

Advocating for your loved one during a crisis

A guide for parents and caregivers while at the hospital emergency department

Family members who have experienced crisis situations with their own children of all ages developed this guide. These experiences revealed the importance of developing self-advocacy skills in today's health system.

Family leaders share their insights here to empower parents and caregivers to:

- Express their views and concerns,
- Access information and services,
- Understand their patient rights and the rights of family and natural supporters,
- Learn the language used in the emergency department, and
- Explore choices for next steps.

Licensed health professionals did not write this guide. Do not use it as a substitute for professional medical care or advice.

Coming to an emergency room because a child is in crisis or in danger isn't something any parent wants to do. Many families have told us that understanding common processes and questions at the hospital would have helped them understand what is happening and make difficult decisions more easily. We have taken that feedback and developed this guide to help you advocate for your loved one and achieve the outcomes that are best for your family.



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What to expect at the emergency department

Emergency department workers will:

- Stabilize and assess the patient (your child)
- Decide if there is an urgent danger from suicidal thoughts or a risk of harm to self or others
- Make clinically-informed plans for follow-up treatment

Whenever possible, bring someone with you or have them meet you at the emergency department. This person can help support you and take notes. That way you can focus on being completely present for your child.

Check-in

- Explain what happened, why you are there and what you need.
- Provide basic information. Include name, address and insurance.
- Have the following with you in the emergency department:
 - All medications, or a list of medications, that your child is taking
 - Your child's health history
 - Names and phone numbers of your child's primary care provider, therapist, and other health providers.

If you did not bring this information, call someone to bring it to you.

Set up information in a portable file you can quickly grab or keep with you if you need it in the future.

Medical health assessment

Emergency department staff will conduct an assessment that focuses on four areas:

1. **General medical assessment**
 - Blood pressure, temperature, etc.
2. **Overall physical condition**
 - This includes possible side effects of medicines or other drugs
3. **Suicide attempt circumstances**
 - What your child did to harm themselves
4. **Overall mental state**
 - History of attempts
 - If there was a suicide note
 - What might have prompted the attempt (relationships with friends, school, family, etc.)
 - How your child feels now (disappointed, angry, relieved, etc.)

Emergency medical treatment

Your child will receive treatment for immediate physical conditions first. You may hear this referred to as "medical treatment."

Mental health assessment

The health professionals will assess the level of urgency for possible psychiatric admission. One or more of the following may ask you to speak with them in a private room:

- Emergency department doctor
- Psychiatrist
- Psychiatric nurse
- Mental health crisis worker

For your child's safety, they may be in a psychiatric hold room while they wait for a mental health assessment. These rooms are a relatively bare space. Medical staff may ask the child to change into a gown, scrubs and slippers.

Questions from the person making the assessment may include:

- Why did you bring your child to emergency today?
- Did anything different than normal happen today or during the past week?
- Has your child attempted suicide before?
- Does your child have a history of harmful behavior (cutting, overdose, drug or alcohol use)?
- Are there any recent or near future events that distress your child?
- Do you know of anything that may have prompted the attempt?
- Is there abuse or a possibility of abuse, including bullying?
Is it occurring at school, in the home or somewhere else?
- How is your child doing at school?
- Is there a family history of mental illness, addiction or suicide?
Are there medicines that helped that family member?

When answering the emergency staff questions, try to be brief. Staff are looking for specific information. This information will help them provide the best care for your child. It will help them stabilize, evaluate, and determine what to do next.

Suicide risk assessment

The emergency staff will assess your child's risk for suicide. This is more than just asking your child if they are actively thinking about suicide. A child may not have suicidal thoughts in the safety of a hospital. However, they may be at risk of an attempt again after returning to stresses at home or at school. An assessment should include:

- Reviewing current medications, including any alcohol or illegal drug use
- Setting up follow-up care, which includes:
 - The ability to look after themselves
 - Need for peer support, and
 - Other community-based services
- Thinking about what will happen after the emergency department visit. This includes returning home or moving to other levels of care.

You may hear about risky behavior or things you did not know about. Hearing this may be shocking.

Try your best to not show a reaction or ask for more details. Instead, make sure the safety plan covers the behavior. You will have a chance to address your own emotional shock and concerns after the immediate crisis.

How to advocate for you and your child in the moment

Be clear about why you are in the emergency department and what you want for your child. Ask questions about the safety plan and follow-up care. If the hospital wants to release your child to go home and you don't feel you can keep them safe, listen to your instincts. Clearly explain your reasons. Is your child a risk to themselves or others? Will your child be alone at times during the day or night?

If you don't believe your child will be safe, do not sign the release from the emergency department.

Contact the hospital patient advocate and the Oregon Health Authority ombudsperson immediately. File a complaint documenting your objections.

Before you leave the hospital

Release from the emergency department

Based on the evaluation of your child, you may be given several recommendations. Your child may be cleared to go home, transferred to an inpatient or residential treatment setting, or referred into a community-based program to help you make a plan for long-term treatment. If you are home and you didn't receive answers to all the questions below, it's not too late to contact the emergency department staff and ask them.

Questions to ask the emergency department person who does the assessment:

1. For the doctor or nurse: When can I expect a psychiatrist or behavioral health professional to do a mental health assessment of my child?
2. Has my child signed a release of information form for the provider to talk to others (primary physician, providers, school, etc.)?
3. Have you performed a full suicide risk assessment? What are the results?
4. What did they find? What are the possible underlying reasons (diagnoses) and possible options for treatment?
5. Will my child be admitted to a hospital or psychiatric bed? What type of ongoing care is needed?
6. Will my child need any medications? How long will my child need to take it?
7. Should I carry naloxone to use with an opioid overdose? How do I use it? Where can I get it?
8. Do you have referrals for specific professionals?
9. What should I do to make sure my child is safe? Are there warning signs I should look for to prevent a suicide attempt?
10. What should I do in the event of another crisis or if I feel like another crisis is building? Who should I contact?
11. How do I interact with my child moving forward? Are there questions I should ask my child?
12. Is there a **family support specialist** in the area? If so, have they been contacted to assist my family? How can I get in touch with one?
13. What support or services are available if we must wait for treatment?

