Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's e-mail address. Letters commenting on material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

Ultrashort Stays and a Focus on Recovery

To the Editor: Many thanks to Drs. Glick, Sharfstein, and Schwartz for addressing the timely and important topic of ultrashort psychiatric hospitalizations in their Open Forum in the February issue (1). The concern that brief, formulaic, and discontinuous treatments may lead to poor medical care is not limited to psychiatry (2). In psychiatry, the constant pressure to discharge patients and the view that only biologic treatments are medically necessary interventions are major drivers of ultrashort stays. Our profession has sometimes exacerbated these pressures by embracing what has been called the "bio-bio-bio" model of treatment (3,4).

However, I am not sure that I agree with the authors' argument that ultrashort stays are responsible for clinicians' lack of a person-centered approach. I do agree that this is often the reason put forward, but is it at least partly an excuse? Was psychiatric treatment so recovery focused before length of stay fell to five days? Do we fully believe the assumption that a recovery-focused approach always has to take more time?

A consultation that I recently completed at a nearby hospital illustrates this issue. The patient, a homeless man, was admitted in an acutely agitated state after having been beaten up, his face battered. His treatment team never learned the details of the beating but instead got into a conflict with the patient over his taking psychiatric medications for the agitation. He had never taken psychiatric medications. The team withheld his regular medications in an attempt to determine whether they were contributing to the agitation.

This standoff over medication ended up involving a judge, patient advocates, and the state mental health department, and it cost time. Meanwhile, an opportunity to build an alliance with the patient and learn about the important context of the hospitalization was lost. Did the patient need anything more than short-term PRN psychiatric medications? When the clinicians on the hospital team discharged him (on medications he never wanted and most likely immediately discontinued), did they send the patient back to a potentially dangerous situation where he could be beaten again? Because of their narrow focus on the symptoms in front of them, they would never know the answers to these questions.

I heartily agree with Dr. Glick and colleagues' basic thesis and their cautionary tale about where our profession is with respect to inpatient care. Yet I also think there is much we can do to become more recovery focused even within the system's current constraints. Doing so would serve patients better and would ultimately be more satisfying for clinicians.

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To the Editor: The Open Forum by Dr. Glick and colleagues (1) raises important concerns and offers a valuable treatment model for child and adolescent psychiatry. The concerns these authors describe are also issues in providing care to youths (2): ultrashort stays similar to those for adults; a single criterion—dangerousness—for admission decisions; limited availability at hospital admission of information from previous therapies; infrequent psychological and medical evaluations; lack of attention to collaborative care that meets the physiological and safety elements of Maslow's hierarchies (3); few treatment objectives other than safety; lack of evidence-based psychosocial programming; inadequate family involvement; administrative barriers to evaluating interventions , such as out-of-hospital passes; and restricting the options of the treating child psychiatrist to evaluation, treatment of behavioral crises, medical management, and dealing with abrupt discharges when the managed care company denies further treatment.

The three-phase treatment mode—assessment, implementation, and resolution—proposed by Dr. Glick and coauthors can address many of these issues, but I would like to highlight several that I feel are particularly important.

The role of the child psychiatrist should return to being that of a comprehensive deliverer and director of all aspects of treatment, so that coherent psychosocial diagnosis and individual, group, and family treatment can occur. This would be a time-intensive effort that could result in the development of child psychiatry hospitalists. In addition, treatment authorization must be based on psychosocial and diagnostic issues. Treatment goals for the child and family should be clarified at admission, a process that must include

asking about perceptions of hospitalization, which may be based on films such as *Sucker Punch* or *Girl, Interrupted.* Also, viable individual safety plans (4) should be developed at admission for children who are prone to behavioral crises and harm to themselves or others.

Furthermore, admission screening questionnaires should be routinely used, including a children's depression inventory, a trauma assessment inventory, a substance abuse screen, and an incomplete-sentence form. Children may be willing to disclose their concerns on written forms rather than to an unknown professional. Screening for medical illnesses must also be routine and under the direction of a pediatrician who works closely with the child psychiatrist to identify chronic conditions, such as hepatitis, anemia, hyperglycemia, and obesity. In addition, a structured collaborative teaching and treatment environment should be created for the delivery of care. "A CBT Approach to Inpatient Psychiatric Hospitalization" (5) describes an effort developed to achieve these goals. Designed for stays of five to 12 days, the program is compatible with managed care treatment limits.

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In Reply: We agree completely with Dr. Barber's contention that even ultrashort hospitalizations can become more recovery oriented than they currently are. Implementing recovery practices on inpatient units requires an attitude of culture change in which the focus shifts from getting the work done in the most efficient manner to ensuring that patients' interests are at the center of all we do. The problem with ultrashort hospitalization as it is practiced today is embedded in this notion: the patient's best interests, especially as the patient and the recovery community may see them, are often at odds with an institutional staff that is obligated to move the patient through a mindless sequence of steps in a very limited time frame. Recovery-oriented inpatient treatment requires respect, dignity, and careful attention to the context of the patient's life. Let's be respectful and spend the time necessary to do this right.

We appreciate Dr. Masters' thoughtful approach to the admission and treatment of children and adolescents. When the sole focus of a hospital stay is crisis stabilization and safety, this precludes such an attentive approach to the special needs of children.

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