

Adolescents' Experiences During "Boarding" Hospitalization While Awaiting Inpatient Psychiatric Treatment Following Suicidal Ideation or Suicide Attempt

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ABSTRACT

BACKGROUND: Two million adolescents experience suicidal ideation (SI) or suicide attempt (SA) annually, and they frequently present to emergency departments. Delays in transfer to inpatient psychiatric units increasingly lead to "boarding" in emergency departments and inpatient medical units. We sought to understand adolescents' perspectives during boarding hospitalizations to gain insight into helpful practices and targets for improvement.

METHODS: Using convenience sampling, we conducted semistructured interviews with 27 adolescents hospitalized for SI or SA while they were awaiting transfer to an inpatient psychiatric facility. Interviews were recorded and transcribed, and the thematic analysis was organized using NVivo 11.

RESULTS: Eight themes emerged: (1) supportive clinical interactions, (2) information needs, (3) repetitive inquiries, (4) safety, (5) previous hospital experiences, (6) activities and boredom, (7) physical comfort, and (8) emotions. Adolescents expressed appreciation for compassionate clinicians and for receiving information about what to expect, experienced the hospital as a safe environment, emphasized the value of staying occupied and of physical comfort, and were relieved to be receiving help to reduce their suicidal thoughts or behaviors. Reports of embarrassment and discomfort about repeated inquiries from the clinical team, comparisons with previous hospital experiences, and unanswered questions about what would occur during the planned inpatient psychiatric hospitalization were common.

CONCLUSIONS: The perspectives of adolescents seeking care for SI or SA are an important source of information for health care systems seeking to improve hospital care. Clinicians can relieve distress of adolescents awaiting psychiatric hospitalization by focusing on compassionate connection, minimizing repeated inquiries, and providing complete and concrete information about treatment plans.

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Two million US adolescents experience suicidal ideation (SI) or a suicide attempt (SA) each year, and suicide is the second leading cause of death among 10- to 24-year-olds.¹ Adolescents are increasingly visiting medical emergency departments (EDs) with SI and/or SA, where they typically receive an initial medical evaluation.² Those who require further psychiatric evaluation and treatment are often transferred to inpatient psychiatric units, but limited bed availability can lead to transfer delays even after medical needs have been met.³ To ensure the safety of young people at risk for suicide, many institutions house them in EDs or inpatient medical units for observation while they await transfer to an inpatient psychiatric unit, a practice commonly referred to as “boarding.”⁴

Observation in medical EDs and inpatient units helps to ensure physical safety, but medical units are not equipped to provide definitive psychiatric care, and staff may not be well trained in the care of youth with SI or SA.^{4,5} In addition, whereas there are resources available to guide acute management of patients in EDs who are suicidal,^{6,7} there is no current consensus on best practices for the care of patients who are boarding. In addition, little is known about how children and adolescents experience their time in the hospital while boarding despite the fact that this health care encounter represents a chance to engage young people in care. Boarding experiences have the potential to influence future treatment; in previous research, it has been established that both positive and negative experiences with mental health care affect willingness to seek future care.⁹⁻¹⁰ In light of the fact that some young people experience recurrent SI or SA,¹¹ understanding factors that promote or discourage positive engagement with the health care system regarding SI or SA is an important goal.

In keeping with previous efforts to incorporate adolescent perspectives into care models,^{12,13} we sought to gather information about the perspectives and experiences of young people with SI or SA who were boarding in an ED or medical unit while awaiting inpatient psychiatric

treatment. Our primary objectives for the study were to understand (1) how adolescents perceived interactions with the clinical team, (2) which clinical practices adolescents felt were beneficial, and (3) what adolescents thought should be changed about the hospital stay.

