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A manual for emergency room social workers

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A MANUAL FOR EMERGENCY ROOM SOCIAL WORKERS

by

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TABLE OF CONTENTS

INTRODUCTION

The purpose of this manual is to fill the void I encountered when I first began doing emergency room social work. After reading a mass of material on crisis theory, depression, suicide, psychiatric emergencies, etc., after having role played an emergency room crisis counselor, and after reviewing what seemed an infinite number of required hospital procedures, I began work as an emergency room social worker. The first few cases I encountered on my own were bewildering. When emergency room personnel would refer a patient to me with the preferatory remark: " This guy looks like he has real emotional problems. See what you can do ", I would nearly freeze as I wondered which form to fill out before seeing the patient, what questions to ask the patient, which theory to review before interviewing the patient. After the interview, I confronted the problem of deciding upon an appropriate referral, which forms to fill out, whom to confer with, etc. Frankly, the entire situation was pretty overwhelming to me.

I began generating lists which defined my role as an emergency room crisis counselor. What questions do I ask a patient if he appears depressed? How do I evaluate an agency to which I want to refer a patient? What resources are available to an elderly, isolated alcoholic? What are the guidelines for evaluating suicide potential in a patient? The lists went on and on. I carried a briefcase full of current relevant theory on several problem areas which I frequently encountered and found I needed to review. The problem, quite simply, was that although theory abounded on each of the problem areas I encountered, nowhere was there a manual which brought all this theory together in

a concise fashion and provided specific guidelines for dealing with certain common problem areas. Nowhere were there materials which specified the tasks of the social worker in the emergency room beyond very general terms.

This manual then is an attempt to help fill that void. It has two purposes. The first is to provide the salient characteristics of crisis theory and theory relevant to problem areas most frequently encountered in the emergency room. These are provided for the social worker to review when necessary as an aid in providing comprehensive treatment. The second purpose of this manual is to provide guidelines for the tasks of the emergency room social worker as a resource person, a counselor, an educator, and a member of the emergency room staff.

It should be pointed out that this manual is not meant to replace the many fine works available on crisis counseling and related subjects. Indeed, the emergency room social worker should be well read on all these subjects. The manual is meant rather as a memory quickener and a partial antidote to the question : " Was there something else I should have done? "

Full time, on duty social workers in hospital emergency rooms is a relatively new concept which is swiftly gaining in popularity. Research has shown the value of immediate counseling for the patient in crisis. [1] I hope that in time, all emergency rooms have access to an on-duty or on-call social worker twenty-four hours a day. As the trend seems to be in this direction, I further hope that this

[1]Naomi Golan, " Crisis Theory, " in Social Work Treatment: Interlocking Theoretical Approaches, edited by Francis J. Turner (The Free Press, 1974), p. 447.

manual may be of some use to those social workers. It is a highly
demanding profession and one that fills a deep need.

CHAPTER   I

CRISIS IDENTIFICATION AND TREATMENT

Crisis is a state of sudden, relatively brief disequilibrium.[2]
It can occur in every phase of life from financial crisis, to physio-
logical crisis, to emotional crisis. Here we are dealing with emo-
tional crisis as seen in a hospital emergency room. An emotional
crisis occurs in response to an individual's perception of events.
A combination of specific unfamiliar events and a person's inability
to deal effectively with these events results in a crisis state. The
individual's usual " coping mechanisms " do not work for him, they
do not fit a particular situation he is confronted with and his
repetoire of responses does not resolve the ensuing conflict. It is
as if the individual has been walking a tight rope and suddenly falls
off. What he experiences in crisis is similar to a man falling: he is
off balance, he is severely anxious at not knowing what will happen
to him, all efforts to gain control are to no avail. Hirschowitz says
that

>   For a crisis to occur, a 'no exit' situation is required-
> the demand for change must, by definition, be inescapable.
> The situation can neither be changed nor avoided. The signs
> of crisis mean that the individual has a relatively inade-
> quate set of coping skills to master the demands of life
> change; the more adequate his coping capacity, the fewer are
> the signs of crisis that will occur.[3]

The fact that an emergency room patient is in a crisis state can
be diagnosed by (1) getting a history from the patient that delineates

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[2]Ralph G. Hirschowitz, " Crisis Theory:A Formulation, " Psychiatric
Annals 3 (December 1973) : 36.