- You have the right to ask the doctor or other health care worker for written information about your child's diagnosis and ideas for next steps.
- You also have the right to ask for a second opinion and to read the hospital's discharge or release policies.
- The emergency department is often overwhelming and there may be a lot of new information.
- It is okay to ask questions if you don't understand or you don't agree with what is being planned.

Family support specialists have experience raising a child with behavioral health challenges and are trained and certified to help other families navigate systems and advocate for themselves. In some areas of the state, there are also **youth support specialists** available who are trained, certified and have experience. They can walk with your child through their recovery. Ask your child's provider or a **family support specialist** about contacting a **youth support specialist** in your area.

Going home

If you are going home, you should receive a written plan with information about after-care, safety and finding and setting up follow-up services.

Be sure to discuss:

- **A safety plan** with the person who did the mental health assessment, your child, and yourself or another caregiver. Make sure it has phone numbers for you or your child to call if you have questions or concerns.
- **Safety precautions** — especially how to make a plan to lock up, remove or make safe anything that could be used in a suicide attempt. This includes guns, medications, drugs, alcohol, rope, chemicals, etc.
- **Information** on taking care of your loved one after an attempt.
- **A set follow-up appointment** within the next week. This may be with an outpatient therapist or with a community-based team, if available.
- **Prescriptions for any medications** — Be sure the first prescription is filled before you leave the hospital or immediately after. Also, make sure you understand what the medications are for and any possible side effects that may need immediate attention.
- **Connections to peer support or other community-based support** — This may include a **family support specialist** for you or a **youth support specialist** for your child.

Be sure you can answer the following questions before leaving the hospital:

1. How do I act with my child once we are home? What should I do or say?
2. What warning signs should I look for?
3. What do I do if I think my child is becoming unsafe?
4. What is the plan for what my child will do or say if they feel unsafe?
5. Who does my child want to involve in next steps?

See the safety plan page of this packet for more information.

If your child is held in the emergency department for more than 24 hours waiting for a bed to become available, contact the Child and Family Behavioral Health Unit at the Oregon Health Authority, 503-957-9863.

If you say you are not taking your child home due to safety concerns, Child Protective Services (CPS) may be called. If this happens, do your best to stay calm. Child Protective Services does not want to take custody of a child when someone can care for them. Ask the CPS staff to help you negotiate a safety plan with the emergency department staff and/or request a **family support specialist** who can help you work through next steps.

When you are not satisfied with services

Before filing a complaint or concern, try requesting the service you need directly from the hospital staff or the crisis worker. The Patient's Bill of Rights can tell you more about your rights. The hospital staff or a **family support specialist** should be able to locate it for you or you can look up "U.S. Patient's Bill of Rights."

Filing a concern or complaint

A complaint is a concern you may have with any aspect of health care services or with the provider of your health insurance.

Sometimes it is also called a grievance. Examples include:

- Interactions with staff that you felt were insensitive, shaming or otherwise offensive
- Requested service or help was not received
- Receiving incorrect services or medication
- Condition of facilities
- Unreasonably long wait times
- Refusal to provide an interpreter or asking a family member to interpret

Filing a complaint is a way to improve how or what services are provided in the future. A change in services or procedure will not happen right away. It will likely take a while to process your concern and to see a change, but try to stick with it. This is how systems adapt and get better.

Oregon Health Authority has an ombudsperson who can help you. An ombudsperson is a public advocate officially charged with investigating complaints and resolving them quickly. Call **1-877-642-0450** (toll free) or call or text **(503) 957-9863**.

Filing a concern with your coordinated care organization (CCO) or Oregon Health Plan provider

Each **coordinated care organization (CCO)** has a written grievance process which should be on their website. You may call customer service to ask for help. The number is located on your insurance card. It is also a good idea to submit a written request or complaint. If you send a written request or complaint, the CCO must reply in writing as well, usually within 5 work days.

Filing a concern with your private insurer

Each private insurer has its own method of filing a complaint. Look on their website and search the terms "grievance" or "complaint." You may also file a concern about your insurance company with the state at the Division of Consumer and Business Services (DCBS) at <http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx> or by calling **888-877-4894**.

Filing a concern about the hospital with the state

If you filed a complaint with your CCO or health plan provider and are dissatisfied with the outcome, you can submit your complaint to the state either through the Governor's Advocacy Office or through the Oregon Health Authority at <http://www.oregon.gov/oha/HSD/OHP/Pages/Complaints-Appeals.aspx>

Filing a concern about Child Protective Services or services for children with intellectual or developmental disabilities

Department of Human Services, Governor's Advocacy Office (8 a.m.–5 p.m.): **1-800-442-5238**

If you have any questions or concerns, seek out your family support specialist to assist you with the process or call the state's Child and Family Behavioral Health Unit at 503-957-9863.

Release to other levels of care

Many levels of care exist to meet your child's clinical and behavioral health needs. Safety is the most important factor in deciding the next steps for your child. Understanding the possible treatment levels will help you share in making the best decisions.

Most youth will leave the emergency department with a doctor's advice to follow up with a community doctor, therapist or psychiatrist.

