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Inpatient psychiatry

October 2026

The scope of this current awareness bulletin is inpatient psychiatric care and patient discharge. The bulletin focuses on administration and organisation of inpatient psychiatry rather than psychiatric treatment itself. UK/Europe/North America/Australia/NZ limits.

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References

Dixon J., et al. (2026) '[Associations between the Nurse Work Environment and Job Outcomes among Inpatient Psychiatric Mental Health Registered Nurses: A Cross-Sectional Observational Study.](#)' *Journal of Psychiatric and Mental Health Nursing* (pagination), Date of Publication: 31 Jul 2026.

INTRODUCTION: Psychiatric Mental Health Registered Nurses (PMH-RNs) are the largest group of healthcare providers working within inpatient mental health settings. Despite longstanding concerns about the emotional demands and safety of nurses practicing in these settings, few studies have examined associations between organizational factors and nurse job outcomes among inpatient PMH-RNs.

AIM/QUESTION: To examine burnout, job dissatisfaction and intent to leave among PMH-RNs employed in inpatient psychiatric units and how these job outcomes are associated with the quality of their nurse work environments.

METHOD(S): This cross-sectional study combined data from the 2023/2024 Penn Nurses4All and 2023 American Hospital Association (AHA) survey data.

RESULT(S): Approximately 4 out of 10 inpatient PMH-RNs experience high burnout as well as high levels of job dissatisfaction and intent to leave their roles. More favourable nurse work environments were associated with reduced negative job outcomes among inpatient PMH-RNs.

DISCUSSION(S): Our findings provide insight into the current state of the PMH-RN workforce and how the nurse work environment may represent a modifiable factor to improve nurse wellbeing, job satisfaction and job retention among this group.

Policymakers and administrators should prioritize this vital group of health care professionals by improving interdisciplinary teamwork, promoting adequate staffing

levels and creating a safe and inclusive environment for PMH-RNs.
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Fedorova T.D., et al. (2026) '[Frequent Readmissions After Hospitalization for Alcohol Withdrawal: A Systematic Review and Meta-Analysis.](#)' *Addictive Behaviors* 183(pagination), Article Number: 108822. Date of Publication: 01 Dec 2026.

Background Alcohol use disorder and alcohol withdrawal syndrome impose substantial clinical and economic burdens, with repeated hospitalizations being common. We aimed to systematically review readmission rates following inpatient detoxification, assess variation across study designs and hospital settings, and identify key risk and protective factors. Methods We performed a literature search in Embase and Pubmed on 10/04/2026 focusing on studies assessing in hospital alcohol detoxification. Exclusion criteria included studies on substance use other than alcohol and outpatient or residential treatment. Main outcome was rehospitalization, and meta -analysis was performed to estimate pooled readmission proportions. Secondary outcomes were risk factors and protective factors influencing the rate of rehospitalization. Results Twenty-five studies were included. The pooled proportion of readmissions following alcohol detoxification was estimated at 17% (95% CI: 14%-21%; 13 studies, n = 287,896) within 1 month, increasing to 44% (95% CI: 36%-52%; 8 studies, n = 2,877) at 1 year. Substantial between-study heterogeneity was observed. Subgroup analyses found no significant differences by hospital setting or time period. Findings for study aim and study design were mixed and based on limited data A small number of studies suggested associations with housing stability, employment, and treatment engagement. Conclusions This meta -analysis suggests that approximately one in six patients are readmitted within 1 month and nearly half within 1 year after inpatient alcohol detoxification. However, readmission rates varied considerably across settings and populations. Future research should evaluate targeted interventions to reduce readmissions among high-risk patient groups.

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Giri Y.R., et al. (2026) '[Discharge Location as a Predictor of Prolonged Length of Stay in an Inpatient Psychiatric Hospital: A Retrospective Study.](#)' *Brazilian Journal of Psychiatry* 48(pagination), Article Number: e20254406. Date of Publication: 2026.

Objective: This study examines discharge location as a predictor for prolonged length of stay (LOS) in an inpatient psychiatric hospital.

Method(s): Retrospective study of 2,717 adult patients in an inpatient psychiatric hospital in New York. The outcome variable of LOS was ≤ 25 days vs. > 25 days. Multivariate logistic regression analysis was used. We adjusted for demographics, psychiatric diagnosis, medical history, and psychiatric history.