METHODS

Setting

This study was conducted at a 535-bed freestanding children’s hospital in the mid-Atlantic United States that serves as an urban community hospital and a national referral center. There is no inpatient psychiatric unit. For patients presenting to the ED with SI and/or SA, the usual care process begins with evaluation by an ED physician, social worker, and psychiatrist to determine the severity of physical and mental health concerns. Patients requiring medical treatment are admitted to a medical floor. Patients requiring inpatient psychiatric treatment are typically transferred to 1 of 5 psychiatric hospitals in the region. When no inpatient psychiatric unit bed is available within several hours, the patient is admitted to a medical inpatient or observation unit. The patient is then cared for by a general medical team, mental health consultation service, pediatric nursing staff, and continuous 1:1 safety observer. Rounds are most often conducted without the patient or family present, and individual clinicians inform patients and families of updates after rounds. Most safety observers are psychiatric technicians (ie, bachelor’s degree–prepared hospital employees with training in mental health or child development).

Participants and Procedures

Study procedures were approved by the hospital’s institutional review board. Patients were eligible for study participation if they were (1) aged 9 to 21 years; (2) hospitalized for SI and/or SA, medically cleared, and awaiting transfer to an inpatient psychiatric unit; and (3) able to complete an interview in English. Patients were ineligible to participate if they had significant cognitive impairment, aggression, or self-injury during the hospitalization; were in the custody of juvenile justice or social services (because

of the difficulty of obtaining legal consent for participation); or if the medical team considered the patient inappropriate to approach for research.

We recruited participants between September 2017 and May 2018. In light of the fact that a parent or guardian was needed to provide consent, we recruited during a broad range of hours (including evenings and weekends) to accommodate various family visiting schedules. On the basis of typical sample sizes in other qualitative studies, we anticipated that interviewing 25 to 30 adolescents would be sufficient to provide thematic saturation. We ultimately identified 135 adolescents who were eligible to participate and interviewed those who had a parent or guardian available to provide informed consent and who remained in the hospital long enough to complete the interview. No eligible family declined participation or terminated participation after providing consent.

In accordance with state law, guardians of younger children, as well as participants 14 years of age and older, also provided written consent to allow for mental health information obtained from the electronic health record and disclosed in interviews to be used in the research. Youth received a \$20 gift card for participating in the study.

Data Collection

Four trained interviewers (who were in graduate school or had a master’s degree) conducted semistructured qualitative interviews. Interviews lasted ~1 hour, and interviewers inquired about (1) events leading up to the hospitalization, (2) how adolescents perceived interactions with the clinical team, (3) which clinical practices adolescents felt were beneficial, (4) positive or negative feelings about their care and hospital stay, and (5) what they would change about their hospital stay (see Fig 1). In addition, adolescents self-reported sociodemographic information using an electronic tablet. Research staff obtained indication for hospitalization (SI or SA), psychiatric diagnoses,¹⁴ chronic conditions,¹⁵ complex chronic conditions,¹⁶ payer information, and length of stay (ie, time from ED arrival to hospital discharge) from the electronic health record.

Please walk me through the events that have happened since you arrived at the hospital.
Can you tell me about the decision to come to the hospital?
What has been hard about being in the hospital?
What has gone well since you have been in the hospital?
What has been confusing to you?
What has been helpful since you have been here?
Who here seems to understand you?
What are you hoping for after you leave the hospital?
What, if anything, are you worried about?
What would you change about your stay here in the hospital?

FIGURE 1 Sample interview questions.

Data Analysis

After transcription of the audio recordings, 2 trained coders independently reviewed and coded each interview transcript to identify themes using the principles of conventional content analysis.¹⁷ All members of the study team reviewed all transcripts and codes and met at regular intervals to discuss emerging themes. Coding discrepancies were resolved through discussion to reach consensus. One-fifth of interview transcripts were independently coded by 2 coders to establish interrater reliability, resulting in Cohen's $\kappa = 0.98$. In keeping with principles of thematic saturation,¹⁸ the study team achieved consensus that thematic saturation was reached and closed recruitment after 6 successive additional interviews had not added new themes. NVivo 11 (QSR International, Melbourne, Australia) was used in organizing the thematic analysis.¹⁹

RESULTS

A total of 27 patients were enrolled in this study. Patients' sociodemographic and clinical characteristics are displayed in Tables 1 and 2, respectively. SI ($n = 22$) was more common than SA ($n = 5$) in this relatively diverse group of young people. The most common clinical diagnoses were depressive disorders, and although no participant had a formal diagnosis of posttraumatic stress disorder, more than half had a documented traumatic experience such as sexual assault or the death of a close family member. The median length of stay was 2 days (interquartile range: 2–3).