If your child's condition is not stable enough for this option, you and the doctors may decide you need a higher level of care to further assess and stabilize your child. If this is the case, they will look for an available space in an inpatient care facility, which will be referred to as a "bed." If there are no available beds, your child may be sent home until one is open or they may stay in the emergency department. If a bed is available while you are in the emergency department, the staff there will discuss transportation with you.

Be sure to ask the emergency department staff and the place where your child is going about what they will be allowed to have at the new location. Each place has rules about clothing, personal belongings, cell phones, etc.

Levels of care:

- **Outpatient services:** There are outpatient programs with different intensities or specialties. Some, like Early Assessment and Support Alliance (EASA) and Wraparound, specialize in early intervention with a psychotic episode or intensive community treatment services. These can include treatment and skills training in your own home several times a week. There are specialists for substance use disorders, trauma, eating disorders, etc.
- **Acute care:** Short-term, inpatient hospital care with the goal of stabilization. Hospitals in Oregon that have psychiatric inpatient units for children under 18 years old are Unity Center for Behavioral Health in Portland and Providence Willamette Falls in Oregon City.
- **Subacute:** Brief, intensive services provided in a residential setting. Youth receive a psychiatric assessment and have access to mental health professionals. The goal of this type of care is achieving behavioral health stabilization to prepare them for the next phase of care. Facilities in Oregon that offer subacute care are Trillium Children's Farm Home, Trillium Parry Center and Albertina-Kerr.
- **Residential treatment services:** There are other residential treatment centers that may not accept Medicaid, but do accept commercial insurance or private payment. They involve outdoor programs, non-medical programming, or specialized therapeutic or medically supervised treatment. Talk to a **family support specialist** or your child's provider for more information about these services.
- **Substance use disorder treatment programs:** Short-term, inpatient care for youth recovering from alcohol and drug use. These programs provide a variety of treatment methods including recovery skills, life training skills, self-help, group and individual therapy, and relapse prevention.
- **Psychiatric residential treatment services (PRTS):** Short-term, residential services for children and youth that require 24-hour support for emotional and behavioral challenges. Children and youth participate in therapy, therapeutic activities and school. There are several of these facilities in Oregon, including Jasper Mountain, Trillium Children's Farm Home, Trillium Parry Center and Kairos New Beginnings.
- **Secure Children's Inpatient Program (SCIP) and the Secure Inpatient Adolescent Program (SAIP):** State hospital level of care for children and youth who need longer term care and intensive therapy services. Children and youth participate in individual and family therapy, therapeutic skills groups and go to school at that location. SCIP is a section of the Parry Center that accepts children 12 years of age or younger. SAIP is a section of the Children's Farm Home that cares for youth age 13–18 years.

Safety planning at the emergency department

When youth come to an emergency department with suicidal thoughts or actions, it is normal to develop a “safety plan” before leaving the hospital. The goal of the plan is to state how everyone will support safety from suicide risk or overdose and to help everyone feel that returning home following the crisis is safe.

A crisis worker should lead a discussion to develop the safety plan. The discussion must include the youth and all family members who will help with any part of the plan. Because suicidal urges may come and go, safety plans help the youth and family develop ways to cope when the risk of suicide is high.

Making a safety plan with your child

A safety plan is designed to guide you and your child through a crisis. As your child goes through the steps in the plan, they can identify relationships and activities that give them hope and make them feel safer. The plan should be easily understood by anyone who is a part of it. Make copies and post one in a common space in the home, like on your fridge. Your child will guide the first section of the plan. It is about what they can do to ensure their own safety, including the following:

1. **Recognize your personal warning signs.** What thoughts, images, moods, situations and behaviors tell you that a crisis may be developing? Write these down in your own words.
2. **Use your own coping strategies.** List things you can do on your own to keep you from acting on urges to harm yourself.
3. **Name others who may offer support and distract you from the crisis.** List people, friends, things you can do with others and social settings that may help take your mind off of difficult thoughts or feelings.
4. **Identify family members or friends who may help to solve a crisis.** Make a list of people who are supportive and who you feel you can talk to when under stress.
5. **List mental health professionals or agencies.** Make a list of names, numbers and locations of clinicians, local emergency rooms and crisis hotlines you are willing to contact. Put the Lifeline number (800-273-8255) and the Oregon Youthline number (877-968-8491) into your phone. For a text option, text “teen2teen” to 839863.
6. **Ensure your home or where you are going is as safe as possible.** Have you thought of ways you might harm yourself? Develop a plan to limit access to weapons, poisons, medications, etc.

Additional steps in the safety plan to talk about with family members:

7. **Ways your parents, family and friends will recognize you need help:** What signs might the people closest to you see that you might not notice for yourself?
8. **Things that are helpful for you to hear from the people in your close circle:** List the ways you can best hear concerns from others.
9. **Things that are definitely not helpful to hear:** List words, reactions or emotions that are activating for you. Ask for people to be careful to avoid these and choose other helpful ways to communicate with you.
10. **Who will help your child call health professionals or a crisis hotline if they is unable to do it for themselves?** This includes siblings or childcare people who may have to make a call.
11. **What will be done at home to create a safe place for everyone who lives there?** This includes suicide safety steps like locking up or removing medications, weapons, alcohol and sharp items. It also considers the needs of siblings, childcare and pets in the event of another crisis.

The plan you develop today in the emergency department is likely to change over time and with progress in treatment and recovery. Be flexible with the changes that need to happen and edit the plan as needed. The goal is to have a useful plan everyone understands.

Example of a safety plan template

Warning signs that a crisis may be developing (mood change, thoughts, images, situations, behavior).

1. _____
2. _____
3. _____

Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, pleasurable activity).

1. _____
2. _____
3. _____

People and social settings that can distract me:

1. _____
2. _____
3. _____

Things my family can say or do to support me:

1. _____
2. _____
3. _____

Things my family should avoid saying or doing.