Result(s): Discharge to supportive housing (OR: 2.34, 95%CI 1.89-2.89, $p < 0.001$), a long-term psychiatric facility (OR: 44.48, 95%CI 17.70-111.78, $p < 0.001$), nursing home/assisted living facility (OR: 10.38, 95%CI 4.49-24.01, $p < 0.001$), and substance abuse rehabilitation center (OR: 2.16, 95% CI 1.31-3.58, $p = 0.003$) were each significantly associated with increased odds for LOS > 25 days. Discharge to a jail/correctional facility (OR: 0.43, 95%CI 0.19-0.93, $p = 0.032$) was significantly associated with decreased odds for LOS > 25 days. No significant associations were found for medical/surgical floors and short-term psychiatric facilities. These

significant findings for discharge locations persisted even adjusting for often-studied variables.

Conclusion(s): As discharge location is associated with LOS, we recommend that mental health care providers begin safe discharge planning from the day of admission and involve a multidisciplinary team with the goal of stabilizing the patient as soon as possible.

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Holland K.E., et al. (2026) '[Constant Observation in an Inpatient Psychiatric Setting: A Scoping Review.](#)' *Journal of the American Psychiatric Nurses Association* , 10783903261478887.

BACKGROUND: Observation of patients is integral to nursing's role in inpatient psychiatric settings. Constant observation (CO) is a common strategy for managing high-risk behaviors. Although widely used, the field seemingly does not have a standard definition of CO, and policies for the use of CO vary across institutions. To date, literature has focused on experimental data regarding CO improvement or has been limited in scope. Resultantly, researchers and clinicians have been restricted in their ability to characterize the usage of CO and the effectiveness of CO as a risk reduction strategy. AIMS: The purpose of this scoping review was to characterize the extant data regarding CO use and to assess how CO is being discussed in the literature.

METHOD(S): This review included published manuscripts, that is, clinical discussions, critiques, commentaries, and research studies pertaining to CO within inpatient psychiatric units.

RESULT(S): Fifty-nine articles were identified and reviewed. Findings suggested a lack of consensus regarding CO policy. Overall, more patients with more severe symptoms were more likely to receive CO, and high-risk behaviors were predictive of CO use. However, there is limited research suggesting that CO is an effective intervention to prevent or reduce high-risk behaviors. Even so, CO is generally well-accepted across disciplines and by patients, despite it being costly and resource-intensive. Some studies identified interventions such as restructuring staffing, increasing therapeutic interventions, and including patients in problem-solving as effective means of reducing CO use without increasing high-risk behaviors.

CONCLUSION(S): The role of CO in psychiatric settings was examined, and recommendations were made.

Jang S., and Chen, J. (2026) '[Hospital Artificial Intelligence Tools and Inpatient Utilization and Costs in Older Adults with Alzheimer's Disease and Related Dementias.](#)' *Journal of the American Geriatrics Society* (pagination), Date of Publication: 14 Se 2026.

BACKGROUND: Hospitals are increasingly adopting artificial intelligence and machine learning (AI/ML) tools to support clinical decision making and care management. However, evidence on how hospital AI/ML adoption relates to inpatient utilization and spending among clinically complex populations remains limited. Older adults with Alzheimer's disease and related dementias (ADRD) experience higher rates of readmissions and potentially avoidable hospitalizations.

METHOD(S): Cross-sectional study was conducted using 2023 inpatient claims linked to the Medicare Beneficiary Summary File and the American Hospital Association Annual Survey Information Technology Supplement to examine associations between hospital adoption of patient-related AI/ML tools and inpatient utilization and spending among Medicare fee-for-service (FFS) beneficiaries with

ADRD. The study included 340,509 FFS beneficiaries aged 65 years or older with ADRD who experienced at least one inpatient hospitalization in 2023. Hospital adoption of patient-related AI/ML tools was measured using four indicators reflecting AI/ML use to predict inpatient health risks, identify high-risk outpatients, monitor patient health, and recommend treatments. Outcomes included frequent hospitalization, 30-day readmission, preventable acute and chronic hospitalizations, total Medicare payments, and beneficiary out-of-pocket (OOP) spending. Multivariable regression models adjusted for beneficiary and hospital characteristics. RESULT(S): Greater hospital adoption of patient-related AI/ML tools was associated with lower odds of frequent hospitalizations, 30-day readmissions, and preventable acute hospitalizations. Inpatient risk prediction and high-risk outpatient identification tools were consistently associated with lower inpatient utilization. Inpatient risk prediction was associated with lower total Medicare spending, while high-risk outpatient identification was associated with higher Medicare spending. Treatment recommendation tools were associated with higher beneficiary OOP spending. CONCLUSION(S): Among Medicare FFS beneficiaries with ADRD, hospital adoption of patient-related AI/ML tools, particularly those focused on risk prediction and high-risk patient identification, was associated with lower inpatient utilization without increasing overall spending. Heterogeneity across AI/ML tool types suggests the importance of evaluating AI/ML tools based on their specific clinical functions. Copyright © 2026 The Author(s). Journal of the American Geriatrics Society published by Wiley Periodicals LLC on behalf of The American Geriatrics Society.