Eight themes emerged: (1) supportive clinical interactions, (2) information needs,

(3) repetitive inquiries (4) safety, (5) previous hospital experiences, (6) activities and boredom, (7) physical comfort, and (8) emotions. Selected quotes to illustrate these themes can be found below and in Table 3.

Supportive Clinical Interactions

When asked what was going well during their hospitalization, approximately half of adolescents mentioned communication with clinicians. Adolescents cited several practices that contributed to feelings of trust and safety. Specifically, adolescents felt more secure when clinicians described the processes of the ED visit, pediatric hospitalization, and inpatient psychiatric hospitalization to them; this helped them feel less stressed about the current hospitalization and the plan for an inpatient psychiatric hospitalization. For example, a participant explained, “[The psychiatrist] really knows more about what’s going to go on at the other hospital.... So, me listening to him helped.”

Participants expressed gratitude toward clinicians who showed compassion and interest in their well-being. Adolescents reported being more comfortable with their providers when the providers reassured them that they would receive help. In particular, participants reported feeling comfortable with clinicians who communicated transparently. They described both medical and mental health clinicians as approachable, easy to talk to, and nice.

Adolescents also experienced a high level of comfort with 1:1 staff observers. Many patients stated that the 1:1 observer helped them understand the reason for their hospitalization and process emotions. One participant said, “The second the [1:

1 psychiatric technician] walked in, they cracked me up. They made me—they really honestly made my day so much better.”

Information Needs

Most adolescents had unanswered questions, and some noted that lack of information caused them anxiety. For example, 1 adolescent stated, “I just want to know what’s happening. That would put my mind at ease, but I am not really getting anything. So that’s freaking me out.” Adolescents expressed interest in receiving several types of information about psychiatric hospitalization: food, visitation policies, length of stay, entertainment, daily activities and schedules, location, clinicians providing treatment, types of therapy provided, and the physical structure and layout of inpatient psychiatric units.

Some adolescents felt uncertain about whether they had received all pertinent information about their care, including 1 who remarked, “I feel like there’s some nurses and doctors who understand that I’m not a little kid and I can handle information. Then there’s others—I guess it’s a children’s hospital, so I guess they’re just used to having—talking to younger kids and just like not giving me all the information.” On the other hand, adolescents who did feel well informed reported that this contributed positively to their experience. One participant referred to “the nurses telling me what’s going on” and “the psychiatrist who told me I’m going to another hospital to get help.”

Repetitive Inquiries

Many participants described feelings of stress, anxiety, and embarrassment when they were asked repeatedly by different clinicians to explain their health history and reason for hospitalization. Adolescents who felt remorse over their suicidal crisis cited heightened anxiety when having to repeat the story of why they presented to the ED. As 1 patient reported, “The first time it felt nice to be able to get everything out. But then after the second time of having to say everything, it was just like I didn’t want to talk. I was starting to feel like I had just explained this and I didn’t want to keep having to explain it.” In addition to the repetitive inquiries, patients described

TABLE 1 Sociodemographic Characteristics of Adolescents Boarding While Awaiting Inpatient Psychiatric Treatment of SI or SA (*N* = 27)

Characteristic ^a	<i>n</i> (%)
Age group, y	
9–14	18 (67)
15–18	9 (33)
19–21	0 (0)
Gender	
Male	12 (44)
Female	11 (41)
Transgender or gender nonconforming	4 (15)
Race	
White	12 (44)
African American	10 (37)
Other	2 (8)
>1 race	3 (11)
Hispanic ethnicity	1 (4)
Sexual orientation	
Heterosexual	21 (77)
Bisexual	1 (4)
Lesbian	1 (4)
Queer	1 (4)
Other	3 (11)
School type	
Public	21 (78)
Private	2 (7)
Technical	1 (4)
Not reported	3 (11)
Family owns a car	21 (78)
Family owns a home	16 (59)
Payer	
Medicaid	16 (59)
Private insurance	11 (41)

^a Information was self-reported by adolescents, with the exception of payer (obtained from electronic health record).

feeling intimidated by having to interact with a large number of staff and confused about the roles of different team members.

