Taking a Child to the Emergency Room

childmind.org/article/taking-a-child-to-the-emergency-room

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Dear Parent,

You are not a failure because you have taken your child to the ER. You may feel terrified and ashamed, but you are not a failure.

You are, in fact, a hero. You have done the brave thing, the hard thing, the only thing you knew to do to keep your child safe. That is honorable. So if anyone — relative, friend or acquaintance — tells you in the next few days that you overreacted, or that your child simply needs more discipline, or that it's all in your kid's head, you have the right to say, gently and firmly, "Please don't be critical. It's not like I *wanted* to go. I am scared and I really need your support." If that person can't be helpful to you in this strange new world, find someone else who can.

Since you're here, and heaven knows you have time, it might help to have a few pointers so you know what to expect. You see, an emergency room visit for psychiatric issues works a bit differently than one for a physical problem.

First — and this is hard — you need to know that they are not going to fix anything. There's no psychiatric equivalent of setting a broken leg or removing a ruptured appendix. There are no blood tests or lab results to tell you what's wrong (though they may take blood to check for physical problems that could be contributing to your child's difficulty). You're probably going to walk out of here without having a diagnosis, and even without medication. You will have a better understanding of how dangerous your child's situation is, and what the best course of action is going forward.

Assessing safety

The primary thing the doctors do here is assess the safety of your child. The key question they will be trying to answer is whether or not your child is an imminent danger to herself or others. This assessment centers on three main issues: thoughts, plans and intent.

- **If your child has intrusive thoughts** about dying or about doing harm and is upset but doesn't intend to do anything, he requires ongoing care, probably on an outpatient basis. Many teens who cut themselves fall in this category (cutting, while a profoundly disturbing behavior, is not necessarily an indicator of suicidal intent). Kids who are depressed but not actively suicidal, and those who are verbally explosive, often fall in this category as well. Weird as it may seem, this is relatively good news. You will most likely be going home with a recommendation for follow-up care with a therapist.
- **If your child wants to harm herself or others yet doesn't have a plan**, that's a step higher on the worry scale. Risk factors that doctors consider in gauging the best course of action include how impulsive your child is, her recent pattern of behavior, and any known triggers in the home or school environment that could lead to a crisis.
- **If your child has ideas about how to harm himself or others but no firm plans to put those plans into action,** this is more concerning. If you are sent home, be sure you ask what kinds of methods are lurking in your child's mind so that you know how to minimize the risks of action.
- **If your child has a plan** for suicide or harm to others, **has made an attempt** or **is acting in a highly impulsive manner that makes an attempt likely**, hospitalization is almost always required. This is because everyone's No. 1 priority is to keep your child safe and alive.

The doctors will make this safety assessment by talking with you and your child. At some point you will be asked to step out of the room so that the doctors can speak privately with your son or daughter. That's okay. Doctors do this because it is not uncommon for a child to reveal a suicide plan to doctors that the parent knew nothing about. Do not feel guilty if your child tells a stranger things you didn't know. Kids love their parents and often fear hurting them, so they don't want to tell you about their deepest pains because they want to "protect" you from the truth.

If you are told your child has a suicide plan

Allow yourself time and space to grieve. To avoid distressing your child with your tears, you can excuse yourself to get a cup of coffee, pick up something to eat or call your significant other. Ask a nurse for tissues and a place you can cry. Your child will be safe while you are gone. It's okay to leave for a while. Just remember to bring back the coffee or whatever it was you said you'd gone to get! And remember to be thankful that you brought your child to the hospital: You did the right thing.

After you have fallen apart and pulled yourself more-or-less together again, go back in to your child and say, very gently, "The doctors told me you have a suicide plan. I am so, so sorry you are hurting that much. I love you, and even if *you* can't see how life is worth living right now, I can see many beautiful things still inside you. I love you very much. I am so glad we came to get help." And then you can cry, together. Or not.

Make sure you write down the names of all the doctors who speak to your child. Take notes of everything they say. Your emotions are running too high to process everything — or even anything — that's coming at you right now, so write it all down.

If outpatient treatment is recommended

If you are advised to seek outpatient treatment, you probably won't be given advice on how to manage life at home better between when you leave the hospital and when you walk into your child's first therapy appointment.

It is appropriate to ask if there are books you should read or websites to explore that would help you handle your situation better. If the doctor doesn't have suggestions, look at some of the free booklets online at SAMSHA.gov, and explore childmind.org and NAMI.org for helpful information.

You will probably be told to bring your child back to the hospital if she exhibits dangerous behavior. Ask the doctor to explain exactly what that means, and for rules of thumb so that you know the difference between what feels dangerous to you and what merits a return visit. The doctor may not be particularly helpful with this. Few medical professionals have ever parented a mentally ill child, and they may not know the reality of what your life at home is like. At a minimum, if your child has violent rages, ask to be shown how to hold her in a way that minimizes your risk of getting hurt.