Ketzer M., et al. (2026) 'Nurse Staffing in Psychiatric Inpatient Care: A Multicentre Study using Routine Patient and Structural Data.' *Journal of Nursing Management* 2026(1), e5552920.

BACKGROUND: Nurse staffing in psychiatric inpatient care is difficult to plan because reliable measures of patient demand are lacking. Existing indicators are not well established across diverse patient groups. The Health of the Nation Outcome Scales (HoNOS), routinely collected in Switzerland, may provide a pragmatic proxy for patient acuity to inform staffing decisions. DESIGN AND METHODS: We conducted a multicentre cross-sectional study (MatchRN Psychiatry) in adult, nonforensic psychiatric inpatient units in Switzerland, linking 2022 routine patient data with 2023/2024 unit-manager reports of typical structural staffing configurations. Patient mental health status and symptom severity were measured using the HoNOS. Associations between nurse staffing hours, HoNOS scores and unit characteristics were analysed using lasso-selected linear mixed-effects models. Model estimates were used to describe how RN staffing varied with patient acuity, and model-predicted staffing was compared with reported staffing to characterise between-unit variation.

RESULT(S): Data from 107 psychiatric inpatient units in 13 hospitals (25,294 patient cases) showed wide variation in unit structures and patient mental health status but relatively little variation in staffing patterns. The median number of beds was 21, and the typical early shift included 2 registered nurses. Regression analyses indicated that higher HoNOS total scores and several single items were significantly associated with increased RN staffing, with the total score showing the strongest effect. A 20% increase in the HoNOS total score corresponded to 48.5 additional registered nurse hours per week or 1.3 full-time equivalents per year. Comparing predicted with reported staffing, smaller units tended to fall below and larger units above their predicted levels.

CONCLUSION(S): Routinely collected clinical data, particularly HoNOS scores, were linked to nurse staffing in psychiatric inpatient care. Patient acuity and unit size were both associated with staffing, indicating that routine data can provide a pragmatic basis for more transparent and sustainable workforce planning.

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Khitra K., et al. (2026) '[Carer Perceptions of Inpatient Psychiatric Hospitals and the Treatment of their Loved Ones: A Meta-Review of the Literature.](#)' *Australian and New Zealand Journal of Psychiatry* (pagination), Date of Publication: 2026.

Background: Inpatient psychiatric admission remains a key intervention in severe mental illness; however, less is known about how informal carers perceive these settings. A meta-review, that is, a systematic review of systematic reviews, was conducted to synthesise factors shaping carers' perceptions of inpatient psychiatric hospitals.

Method(s): MEDLINE, PsycINFO and EMBASE were systematically searched for eligible reviews. Methodological quality was appraised using the AMSTAR-2 framework adapted for qualitative evidence, excluding reviews rated "Critically Low." Thematic synthesis was used to detect key overarching factors that generalised across multiple reviews.

Result(s): Seventeen systematic reviews were included, from which five key themes were identified: exclusion and disempowerment; communication and information deficits; emotional and care burden; systemic barriers and crisis-driven pathways and a desire for partnership and collaborative care.

Conclusion(s): Carers frequently described experiencing marginalisation, confidentiality being applied in exclusionary ways, as well as fragmented services, particularly around involuntary admission and discharge. Findings highlight modifiable targets for practice, including family-inclusive routines, transparent information-sharing and structured involvement in treatment and discharge planning, which are crucial given the elevated post-discharge suicide risk. Addressing these factors may reduce carer burden, strengthen trust and improve perceptions of quality and safety in inpatient psychiatric care. Limitations of this meta-review and directions for future research are discussed.

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Kleiman E.M., et al. (2026) '[An App-Enhanced Inpatient-to-Post-Discharge Intervention Model for Suicidal Patients: Acceptability, Feasibility, and Preliminary Effectiveness.](#)' *General Hospital Psychiatry* 102, 95–104.

