DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

CRISIS CARE MOBILE UNITS PROGRAM

What Caregivers Should Know About a Child Having a Behavioral Health Crisis

Many children and adolescents struggle with behavioral health challenges. Rates of depression and anxiety, already high among young people, have increased since the beginning of the COVID-19 endemic. Most children will find ways to manage their feelings with the help of caregivers who offer support, empathy, and compassion. However, some children may experience significant changes in their mood, behavior, or social life that persist or worsen over time.

Children who are unable to regulate their thoughts and emotions may experience a behavioral health crisis that requires immediate intervention. Children in crisis may or may not have shown earlier signs of depression or anxiety. They may be responding to a change or new stressor. It's important to understand that crises can happen to anyone, at any time.

This resource is intended to help caregivers navigate a behavioral health crisis with their child. Knowing what you can expect from crisis services, what you can do to support your child, and what resources are available to your family can help you steer your child through the crisis more confidently and calmly. Moreover, this resource covers both the rights of your child and your rights as their caregiver throughout the crisis intervention process. Understanding these rights can help ensure that your family can access the information and resources that you need.

This resource is broken into sections which follow the different possible outcomes for a child experiencing a behavioral health crisis.

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At the end of this document are three scenarios of different behavioral health crises that provide further insight into best practices.

What is a Crisis?

The National Alliance on Mental Illness defines crisis as “any situation in which a person’s behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community.” At its simplest, a behavioral health crisis occurs when feelings become intolerable, and the person experiencing these feelings is not able to cope with them. A crisis can emerge from mental health-related symptoms, substance use-related symptoms, or both.

People in crisis may lack the ability to take care of themselves or use the social supports available to them. A person can experience a crisis when internal stressors such as hopelessness or loneliness become overwhelming or in response to external stressors such as a breakup or the loss of a loved one. A person in crisis may have thoughts of self-harm, thoughts of suicide, thoughts of harming others, hearing or seeing things that are not there, severe anxiety and panic attacks, paranoia, and so on. A person can be “activated” by external events, which can worsen already existing behavioral health conditions. An activation event or stressful new situation can worsen the way a person feels, thinks, acts, and relates to others and can impede their ability to make healthy choices.

What Should I Do if My Child is in Crisis?

If your child is in crisis, you are not alone. There are people who can help. If you are worried about the safety of your child or the safety of others in the household, a good first step is to call your county’s mobile crisis hotline. Most California counties provide crisis services that are available 24/7. This service is free and gives you access to behavioral health professionals. They can help you decide the kind of support your child needs.

Can Someone Else Call for Crisis Services on Behalf of My Child?

A crisis intervention can be initiated by anyone who believes that your child is in crisis, including your child themselves. These services can be requested by family members, friends, and colleagues; members of community agencies such as teachers, coaches, and mentors; and other residents in the community.

What Happens When I Call Crisis Services?

Your call will be answered by a professional who is trained to assess whether your child can be helped over the phone; needs immediate, in-person support; or should be seen by emergency medical personnel. The hotline staff will ask you about the current situation, symptoms, and behaviors of your child. Some of the questions allow hotline staff to assess whether your child needs emergency medical attention. They will also ask you questions about the immediate safety of your child. If possible, they will work with you and your child over the phone to help your child calm themselves and give them resources to stay calm. Sometimes a crisis can be resolved this way and does not need additional intervention.

What Happens If My Child Needs In-Person Crisis Support?

If the crisis can’t be resolved over the phone, the hotline will dispatch a mobile crisis team to come to your house. Team members may be licensed behavioral health professionals or people with lived experience called “peers,” who have experience with mental health crises.

Their focus is to ensure the safety and stability of your child in the "least restrictive" setting possible. This means their goal is to prevent hospitalization whenever possible. If it is safe to do so, responders will work with your child in your home to provide a brief intervention. These interventions are designed to reduce your child's pain and provide them with coping tools to help them avoid future crises.

Will the Mobile Crisis Team Include Law Enforcement?