Safety

Most participants described feeling relieved or, in 1 adolescent's words, "safe and secure" while they were in the medical hospital. One participant reported feeling glad about being in the hospital because she "didn't want to just go home and be yelled at." Another recounted feeling

TABLE 2 Treatment and Clinical Characteristics of Adolescents Awaiting Inpatient Psychiatric Treatment (*N* = 27)

Characteristic ^a	Results
Reason for admission, <i>n</i> (%)	
SI	22 (81)
SA	5 (19)
Length of stay, d, median (IQR)	2 (2–3)
Required acute medical treatment, <i>n</i> (%)	5 (19)
Previous inpatient psychiatric hospitalization, <i>n</i> (%)	10 (37)
Psychiatric condition, <i>n</i> (%) ^b	
Depressive disorder	20 (74)
Anxiety disorder	8 (30)
Attention-deficit/hyperactivity disorder	5 (19)
Bipolar disorder or schizophrenia	3 (11)
Oppositional defiant disorder	4 (15)
Health conditions, <i>n</i> (%)	
Chronic, noncomplex ^c	7 (26)
Complex chronic ^d	3 (11)

^a Data were obtained from the electronic health record.

^b Categories are not mutually exclusive, so percentages do not sum to 100.

^c Identified by using the Chronic Condition Indicator system,¹⁵ excluding complex chronic conditions.

^d Identified by using the complex chronic condition classification system.¹⁶

relieved that she had "no suicidal thoughts" since coming to the hospital.

Several participants raised concerns about whether they would be physically safe after transfer to the psychiatric unit. One adolescent shared, "I'm just scared of the other kids because I know there's kids that's worse than me. I don't want them to hurt me or anything." Another participant described that she had "seen videos of abandoned hospitals and stuff, and it was creepy."

Some expressed concerns about how they would stay safe once leaving a hospital environment. As 1 adolescent stated, "In the hospital... I'm not gonna really have to deal with any of the problems on a regular basis that I did at the house or at school. So it's gonna be like all fine and dandy and I'm gonna have a plan. And then once I step out it's gonna be like welcome to real life."

Previous Hospital Experiences

Many adolescents compared their current hospitalization with previous medical hospital experiences. For some patients, being in a medical hospital felt familiar and comfortable: "I was actually here in the summer because I had [surgery] and I got it done here. I always loved [this hospital]." For other patients, fears related to previous

medical experiences emerged; several patients worried about the possibility of painful treatment.

Other participants recounted worries related to negative experiences during previous inpatient psychiatric hospitalizations, such as witnessing other children become violent, receive injectable medications, or be placed in physical restraints. Finally, some patients expressed concerns about whether they would be able to maintain their privacy and dignity, recounting previous experiences in which they felt they had not been treated fairly or respectfully.

Activities and Boredom

Participants appreciated opportunities to engage in activities alone or with other adolescents. Most participants reported enjoying individual activities such as making crafts, playing video games, and watching TV. Several reported that interacting with child-life specialists or creative arts therapists felt beneficial to them. Many used their smartphone or a family member's smartphone to access social media or send text messages to friends. Adolescents reported feeling bored and distressed when they were not engaged in activities or conversation.

TABLE 3 Key Thematic Areas and Sample Statements From Adolescents' Descriptions of Their Hospital Experiences While Awaiting Inpatient Psychiatric Treatment