Background/Objectives Inpatient psychiatric hospitalization represents a critical but time-limited opportunity to provide suicide-focused intervention. Yet brief stays and system constraints limit patients' ability to learn, retain, and apply evidence-based skills after discharge. The goal of this open pilot study was to evaluate the feasibility, acceptability, and preliminary within-person effects of a multimodal continuity-of-care intervention model that integrates brief inpatient sessions, post-discharge telehealth, and an app-based ecological momentary intervention (EMI). Methods Psychiatric inpatients (n = 60) admitted for severe suicidal ideation or behavior completed a brief

in-hospital intervention, followed by app-based ecological momentary assessment (EMA) and optional EMI practice for 4 weeks post-discharge. Results Feasibility was mixed: most participants completed all inpatient sessions and nearly half completed at least one via post-discharge telehealth, but only 63% used the app at least once (37% never did, and some who did engaged only a few times). Acceptability was high among those who engaged, who rated the intervention as helpful and relevant. EMI practice was associated with short-term reductions in negative affect variables (overall negative affect, sadness, anxiety) and suicidal thinking, and with modest longer-interval reductions across EMA assessments. Conclusions These results show that blended inpatient-to-post-discharge model that begins during the inpatient stay and continues post-discharge incorporating app-based skills practice appears feasible, acceptable, and safe for suicidal inpatients. EMA results provide preliminary support for short-term symptom improvement, supporting the need for a controlled trial to test clinical effectiveness.

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Lanca M., et al. (2026) '[Clinician Perspectives on Measurement-Based Care to Inform Pre-Implementation Training and Workflow Design on an Adolescent Psychiatric Inpatient Unit.](#)' *Evidence-Based Practice in Child and Adolescent Mental Health* 11(3), 337–354.

Background: Measurement-based care (MBC) in an inpatient psychiatric setting is uncommon.

Objective(s): Our aim was to understand clinician pre-implementation attitudes about MBC to optimize workflow and training for MBC implementation in an adolescent inpatient psychiatric unit.

Method(s): We assessed clinician attitudes toward MBC prior to implementing it in a real-world clinical setting using interviews and a survey. Qualitative interviews were analyzed using the Consolidated Framework for Implementation Research (CFIR) and then mapped to potential solutions via the CFIR-to-ERIC (Expert Recommendations for Implementing Change) matching tool. These results, combined with the survey responses, informed MBC training and workflow design. We then re-assessed MBC attitudes with a post-training survey.

Result(s): The top CFIR barriers emphasized: 1) measure compatibility with unit context, 2) advantage and priority of the measure, 3) evidence strength and quality of MBC, and 4) existing beliefs about MBC. These barriers were mapped to potential implementation strategies via CFIR-to-ERIC matching tool. Top solutions informed an MBC workflow, clinician training, and a pre- and post-training survey. Identified workflow and training strategies included a need to prepare MBC champions, assess clinician readiness, and conduct training. The pre-training survey showed that clinicians strongly agreed with the rationale for MBC, moderately agreed that MBC would promote patient progress, and less strongly agreed that MBC could be feasibly added to their workloads. Post-training survey findings reflected continued high interest in MBC, an increase in attitudes that MBC could promote patient progress, and an increase in feasibility attitudes, though time constraints remained a concern.

Conclusion(s): An MBC training and workflow were tailored to incorporate these findings. Pre-implementation attitudes toward MBC critically informed workflow and training development and should be considered in the implementation phase. Specific challenges when implementing MBC within a diverse safety net adolescent

inpatient setting are discussed.

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Lucchese S., et al. (2026) '[Delayed Discharges in Older Adults with Mental Illness and/Or Dementia in Hospital: A Scoping Review.](#)' *BMC Health Services Research* 26(1) (pagination), Article Number: 1218. Date of Publication: 01 Dec 2026.

Background: Delayed discharge among older adults is rising in hospitals across many countries, placing increased strain on healthcare systems and negatively affecting patients' emotional and physical well-being due to prolonged hospital stays and uncertainty. Despite this growing issue, limited research has explored the specific impact of delayed discharge on older adults living with a mental illness and/or dementia. This scoping review aims to examine what is currently known about older adults (aged 65 and over) with a diagnosis of dementia and/or mental illness who experience delayed discharge from hospital settings.