[3]Ibid., p. 36.

the causative situational circumstances and (2) noting the behavior-
al symptoms the patient is experiencing and exhibiting. The diag-
nostic history would demonstrate an unfamiliar, recent event (or
series of events) which threaten the health, the security, or the
affectional ties of the individual. [4] The state of crisis has lasted
between one and six weeks, according to Caplan. [5] If it has been
going on for a time shorter than a week, the individual has not had
adequate time to try his various coping mechanisms and may yet head
off a crisis. If the state of crisis has been going on longer than
six weeks, some coping mechanisms have been established, even if not
necessarily healthy.

The diagnostic behavioral symptoms to observe would be those
symptoms which demonstrate that the individual is immobilized by
the crisis. He may or may not be trying various coping mechanisms
but the fact is that he is at a standstill. Nothing is working very
effectively for him in terms of resolving the discomfort accompanying
the crisis state. Emotionally, he may demonstrate great fluctuation
in moods, his usual range of emotions such as anger, fear, anxiety,
excitement, confusion, fatigue, depression are usually present in a
stronger and wider range than that to which he is accustomed. Anxiety
and ambivalence are usually present and quite pronounced. In terms of
cognitive functioning, he demonstrates varying degrees of disorienta-

[4]Howard J. Parad, " Brief Ego-Oriented Casework with Families in
Crisis," Ego-Oriented Casework: Problems & Perspectives, ed. Parad &
Miller (New York: Family Service Association of America, 1963),p.146.

[5]Lydia Rapoport, " The State of Crisis: Some Theoretical Consider-
ations," The Social Service Review 36 (1962); reprint ed., Crisis
Intervention: Selected Readings, ed. Howard J. Parad (New York: Fam-
ily Service Association of America, 1965), p. 26.

tion, poor reality testing, inability to concentrate and focus, to think " clearly " as he usually does; he seems stuck in the past, unable to look at the present and the future in any clear, objective manner. In relating to other people, the individual in crisis tends to demonstrate considerable dependency and perhaps clinging, or may on the other hand completely withdraw from those around him. [6] Behavior- ally, the individual might demonstrate a wide range and variety of symptoms such as impulsivity, somatization, withdrawal, hyperactivity.[7]

The course of the crisis can be delineated. Naomi Golan has given a concise outline of the progression. To begin with, some " hazardous event " takes place that is unusual and sudden. Often it is totally unexpected (accident, death, getting laid off work, natural disaster, etc.) and viewed as of such magnitude that the individual is unpre- pared to deal effectively with the situation. On the other hand, the event may be one which was anticipated (death after an illness, divorce, firing from job, bankruptcy) but when the event actually occurs, the individual finds himself unable to cope. [8] Either way, the individual is then in a " vulnerable state," [9] a psychological frame of mind where he has been thrown off guard by the event and is weakened. The " precipitating factor " is the final blow, the event that converts the weakened individual into one who is definitely unable to cope, utilizing his present repetoire of behaviors. The precipitating factor

[6]Hirschowitz, " Crisis Theory:A Formulation," pp. 37-39.

[7]Phil Dimeco, " Psychiatric Emergencies," Department of Social Work, Providence Medical Center, Portland, Oregon, 1977, pp. 3-5. (Mimeographed)

[8]Naomi Golan, " When is a Client in Crisis?" Social Casework (July 1969): 390.

[9]Ibid., p. 391.

could conceivably be the actual hazardous event itself or it may be something relatively minor that was the final straw. This precipitating factor (the one the patient may be able to identify if asked " What brought you here today to the emergency room ") leads the patient to the next stage, that of " active crisis. " [10] Gerald Caplan has described this state in detail, even specifying the time period of active crisis, as already mentioned, to be one to six weeks. This is the time when the patient is most likely to be seen in the emergency room. He will be in a state of imbalance. He may be trying many new behaviors including attempting to withdraw from the stressful situation but basically his efforts are rather fruitless in alleviating his discomfort.

Whether or not some form of therapeutic crisis intervention occurs at this stage, the individual nevertheless will go into the " reintegration stage " [11] where he will develop some coping mechanisms and thus reestablish equilibrium. The manner in which he integrates this experience will result in a higher, lower, or similar level of functioning as prior to the crisis. Depending upon his assets and liabilities previous to the crisis as well as the type of intervention provided, he will come out of the situation in varying degrees of " health."

If the crisis experience has been negative and little or no constructive learning has occurred, the individual will reintegrate in such a way that he is actually more fragile than prior to the event. He will be less capable of handling stress than before and will have

[10]Ibid., p. 393.

