PARENTING CHALLENGES

Having a Child in Inpatient Treatment

EN ESPAÑOL

An open letter from a parent on what to expect from psychiatric hospitalization

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Dear Parent,

I am so sorry you need to read this letter. If your child is heading for hospitalization, you are in a tough place, and a scary one. Hopefully, as you read this you will have a better idea of what lies ahead.

What to expect when you arrive

Assuming your child has been **referred to inpatient from an emergency room**, once an inpatient bed is found your child will be transported by ambulance to the facility. You will be allowed to ride along. There will be another intake assessment

upon arrival, at which you will have to re-tell the saga of what led up to the hospitalization. You will be asked about your family's history of mental illness. Be 100% honest. Genetics play a huge role in mental health, and if you have an aunt with schizophrenia, a cousin who committed suicide and your spouse's Grandpa Joe self-treated his depression with alcohol, this is relevant to the kinds of medications that may be appropriate for your child.

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Ask under what circumstances the hospital will reach out to you. There are likely to be only three situations that trigger a phone call:

1. **They want to add to or change your child's medication and need your permission to do so**. They will only contact you for new meds, not for subsequent increases or decreases in dosage. If you get a call like this, write down the date, time, name of the doctor and what the conversation consisted of.
2. **Your child has been involved in an "incident."** This may be a physical accident (rare), injury caused by another patient (rare) or notification that your child was taken to a seclusion room because she became violent (hopefully not your nightmare). If you get a call like this, ask for details. If your child was taken to seclusion you want to know if she went willingly, if she was taken by force and if restraints were used. Write this down in a notebook, ask questions about what led up to the incident, record the date of the call and the name of the person calling and later speak to your child to get his version of the story. If need be, you should also get an account of what happened from someone else who witnessed it. Every account will be different. That doesn't mean someone lied, just that you're not going to get the full story from one perspective.
3. **They want to set up a "family meeting" to discuss plans for discharge**. This will happen several days or even a week before the actual discharge, because it takes a while to put plans in place. "Family" in this case means the parent, the child in the hospital, a social worker and usually the psychiatrist. Take copious notes at the meeting, or bring someone (spouse or relative, preferably a male in casual business attire) to take notes for you. If you did not already have a treatment team prior to hospitalization, the social worker will

help you find one; in most states you will need an appointment on the books before discharge. Private-pay hospitals may not need to follow the same procedures.

You will be able to call the nurse's station whenever you want to find out how your child is doing, to ask questions or to ask to have the doctor or social worker call you. Put the number of the nursing station into your phone immediately, so you don't lose it.

If you have missed a meal in transit, ask for food. Most intake departments will have sandwiches or something on hand, but the actual unit will not.

Leaving your child

Someone will sort through your child's belongings and decide what can and can't stay on the unit. Anything sharp, made of glass or long enough to tie around the neck (including belts, drawstrings and shoelaces) will not be permitted. Some hospitals do a body check, so that the hospital has an inventory of the patient's wounds and scars prior to entry. Then your child will be brought over to her room. You will probably be allowed to go along to say goodbye.

Prepare yourself. The psychiatric unit will almost certainly be locked with a two-stage door system. You will later have to show ID to enter, and phones with cameras are usually not allowed (so no one can post pictures of patients online). A nurse on the unit will ask you whose names should be placed on the visitor list. In some cases only family is permitted. You are not obligated to include relatives who will be critical of you or your child when they visit. Only list people who will be helpful.

You will almost surely cry after you leave your child and the door is locked behind you. You are allowed. But if you are so overwhelmed that you feel numb, that's normal also.

What will happen once your child is in

The key bit of information you need to swallow up front is that the sole purpose of an inpatient stay is to stabilize your child enough so that he can be discharged to outpatient care. In other words, they aren't going to cure anything here. At best, your child's symptoms or behavior will improve 10%, maybe 20%. That's a long way from the complete hell you've been living in, but it's almost certainly not what you were hoping for.