Method(s): This scoping review followed the five-stage framework outlined by Arksey and O'Malley. Comprehensive literature searches were conducted in Medline, Embase, Emcare, PsycINFO, Web of Science, and CINAHL. Studies were included if they focused on hospitalized older adults (65+) with delayed discharge and a diagnosis of dementia and/or mental illness, including the perspectives of patients, family care partners and healthcare providers. Eleven articles and one grey literature report met the inclusion criteria. Data synthesis was guided by Grembowski's Conceptual Model of Complexity.

Result(s): Delayed discharge is a prevalent problem in this population. Patient characteristics, including ages 79 years and older, diagnosis of dementia, cognitive impairment, high levels of care dependency and lack of continuity of care with a primary care physician in the community, were identified as key risk factors for delayed discharge. The most commonly reported cause of delay was the unavailability of appropriate discharge destinations, primarily long-term care homes or adequate support services in the home. Delayed discharge carries significant risks of adverse events for older adults and is distressing to care partners.

Conclusion(s): Upstream approaches to service provisions, such as continuity of care in primary care settings likely helps to reduce delayed discharges. Care practices within the hospital setting, including early family and patient involvement in discharge planning, education and training in dementia and mental health care, and improved collaboration between inpatient and community services are important considerations to address delayed discharge. Further research is needed to address knowledge gaps and inform system-level interventions tailored to this population experiencing vulnerabilities during hospitalization.

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Mach A., et al. (2026) '[Clozapine Levels in Inpatients with Schizophrenia are Not a Predictor of Rehospitalization: A Naturalistic Retrospective Study.](#)' *Pharmacological Reports* 78(4), 1208–1216.

Background: Although therapeutic drug monitoring (TDM) is recommended for personalized clozapine (CLO) dose titration, there are no widely accepted international guidelines regarding routine TDM during long-term outpatient CLO treatment and many clinicians have limited access to TDM. This retrospective, naturalistic study aimed to examine whether CLO and norclozapine (NCLO) concentrations measured only at the time of inpatient care could predict the risk of psychiatric rehospitalization after discharge, irrespective of the potential influence of

confounding factors on long-term outcomes.

Method(s): A total of 141 blood samples from psychiatric inpatients (71 females and 70 males, aged from 18 to 74 years) were analyzed. Serum CLO and NCLO levels were determined with high-performance liquid chromatography coupled with a UV detector. We assessed the rates of rehospitalization over 360 days after discharge.

Result(s): There was no correlation between either CLO or NCLO concentrations and psychiatric rehospitalization rates at any follow-up time points (day 90, 180, or 360). However, patients receiving CLO as a single psychotropic drug had significantly fewer rehospitalizations (assessed at 180 and 360 days of follow-up, $p < 0.001$) occurred among patients receiving CLO as a single psychotropic drug compared to combination therapy. The risk of rehospitalization was also higher in patients with a greater number of previous hospitalizations (OR = 1.15, $p = 0.002$) and in those taking additional psychotropic drugs (OR = 1.51, $p = 0.010$).

Conclusion(s): Our naturalistic retrospective study (based on an in-hospital TDM database) showed no association between the baseline steady-state CLO and NCLO levels established during hospitalization and the risk of psychiatric rehospitalization. However, the use of CLO in combination with other psychotropic drugs and the number of previous hospitalizations correlated with the risk of rehospitalization. Clinical trial number: Not applicable.

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McMahon J., et al. (2026) '[Benzodiazepine Prescribing at Discharge from Adult and Older Persons Psychiatric Inpatient Units: A Systematic Review and Meta-Analysis.](#)' *Australasian Psychiatry* (pagination), Date of Publication: 2026.

Objective: Psychiatric inpatient discharge is a prescribing transition at which benzodiazepines initiated for short-term symptom control may unintentionally continue beyond discharge. Existing guidance is limited for prescribing decisions. We aimed to estimate benzodiazepine discharge prevalence from adult and older persons psychiatric inpatient units and examine between-study heterogeneity.

Method(s): We searched five databases from inception to 31 December 2022, updated the search on 27 November 2025 (PROSPERO: CRD42022368986), and included studies reporting benzodiazepine prescribing at discharge from adult and older persons psychiatric inpatient units.

Result(s): Twenty-five studies contributed 28 cohorts and 15,517 discharge observations. Pooled discharge prevalence was 50% (95% CI: 37-62) in acute adult cohorts and 27% (95% CI: 18-38) in older persons cohorts, with substantial heterogeneity and very low certainty of evidence. Admission-to-discharge change was small and non-significant across 11 paired cohorts.

