Youth Inpatient Satisfaction Survey:
Family and Youth Perspective of Services for Children and Adolescents during Inpatient Hospitalization

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Agency and Program Description

The Family Empowerment Satisfaction Team (FEST), a program of the Mental Health Association of Southeastern Pennsylvania, an independent nonprofit corporation, is contracted by Montgomery County Behavioral Health to survey parent/caregivers of children and adolescents who are receiving or recently received county behavioral health services. Using a strengths-based approach of Appreciative Inquiry (Hammond, 1998), these surveys are intended to elicit feedback about accessibility, appropriateness and effectiveness of services, and family satisfaction with services. The findings, with recommendations, are reported to the county office and other stakeholders. The insights from youth and families assist county officials and service providers with efforts in making systems and service improvements that are driven by the needs of youth and families and to ensure Montgomery County youth are receiving the best care possible.

BACKGROUND

When youth require treatment for behavioral health challenges, determining the appropriate level of care may necessitate weighing the benefits of the service against the needs of the youth and the family. This is true when a child or adolescent is experiencing emotional or behavioral health crises and may require psychiatric inpatient hospitalization, the most intensive and restrictive service available. While the goal of the service system is to prevent inpatient hospitalization, this level of care may be necessary when the severity of symptoms raises concerns about safety, such as the risk of youth harming themselves or others. While the youth’s admission may be stressful for both the family and their child, the benefits of hospitalization include professional care in a safe environment, crisis stabilization, therapy, and an opportunity to measure the effectiveness of available medications. Because the potential benefits of inpatient psychiatric care and the difficulties associated with out-of-home treatment are great, it is vital that inpatient hospitals maintain the highest standard of care while simultaneously addressing the needs of youth and their families.

In 2013, Montgomery County Behavioral Health requested that FEST, acting as an independent agent for the county, conduct an annual survey of youth from Montgomery County and their parents or caregivers concerning their experiences with inpatient services the child or adolescent recently received. The county office designated four facilities with the highest utilization by Montgomery County youth for this survey. (Figure 1)

Objective

The objective of the 2013 Youth Inpatient Satisfaction Survey was to gain input from families and youth on their experience with the recent hospitalization of the youth to help identify what is working well with services and what areas need improvement. In addition to showing systems trends, individual provider results will be used by the county for provider profiling, an initiative designed to help families make an informed choice in the placement of a child when psychiatric hospitalization is required.

METHODS

FEST met with the county office to establish the procedure for providing FEST with youth contact information following discharge. FEST also spoke with administrators from each of the participating hospitals to discuss surveying youth ages 14 to 18 in the facility prior to discharge. Each provider designated a contact person to communicate with FEST weekly, advising FEST of the census and status of eligible Montgomery County youth in their facility and arranging for FEST to survey the youth on the inpatient unit.

Survey Sample

Montgomery County youth, as well as their parents or caregivers, were invited to participate in this survey if the youth had Magellan Behavioral Health as their primary or secondary insurance and received inpatient services between January 2013 and June 2013 from Brooke Glen Behavioral Hospital, Devereux Children’s Behavioral Health Center, Foundations Behavioral Health, or The Horsham Clinic. In total, this criteria was met by 151 parent/caregivers, 111 youth ages 14-18, and 49 youth ages 13 and under.

Survey Tool

The survey tool, developed in 2008, consisted of three questionnaires. The parent/caregiver questionnaire was comprised of 29 questions, the youth ages 14-18 questionnaire had 20 questions and the youth ages 13 and under questionnaire had five questions. Each survey included quantitative, multiple choice questions and qualitative, open-ended questions. The parent/caregiver and youth ages 14-18 questionnaires also contained three state-mandated questions.

FEST also developed supplemental interview questions to gain additional feedback on areas of interest identified using results from the 2012 Youth Inpatient Satisfaction Survey. Interview questions for youth ages 14-18 focused on goal setting,
therapy, and family involvement. Parent/caregiver interview questions targeted participation in their child’s treatment, treatment strategies, and communication between staff and the family.