1. _____
2. _____
3. _____

People I can ask for help:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Professionals or agencies to call in a crisis:

Clinician (therapist) name: _____ Phone: _____

Local urgent care: _____ Phone: _____

Primary care or other professionals or agency: _____ Phone: _____

Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255) | Oregon Youthline: 877-968-8491

Confidentiality — Understanding the basics

HIPAA stands for the Health Insurance Portability and Accountability Act. This federal regulation created national standards to protect patient identifiable information in health records. HIPAA also allows a patient greater access to his or her own records. HIPAA is confusing to most people and may be misused.

Understanding these basics will help you with important paperwork and decision-making.

A signed **Release of Information (ROI)** form is necessary for the hospital to discuss medical information with anyone other than the patient or legal guardian. It also allows the hospital to transfer your child's medical information to another medical or mental health provider. A youth age 14 or older can sign an ROI.

A minor is any person under the age of 18.

For youth under the age of 14

In most cases, the parent or guardian that will consent to medical care and releases of information. At age 14, a youth can access and consent to care without a parent's permission. However, if the youth is a minor, the parent or guardian must be included in the youth's care before treatment ends. Depending on their age, minors can request certain levels of confidentiality and consent to some health care matters. Please know that health care professionals may be able, or even required, to disclose certain health information about minor patients to state agencies (such as communicable diseases or suspected abuse or neglect).

What kind of information is included in HIPAA?

Protected health information (PHI) is any information that could identify a person, such as name, address, birthday, Social Security and phone number. It also includes any information about your health, diagnosis or treatment. You can authorize your provider to discuss your needs without giving the details of what you talked about in a treatment or therapy session.

Signed consent is you or your legal guardian's agreement that you:

- Understand the treatment you will get
- Authorize and allow the treatment, and
- Understand how private information will be shared.

Informed consent for health services should include:

- A description of the treatment the patient will get
- A description of other treatments
- A description of risks and benefits of each treatment.

Confidentiality for substance abuse treatment programs (42CFR Part II)

This is a federal regulation, like HIPAA. However, it only applies if you are a current or past patient of a substance abuse treatment program that gets federal funds. The program and its staff cannot disclose that you are or have been a patient, nor whether you have any current or past problems with substance use or abuse.

Exception to confidentiality — Medical providers can tell parents about a diagnosis or treatment plan when the youth's condition has deteriorated, there is a need for surgery, there is a risk of suicide or inpatient treatment is necessary.

It is good to have a calm discussion with your child and the provider about signing a release of information (ROI) form specifying what medical information can be shared. Most ROI forms indicate what information is to be released, to whom and for how long. Discuss how this will help you support your child.

You do not need a ROI to develop a safety plan or to give information to your child's regular physician or other health care provider.

For more information, search "Minor Rights: Access and Consent to Health Care" or visit this website: www.oregon.gov/oha/ph/HealthyPeopleFamilies/Youth/Documents/minor-rights.pdf

Q and A for parents and youth

For parents or guardians

What can I tell a provider if my child has not signed a release of information?

HIPAA and all other confidentiality rules do NOT control what you say about your child to a provider. It only controls what the provider says to you. Tell the provider what you know about your child's behavior, things that are happening at school or with friends and family, and what concerns you about past or future events or behavior.

What can a provider tell me if my child has not signed a release of information?

Chemical dependency and domestic violence programs cannot tell you if your child is participating in their program. However, providers can talk to you when it is helpful for your child's treatment. The provider can guide you in how to talk with your child about developing a plan of care, a safety plan or a relapse prevention plan. They can also help you talk to your child about the benefits of signing a release of information that meets the privacy needs of your child and your own need to know when and how to help. *Providers must involve you when there is a threat of suicide or homicide or speedy medical treatment is needed.*

What can I say to my child about signing a release of information?

It will be helpful to openly talk about what information you want to know and what you will do with that information. One way to guide that talk is to focus on how you will work together to stay safe and what you may need to do in case of a crisis. You do not need to know what happens in therapy, only what you can do to help with your child's progress.

What is the goal of signing a release of information?

The goal for the parents and the youth is to have a real talk about sharing the responsibility for safety and planning for wellness, harm reduction and relapse prevention. This is an opportunity to share concerns, reassurances and plan responsibly together.

What can I do if I think a provider has violated HIPAA rights or is unwilling to honor a request for information?

File a grievance with the specific agency and the state. You can find these forms online or at the front desk of the agency or ask how to contact a family **support specialist** or **youth support specialist**.

For youth

Why would providers need to share information about me?

Providers use your information to work with each other to give you the best treatment. You can specify exactly who you give permission to and for how long. Some examples of why your information would be used include:

- Your primary care provider needs to talk to your psychiatrist about medications because they can interact badly with each other.
- Your care coordinator wants to make sure that all the people in your life are following through with what they said they would do.
- Your parents or family members want to help create a safety or relapse prevention plan so they know how you want them to support you.

How do I know who is allowed to share my information?

For the most part, if you are over the age of 14, you are responsible for signing a release of information (ROI). This form says that you give permission for one provider to talk to another provider or person, like your parent. It also means that you can limit what is shared or cancel the ROI at any time.

What if I don't give my permission?

Providers must do what you say about releasing information unless keeping the information confidential might cause danger to yourself or others. The provider must release information to keep you or others safe.

When can providers talk to parents?

Providers can talk to parents when it is clinically appropriate and make sense as part of your treatment. This would not include the details of what you say in treatment. This sharing would help your parents understand how to support your recovery. Involving your parents is useful when you must be admitted for medical treatment (including detoxification) or when there is a risk of suicide. When providers think there may be a dangerous situation, they will release some information to your immediate caregiver. An example of this is if you post a plan for self-harm or suicide on social media.