Thematic Area	Sample Statements
Supportive clinical interactions	<p>"I feel like the people who are here with me for hours on end [seem to understand me]... Even witnessing the way I interact with my parents and just listening, they understand my frustrations and everything because I am talking to them the entire day."</p> <p>"The nurses just seem really nice. They're not really patronizing or they're not being like, 'Oh, I'm so fed up.' They actually seem to care."</p>
Information needs	<p>"What's taking so long to find me a bed? Why am I still here?"</p> <p>"Well, at my [previous hospitalization], they really sugarcoated it. I really wish that they would have told me what other types of kids were going to be there. I really wish they would have told me what the place was like, because when I got there it was definitely much, much worse than they made it out to be."</p>
Repetitive inquiries	<p>"I guess it was a little bit overwhelming, especially when multiple people would come in the room at once. Like when there was three different people in there and it was kind of just a little nerve wracking."</p> <p>"Everybody was asking me questions about...how I got here and stuff like that. It made me feel overwhelmed and bad about myself."</p>
Safety	<p>"I feel better. Because at first, I was scared, but now, I'm not scared."</p> <p>"They wanted to make sure I was safe. And they asked me if I felt safe going home and I was like as much as I probably want to go home, I don't feel safe."</p>
Previous hospital experiences	<p>"I don't know if I'm gonna get needles or not. I am very scared of needles."</p> <p>"I mean, I'm a little scared. But I mean, I feel okay about it because I've actually been in one [a psychiatric unit] before, so I know how it goes."</p>
Activities and boredom	<p>"I am kind of bored and just like a lot of sitting and just like I know I can't really get up and then just walk around. And I started thinking that I don't want to be here then I just get upset and stuff."</p> <p>"I enjoy doing some arts and crafts. I enjoy doing coloring, watching movies, watching TV, just talking, playing games."</p>
Physical comfort	<p>"The blankets are like the thinnest. And I've gotten used to the temperature, but it's really cold in here."</p> <p>"I would wanna stay here because this is a very comfortable bed."</p>
Emotions	<p>"I've been less stressed, which means no suicidal thoughts."</p> <p>"I was way worse but I guess now that I feel safe and stuff, I guess it's kinda relaxing me a little bit. But I'm still anxious. I don't know what's next."</p>

Physical Comfort

Participants commented on privacy, hospital amenities (particularly bedding and temperature), and personal hygiene. One participant shared a positive experience: "My sister was able to visit to give me pants, so that's nice. It's also good that I'm allowed to shower even if I can't be by myself in the room." Many compared the physical environment in their current hospital room with the environment in other health care facilities, both favorably and unfavorably.

Emotions

Most participants reported that their emotions had become more positive since arriving in the hospital. One adolescent said, "When I first came in, I realized that I was kinda a little bit more scared and tensed up and not really wanting to do anything. But now, I'm kinda calm and feel comfortable." Another reported that being in the hospital had given her a break from daily life stressors. Some adolescents acknowledged

difficulty expressing emotions. In 1 participant's words, "you put on a facade or a mask or a character while you're in the hospital."

Some patients shared negative or difficult emotions. They acknowledged stressors at home, and some expressed feelings of guilt or remorse about their mental health crisis. One patient who had made an SA shared, "I regret the decision I made." Other adolescents acknowledged that it felt difficult to know that their loved ones were worried about them.

Many participants expressed hopes for the future. Common themes included adolescents looking forward to returning to school and seeing their friends and family. One adolescent shared, "I just want this all to be over and just go home."

DISCUSSION

In this investigation of young people's experiences with boarding in a medical

hospital after ED presentation for SI or SA, we found that adolescents experienced several aspects of clinical care as supportive. Many felt safe in the hospital and had positive emotions associated with being hospitalized. Patients felt most comfortable when clinicians conveyed understanding of their concerns and provided specific information about the treatment plan, and they reported that engaging in leisure activities helped relieve distress. In addition, many patients believed that interacting with a 1:1 staff observer helped them process emotions and understand the hospital experience. At the same time, adolescents pointed out opportunities for improving clinical care: they felt overwhelmed by repetitive inquiries from the clinical team, they had unanswered questions about the medical hospital's care processes, and they had questions about what to expect after their planned transfer to an inpatient psychiatric unit. These novel insights into the

health care experiences of adolescents who are suicidal can help clinical teams design patient-centered care for adolescents hospitalized in medical units during mental health crises.

It is notable that many of the aspects of care that adolescents felt were especially supportive, including compassionate staff, opportunities to stay occupied with activities, and efforts to ensure physical comfort, are consistent with patient-centered hospital care in general. Our findings underscore that even in hospitals where mental health specialists are not readily available, general medical clinicians can provide young people with substantial benefit if they ensure high-quality routine hospital care. Clinicians may feel reassured and empowered knowing that young people with SI or SA have many of the same basic needs as those experiencing a general medical illness or emergency, and thus it is possible to provide valuable services to patients even without specialty mental health training.