**Procedures**

FEST team members administered the questionnaire in-person to youth ages 14 to 18 on the inpatient unit if they consented and met eligibility criteria. Youth were offered the opportunity to be interviewed, as well. Those youth ages 14 to 18 who were not surveyed in-person prior to their discharge, were mailed a letter of introduction and a questionnaire. FEST mailed a letter of introduction and a questionnaire to parent/caregivers of all youth after receiving contact information. A separate questionnaire was included with the parent/caregiver mailing if the child was age 13 or under. Also, FEST made follow-up calls to parent/caregivers to provide them with an additional opportunity complete the questionnaire by phone and/or answer interview questions.

Data collection ended in June 2013. All data were entered in an Excel workbook and calculations were run for analysis. FEST members reviewed the data and prepared a report, with recommendations, for the county office.

**FINDINGS AND DISCUSSION**

Fifty-four parent/caregivers and 61 youth ages 14-18 took part in this survey, representing 36% of the parent/caregivers and 58% of the youth eligible to participate. Thirty-four of the parent/caregivers completing the questionnaire by phone also consented to answer additional interview questions. In addition to completing questionnaires, 54 youth ages 14 to 18 also agreed to be interviewed, including one youth who chose not to complete a questionnaire. Three children completed the questionnaire for youth ages 13 and under. In response to demographic questions, parent/caregivers reported that their children were between ages 7 and 17, with 57% of children being male. Responses to the Youth 14-18 Survey indicate the respondents ranged in age from 14 to 17, with 52% reporting their gender as male.

Survey results indicate inpatient hospitals are providing opportunities for parent/caregivers to participate in their child’s treatment and for youth to guide aspects of their treatment. An analysis of both the quantitative and qualitative results by parent/caregivers and youth ages 14 to 18 indicate providers are doing well in areas of service and suggest other areas in which improvement is needed. FEST reviewed parent/caregiver and youth results independently, taking into account that each group would have its own perspective of the hospital experience. Looking at the more in-depth qualitative responses together with the quantitative results, FEST identified themes that emerged as the focus for the following discussion of the findings from the parent/caregiver survey and those from the youth survey. Parent/caregiver results are presented in relation to the parent/caregiver perspective regarding communication issues, appropriateness of care, and discharge issues. Survey results for youth ages 14 to 18 are discussed according to the youth perspective concerning their participation in treatment, the effects of interpersonal relationships during their treatment, and facility and policy issues that affected them while hospitalized.

**Parent/Caregiver Results**

**Communication**

Parent/caregiver quantitative survey results and qualitative interview responses indicate providers are doing well in aspects of communication with families, although results suggest certain key areas are in need of improvement. (Figure 2) Almost 80% of respondents reported being invited to attend treatment planning meetings. Parent/caregivers indicate that staff members are talking to families in a respectful manner, with 93% of parent/caregivers agreeing that staff used language they could understand, rather than using unfamiliar clinical terms. While parent/caregivers reported moderate agreement that their child’s medications had been discussed with them, interview responses suggest that doctors are clearly explaining medications to families, including the desired effects and possible side effects, and are answering parent/caregivers’ questions about medication. Most parent/caregivers reported being kept informed of medication adjustments. One parent stated, “The psychiatrist would call and explain side effects and therapeutic effects. Made sure I understood everything.”

**Support for Families**

Helped family feel hope 83%
Staff cared about family 65%
Family told what they did well 64%

**Discharge Planning**

Part of discharge planning 89%
Child prepared for transition 76%
Comfortable with after care 78%
Knew how to access supports 76%

**Outcomes**

Care appropriate for child 80%
Would recommend facility 76%

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**Figure 2**

<table>
<thead>
<tr>
<th>Agreement by %</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% - 100%</td>
<td>▶️</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>60% - 79%</td>
<td>▶️</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>59% or less</td>
<td>▶️</td>
<td>📷</td>
<td>□️</td>
</tr>
</tbody>
</table>