Safety precautions at home and at school

Home

Things will be different at home. Returning home after a suicide attempt or a hospital stay is a high-risk time. It is normal to want to protect your child or wrap them in a cocoon. However, it is helpful and empowering for your child to be a central part of ensuring their own safety and well-being. Whenever possible, try to work with them. That being said, there are important things you can do to help protect them.

- Keep the following items out of reach of your child even if the new place may be inconvenient:
 - Firearms — Assume your child knows where to find the hidden key to a gun safe. It is always safest to remove all the guns from the home, at least temporarily. If they cannot be removed, consider storing the guns and bullets in different places.
 - Prescriptions medications, large bottles of over-the-counter medications, recreational drugs
 - Car keys
 - Sharp instruments
 - Poisons, including bleach or other cleaners
 - Things that are designed to cause fires, like gasoline
 - Ropes, extension cords, smart phone charging cords, ties.
- Discuss significant mood or behavior changes, use of alcohol or drugs, or suicide attempts with your child's clinician.
- Identify events or past circumstances that caused a stressful reaction, especially those that involve personal or interpersonal disappointment. Note patterns of behavior and feelings around these events. Avoid similar situations until your child connects with a behavioral health specialist. For situations that cannot be avoided, do your best to remain calm and not increase your child's stress reaction.
- Ask how you can help. How do they want you to help if they don't feel or seem safe?

If your teen or young adult has misused opioids (street drugs or prescription), consider carrying naloxone. You can buy it at your local pharmacy without a prescription. In the event of an overdose, the spray will help keep your child breathing while you wait for the paramedics.

A good suicide safety plan includes how your family will remove things that could be used in a suicide attempt from the home or secure them so your child cannot get to them. Remove whatever your child used to attempt suicide before your child comes home or as soon as you get home. If you have access to a [family support specialist](#), discuss your plans to remove these things with them.

School

A safety plan for school will look different than the one created in the emergency department. Returning to school can be very stressful for your child, especially if siblings attend the same school. There are some ways the school can provide support in this time. When the school knows about your child's suicide attempt, crisis or hospital stay, the school counselor, nurse, teacher or administrator can help support the student's return to classes.

You and your child should discuss who will have access to your child's safety plan. School personnel who are a part of the safety plan need to know their own roles, but they don't necessarily need to know all the details of your child's plan. The safety plan at school should not be kept in the student's main file. This ensures no one can access it that is not approved to do so.

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of students' educational records in all schools that receive federal funds. Generally, schools must have written permission to release any information from a student's educational record. However, the school may release information without consent under certain circumstances, including:

- Information necessary to protect the health or safety of the student or other individuals
- School officials with legitimate education interest or
- Other schools to which a student is transferring.

When school staff is aware of your child's needs, they can respond better to behavior changes or concerns. School staff may also become more alert to possible triggers in a way that would not be possible if they were unaware of the concern. The counselor or another member of the school staff will be the contact person for communicating with families on how the student is adjusting and performing in school.

It is important that any information shared with school staff be discussed with and approved by the student. Your child understands more about the school personnel and environment than you do and it is important to make them feel comfortable and empowered in this process. The type and amount of information shared will depend on your child's trust level and could change over time.

As a family, you may wish to share with the school only that your child has had some medical problems and that you need to be called immediately upon your child's request. Reassure the school that the doctor is aware and has approved the child being in school. Then, be mindful to have your phone available so you can respond to your child's call or text.

Why would my child's school need to know about their recent medical emergency?

The school may provide the following, along with other options:

- Hold your child's medication in the nurse's office and dispense it as needed.
- Set up a comfortable, quiet room where your child can have time to themselves.
- Allow headphones for music or other aids for self-regulation.
- Postpone or extend time to complete a test or assignment.
- Assign an alternate project if an assignment is triggering.
- Change your child's schedule or classes.
- Provide time for your child to go outside for a pre-approved physical activity to relieve stress.

What youth want parents and caregivers to know

What advice would you give other parents and families in similar situations? What made you feel supported when you were struggling? What was important for you to hear from those supporting you?

These are the questions we asked youth from across the state. Everyone who was asked had faced a mental health crisis that led them to the emergency department. For some of them, that experience was as recent as last year and for others it has been a decade or longer. What they all have in common is an interest in helping other young people and their families through this experience. Below are their answers which have been edited for length and clarity.

- Listen to me and respect my opinions and choices. I may want to talk to the emergency department staff alone because I may not be ready to share some information with you.
- If you are too emotional to support me in the emergency department, ask someone else to be in the room with me. Let me decide who sits with me.
- Be gentle. Let me have time to sort out what is going on with me. Remember, it takes time to recover.
- Bring something to the emergency department that will help distract me, like a portable gaming system or coloring books, if it is allowed.
- Make sure I get a proper physical and mental health assessment. The doctor may dismiss or make assumptions about my physical complaints.
- I trust you to keep me safe. Be honest about what is going to happen and stay with me if it is allowed.
- Stay calm. Be patient. Don't blame or shame me. Be fully present.
- Comfort me. Listen to me. Validate my feelings. Let me listen to music or something else if I am interested.
- Don't ask me a lot of questions and be supportive, but not pushy!
- I need you to know that I did not attempt suicide for attention.
- Do not talk about my suicide attempt without first talking to me. I felt scared and embarrassed and it was hurtful for my business to be made public.
- Don't judge me. Look at me as a whole person to determine why I am in crisis.
- Stay calm and listen to me.
- I know its stressful for you as a parent/caregiver, but keep in mind that I am going through something too and you getting upset or freaking out is not going to help me. In fact, it may make it worse. Just try and stay calm and remember that you cannot fully understand what I am experiencing.