In most cases, mobile teams do not include law enforcement. Law enforcement is only called in when there are concerns about the safety of your child or the mobile crisis team. For example, if your child is experiencing psychosis and is acting aggressively, law enforcement may be necessary to ensure safety for everyone. If law enforcement will be part of the response team, hotline staff will notify you. Caregivers should feel free to ask the hotline staff questions about the involvement of law enforcement.

What Should I Do Before the Mobile Crisis Team Arrives?

If you think your child may hurt themselves or others in the household, you should stay with your child until the team arrives. If it is safe to briefly leave your child in a room, it is helpful to gather up the information listed in Table 1. One of the most important things you can do is gently explain to your child that the mobile crisis team is coming to help them and that they should honestly answer their questions. Let your child know that they can speak privately to the mobile crisis team. Helping your child know what to expect is a great way to help them stay calm. When you stay relaxed and open, it's easier for your child to model this behavior.

Information for the MCT

- Insurance cards *if applicable*
- Prescribed medication
- Names and contact information for any current behavioral health providers
- Any other items/documents to support information sharing as much as possible

Table 1

What Happens When the Mobile Crisis Team Arrives?

Once the team arrives, your child will likely receive a crisis assessment. The goal is to provide a brief, face-to-face intervention to help the team evaluate the current stability of your child. The assessment can also help reduce any immediate risk of danger to self or others and is used to create a short-term strategy for restoring stability and a plan for follow-up care.

What Kinds of Questions Does the Assessment Include?

The mobile crisis team will ask about frequency and intensity of crisis-related behaviors, relevant information related to mood and behavior, and your child's capacity to adequately participate in a collaborative safety plan. The crisis assessment team may use a particular tool to complete the assessment. Some sample questions that you and your child may be asked are shown in Table 2.

Tell the MCT About Any of These Symtoms

- Information about what might have caused the crisis, like recent trauma, legal trouble, or substance use
- A history of current or previous mental health symptoms
- Experience of social isolation, disconnection from others, loss of loved ones, reduced performance in school or at home, or increased conflict with others
- A history of any trauma or abuse
- Previous suicide attempts or self-harm
- Strengths and resources of the child experiencing the crisis, as well as those of family members and other natural supports
- Relationships with any behavioral health providers, including any prior hospitalizations
- Information about medication or other substances, either prescribed or used
- Any warning signs for suicide risk
- Medical history as it may relate to the crisis

Table 2

What Information Should I Give the Mobile Crisis Team?

You can help your child by providing information about any changes in your child's mood and behavior. Although crises are not planned nor predictable, there may have been signs that indicated that your child was struggling. Sharing your observations about changes in mood, behavior, and social interactions will help the mobile crisis team understand what your child needs.

Tell the MCT About Any of These Symtoms

- Increased isolation
- Increased substance use
- Irritability
- Loss of interest
- Changes in sleep
- Changes in appetite
- Talking about suicide
- Agitation
- Hopelessness
- Current and past medications
- Self-directed violence
- Past suicide attempts
- Giving away their valuables
- Avoiding daily routines or responsibilities
- Putting affairs in order

What Happens After the Crisis Assessment?

In most cases, the mobile crisis team will be able to stabilize your child in their home. This means that they have helped your child to regulate their thoughts and feelings and have

created a “crisis safety plan” in collaboration with you and your child. A crisis safety plan is a tool that your child can use to identify warning signs that they are having mental health challenges. It generally lists coping and distracting strategies, along with people they can call for help. The plan is very personal and is something that you, your child, and the mobile crisis team will create together. Your engagement during the safety planning process will help you learn how to keep your child safe in the future. The mobile crisis team will also schedule a follow-up check-in with your child, usually within the next 72 hours. The follow-up check in is an additional support put in place to ensure your child’s stability after the crisis.

Is My Child’s Crisis Care Confidential?

