FREQUENTLY ASKED QUESTIONS (FAQs) ABOUT CHILDREN/YOUTH PSYCHIATRIC EMERGENCY DETENTIONS

Wisconsin laws give law enforcement, with county approval, the authority to place children and adolescents in a hospital when there is a need to protect the young person from harming themselves or others; this is called an "emergency detention" and is commonly referred to as an "ED". In Wisconsin, these involuntary psychiatric hospitalizations appear to be on the rise.[1] The Office of Children's Mental Health is examining data related to this alarming trend. In the meantime, we hope to answer some commonly asked questions related to involuntarily hospitalizing a young person.

FAQ #1: Can't the hospital fix the child?

Parents and/or professionals who request an ED may believe that the hospital will be an effective way to address a child's mental health or behavioral issues. In reality, many of these children are released back home within just a few days.[2] Even when the child has a treatable condition, the hospital is best equipped to offer short-term crisis stabilization, not long-term interventions. It is up to the parents, educators, social workers, and other community based support people to examine what might be going on in a child's life that corresponds to the alarming behavior and subsequently to help the child and family develop a plan to address the child's needs in the community over the long-term.

FAQ #2: Don't we need to ED this child to get him/her access to mental health services?

Wisconsin faces a shortage of mental health providers. Many families spend months or even years on waiting lists trying to access services. As a result, some people believe that the only way to gain access to mental health professionals is to have the child hospitalized. While hospitalization does result in a mental health assessment, it does not guarantee access to ongoing services. In fact, an analysis of children on Medicaid in 2013, shows that only half of the young people received any mental health outpatient services following an ED. Even when children did receive follow-up therapy, most of the time they only received one or two sessions. [3] The exact reasons for this are unclear, but it is important for those working with a child to know that an ED is not a guarantee that services will be accessed. County human services can provide information about the types and extent of services available in the community.

FAQ #3: Isn't this a way to get him/her to take medications?

Hospital-based psychiatrists can prescribe medications. However, just because a youth is in a hospital under an ED does not mean that the detained young person can be forced to take medication; this requires an additional legal step which, according to data from the Department of Health Services' Winnebago Mental Health Institute, almost never happens for children and adolescents.

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[1] Office of Children's Mental Health analysis of admission data from Winnebago Mental Health Institute (WMHI) shows that EDs have become a much larger proportion of youth admissions in the last decade.
[2] Based on WMHI admission/discharge data from 2003-2013, 2013 Medicaid records, and 2013 data from the Department of Health Services, Division of Mental Health and Substance Abuse Services (DHS/DMHSAS).
[3] Based on an analysis of 2013 Medicaid records and 2013 DHS/DMHSAS data.

FAQ #4: Won't the hospital at least provide structure and routine in the midst of chaos?

Psychiatric hospitals provide structure and routine, which is something that might otherwise be missing from the life of a child in crisis. However, many hospital stays are too short for the youth to develop a new routine and subsequently sustain these benefits once out of the hospital. Even when stays are longer, the routine established is not generally one that can be easily replicated back in the community. For that reason, it makes more sense for those working with the child to try to build routine into the community setting. During high levels of family stress, structure and routine, though very helpful, are often hard to achieve. There may be other ways to temporarily remove a child from a stressful or chaotic home environment to allow for de-escalation, such as staying with other relatives or friends or using respite services where available.

FAQ # 5: When a young person starts talking about suicide or self-harm, don't we need to move him/her to a locked facility for 24/7 monitoring?

Suicide is a real risk, and everyone around a child is right to want to keep him safe. At the same time, many children and adolescents who express an intention to harm themselves feel overwhelmed and lack the language or communication skills to ask for help. When a child or adolescent expresses a desire to harm him or herself, it is important to take appropriate steps. These may include putting the child in contact with someone who knows how to question, persuade and refer (QPR), calling the Hopeline, or arranging a thorough, face-to-face suicide assessment by a qualified mental health provider. Starting a conversation can help determine the best way to approach the situation to both keep the young person safe, and to reduce the short and long-term negative consequences related to having a child/family go through the ED process.

FAQ #6: Isn't it better than nothing?

When a child is in crisis, it's understandable to consider a hospital stay as a solution. However, there are clear downsides to submitting a child or adolescent to an ED. EDs can be a traumatic experience. Children and adolescents are often taken to the hospital in the back of a police car, often in handcuffs. They are taken to a facility often hours away from their home, family and friends, and made to stay with people they don't know. They may see other children who are in severe distress. If they are inappropriately placed, the treatment experience could be brief and positive outcomes may be minimal. Once they return home, children and adolescents may feel the stigma of being the subject of an emergency detention. The whole process is stressful for the child and family, time consuming for those involved, and very expensive. Unless there is a well-founded concern of serious impairment to the child based on a professional assessment, emergency detention and hospitalization may actually be detrimental to the child and family.

FAQ#7: What else can I do?

When a youth is in crisis and adults feel like they have few other options, it may seem that an ED is the only choice available. However, hospitals, psychiatrists, crisis workers, parents and schools report that many approaches do work. Here are some options:

- **De-escalate:** Oftentimes what appears to be an enduring crisis is a short-lived burst of intense emotion. By taking a few simple steps, adults can often assist the young person to successfully move through the emotions. These steps might involve bringing in people the child is close to (e.g., a grandparent, favorite teacher, etc.), silently being present, speaking calmly to the child and listening to the anger or fear without argument or judgment, modeling breathing techniques, taking the child for a walk to get out of an enclosed space, gently leaving the child alone to work through the emotions, etc.

- **Look for the least restrictive option:** EDs are the most restrictive and heavy-handed response to a crisis. If there is any way that a child can safely stay at his own home or at the home of a friend or family member (i.e., a diversion), this should be the first option. This may involve ongoing contact with crisis workers or other supports. If those options are not feasible, some areas have non-hospital crisis intervention or stabilization sites where youth can stay for a few hours or a few days. Voluntary hospitalizations are the next option, followed by EDs.

- **Plan ahead:** All adults working with a child or adolescent can help determine what situations trigger intense emotions and how such situations can be avoided or handled more successfully in the future. Many community resources are trained to do such planning. Comprehensive Community Services (CCS), Coordinated Services Teams (CST), Positive Behavioral Intervention and Supports (PBIS) Tier 3 folks, and Crisis Intervention workers are all trained to help develop an effective "planned response". These services can be accessed through your county and/or schools.

- **Use your primary care physician:** Primary care physicians can prescribe appropriate medications, or consult with psychiatrists to do so. Oftentimes what appears to be a medical or mental health issue is rooted in a traumatic or challenging situation in a child's life, so conversations about medication should ideally include questions about what else might be affecting the child.

- **Get support for the whole family**: Crisis workers frequently report that when they are called to deal with a child, what they find is that the whole family is experiencing distress. They see a pattern of youth going to the hospital only to return to the same home environment that sparked the crisis in the first place. Consider whether the parents might benefit from mental health or substance abuse treatment, peer support, parenting information, or even just time away. Parents who feel supported in their own lives have more resources to help stabilize their child.