As with other hospitals, nothing of substance happens on weekends. If your child enters on a Friday, Saturday or Sunday, he won't be evaluated by the regular team on the unit until Monday.

Once the doctors have visited with your child (you won't be there when this happens), they will come up with a working diagnosis.

Your child's day will be structured on a schedule that includes a daily (brief) check-in by medical staff, school (usually only an hour or two, of limited educational value except your child will get attendance credit) and various group therapies. These may include classes or groups on coping skills, information on mental health, and family therapy. Some hospitals also use experiential therapies that incorporate animals, music, art or horticulture. There is unlikely to be any individual counseling. Remember, the goal isn't to get to the bottom of anything. The goal is to get your child stable enough to move to outpatient treatment, where the long-term work takes place.

The TV in the day room will blare during free time, and much of the day will be very low key. This can make it seem that the hospital isn't doing much of anything. What they do is provide structure, medication and monitoring. (If you stop to think about it, this is pretty much what a medical hospital does, too, minus the structure). The group therapies do tend to force depressed kids to get up and do something, and tend to tone down the pace of the over-activated kids.

Rules and privileges

Most psychiatric hospitals use some kind of level system in which the kids earn privileges if they comply with behavioral expectations. You don't need to know the details; your child will gripe about them. Your job is to nod and empathize.

You may be shocked by the limited visiting hours. Then again, you're likely to have some ambivalence about visiting, or unable to get to the hospital easily. You don't need to come every day; the most important time to visit is on the weekends, when there's less structure and less for the kids to do. If you bring food (which your child will probably beg you to do), ask in advance about what's allowed. Bring it in a paper bag; plastic won't be allowed.

There will be a ton of rules. The ridiculous nature of many of them will be the topic of your conversation with your child over the next several days. That's okay. Expect complaints.

Medication

The doctor is usually required to discuss meds changes with you prior to implementing anything. If your child already has a psychiatrist, make sure the inpatient doctor is in contact throughout the stay. Besides knowing your child better than the inpatient doctor, your child's psychiatrist will also be responsible for monitoring the effects of any medication changes over the long haul, so communication is important.

Things you will want to ask about medications (and take notes about):

1. **What is the doctor's thought process behind choosing this medication?** What alternative medications are there? If you have family members on similar medications or with similar problems, tell the doctor what meds have been effective and which have been a disaster. There's no guarantee your child will respond to meds in the same way, but when you have a range of options it's worth choosing the one that worked for others in your child's genetic pool.

2. **How long it will take before the medication kicks in?** A few psychiatric meds are effective the same day. Many take a good amount of time to take effect. Antidepressants, for example, may not reach full potency for 4-6 weeks. What you want to know is what to expect and when. You may also want to ask what happens if the doctors *don't* see that effect. Because changes might not be visible until after your child leaves the hospital, make sure your child's outpatient psychiatrist is included in medication decisions that are made while your child is in the hospital.
3. **What are the common side effects?** How long do they tend to last? Many side effects pass after a while, but some don't. Sleepiness, for example, is usually more of a problem in the first week or two. Other meds are notorious for weight gain, so speak up if diabetes runs in your family. You should also be told about any dangerous but rare side effects, when these are likely to show up and what they look like. Lamictal, for example, causes a rash in a small percentage of cases that can be very serious.

Keep good records of what meds your child is on, when dosages change, and any notable changes in behavior.

Coping while your child is an inpatient

You are likely to have many intense feelings about having a child in a psychiatric hospital. Please, please, allow yourself to feel them all. All of them are real — including shame, guilt, fear, anger, sadness, and relief — and you will be better able to help your child if you process your own emotions. Your partner's mix of feelings will undoubtedly be different than yours. You're both allowed to feel what you feel. With whatever shred of emotional margin you have, be kind to each other, for you are each hurting in your own way.

No matter what thoughts and feelings are bumbling their way through your mind, there is one thing you will need to tell yourself over and over again: your child is SAFE. This, at least, is good.