All medical records are protected health information. This information will only be provided to those involved in the provision of your child’s medical or psychiatric care. You must give written consent before others can access your child’s private health information. Exceptions to this privacy protection include a court order or provisions in the law.

What Resources are Available to My Family After a Crisis?

Part of follow-up care is continuing to provide you, your child, and your family with skills and resources that can support the entire family with navigating difficult situations, transitions, and unexpected changes. Depending on family needs, this linkage can be to a therapist, psychiatrist, food and housing resources, insurance programs, and any additional services from which your child and family may benefit. The crisis team can help identify resources and supports your family may need following a crisis.

After Crisis Treatment Options?

- Problem solving training
- Dialectical Behavioral Therapy (DBT)
- Cognitive Behavior Therapy (CBT) for suicidality
- CBT Group Approach
- Collaborative Assessment and Management of Suicidality (CAMS)
- Mentalization- based therapy
- Medication management

(Spruill 2016)

What Should I do After the Mobile Crisis Team Finishes Their Follow-Up?

Continuous follow-up care is imperative after a crisis to make sure your child is getting the care they need to stay safe and well. If your child is currently in treatment, inform your child’s treatment providers that your child has had a mental health crisis and was assessed by the

mobile crisis team. Your mental health providers should work with your child to understand the events leading up to the crisis and help your child cope with their overwhelming feelings. They should also monitor symptoms and provide support in preventing future crises. Following a crisis, it is normal for therapy sessions to increase in frequency to ensure that appropriate follow up care is provided.

Should I Inform My Child's School About the Crisis?

Informing your child's school counselors or mental health team is a best practice as they can help provide support for your child The school team will be able to provide support while your child is on campus and identify and provide any accommodation that may be needed during your child's time in school following a crisis. When you call the school, they will connect you to the right people, which may include school counselors, social workers, or psychologists. Generally, you will be invited to meet with the school team to identify what kinds of supports will be most helpful for your child. You can also request specific supports from your child's school. These can include regular check-ins with a campus counselor, a place for your child to go on campus when feeling overwhelmed, and informing your child's teachers that they may need to leave class to tend to their mental health and wellness.

What Happens if My Child Needs More Help?

In some cases, the mobile crisis team will determine that it is not safe for your child to remain at home. This decision is based on the mobile crisis team's belief that your child is unable to cope in a healthy way, unable to safety plan, and that there is a real risk for harm to self or others. When a person in crisis is believed to be high-risk, they will be referred for a higher level of support. This can mean a hospital, mental health treatment facility, sobering center, or crisis stabilization unit.

Involuntary Treatment: WIC 5150/5585

A psychiatric hold WIC 5585 for anyone under the age of 18 is defined as a "application made for the assessment and evaluation of a minor for up to 72-hour assessment, evaluation, and crisis intervention, or placement for evaluation and treatment at a designated facility pursuant to Section 5150, et seq. (adult) or Section 5585 et seq. (minor), of the W&I Code," DHCS 2019.

If your child needs to be seen at a facility, their transfer can be either voluntary or involuntary. A voluntary transfer offers the least restrictive measures to provide your child with the services they need. Voluntary treatment should always be offered to parents and guardians of minors. Involuntary treatment is also known as an "application for further evaluation and treatment," which can be done under WIC 5150/5585.

- **Voluntary Treatment.** Mobile crisis teams are required to tell you that your child can receive additional mental health treatment on a voluntary basis. The crisis team can help you decide whether you and your child are willing or able to accept voluntary treatment.

- **Involuntary Treatment.** There are specific and very limited circumstances under which involuntary treatment may be indicated, including reliable indications of child

abuse. Otherwise, minors may only be taken into custody if the caregiver is not available or willing to authorize inpatient treatment and the child is believed to be a danger to themselves or others. If your child is placed on an involuntary WIC 5585, you have the right to request access to a patient's rights advocate. You can access a patient's rights advocate by contacting your county's local patient's rights office.

What Happens While We Wait for Transportation?