- You should try to calm me by keeping a friendly demeanor. Talk with me about things that I am interested in. Any way you can lower my stress is always helpful.
- Help me through this process so I don't feel alone.
- Ask me, "What would make you feel better right now?" Listen to my answers and try to find a solution that works for both of us.
- Make sure I am present when you are talking to my health care provider about me, so I can ask questions and be included in making decisions.
- When talking to me, use plain language. Help me find the right health care specialist and protect my privacy. Listen to me and accept my feelings.
- Let me have some space. Focus on other things and give me moments when I am not the center of your attention.
- Be a positive part of my treatment. This can help ease the transition back home. Having a support system that helps meet my needs, also helps create a safe, positive space for growth and healing. If you are not able to offer support to me, help me find another support system. Leaving the hospital does not mean that the work is done.
- I wish my parents had known that this wasn't my fault or something I chose. I needed my parents to show me that they love me even with my mental health challenges rather than in spite of them.
- Be there for me and advocate for my care. Believe what I tell you. Don't get angry with or blame me.

Common myths

1. Myth: Talking about suicide or asking someone if they have thoughts of suicide will encourage suicide attempts.

Fact: Suicide is the second leading cause of death for young people age 15–24. Talking about suicide does not increase the risk of suicide. Rather, openly talking about fears is the first step in encouraging a suicidal person to live. That conversation can simply be asking the person if they intend to end their life. The danger is in not asking when you feel there is a risk.

2. Myth: Once a young person is suicidal, they will be suicidal forever.

Fact: Most young people who are considering suicide will only be that way for a short period of their lives. The key is interrupting the thought of suicide with meaningful activities and positive relationships. Encourage the youth to engage with people, activities and places that take their mind off suicide. Given proper help and support, they can recover and live happy, healthy lives.

3. Myth: People who threaten suicide are just seeking attention.

Fact: Suicide is an action of despair by someone who is in a lot of pain and wants their pain to stop. All suicide attempts must be treated as though the person wants to die. A mental health professional must evaluate them as soon as possible.

4. Myth: I cannot help a youth who is using illegal substances.

Fact: Overdose is the third leading cause of death for young people age 15–24 years. Just like when you suspect someone is experiencing suicidal thoughts, you should talk openly about misuse of alcohol and drugs with someone you suspect is misusing them. You don't have to wait until they are arrested or "hit rock bottom." Urging by loved ones is one of the primary reasons people seek treatment. However, it's important to remember that people are most likely to relapse in the first few months after they stop using. While not every action of self-harm, like superficial cutting or drug use, is a suicide attempt, there is a bigger risk of suicide when using and after someone stops using. Make sure you discuss a safety and wellness plan with your loved one.

5. Myth: People who get addicted to prescription drugs or alcohol are different from people who get addicted to illegal drugs

Fact: All have the same risk of addiction and all carry stigma and shame. Addiction is a chronic disease like heart disease, diabetes and cancer. Addiction is not a moral issue. It is a brain disease that requires new skills to overcome.

6. Myth: Noticeable and sudden improvement in the mental state of a young person following a suicidal crisis or depressive period says that the suicide risk is over.

Fact: The opposite may be true. A suicide attempt is regarded as a sign of further attempts. A young person is most at risk of taking their own life in the three months following an attempt. The visible lifting of the problems could mean the person has made a firm decision to kill themselves and feels better because of this decision. Continue using the safety plan and updating it as your needs change.

7. Myth: Most suicidal young people never ask for help with their problems.

Fact: The opposite is most often true. Evidence shows that youth give cues 70% of the time. Youth are more likely to ask for help through body language or indirect hints. Ideas like “You’d be better off without me” or feeling useless or like a burden can be strong indicators of risk.

8. Myth: Younger siblings can be kept unaware of the crisis.

Fact: Younger siblings, including infants and toddlers, are sensitive to the emotions of other members of the family. They will also have an emotional reaction, though they are likely unable to talk about it aloud. Because they cannot voice their feelings, they may show changes in behavior not directly connected to the family event. Changes in sleep, feeding and other behaviors can happen. Being aware of the infant or toddler’s experience and making time for them are steps to protecting their health and well-being during these challenging times.

Talking to family and friends about the crisis

Before talking to anyone else, sit down with your child to discuss who can be told about what happened and how much of the story to tell. Ask your child what they may want you to say if asked about the suicide attempt.

It is okay for you to talk about your own feelings with your support system. However, it is important to avoid sharing your child's feelings or any parts of the story your child has not given you permission to share.

If your child does not want to tell anyone, discuss the thoughts and emotions behind their desire to keep the suicide attempt private. They may not want to share all their reasons with you. Be understanding. Accept their feelings and be up-front that you may need to tell others for your own support. See if you can find a part of the story your child is willing to share. This story may be different depending on who is asking.

Talking to family members is different than talking to others in your community. Siblings, including infants and toddlers, usually sense when something happens and may be confused, afraid and upset. Older children may even feel like they did something wrong. Make sure to emphasize that

no one is at fault. Discuss the safety plan with them and how it applies to each person in the family. Tell them what they can do or say that will help support your child and the rest of the family.

Talking openly with family members about the suicide attempt and suicide in general can help them understand their feelings and reactions and get over feelings of guilt. Knowing how to talk about suicide or crisis events in a way that is appropriate for the developmental age of each child is very important. Seek help from your health care provider for advice and resources on how to talk about suicide attempts with young children. By educating your family members about suicide or the crisis, they can better understand what your child is going through and better help your child's recovery.

Considerations when talking with children...

Tell the truth. When talking with children, use language they can understand. Do not give details of the suicide attempt or overdose. Let their questions guide the conversation. Be prepared to repeat. Children tend to ask the same question over and over as they try to make sense of what happened.