**Parent Caregiver Survey Results**

<table>
<thead>
<tr>
<th>Staff Communication</th>
<th>Agreement by %</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication was discussed</td>
<td>☑️</td>
<td>74%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Staff responded to phone calls</td>
<td>☑️</td>
<td>66%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Informed of child’s progress</td>
<td>☑️</td>
<td>65%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Invited to planning meetings</td>
<td>☑️</td>
<td>78%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Told how to file complaint</td>
<td>☑️</td>
<td>50%</td>
<td>📷</td>
<td>□️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent Participation</th>
<th>Agreement by %</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made treatment decisions</td>
<td>☑️</td>
<td>69%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Important in child’s treatment</td>
<td>☑️</td>
<td>67%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Staff valued parent’s input</td>
<td>☑️</td>
<td>76%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Helped plan treatment goals</td>
<td>☑️</td>
<td>74%</td>
<td>📷</td>
<td>□️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respetful of Family</th>
<th>Agreement by %</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child treated with respect</td>
<td>☑️</td>
<td>89%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Used words parent understood</td>
<td>☑️</td>
<td>93%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Sensitive to family’s culture</td>
<td>☑️</td>
<td>94%</td>
<td>📷</td>
<td>□️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support for Family</th>
<th>Agreement by %</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helped family feel hope</td>
<td>☑️</td>
<td>83%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Staff cared about family</td>
<td>☑️</td>
<td>65%</td>
<td>📷</td>
<td>□️</td>
</tr>
<tr>
<td>Family told what they did well</td>
<td>☑️</td>
<td>64%</td>
<td>📷</td>
<td>□️</td>
</tr>
</tbody>
</table>
Frequent communication with hospital staff is important to families, especially when the staff openly shares information and quickly responds to parent/caregivers’ questions or concerns. Quantitative results and interview responses indicate a need for improvement in these aspects of communication with families. While some parent/caregivers provided qualitative responses such as, “I was always kept in the loop,” only 65% of respondents agreed with the statement The staff kept me informed of my child’s progress. Survey results show 66% of parent/caregivers agreed with the statement I could call about concerns with my child’s treatment, and someone was available to talk to me. Parent/caregiver qualitative accounts regarding staff responsiveness varied, ranging from “Very open to phone calls and would call back if busy” to “Never spoke with medical staff. I left several messages that were never returned.” Overall, interview responses indicate the parent/caregiver experience was inconsistent with both information sharing and staff responsiveness, often resulting in families feeling left out and limited in their ability to participate in their child’s treatment. Parent/caregivers need information to make informed decisions about their child’s treatment, to feel comfortable with the care their child is receiving, and to become better educated about how to manage their child’s care following discharge.

**Appropriate Care**

The delivery of behavioral health services to youth in which the family participates as a full partner in all stages of the decision making and treatment planning process including implementation, monitoring and evaluation is an accepted practice and a core principle of CASSP. Encouraging active involvement by parent/caregivers in their child’s treatment and providing families with support they need may increase the positive perception of parent/caregivers about the quality of care their child is receiving. This influence is suggested when comparing the results of the 80% of parent/caregivers who agreed with the statement The care that my child received was appropriate for his or her needs to the results of the 20% of parent/caregivers who did not agree. Those who agreed that the care met their child’s needs were more likely to report that they were invited to treatment planning meetings, were involved in planning goals for their child’s treatment, believed that staff valued their input, and felt staff helped to instill a sense of hope that their child’s condition would improve. These results suggest that hospitals fostering a collaborative relationship between parent/caregivers and staff by encouraging active engagement of parent/caregivers in their child’s treatment, utilizing family input and promoting open and accurate sharing of information. This, in turn, can help promote treatment that is individualized to meet each child’s specific needs. When answering an interview question, one parent stated, “The doctor called and talked with us when my child’s meds needed to be changed, wanting to know specifics about the child. There was an almost immediate improvement with my child after this change of medication.” By working collaboratively with the child’s parent, the doctor utilized the parent’s expertise about the child to help determine appropriate adjustments to medications which, in this instance, immediately benefited the youth.

**Discharge**

Discharge planning should begin once the child or adolescent is admitted. It is critical that parent/caregivers and youth have significant input in the planning process. Based on survey results, providers are doing well with involving families in discharge planning. The statement I was included in discharge planning elicited parent/caregiver agreement of 89%, which was among the highest in the survey. However, fewer parent/caregivers reported feeling they and their children were sufficiently prepared for the discharge. Lower agreement to statements about being comfortable with the after-care plan, knowing how to access supports and services, and the child being prepared for the transition home suggest hospitals need to do more to ensure that families are ready for discharge.