At the same time, our findings reveal that patients with SI or SA have unique needs. Particularly in cases in which SI or SA is related to a recent traumatic stressor, strategies to reduce the number of times an adolescent is asked to discuss upsetting events is likely to minimize patient distress. This is in keeping with current “mental health first aid” best practices, which acknowledge the importance of allowing individuals to open up at their own pace.²⁰ During an initial ED visit, particularly in academic medical centers, current practice typically involves multiple clinicians asking a history; an individual might be asked to describe their reason for presentation to a triage nurse, ED nurse, ED resident, ED attending, social worker, psychiatrist, and/or 1:1 observer. Although repetitive inquiry can sometimes elicit new details or offer clarity, clinical teams might consider instead offering patients the option of sharing their story with additional clinicians or of adding any information they have not already given rather than asking them to give a full report. This way, adolescents are not forced to repeat information that makes them uncomfortable. Use of an electronic health record or a sign out system to

ensure that all the relevant information is available to each clinician could avoid each clinician needing to inquire about the complete history.

Our findings highlight the importance of offering information to patients. Given that adolescents who are boarding are awaiting transfer to inpatient psychiatric care, it is understandable that they have additional information needs. Educational materials or directed conversations could help adolescents better understand the processes of clinical care.^{21–24} Clinicians can elicit questions or practice a teach-back method to determine if young people have unanswered questions or concerns. A visual educational resource, such as a video or slideshow, could improve adolescents’ knowledge of what to expect in local psychiatric hospitals. For example, such a resource could include photographs of psychiatric unit physical spaces, examples of schedules and activities, and information about specific expectations. If such a resource is created in partnership with local psychiatric units, it could help clinical teams initiate some of the expectations that would be enforced in psychiatric units (eg, daily schedules, limiting social media access) while the adolescent is boarding. When logistically possible, medical clinicians could consider visiting psychiatric hospital units to enhance their ability to explain what young patients should expect.

Ensuring commitment to patient-centered care for patients who are boarding requires an organizational commitment to patients with SI or SA in the vulnerable waiting period between a suicidal crisis and the next phase of care, even in units not designed for psychiatric specialty care. In the hospital where this study was conducted, teams caring for a high proportion of adolescents with psychiatric illness have invested in professional development opportunities to learn advanced mental health skills for nursing and pediatric staff, including Crisis Prevention Institute training²⁵ and Trauma-Informed Care training.²⁶ All psychiatric technicians and some nurses receive introductory training in applied behavior analysis. A new policy statement from The

American College of Emergency Physicians calls for all ED staff to be trained in child mental health issues, including SA,²⁷ and our findings suggest that institutions seeking to implement such training might begin with mental health skills training for the staff who complete 1:1 safety observation and other staff caring for patients with SI or SA, whose influence was cited by adolescents who interacted with them. Numerous training opportunities exist for general clinicians, including those cited above and those offered through the REACH (Resource for Advancing Children’s Health) Institute.²⁸

Several study limitations warrant consideration. We did not capture the perspectives of some categories of vulnerable adolescents: those from families with limited English proficiency, those in the juvenile justice system or in the custody of social services, or those with aggression. In addition, we conducted the study at a nationally known children’s hospital, where the care is tailored toward children and adolescents. Young people presenting to general EDs and hospitals without a pediatric focus may have different experiences, and our findings on the value of provider kindness, efforts to create a sense of safety, and sensitivity to information needs are likely to be particularly important for clinicians to consider when caring for young people in other settings.

Future research to understand the perspectives of patients’ family members will also be important, particularly given that parent perspectives have been shown to influence willingness to engage in future mental health care.^{8–10} Understanding the perspectives of clinicians caring for patients who are under safety observation will be another critical step toward identifying barriers to and facilitators of effective care.

CONCLUSIONS

Children and adolescents with SI or SA who are awaiting psychiatric treatment have unique needs, and understanding their perspectives and experiences can help medical hospital leaders develop safe, effective, and patient-centered safety protocols and staff training.

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