Listen. Really hear their worries and feelings. Try repeating back what they say to show them that they have been heard. Offer reassurance, but try not to make promises that cannot be kept.

Expect different reactions to emotions. Some may not outwardly react, others may want to be left alone or some may have difficulty being by themselves.

Set time for play. Children often process stories in small pieces. They need time when they can laugh and play and focus on something else. Ask them what they need and go along with what they say. Some elements of the event may emerge in young children's play. This is a healthy way for them to process the experience.

Give comfort. For infants and toddlers, do your best to maintain family routines. Try to include time for talking in this routine. Your family will need time and help to process their feelings. Talking about the suicide attempt openly with your family and admitting your fears aloud can be the first step in coping with it. Think about seeking out a counselor or therapist who can help with these discussions.

Talking to others outside your family

Support can come from many sources. It is important to know that contact with suicide or suicidal behavior within your family, friends, people you know or in the media can increase the impulse to attempt suicide. This situation is called contagion. Knowing how to handle stress after a suicide attempt in your community or in the media is essential because these skills can help prevent others from attempting similar behavior.

Try to stay connected to your community. People may be interested in what happened and may even ask you directly about the event. Move the conversation away from blame and from the details of the suicide attempt. Focus it on positives, things that connect you to your community and on the future. Help other parents talk to their children about suicide and suicidal thoughts.

Encourage other young people in your community to seek help. Your child's friends may feel confused or have any number of emotions. They may feel like they could have done something to prevent the suicide attempt. Ask them to talk with someone who can help them process their reactions and feelings.

Talk to a family support specialist. Conversations about suicide, particularly your concerns and experiences, are complicated. A **family support specialist** can help because many of them have had similar things happen in their family. They can listen as a source of nonjudgmental support, give you understanding, offer insights and coach you through difficult conversations. They can also connect you with other helpful resources, training and expertise.

Over time, your perspective will evolve

Over the course of time, as your child grows older and takes on more responsibility for their health and relationships, the story of today's struggles will change. It's okay to hold onto the information that helps guide future decisions. It is also okay to let go of the parts of the story that are no longer needed. We all need to be kind to ourselves so we can grow into our future selves without being defined by our past.

After the crisis — Dealing with grief and trauma

A recent suicide attempt, overdose or psychiatric crisis may affect your relationship with your child. You may feel awkward, anxious or more protective. You may not be thinking as clearly as you would under less stressful circumstances. Your child may feel angry, embarrassed or avoid you. Let them know that it is okay to talk to you but don't ask a bunch of questions, especially not "why" questions, such as "Why did you do that?"

Say how you feel and listen. It can be hard and frightening to hear someone talk about their thoughts of suicide. You can let them know it is hard for you to hear their pain and watch them suffer, but that you know it is important they have someone to talk to. If you are not ready to hear their thoughts or they don't want to share with you, encourage them to talk to someone else if they have new thoughts of suicide. Discuss who this person or people may be.

With your child

- Go slowly. Safety and recovery take time. Give your child the time they need.
- Support honest and open talks with your child, their siblings and other family members. Listen with caring and an open mind. Know that your child may shut you out at first as they try to process what happened.
- Tell your child they are important to you, that you care about them and that they have value.
- Support them by being there. Sometimes, it may be very difficult to keep your child safe from their own actions to harm themselves. Being there to help is important, as is learning what actions you can take to help them control their own emotions. When youth feel calm, it allows them to be an active participant in their own safety.
- Work with your child to look after themselves, including getting plenty of rest, healthy food, water and exercise.
- Help them to break time into smaller units: "I just need to get through the next day, the next hour, the next minute, the next few moments."
- Avoid promising that everything will be okay in the future.
- Connect your child to a youth support specialist or a peer support group, if available.
- Keep checking the safety and recovery plan.

Try to recognize or value one positive thing your child has said or done each day.

With yourself

- Avoid blaming your child or yourself. This is hard, but very important. Feeling bad or guilty does not help recovery.
- Make plans for the future. It can be something small, but pick something that you and your family will enjoy. It helps to have something to look forward to in the future, and it may help your child later in recovery to focus on something positive.
- Be kind to yourself. Helping others can leave you feeling angry and exhausted. It is okay to set limits and boundaries while still supporting your loved one.
- You and your child don't have to travel this journey alone. See the "Resources" page in this folder for information about organizations that can help you create your own network.

It is okay to lean on other people. Try to find a couple of people you can rely on for a variety of things, including rides, meals, helping with siblings, a shoulder to cry on and even with emergencies at any hour of the day.

How are you feeling?

You may have a strong emotional reaction to everything that has just happened. You and members of your family may be feeling shock, upset and even grief.

- **Grief** is the normal and natural emotional reaction to loss or a serious life event of any kind. It is not unhealthy. This is a normal emotional response of a parent whose child has attempted suicide.
- Everyone in your family may experience grief differently.
 - You may feel sad, anxious, guilty, confused, rejected, shameful, angry or overwhelmed.
 - Physical expressions of grief often include crying, headaches, loss of appetite, loss of concentration, difficulty sleeping, weakness, exhaustion, aches, pains or flu-like symptoms.
 - You may feel a grief “ambush” or “storm” (a quick flooding of emotion or physical reaction) when a memory of a loss is set off by words, places, events or thoughts.

Your recent experience may have been traumatic to everyone involved.

- **Trauma** is an emotional and physical reaction to a distressing or disturbing experience or event.
- Being in the emergency department can be traumatic and events that brought you there even more so.
- You may recognize trauma more as shock. Its symptoms may include: denial, disbelief, confusion, difficulty concentrating, sadness, hopelessness, anger, irritability, mood swings, anxiety, fear, guilt, shame, self-blame, pulling back from others, disconnection and numbness.