If your child is going to be admitted for behavioral healthcare services, they will be closely monitored until transportation arrives. The crisis team will help you and your child prepare for admission to the unit. The crisis team can provide general information about what possessions your child can take with them. Typically, hospitals do not allow any clothing or shoes with any type of string attached (i.e., shoestrings, hoodies, and sweatpants with drawstring). Stuffed animals and books are typically allowed. Cell phones and any other electronic devices are not permitted and are best left at home. Any possessions confiscated at admission should be given to you or stored securely under your child's name. You can request an inventory of the property to ensure your child's property is accounted for and returned to you. It is best to confirm what items are permissible prior to arrival and leave prohibited items at home. The mobile crisis team will be able to assist you with understanding facility-specific allowable and non-allowable items.

What Will Happen When My Child is at the Behavioral Health Facility?

If your child is admitted to a facility, they will generally be there from one to three days. Most psychiatric holds are for 72 hours. Your child will be regularly assessed and may be released into your care before the full 72 hours have passed. In very limited circumstances, the treatment team may appeal to keep your child longer than the initial 72-hour hold.

Will I Be Allowed to See My Child in the Facility?

Unless a child tells their treatment team that they do not want to see their caregiver(s), you have the right to visit your child in the facility. Each facility will have designated visiting hours, so be sure to check with the facility before going to visit. Caregivers and children also have the right to phone conversations. There will likely be a facility phone that your child can use to call you. The Child Mind Institute-Having a child in inpatient treatment resource provides great information on what to expect and how to show support and keep regular contact if your child is in a psychiatric hospital.

What Rights Does My Child Have in the Hospital?

Even if your child was hospitalized involuntarily, they still have essential human rights. Rights that cannot be denied include the right to humane care, to be free from abuse or neglect, to access social activities and recreation, to education, to religious freedom and practice, and to be free from discrimination. Your child also has the right to wear their own clothing (permissible per facility guidelines). They have the right to visitors based on the visitation policy in the facility. They must be given storage space for personal items and have a right

to access these personal possessions. Your child has the right to reasonable telephone access to make or receive confidential calls and the right to send and receive unopened correspondence, including the right to receive letter-writing materials. A full list of your child's rights during inpatient treatment is in the appendix.

These rights cannot be revoked as punishment, for the convenience of staff, or as part of the treatment program. Under very specific circumstances, these rights can be revoked if the treatment team believes that exercising these rights would be dangerous to your child, the staff, or the facility. If the facility revokes any of your child's rights, they must inform you and explain their decision.

Will I be Informed About My Child's Treatment and Progress?

As a caregiver, you will have the opportunity to be active in the treatment efforts on behalf of your child. You also have the right to request treatment records for your child. This will include the initial diagnosis (or diagnoses), the specific kinds of treatment provided in the facility, and the recommended follow-up. It will NOT include the case notes made by clinicians in the facility. Your child is entitled to speak confidentially to their clinical team.

Medication Consent

You must give consent before any medication is given to your child. The facility must answer your questions about the benefits and side effects of any medication they are seeking to prescribe.

What Will Happen When My Child is Ready to Come Home?

You will be asked to attend a meeting with your child, their treatment team, and, if you choose, any of their current or previous behavioral health providers. This meeting is called "discharge planning." It is very important that you follow up with a mental health provider after your child is released. This clinician can help you identify the factors that are contributing to your child's mental health struggles and provide both reassurance and clear next steps. They can also offer insight into your child's strengths and challenges and work with you to decide what interventions will be best for them.

Am I Responsible for Paying the Crisis Bills?

The state has general funds allocated to maintain programs such as crisis lifelines, mobile crisis teams, inpatient psychiatric facilities, and emergency rooms. In some instances, your insurance may be billed for these services. Despite this, you may receive a bill for services provided to your child when they were in crisis. Calling the number on your insurance card is the first step in understanding your coverage and potential cost to you in the event of a crisis. Contacting your insurance provider can also connect you with behavioral health professionals within your insurance network. Once the crisis is resolved, the crisis team working with you and your child/dependent may also provide you with information and resources about how to find a local mental health provider in your area.