Conclusion(s): Benzodiazepine prescribing at psychiatric inpatient discharge was common and highly variable. Marked setting-level variation, lower prevalence in older persons settings, and divergent admission-to-discharge trajectories suggest modifiable systemic influences beyond patient-level factors. Although continuation may support community transition after inpatient stabilisation, its downstream impact remains unclear because post-discharge patient-centred outcomes were not reported. Future research should clarify the risk-benefit profile of continuation to inform transition-specific prescribing guidance.

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Obegu P., et al. (2026) '[Routine Follow-Up Care Patterns After Psychiatric Hospital Discharge and Associations with Rehospitalization and Mortality: A Longitudinal Cohort Study using Latent Class Analysis](#).' *General Hospital Psychiatry* 102, 115–122.

Objective The risk of psychiatric readmission and death is high in the year after discharge. Existing posthospitalization interventions show modest and sometimes inconsistent average effects, suggesting that optimizing routine follow-up care may require identifying clinically meaningful heterogeneity in routine care practice. This study aims to identify latent subgroups of follow-up care patterns during the 12 months after psychiatric discharge and examine their associations with patient characteristics, rehospitalization, and all-cause mortality. **Methods** Using provincial linkable health administrative databases, we investigated a cohort of 3467 patients discharged after psychiatric hospitalization. Latent class analysis was used to identify subgroup memberships of follow-up care. Multivariable analyses estimated subgroups' associations with patient social and clinical correlates, and survival analyses estimated subgroups' associations with rehospitalization and all-cause mortality. **Results** Five distinct subgroups of follow-up care patterns were identified, including low to high quality of care, diversified care and high access to primary care, with two subgroups having frequent emergency (ED) use. Serious mental disorders and prior hospitalizations were concentrated in the high follow-up care subgroups, where rehospitalization hazards were significantly elevated and approached one-third. Mortality did not differ across subgroups. **Conclusion** Follow-up care after psychiatric discharge is heterogeneous, reflecting patients' clinical risk profiles and outpatient contexts. Rehospitalization was driven primarily by clinical severity, while frequent ED use signalled unmet follow-up care needs, demonstrating two distinct post-discharge dynamics with different implications for quality monitoring and service improvement. These findings support subgroup-informed post-discharge optimization and may help explain the average modest effects of transitional interventions observed in prior research. Both carry direct relevance for policy and practice. Copyright © 2026. Published by Elsevier Inc.

Reynolds Q.J., et al. (2026) '[Systematic Review of Trauma Informed Care Model use and Trauma Specific Treatment in U.S. Inpatient Psychiatric Settings](#).' *General Hospital Psychiatry* 102, 155–166.

Background Individuals with serious mental illness (SMI) experience disproportionately high rates of trauma exposure and trauma-related symptoms relative to the general population, yet many receive treatment in acute psychiatric settings that may inadvertently contribute to replication of traumatic experiences. Trauma-informed care (TIC), has emerged as a framework to mitigate and address trauma-related responses by implementing systems and individual level clinical interventions to improve patient care and reduce adverse outcomes. While research on TIC implementation in psychiatric settings is growing internationally, the unique features of the U.S. mental healthcare system warrant a focused examination of TIC practices including systems level models and trauma specific treatments. To our knowledge, this is the first systematic review examining trauma informed models and trauma specific interventions in U.S. inpatient psychiatric settings. **Methods** A systematic review of articles published between January 2014 through November 2024 following PRISMA 2020 guidelines using a PROSPERO-registered protocol (ID

600061) with PubMed and SCOPUS databases, and supplementation through Google Scholar. Included studies examined TIC models or trauma-specific treatments or interventions in U.S. inpatient psychiatric settings and reported clinical or system-level outcomes. Results Of 2269 identified records, six studies met inclusion criteria, and all were conducted in child or adolescent inpatient psychiatric units. Five studies examined TIC systems level implementation while only one study described a trauma-specific therapeutic intervention (Brief STAIR-A). Conclusions There is a substantial gap in the literature on TIC implementation, and trauma specific treatments in U.S. inpatient psychiatric settings. Findings center around pediatric populations with an absence of literature in adult acute care. The quality of evidence of most studies was limited and focused on implementation of milieu level TIC but not on clinical symptom assessment or outcomes. Development and evaluation of brief, scalable trauma-focused treatments or interventions may be a more flexible implementation strategy that can directly influence measurable inpatient outcomes.