Further analysis of quantitative results suggests that, of the parent/caregivers who agreed with all discharge-related statements, many reported that staff shared information with them, encouraged them to participate in the child’s treatment and helped their family to feel hope (Figure 3).

A closer examination of parent/caregiver qualitative responses provides additional insight into families’ experiences with discharge. When asked to identify what part of inpatient treatment was most effective, one parent responded, “Helped us to get services and gave us direction.” However, another parent suggested improvement was needed in the area of discharge, stating, “Only thing I didn't like was the lack of involvement with discharge planning. Felt like I was just handed a bunch of papers.” Interview questions concerning family participation, inclusion in treatment decisions, discussions about medications and feelings about the effectiveness of treatment also elicited responses that referred to the youth’s discharge. Overall, 20 out of 54 parent/caregivers commented on the discharge process, offering a mix of both positive and negative experiences.
Youth Ages 14 to 18

Participation in Treatment
Youth ages 14-18 results suggest that providers are doing well involving adolescents in treatment, with 79% of youth agreeing with the statement The staff encouraged me to participate in activities that were part of my treatment plan. (Figure 5) However, results suggest improvement is needed in other treatment-related areas. The statement My medications were discussed with me yielded a result of 73% agreement. When medication options are discussed with youth, it allows them to make informed decisions about their use. Participating in making treatment decisions, such as with medication, offers youth a means to guide their own care.

Although only 62% of youth ages 14-18 reported being involved in making treatment decisions, interview responses offered a more in-depth look at youth participation in specific areas of treatment. Youth identified individual and group therapy sessions, group activities, family meetings, and setting short-term and long-term goals as ways in which they were involved in their treatment. When asked about their therapy preferences and what they found most helpful, 31 of the 54 interview respondents cited group therapy as being most helpful, while 17 respondents preferred individual therapy. Youth who preferred group therapy often mentioned the therapeutic role that their peers played in the group setting as the reason for their preference, using words such as relatable, supportive, and informative to describe their peers. One youth stated, “I prefer groups. People there feel what I feel or at least can understand me.” Responses from youth who found individual therapy most helpful tended to focus on privacy and individualized attention as reasons for their preference.

Setting goals is an avenue which allows youth to make treatment decisions. Youth reported various levels of involvement when setting goals. Of the 54 adolescents interviewed, 46 reported setting daily short-term goals and 47 said that they had set long-term goals while in the hospital. The content of their responses suggests there is a distinction between active and passive involvement with setting goals. An example of active involvement was provided by a youth respondent, stating, “I make my goals. I look at the day before and want to do better. Think a lot about what’s going on to make me a stronger person.” Another statement, “The techs ask me what my goal for the day will be,” suggests a more passive level of youth involvement. A review of adolescent responses related to setting both short-term and long-term goals yielded similar results, with about 70% of youth indicating they were actively involved in setting their goals. By emphasizing participation in goal setting as an opportunity to make treatment decisions, providers can increase the capacity of youth to guide treatment.

Interpersonal Relationships
Survey results indicate that a youth perception of inpatient treatment can be greatly influenced by interpersonal relationships with peers and staff during hospitalization. In qualitative data, youth cited therapeutic benefits of their interactions with peers. Many adolescents also identified relationships with the staff when responding to the questions What did you find most helpful to your stay? and What would have made your stay better? Hospital staff was mentioned in the responses of 30 youth, with 14 youth finding staff most helpful, 10 youth reporting staff could have made stay better, and six giving mixed responses regarding staff. (Figure 6) Positive comments by youth generally reference the level of support they received from staff, the degree to which they felt staff listened, how staff related to the youth, and staff treating them with respect. Eight of the youth who provided negative comments about staff referred to a lack of respect by staff. Youth ages 14-18 survey results indicated high levels of agreement in response to statements concerning cultural sensitivity of staff and staff using language youth could understand. Nevertheless, results yielded a moderate percentage of youth (69%) who felt that staff treated them with dignity and respect.
The need to be treated with respect is a common theme in adolescent responses regarding their interpersonal relationships with staff members. Youth qualitative results demonstrate the importance of respectfulness in forming relationships, along with its ability to have a positive effect on treatment. Youth comments regarding a perceived lack of respect by staff support the quantitative results regarding dignity and respect, suggesting that this is an area for improvement. It should be an expectation within every psychiatric hospital that all individuals be treated with respect. When working with youth, staff must set the example. Youth are more likely to take an active role in their treatment when they feel they are respected by staff. (Gostin, et al., 2003; Alford, 2009; Moses, 2011)