Scenarios

These scenarios present different kinds of behavioral health crises and different kinds of outcomes. They are a learning resource for parents who want to explore more specific crisis pathways. They do not reflect actual people or situations.

Crisis Services Requested by the School Or Other Agency:

Marie is a 17-year-old female with history of depression and anxiety. She is already receiving mental health services and has biweekly appointments with a therapist and a psychiatrist that she sees every three months. She has been on medication for her symptoms. Marie has expressed thoughts of suicide in the last three months, saying things like “I wish I could go to sleep and not wake up,” or “I’m tired of the struggle.”

She has not previously verbalized a specific plan of self-harm. However, she recently went through a breakup with her girlfriend, and this break up has exacerbated her suicidal thoughts. She is now having thoughts of cutting herself with a knife. She has not talked to anyone about it. Prior to her appointment with her therapist, she completed a questionnaire and answered “yes” to a question about thoughts of self-harm. During her session with her therapist, they discuss this questionnaire and Marie’s responses; the therapist then completes a risk assessment in her office. Marie has been having intrusive thoughts of suicide and has mentally rehearsed how she would carry out her plan. Additionally, Marie has two prior suicide attempts: one by overdosing and one by cutting. She also discloses that she has been drinking her father’s alcohol regularly. The therapist tries to identify additional coping strategies and strengths, but Marie didn’t believe they would help. Marie tells her therapist “I feel worse than I felt during my last suicide attempt.” Marie tells her therapist that she is not able to control the thoughts and is unsure if she can keep herself safe.

The therapist informs Marie’s parents of the immediate safety risk. Marie’s parents, however, do not believe there is a risk. The therapist then calls the local mobile crisis team to assess if Marie may need further support or treatment. The mobile crisis team determines Marie needs in-patient treatment; however, she and her parents are not willing to agree to voluntary treatment. A WIC 55.85 involuntary treatment hold is initiated for danger to self (DTS). Marie and her parents are advised of the treatment hold and the process to follow. The local Emergency Medical Services are contacted for transportation to the local crisis stabilization unit for further evaluation and treatment. Marie’s parents accompany her by following Marie’s ambulance.

What Happened Here?

Marie’s parents recognized that Marie was suffering and have helped her receive behavioral health treatment. Giving your child access to professional treatment helps them develop a relationship with a trusted adult, which can be an important protective factor. It also gives them an opportunity to speak confidentially to that trusted adult about things they may be reluctant to share with you. Having a regular therapist can keep your child safe if, like Marie, they start to experience suicidal thoughts. In this scenario, the therapist made the appropriate decision

to set aside confidentiality because there was an immediate risk of danger. Therapists are mandated reporters and must disclose this information. If your child is under the care of a therapist, you should be able to count on them to assess the immediate risk of danger and promptly alert you. Unfortunately, Marie's parents were not willing to trust the therapist when she told them that Marie was experiencing suicidal intent. This left the therapist with no option other than calling for crisis services on the parent's behalf. Additionally, Marie's parents were unwilling to consent to voluntary treatment, so the mobile crisis team had to initiate an involuntary hold. If your child's therapist tells you that your child is at risk, it is important to take immediate action to connect your child with crisis support teams. It is also better to defer to the behavioral health experts if they recommend in-patient treatment. Voluntary treatment can often be less traumatic because it honors the voice and choice of the person experiencing the crisis.

Crisis Assessment Requested by Parent and Diverted with Linkage:

A mother notices her son Charles has been experiencing increased anxiety as the school year is about to start. He has mentioned having thoughts of self-harm for a while and tells her he feels very overwhelmed by school assignments, pressuring himself to do better than others and better than he has done in the previous years. The new year is causing extreme anxiety and intensifying those thoughts of self-harm. Charles' girlfriend convinced him to talk to his mother about his thoughts of suicide and "ending it all." Charles' mother asked him how long he's been feeling this way and if he has a plan to harm himself. He tells her "No. I don't have any plans to harm myself. I am talking with you because I want you to help me. I don't want to feel this way. I don't like it."