You may (or may not) be told to lock up sharps and medications when you go home, or to remove things that can be used to hang or suffocate oneself. When you go home you should quietly do this anyway: Making it less easy to commit suicide reduces the likelihood of disaster arising from impulsive behavior. You might also want to block how-to sites on suicide from your kid's computer and phone. The internet has a lot of good information, but it's also full of bad ideas.

Plans for follow-up care

If your child doesn't already have an outpatient team, try to have the hospital set up a followup appointment with a provider before you leave. The wait list at most clinics can be several months long, and one huge advantage of an Emergency Room visit is that it can bump you up on the priority list. A phone call from a hospital to a clinic will be returned much, much faster than any call you make personally.

If you are in the ER in the evening or on a weekend, ask for the name of the social worker at the hospital who will be arranging the follow-up appointment, and get his or her direct phone number. Call the social worker first thing the next business day. Call again two hours later. Call however often you need to call until you get the appointment set. If you are not getting a response, consider contacting the patient advocate at the hospital.

If the hospital says they don't have enough staff to arrange an appointment, ask to speak to a patient advocate. You may not win the battle, and if you don't (or simply don't have the energy to fight), ask a good friend or close relative to make the appointment for you. Make sure that the clinic takes your insurance. Make sure that you can actually get there; in some parts of the country services are few and far between.

If you want to use a therapist in private practice, you will have to find one yourself and make your own arrangements. Before you go this route, you need to know that many private therapists do not accept insurance. They will provide receipts so you can seek out-of-network reimbursement, but that only helps *if* your plan allows out-of-network costs *and* you have enough cash flow to wait for reimbursement. The cost, depending on where you live and what kind of professional you need, can be anywhere from $100 to $400 a week. If medication is also required, you will need to find and pay for a pediatric psychiatrist, too. You may find it wise to take whatever clinic appointment the hospital offers even if you plan to go private, so you are getting some sort of help while you get your longer-term plan in order.

If you disagree with the doctor's safety assessment

If you feel your child is a suicide risk or may hurt others, make your opinion known loud and clear. Be specific about your concerns: Cite information your child may have confided to you, and note recent patterns of behavior that indicate things are getting worse. If your child sees a therapist regularly and the therapist can visit you in the ER, ask the doctors doing the hospital evaluation to speak with that therapist (you will have to sign a release so they can share information). If they still do not agree to hold your child, ask who is liable if your child makes a suicide attempt within the next 48 hours. You can also consider writing the words, "Parent has communicated to medical staff that she feels child is not safe to return home" on the discharge papers before signing.

About short-term observation

Some hospitals have a short-term observation unit where a child can be held for up to 72 hours. In some places this is called a Comprehensive Psychiatric Emergency Program (CPEP). When a child is at high risk yet it's not clear if inpatient treatment is needed, a couple of days in a low-stress environment like this (almost no activities, no therapy, 24-hour observation and a *lot* of television) may be a viable option.

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If inpatient treatment is recommended

If your child is admitted for inpatient care, at some point you will want to excuse yourself to "get a cup of coffee" and cry. If you break down in front of your child, she is likely to feel guilty and at fault for hurting you. Right now your kid needs you to be brave, because if there's one thing scarier than being the parent of a kid going into the psych ward, it's being the kid who will actually be there.

It may take a day or two or even more for a bed to open up (especially if you arrived late in the day, on a Friday, or near a holiday). This means your kid may be in the ER for a long time. You can use this interlude to organize your thoughts, scribble down notes about the sequence of events in recent months and to remember that Uncle Harry was depressed for many years and depression can be hereditary.

In most cases, the bed will be in a different facility. Before the social work team starts looking for a spot, ask what the options are. In some cases, one facility may be far away while another is closer, or one may have 12 beds (presumably less chaotic) instead of 24. It's fair to ask which units have the best reputation. This is because the doctor in the ER may never have been to any of the facilities, and may never have treated someone released from there.

Older teens may be eligible for either adolescent or adult units. When possible, opt for adolescent. The severity of illnesses on an adult ward is likely to be more extreme.

If you have a long wait until a bed is found, do not feel that you have to stay in the ER with your child the whole time. Pop out for dinner and trade off with other family members. Allow your child some space. Your kid is probably going to watch television most of the time, anyway, and you need to take care of yourself. Go home and pick up your child's toothbrush, toiletries (nothing in glass bottles), pj's (no drawstrings), underclothes, slippers or socks or shoes without laces and a couple of days' worth of clothes. Don't bring your son's favorite sweater or your daughter's beloved jeans; you don't want to taint them by association with

the hospital. Besides, things do sometimes get lost or stolen. Bring magazines, puzzle books or other forms of entertainment; electronics will not be permitted on the unit. You might want to bring some food for your child, too, since hospital grub isn't the best. And be kind to yourself.

Remember, you are not a failure. What you are doing is heroic.

> Next in this series: Having a Child in Inpatient Treatment, Bringing a Child Home From Psychiatric Hospitalization