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RojasVelasquez, D. (2026) ['The Wait for "Geripsych": Prolonged Boarding of Older Adults Awaiting Inpatient Psychiatry.'](#) *Journal of Hospital Medicine* 21(8), 943–945.

Prolonged boarding of older adults with neuropsychiatric illness has become a common, yet underrecognized, feature of contemporary mental health care delivery. I highlight the ways boarding functions as a de facto stage of care that impacts the system and hospitalists tasked with caring for these patients. Boarding reflects structural vulnerabilities around psychiatric capacity, long-term care, and community services. Boarding time should be treated as a reportable safety metric, paired with unit-level prevention and escalation pathways to guide hospital leaders, hospitalists, and regional planners.

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Ryberg W., et al. (2026) ['Suicidal Ideation After Discharge from Psychiatric Hospital: Momentary Assessment Study.'](#) *JMIR Mental Health* 13(pagination), Article Number: e88745. Date of Publication: 2026.

Background: High suicide risk is observed after discharge among patients hospitalized with suicidal thoughts and behaviors. Suicidal ideation (SI) is a well-known precursor to suicide attempts (SAs) and suicide, and it is a central indicator of subjective distress.

Objective(s): This study aimed to examine patient characteristics and predischARGE symptoms that might (1) distinguish between participants with and without postdischarge SI, (2) predict peak SI frequency, and (3) predict the intensity and longitudinal trajectory of SI.

Method(s): Before discharge, patients hospitalized due to high suicide risk were screened for diagnosis (MINI 7.0.2 [Mini International Neuropsychiatric Interview] and SCID-5-PD [Structured Clinical Interview for DSM-5 Personality Disorders]), general symptom severity (Outcome Questionnaire-45 [OQ-45]), depression (Patient Health Questionnaire-9 [PHQ-9]), SI (Suicide Status Form-IV [SSF-IV] and Beck Scale for Suicide Ideation), and suicidal behaviors (Suicide Attempt Self-Injury Count). Twenty male and 16 female adult participants installed a mobile app on their smartphones and reported their level of SI on a 5-point Likert scale (1=not at all to 5=very much) 5 times per day for 10 days after discharge. Associations between baseline characteristics and postdischarge SI were analyzed using logistic

regression, median regression, and mixed-effects linear regression.

Result(s): SI was present in 49.2% (528/1073) of all completed surveys. Women reported SI more frequently than men ($\chi^2_1=63.39$; $P=.001$). No baseline variables differentiated participants who later did (28/36, 77.8%) and did not (8/36, 22.2%) report momentary SI after discharge. Participants hospitalized due to a high risk of suicide (12/36, 33.3%), compared with those hospitalized following an SA (24/36, 66.7%), reported SI more often ($\chi^2_1=22.64$; $P=.001$) and had a higher frequency of peak SI scores ($\beta=17.74$, 95% CI 8.56-26.91; $P=.001$). Moreover, the variation in the temporal trajectory of postdischarge SI was characterized by large differences between participants (intraclass correlation coefficient [ICC]=0.682), while the intensity of SI did not change over the 10-day period at the group level ($\beta=0.03$, 95% CI -0.01 to 0.06; $P=.09$). PredischARGE scores on the SSF-IV chronic subscale, including hopelessness, self-hate, and psychological pain, predicted the intensity of SI after discharge ($\beta=0.13$, 95% CI 0.05-0.20; $P=.002$). No baseline variables predicted the trajectory of SI.

Conclusion(s): SI after discharge was common, varied substantially between participants, and may be more prevalent than previously reported, particularly in groups with high morbidity and prior SAs. The SSF-IV may be a valuable tool for treatment planning and assessment during the inpatient stay.

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Stenmark L., et al. (2026) '[Electroconvulsive Therapy and Time to Psychiatric Readmission in Schizophrenia.](#)' *Acta Psychiatrica Scandinavica* 154(4), 277–285.

Introduction: There is evidence that electroconvulsive therapy (ECT) can augment the effects of antipsychotics in schizophrenia. However, there is limited evidence from Western populations on whether ECT reduces the risk of relapse compared to non-ECT treatment in schizophrenia. This study aimed to compare time to psychiatric readmission or suicide among inpatients with schizophrenia treated with or without ECT, as well as those receiving index series with or without continuation ECT (C-ECT).