**Facility/Policy Issues**

The youth perspective regarding facility and policy issues emerged in qualitative responses relating to aspects of the inpatient environment that are under the hospital’s control. These issues include the rules and procedures that youth are expected to follow as well as the living conditions within the facility. All youth responses concerning living conditions were elicited by the question *What would have made the stay better?*—seven adolescents cited food-related issues, three youth identified a need for better bedding, two adolescents mentioned facility cleanliness, and two adolescents referred to a need for more privacy, such as installing shower doors. While issues related to living conditions are likely to occur in an inpatient setting, providers should attend to youth concerns in order to avoid unnecessary distractions to youth through the course of their treatment.

Other responses from youth ages 14-18 concerning hospital policies and rules focus on issues that they felt directly affected their inpatient treatment. In response to the questions *What was most helpful about your stay?* and *What would have made the stay better?*, four youth referred to the implementation of a level system. One youth commented, “I’m glad they took away the color safety levels since last time I was here—it took too long to get to the top level.” Another youth responded, “The stay would be better if there were less patients, more outside time, and the stupid ‘level’ system was eliminated.” This comment also touches on another policy-related topic mentioned by youth, which is a need for free time and activities. One youth specifically cited having the means to exercise as being most helpful during the inpatient stay, while four others mentioned a desire to listen to music or participate in other activities. Several youth referred to these free-time activities as a way to practice coping skills and an opportunity to apply insights acquired during treatment.

**RECOMMENDATIONS**

Results from FEST’s 2013 survey indicate that the participating inpatient providers have many strengths that enable them to provide effective care for children and adolescents experiencing acute crises. Providers offer opportunities for families to participate in their child’s treatment and youth to take part in setting goals and benefit from peer social support and positive staff relationships. By acknowledging the positive impact that their services are already having on children and adolescents, inpatient providers can continue to grow and improve in areas that will strengthen the quality of care offered to youth and their families.

Parent/caregiver feedback suggests that information sharing, staff responsiveness, and regular updates on their child’s progress are important to families. It is recommended that providers take steps to improve initial and ongoing communications with parent/caregivers. At the time of admission, providers should assign a specific staff member to help maintain an open channel of communication between the family and the hospital throughout their child’s stay. By establishing a personal connection with the family, the staff member can better understand the family’s unique situation and effectively serve to provide the parent/caregiver with regular updates on the child’s progress and help to answer questions or concerns the family may have. Also during admission, providers should collect information on the parent/caregiver’s preferred and alternate means of communication, such as cell phones, video chat, email, or text messaging, along with the nature of communication they feel is appropriate for each method. For example, while a parent/caregiver may consider it appropriate to be reached by text message in an emergency, they may not want to have progress updates communicated this way.

It is advised that hospitals encourage open sharing of information at all levels to increase information sharing between staff and parent/caregivers and promote a collaborative treatment model in which professional staff value the information parent/caregivers can provide about their child and family. Inpatient providers must ensure that treatment staff receive additional education and training, if needed, to effectively utilize the unique expertise of parent/caregivers when making treatment decisions and in developing an individualized treatment plan for the child. When parent/caregivers are viewed as
equal members of the treatment team, information sharing will become a natural outcome. Offering a variety of ways for families to become actively involved in their child’s treatment will increase opportunities for collaboration and information sharing between staff and parent/caregivers. Staff need to address any barriers families face in participating in treatment and offer solutions, if possible, such as assisting with transportation to and from the hospital or allowing family members to participate in meetings via telecommunication.