Putting on your own oxygen mask

Now that your child is safe, it's time to take care of yourself. By all means, take a day or two to fall apart and give vent to your feelings, but after you've gotten your

sea legs back on, you must, must, must make use of this time to replenish yourself.

It is not disrespectful of your child's pain to do something that nourishes your heart and soul. *You matter, too*. You have been through a horrific ordeal. And here's a fact: your kid is coming back. You need to use this time to breathe and grow stronger, because it ain't over yet. Call your own therapist, consult with your pastor, get a pedicure. Do whatever makes you more resilient and adds energy or perspective to your life. Give yourself permission to go out with a friend, laugh, get your hair cut, or shoot pool with a buddy. Go for that long run, have a glass of wine with your bestie, or take a long walk in the woods. Whatever gives you oxygen.

Note that what rejuvenates you may be different than what you normally do to relax. Often what we do to wind down is numb ourselves with entertainment. That is anesthesia, not oxygen. Oxygen is the stuff that makes us stronger and gets our blood pumping again. Whatever makes that happen for you, do it.

Phone calls, anger and distress

Any guilt or worries you have about having your child in the hospital may be compounded by how she reacts to being there. Kids often feel ashamed, confused and scared about being in a mental health facility. Because they are kids, they are likely to take their feelings out on the person they love the most, the person who is safest: you.

You will not be the first parent to be called the worst mother in the world, nor the last to be on the receiving end of a blistering "How could you do this to me?" Don't take it personally, even if it's addressed to you. Regardless of your fear (and your child's assertion) that she'll hate you for the rest of her life, she probably won't. In fact, she probably won't even remember the details of this stay any more than you have a clear memory of being in labor. She'll remember that she suffered, and that's about it. So when you receive that tenth venomous phone call, or hear yet another heart-wrenching plea to get her out of there, *breathe*.

You can *try* to reason with your child, but don't expect to get far. Remember, she's not entirely herself right now. And logic is rarely effective at de-fanging emotion, anyway. You'll probably make the most progress by acknowledging and empathizing with her underlying feelings:

"It sounds like you're really scared."

"You must be really angry that you have to be there."

"You sound miserable. I'm so sorry it's so rough."

You'll know you're on the right track when you get a skin-removing response like, "OF COURSE I'm miserable! Do you actually expect me to be *happy* here?"

Breathe. Respond to your child's feelings instead of reacting to the words. Keep going with the validation: "Aww, I'm sorry it sucks so much. I sure wish there were a better way, but there isn't."

If you're too fragile to manage this approach (or the calls simply get to be too much for you), talk to nursing staff about limiting phone access. Alternatively, don't pick up every call. You don't have to "be there" for your kid every single hour of the day. It's okay to set limits. Healthy, even.

Running interference on the unit

If you've had experience with other types of hospitals, you know that even in good facilities it's possible to encounter an overbearing nurse, a doctor who doesn't listen well or some sort of aggravating glitch in care. To get the best care possible, you will have to advocate for your child.

There are three obstacles to advocating well.

1. **Your own emotions are running high.** You will need to use caution to avoid overreacting or jumping to conclusions. If your child relates an event that has distressed him or seems

to have been handled badly, take notes on his version of what happened. Remind yourself that your child is not well, and his perception of what occurred may not be accurate. This will help you approach staff with an open mind. Questions like, "My son seems upset about what he says took place with _____. Can you tell me about that?" are going to get a more honest reply than if you bluster in with something accusatory.