Method(s): Register-based study utilizing data from Swedish nationwide registers. Patients with schizophrenia who received both inpatient ECT and non-ECT treatment between 2011 and 2020 were included. Each patient served as their own control, contributing one admission with and without ECT. Admissions with or without ECT, as well as index series with or without C-ECT, were compared in univariate Cox regression analyses regarding time to psychiatric readmission or suicide within 30 days, 90 days, 180 days, and 1 year from discharge.

Result(s): A total of 351 patients were included. Of these patients, 64.1% were male and the mean (SD) age was 48.2 (14.4) years. ECT was associated with longer time to readmission or suicide compared to non-ECT treatment within 30 days (HR: 0.66; 95% CI: 0.50-0.87; $p = 0.003$), 90 days (HR: 0.70; 95% CI: 0.56-0.87; $p = 0.001$), 180 days (HR: 0.68; 95% CI: 0.56-0.82; $p = < 0.001$), and 1 year from discharge (HR: 0.77; 95% CI: 0.65-0.91; $p = 0.003$). Furthermore, 15 patients received C-ECT, which was associated with longer time to readmission or suicide compared to index series without C-ECT within 90 days (HR: 0.13; 95% CI: 0.02-0.91; $p = 0.040$) and 180 days from discharge (HR: 0.26; 95% CI: 0.08-0.81; $p = 0.021$).

Conclusion(s): This study suggests that ECT can be associated with a longer time to relapse compared to non-ECT treatment in schizophrenia.

Tay J.L., et al. (2026) '[Preventing Serious Reportable and Sentinel Events within Psychiatric Inpatient Settings-A Scoping Review.](#)' *Journal of Patient Safety* (pagination), Date of Publication: 04 Aug 2026.

Serious reportable and sentinel events are preventable events that cause death or serious injuries to patients. Such events within the field of psychiatry include abscondment, inpatient suicide, unexpected deaths, sexual assaults, and serious physical assaults. This review aimed to examine the contributing risk factors and preventive strategies of serious reportable or sentinel events. PRISMA for scoping reviews and the updated Arksey and O'Malley methodological framework for conducting scoping reviews guided the methodology of the review. Databases (CINAHL, Embase, PsycINFO, PubMed, ScienceDirect, and Scopus) were searched. Twenty-nine articles were included. The articles explored (1) inpatient suicide [n=18 (62.07%)]; (2) general adverse events [n=5 (17.24%)]; (3) serious assaults [n=2 (6.90%)]; (4) abscondment [n=2 (6.90%)]; and (5) inpatient sexual events [n=2 (6.90%)]. Preventive strategies were as follows: (1) suicide (means restriction, allocation of high-risk patients to higher-dependency wards, safe prescribing, psychiatrist review of high-risk patients around the clock); (2) unexpected death (routine medical review, prompt activation of the code blue team); and (3) sexual incidents (segregation of genders). Consistent preventive strategies common to all adverse events, including establishment and continual review of guidelines, optimal staffing, and training, a secured ward with surveillance and no blind spots, rigorous observation, individualized risk assessments, and supportive counseling to patients. Consistent factors were associated with varying serious reportable or sentinel events. These factors were associated with patient and ward profiles, management, staffing, training, observation, risk assessments, and treatment. Bolstering factors related to the prevention of these events can enhance patient safety and the provision of quality care for psychiatric inpatients.

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Zhang J.L., et al. (2026) '[Emergency Department Physical Health Assessment Prior to Acute Inpatient Psychiatric Admission: A Service Evaluation.](#)' *Australasian Psychiatry* (pagination), Date of Publication: 2026.

Objectives: To describe the current patterns of physical health assessment for patients admitted to the inpatient psychiatric unit via the emergency department (ED) and identify rates of acute medical concerns arising within the first 7 days of admission.

Method(s): A retrospective service evaluation based on electronic medical records was conducted for patients admitted to the inpatient psychiatric unit between 1 March 2025 and 31 May 2025.

Result(s): There were 141 patients admitted to the inpatient psychiatric unit via the ED during the study period. Prior to admission, 88 (62%) had a documented physical health assessment, 124 (88%) had a complete set of vital signs, 48 (34%) received physical examination of at least one system, 49 (35%) underwent blood testing, 12 (9%) underwent imaging and 13 (9%) had urine dipstick testing. A total of 16 patients (11%) developed acute medical concerns within the first 7 days of admission with 3 patients (2%) requiring transfer out of the psychiatric unit for acute medical treatment.

Conclusion(s): Despite variability in ED physical health assessments prior to

admission, acute medical deterioration requiring transfer from the inpatient psychiatric unit was uncommon.
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