Charles' mother expressed understanding and gratitude that he was able to talk to her and validated how scary and lonely it must have felt these past months. She is still scared about her son's concerns and decides she needs to reach out for help. Charles' mother calls her county's mobile crisis line and explains the situation. The county representative asks questions about immediate risk for safety and gathers demographic information. They do a quick over-the-phone assessment to determine the next steps. Together, they decided that a mobile crisis team with behavioral health professionals can offer the best level of support. While Charles and his mom wait for the mobile crisis team to arrive, she explains to Charles what will happen next. On arrival, the mobile crisis team introduces themselves and provides a quick snapshot of what is going to happen. They will do what is called a "crisis assessment."

The crisis assessment includes Charles' history of mental health symptoms, including frequency and intensity. The responders explore any additional stressors and the level of immediate risk to self. The responders then interview both the mother and Charles together, then speak with Charles privately. Once the crisis assessment is completed, the responders assess internal and external coping resources and strengths and gauge the family's willingness to engage in outpatient treatment. Because Charles does not want to harm himself and is motivated to get help because he wants to feel better, the responders, Charles, and mom all agree that it is safe for him to remain at home. Together, they work on developing an individualized Stanley Brown Safety Plan.

The safety plan helps Charles and his mom develop a step-by-step guide to recognize warning signs and document appropriate coping skills. The safety plan identifies triggers and signs of distress. It also lists internal and external coping strategies, the people and places that help calm him, and the people to call for help. During this process, Charles' mom is concerned about how the service will be paid for through their insurance. The mobile crisis team helps her make a phone call to their insurance provider to ask about coverage and achieve linkage to a therapist. An appointment is scheduled within the week. The mobile crisis team encourage Charles and his mom to reach out to the school to establish supports for Charles. Additionally, the mobile crisis team encourages Charles and mother to follow-up with their family doctor to rule out any underlying medical issues.

What Happened Here?

Charles' mother did the right thing by calling for a professional assessment of her son's mental health. If your child is expressing thoughts of self-harm, it is vital that you act swiftly to connect them with mental health supports. She also makes sure to explain to Charles everything that is going to happen when the mobile team arrives. Making sure your child understands the process gives them a sense of control and may help soothe anxiety. It is also important that the parent gives their child privacy to talk alone with the crisis team, as Charles' mother does in the above scenario. This can help your child open up about things they may not be comfortable sharing with you. Like Charles and his mom, both the parent and child should actively contribute to the development of a safety plan. Your child should guide the identification of the things that help them stay calm and safe, but you may need to help them access this plan if they start to experience symptoms in the future. Doing safety planning together helps make you a team and can reduce feelings of helplessness or isolation for your child. Charles' mother may also need to take responsibility for some of the follow-up care, like contacting the school and making the doctor's appointment. Again, working together to implement an agreed-upon plan can make your child feel supported and demonstrates that you are committed to maintaining their wellness.

Involuntary Crisis Assessment Requested by Parent:

Nancy is a 14-year-old and has been feeling depressed, lonely, and unworthy. She thinks that her parents prefer her younger sister and treat her sister better than they treat her. She has been having these feelings and thoughts for about three months. When Nancy's mother Sofia asked her what she would like to do for her birthday, Nancy said "I don't care. I don't care anymore about my birthday." Her parents have noticed that she has been more withdrawn and no longer shows emotion the way she used to. One night, Nancy is feeling more depressed than usual and is seriously considering suicide. She waits for everyone to go to sleep, and, when she is sure that everyone is asleep, she goes to the kitchen medicine cabinet to grab her father's prescriptions medications. She takes them to her room and opens the bottle to take them. At this moment, her mom walks in to remind her of her appointment tomorrow and sees what Nancy is doing. Sofia is confused and shocked but remains calm and tells Nancy that she will get help right away. Sofia says, "I'm here for you and I love you." Nancy puts down the medication and hands it over to her mother and embraces her with a hug.