Although results indicate families are involved in discharge planning, hospitals must do more to prepare parent/caregivers for their child’s discharge. Work needs to begin early in the admission to help families create a realistic aftercare plan that emphasizes natural supports and community resources. Assisting parent/caregivers and youth in identifying individuals to rely on for support, as well as supports in the community, is important when preparing for discharge even if youth will be receiving other services. Additionally, hospitals can increase the ability of relatives and friends to play a supportive role following discharge by providing opportunities for immediate and extended family members and other individuals close the family to participate in treatment, enacting family-friendly visitation policies, and encouraging supportive individuals to attend family meetings.

While it may not be clear exactly when the child will be discharged, families should have some warning that it will happen soon and be given an opportunity to meet with the doctor or social worker in advance to review, discuss, or clarify any questions about medication, the diagnosis, or what should be done while waiting for aftercare services to begin. Parent/caregivers will be better prepared for the child’s discharge when they are provided with information about their child’s treatment on a regular basis. Hospitals can improve the family’s experience with inpatient services by taking steps to reduce stress at the time of discharge and bolster family confidence in managing their child’s transition. Inpatient providers can further assist families by connecting parent/caregivers to free supplemental services that begin working with the youth and/or family during the hospitalization to increase preparedness for discharge and the transition home. Examples include:

- Family Engagement Services offered through Children’s Crisis Support works with children and families on crisis planning and support during hospitalization and in managing the transition back home.
- Family Mentor and Advocacy Network of the Mental Health Association of Southeastern Pennsylvania offers parent/caregivers advocacy and help in navigating the service system and support from other parents who have had similar experiences with their children.

Encouraging youth to guide their inpatient treatment requires innovative approaches by staff and open minds about how youth may express what they want or need. Youth survey results suggest a range of awareness among youth concerning their individual roles and responsibilities in guiding their care. It is recommended that staff receive training to ensure they understand the concepts of youth-guided care and how to apply these concepts to inpatient treatment for adolescents. This includes recognizing developmentally appropriate expectations for youth when giving them opportunities to guide their care. Providers can utilize existing aspects of inpatient treatment, such as goal-setting, as methods for promoting active youth participation in treatment.

Interpersonal relationships and their influence in fostering a positive environment are important aspects of the youth inpatient experience. Respect is a key factor in forming interpersonal relationships and was mentioned often by youth as a determinant of the quality of the relationships formed within a facility. When staff members view youth as individuals with strengths, not as problems or as a list of diagnoses, youth are more likely to feel respected. Therefore FEST recommends that all treatment staff and frontline staff be educated in resiliency and recovery principles and receive ongoing training to help put strengths-based concepts into practice.

Inpatient providers should take heed to the potential for facilities-related issues to negatively impact the adolescent perception of their inpatient experience. The prevalence of comments related to policies, rules and living conditions reported by youth respondents as being the least helpful part of their hospitalization cannot be ignored. Youth input may be very valuable in addressing issues and possible solutions related to living conditions rules and policies. Providers should explore opportunities to increase collaborative problem solving, identify which rules could be more flexible, and provide youth with explanations about why specific policies are necessary. While it takes time to implement organizational changes or to help staff adapt to new treatment concepts, hospitals have the ability to quickly fix many of the problems that youth found distracting or counter-productive to treatment.

CONCLUSION

Many beneficial aspects of inpatient treatment for children and adolescents extend beyond the safety, close monitoring and prescribing or adjusting medication afforded during inpatient hospitalization. An environment that encourages parents to
become partners in their child’s treatment, welcomes the involvement of the whole family during the child’s hospitalization, and recognizes the importance of providing youth with opportunities to make decisions to guide their own treatment is not only optimal for many youth in treatment, it is also attainable. Changes in hospital policy and attitudes that redefine the roles of professional and front-line staff take time. However, the shift in paradigms to reflect service delivery that melds professional knowledge with the personal expertise of the parent/caregivers and the youth receiving care can yield more individualized treatment and better outcomes for many youth. When treatment teams include the parent/caregiver and youth, and parent/caregivers and youth identify any immediate or extended family members, friends or other natural supports to involve in the youth’s inpatient treatment, hospitals can ensure there will be some degree of support following discharge. All parties must work in a coordinated effort to stabilize the youth and develop tools that can be used to avert serious crisis in the future, while simultaneously supporting and educating the family to improve their ability to resume their care-taking role following discharge.

REFERENCES