What can I do?

There are no “normal” timelines for grief and trauma. Every person feels these emotions differently. It is a process and each person will work through it in their own way and their own time. Here are some things that may help you cope with grief and trauma:

- Understand that these intense feelings are normal and will lessen with time.
- Give yourself some time before making decisions. When in shock, you may not be thinking clearly. It is okay to lean on someone you trust to help talk through these decisions.
- Drink water, eat and get regular exercise and rest. Look after yourself and model healthy habits for your family.
- Make time to talk about these events with your adult partner or co-parent. Grief, fear and trauma cause stress on a relationship. Building communication between the adults in the family is important.
- If comfortable, talk to close friends, a **family support specialist** or other community groups, like a support group or your faith community. This journey can be exhausting — don’t try to handle it alone.
- Grief and trauma are complicated. Please contact a counselor or therapist if you have:
 - Difficulty keeping up your normal routine (going to work, taking care of yourself, etc.)
 - Feelings of depression
 - Thoughts that life isn’t worth living or of harming yourself
 - Guilt or you can’t stop blaming yourself.

Sometimes the grief gets in the way of parents being able to talk to each other. Couples who can’t talk to each other about their grief have a hard time talking with their children about the same things. This can lead to couples getting cut-off from each other. A counselor or therapist can be a great resource in helping you begin to communicate effectively again.

Resources and glossary of terms

Resources

4th Dimension Recovery Center — Serves youth in recovering from addiction

3807 NE Martin Luther King Jr Blvd
Portland, OR 97212
<http://4drecovery.org>

Depression and Bipolar Support Alliance

800-826-3632
www.dbsalliance.org

Disability Rights Oregon

503-243-2081
www.drOregon.org

The Dougy Center — Providing Grief Support

866-775-5683
www.Dougy.org

FACT Oregon — Questions about special education

503-786-6082
www.factoregon.org

Lines for Life YouthLine — Confidential Teen-to-Teen Crisis and Helpline

Helpline: 877-968-8491 or Text “teen2teen” to 839863
www.linesforlife.org

National Alliance on Mental Illness — Resources and information for family members/caregivers

Helpline: 800-950-NAMI (6264)
www.nami.org

National Alliance on Mental Illness Oregon — Connect with local support groups and affiliates

Helpline: 800-343-6264
www.namior.org

National Federation of Families for Children’s Mental Health

240-403-1901
www.fccmh.org

National Suicide Prevention Lifeline

1-800-273-TALK (8255) or Text “273TALK” to 839863
www.suicidepreventionlifeline.org

Oregon Council of Child and Adolescent Psychiatry

www.occap.org — resources for families and youth

Oregon Family Support Network — Access to family support specialist

503-363-8068
www.ofsn.org

Partnership for Drug-Free Kids

Bilingual (English/Spanish) Parent Helpline:
1-855-DRUGFREE (1-855-378-4373)
www.drugfree.org

Trevor Project — LGBTQ Crisis and Helpline

TrevorLifeline: 1-866-488-7386
www.thetrevorproject.org

Warmline — Oregon Peer-Run Consumer Support – support for adults with psychiatric issues

800-698-2392
www.communitycounselingsolutions.org/warmline/

Youth ERA — Youth Support Services

971-334-9295
www.youthera.org

Glossary of terms

Caregivers

These individuals do not have legal authority to make medical decisions for the youth. They may be friends, family members, foster parents, neighbors or anyone who is with the youth in the emergency department and will continue to look after the youth in the days after the crisis.

Coordinated care organizations (CCO)

In Oregon, CCOs are healthcare coordinating agencies managed by the state instead of the federal government. They contract with a network of health care providers in their community to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

Counselor

Someone who is not a physician, is licensed and specializes in mental health or addiction treatment.

Emergency department

May also be called the emergency room.

Family support specialists

Trained and certified individuals who use their own experience with parenting a child with health or behavioral health challenges to support other parents and their children ...and help them navigate... services and advocate for their families.

Inpatient

Type of treatment that requires 24-hour care at a live-in facility or hospital; a doctor must write an order to formally admit someone.

Lethal means counseling

Assistance to families and individuals on how to assess and reduce access to dangerous things that may be used to attempt suicide.

Oregon Health Plan (OHP)

OHP is Oregon's public health insurance program, also known as Medicaid.

Outpatient

A place where you get medical and behavioral health treatment or testing without being admitted to a hospital. This can include the emergency department, a doctor's office, a medical lab or therapy.

Parents

As used in this guide, refers to the youth's legal guardians.

Psychiatrist

A medical doctor specializing in mental health. Psychologist, mental health clinician, therapist.

Safety plan

Written, ordered list developed with the youth and family describing coping strategies and resources for reducing risk of suicide, psychiatric emergencies, or alcohol or drug overdoses.

Stabilization in the emergency room

Emergency department staff will focus first on steadying the medical condition of the youth. This means ensuring the youth is conscious, breathing and has vital signs within normal limits before continuing with further assessments. Then, they will work to reduce the immediate risk of suicide, overdose or psychiatric emergency by prescribing a medication and creating a safety plan so the youth can be released home or to another level of care.

Suicidality, suicidal ideation

The likelihood of someone killing themselves; thinking about or being preoccupied with thoughts of suicide.

Wraparound

A coordinated set of outpatient health, psychiatric, and behavioral health services and community support that includes respite, care coordination, family support specialists and youth support specialists.

Youth support specialists

Trained and certified young adults who use their own lived experience with health challenges to help other young people navigate services and advocate for themselves.

Was this guide helpful for you?
Is there something that would be useful to you that is not here?
Are there any sections or topics that need to be clearer?

Please send any feedback to the following:

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