromise is required (one party does not get everything they want, but all parties get enough to allow them to move forward). A focus on informing the parent or responsible adult (therapist, school counselor, relative) if unsafe thoughts arise is a universal aspect to safety planning.

Research on Suicide

- In 2015 SAMHSA released a consensus statement on Warning Signs for Youth Suicide. These factors include:
- Talking about or making plans for suicide
- Expressing hopelessness about the future
- Displaying severe/overwhelming emotional pain or distress
- Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of any of the above 3 warning signs. Specifically, this includes significant:

  --Withdrawal from or changing in social connections/situation

  --Changes in sleep (increased or decreased)

  --Anger or hostility that seems out of character or out of context

  -- Recent increased agitation or irritability

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Research on Suicide (continued)
Protective factors moderate the impact of stress on depression and suicidal behavior. Some of the protective factors that mediate adolescent suicidality include:

- Family and school connectedness (Kaminski et al., 2010)
- Reduced access to firearms (Grossman et al., 2005)
- Safe schools (Eisenberg et al., 2007)
- Academic Achievement (Borowsky et al., 2001)
- Self-esteem (Sharaf et al., 2009)