2. **You don't know how this particular system works.** Frankly, your best bet is to fake it. Be pleasant, form alliances with as many staff as possible, get to know people by name, and dress in respectable clothes when you visit. If you are a single mom, bring a man to the family meeting: stupid as it sounds in this day and age, it makes a difference. Be a reasonable human being. Take lots of notes. You won't figure it all out, but you'll eventually grasp some of it. If you have a concern and you've spoken up about it several times and still aren't getting a response, put it in writing. You may need to quietly ask one of the staff members you've befriended how to get X to happen, or who is in charge of Y. If you are getting stonewalled, push it up the administrative chain.
3. **Staff members vary in how responsive they are.** Some will be caring and proactive, some will be okay, and you may encounter a few who seem to be phoning it in. (Your child will undoubtedly have opinions on who falls in which category.) The most important consideration here is that *any human connection you create with staff* is a good thing. The more you can get the empathy going, the more likely it is that people will be kinder. If you have a partner, divvy up who will play bad cop and who will be the good cop. (These roles can change, by the way, depending on which shift you're dealing with, and which of you has developed rapport with a given staff member.)

As with any other type of hospital visit, you will find it easier to figure out what is going on if you take good notes during each meeting or after every conversation.

Getting ready to go home

It will happen at just about the time you're starting to get the hang of this inpatient thing: They'll start talking discharge. Be forewarned that the key determinant of when your child is released is what your insurance company will pay for. You may or may not agree that your child is ready to come home. Usually the discharge discussion takes place several days or even a week before the actual discharge.

If your initial reaction to the news is a screaming, "Nooooo!" you will want to pause and examine what's going on in your head. You may suddenly remember

how bad things were before the hospitalization, and feel insecure because you don't know what life will be like in the next phase. Take a bit of time to process that.

Then again, some of your reaction to discharge planning may be spot-on intuition that your child truly isn't ready. This, too, merits examination. Make sure you articulate any specific concerns to the doctor, especially if in your private conversations with your child she has indicated that she still wants to kill herself, or you suspect your son is lying in order to get out.

Some parents become upset because the hospital wants a *longer* stay than feels strictly necessary. Ask why they want this. Common reasons are that a follow-up plan of care isn't in place yet or that the doctors feel it isn't safe to discharge your child until she has met certain conditions.

Before you bring your child home

If your child was suicidal or made an attempt, you will want to ask **how much of his new medication constitutes an overdose.** Yes… ouch. But this is better to know than not-know. Ask this several days before discharge, because you may need to buy a lockbox or safe in which to store medication. You'll also need a meds dispensing tray (available in any pharmacy) to set up a week's worth of medication at a time. You don't want to retrieve bottles multiple times a day, because the more you open and close a lockbox, the greater the odds are that you'll leave the key somewhere or your child will see the combination.

Ask if it's safe to leave a tray with a week's worth of meds out and accessible. Believe it or not, the doctor probably won't know the answer off the top of her head, unless the medication is particularly potent. If it's dangerous to leave a week's worth of meds out, buy a tray with detachable compartments that allow you to take a day's worth out at a time. That way you can organize the whole week, keep the bulk of it in the lockbox, and take out only a single day's medication.

If your child has been suicidal or made an attempt, while your child is still hospitalized, do a clean sweep of your home, and especially his room. Hopefully the doctors have told you what method of suicide your child was contemplating. This will help you prioritize what to remove or look for. Lock up high-risk items like firearms, all prescriptions (including your own) and over-the-counter medications like Tylenol and aspirin. Remove poisons (including toxic cleaning products), sharp objects like razors and knives and large plastic bags. You will also need to wrestle with how to make sure that for the next few weeks your child is not left alone for more than very short periods of time at home.

If you suspect your child has hidden something dangerous (sharps, meds, illicit drugs) but you still can't find it, Google "best places to hide ____ in your bedroom." Chances are you kid has visited that page ahead of you.

For a more comprehensive list of steps to take to "sanitize" your home, check the **Grief Speaks** web site.

Get the discharge instructions that tell you what to do and be sure to sign a release saying you'd like the discharge summary when it is ready and to whom you want the discharge summary sent. If your child was given any kind of psychological or ed-psych testing while on the unit, make sure to get a copy of those results before leaving, too.

Also in this series: **Taking Your Child to the Emergency Room, Bringing a Child Home From Psychiatric Hospitalization**

PARENTING CHALLENGES, TREATMENT