Sofia then drives Nancy to the nearest emergency room because she is not certain whether Nancy has taken any of the medication. A crisis assessment is completed after the emergency room doctor declared her medically cleared. Behavioral health staff determine that Nancy needs further evaluation and treatment. Nancy expresses that she wants to go home and states “I won’t go!” Sofia feels uncertain on what to do and tells the team “Maybe I should just take her home.” The team informs mom that Nancy has stated she is actively suicidal and has intent to take her own life. Sofia tells the team “I don’t want to force her though; she wants to go home.” Because Sofia and Nancy are not willing to seek voluntary treatment, an involuntary treatment hold is initiated while she is at the emergency room. Nancy is transferred to the appropriate inpatient psychiatric facility by ambulance to continue her evaluation and treatment. While there, Nancy gives permission for Sofia to visit her, and Sofia receives regular updates from the staff on Nancy’s condition. After two days, the facility tells Sofia that the staff agree that Nancy is stable enough to return home with a safety plan. Nancy and Sophia work with the team to develop a safety plan. Nancy leaves the facility with a prescription for antidepressants and a referral to a psychiatrist. Sofia is also given a list of therapists that serve adolescents and accept Medi-Cal.

What Happened Here?

Sofia did the right thing and removed the means to self-harm immediately. Sofia also helped deescalate the situation by keeping herself regulated. Her reaction to Nancy attempting to overdose was calm, understanding, and supportive, which helped Nancy stay in the moment. It is possible that if Sofia had reacted with fear and anger to Nancy, the situation could have escalated. In times of crisis, it is hard to know how someone might respond, so using your best judgment to determine the level of safety is just as important as approaching the situation with empathy and compassion for the pain your child might be feeling. Sofia recognized the signs of a behavioral health crisis and safely took Nancy to the nearest emergency room because she was worried that Nancy may have taken some medication. This was the right call: an active suicide attempt should always be responded to by behavioral health professionals even if there is no physical danger. She was also reluctant to allow her daughter to be hospitalized, despite the recommendations of the care team. It can be hard to balance what your child wants with what the clinical team advises, but in the case of an active suicide risk, it’s best to be safe and consent to further observation and treatment.

Similarly, intervening as early as possible and addressing observed behavior change could reduce the risk of crises. Recall that Nancy has been showing signs of depression and that her emotional affect has become flat. Sofia might have tried to talk to Nancy about how she’d noticed changes, including isolating herself more and not showing interest in things like her birthday and other things she used to enjoy.

Appendix

Rights of the Hospitalized

According to the Department of Healthcare Services, as a recipient of mental health services your child/dependent /dependent has the following rights:

- A right to be provided with services in the least restrictive setting. A right to dignity, privacy, and humane care.
- A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication shall not be used as a punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program.
- A right to prompt medical care and treatment.
- A right to ask questions about your treatment.
- A right to participate in appropriate programs of publicly supported education.
- A right to social interaction and participation in community activities.
- A right to physical activity and recreational activities.
- A right to refuse to participate in any research project or medical experiment.
- A right to refuse electroconvulsive treatment or other forms of convulsive therapy.
- A right to decide if you want others to be notified of your hospitalization.
- A right to be free from hazardous procedures.
- A right to exercise informed consent to medication including receiving written or oral information about medications that are being prescribed: reasons for taking it, right to withdraw your consent at any time, type, and amount of medication and how often to take it, common side effects, alternative treatments, and potential long-term effects.
- A right to consent or refuse antipsychotic medication.
- A right to be provided with an oral advisement or in writing in your language, if the oral one is not possible. The advisement consists of informing you that you're not under arrest but are being held for a psychiatric examination. You may bring some items with you that will need to be approved by the designated person. You may tell them if you need assistance with turning off appliances or water and you may make a phone call or leave a note for your family/social support.