[11]Naomi Golan, " Crisis Theory, " p. 436.

learned no positive coping mechanisms. He may, for instance, handle the crisis be merely withdrawing and cutting off emotions, he may become catatonic, he may resort to alcohol or drugs to alleviate his discomfort, he may become submerged in external responsibilities in order to avoid dealing with his feelings, etc.

Some individuals on the other hand will grow from the crisis experience. They will gain new coping mechanisms which generalize beyond those applying to the present crisis. They will be able to utilize what they have learned in this particular crisis experience in other areas of their lives. Certain potential future crises may be totally averted.

Though the crisis counselor cannot change the assets and liabilities the client brings to the crisis situation, he can intervene in some specific ways to the client's best advantage.

> Two particularly important events helped to shape the development of current forms of crisis intervention techniques. First, traditional forms of psychotherapy were found to be inappropriate. Most, like psychoanalysis, were geared to major personality and behavior change. Thus, a different type of intervention, one focusing on clients in crisis, had to be found. Second, there was a growing recognition that certain situations tended to precipitate crisis, and that persons experiencing crisis frequently reacted in somewhat predictable patterns. This led to both the study of crisis and to the development of intervention techniques specifically designed to deal with the person in crisis. [12]

And Golan strongly feels that " crisis intervention is not a truncated version of long-term therapy but a unique form of treatment especially adapted to the critical situation. [13]

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[12] William Getz, et al., <u>Fundamentals of Crisis Counseling</u> (Lexington, Mass.: D.C. Heath and Company, 1974), p. 3.

[13] Naomi Golan, " Crisis Theory," p. 422.

One point should be added here. There are people who may simulate a crisis but who actually are not in a state of crisis as previously defined. Those individuals most probably will not be helped by crisis intervention. They are people who live in a continual state of disorganization and upheaval, who go from one crisis to another without resolution or learning. Their manner of adapting to life is one of becoming involved in one crisis situation after another. Another group of people are those who continually live borderline lives, just managing to cope in rather unhealthy ways. [14] They also are in a chronic state of crisis and generally are not amenable to conventional crisis intervention.

For people who are experiencing a genuine life crisis, there is an excellent opportunity for positive growth. The usual, well-entrenched behavioral repetoires are forceably jarred loose, an unusual occurence. Because of the high degree of discomfort, the individual is more willing than he normally would be to " try anything " to alleviate his pain. He is more willing to look (at himself) and listen (to others.) Rapoport states that " all people in distress are motivated to obtain relief from suffering. This...fact is the proper starting point with people in crisis. " [15]

The aims of crisis intervention are to alleviate the patient's suffering and help him reach the highest level of reintegration of which he is capable. Efforts to achieve these aims take place in the treatment interview. The overall course of the crisis interview is

[14]Ibid., pp. 442-3.

[15]Golan, " When is a Client in Crisis? " p. 394.

generally seen as having three segments. In the beginning phase, the patient ventilates and the counselor gathers data. [16] The methodical data collection documents for the counselor and his patient what actually took place, how the patient reacted to the event, how he has coped in the past in crisis situations. The counselor's interventions at this point are primarily furthering and guiding responses to contribute to the data collection and catharsis process. The middle phase finds the crisis counselor involved in the actual problem solving. [17] The counselor utilizes various techniques to help himself and the patient isolate major themes and to help the patient get some perspective on the situation. (Such techniques might include assertive training, confrontation, feedback, interpretation, modeling, reassurance, relaxation training, self-disclosure, ventilation. [18] Sometimes the mere act of ventilating results in the client clarifying and resolving the crisis for himself.)

Now that the problems have been identified, the final phase comes in of developing a workable plan, [19] in other words, coming to an agreement regarding solutions. It must be stressed here that the plan must be realistic and workable most importantly from the viewpoint of the patient. Getz diagrams his " Deductive Model for Crisis Counseling " as follows: [20]

[16] Getz, Fundamentals Of Crisis Counseling, pp. 47-65.

[17] Ibid., p. 67.

[18] Ibid., pp. 33-40.

[19] Ibid., p. 77.

[20] Ibid., p. 52.

Step 1	Step 2	Step 3	Step 4
Facts as client presents them -->	Connecting re-lated themes -->	Isolating major themes -->	Treatment Plan

Step 1:
1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____

Step 2:
1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____

Step 3:
1 _____
2 _____
3 _____
4 _____

Step 4:
A _____
B _____
C _____
D _____

The focus in crisis intervention is primarily here and now. No attempt is made at probing the past and tapping the unconscious. " Go no deeper than necessary. "[21] Reassurance is something most patients are asking for in crisis and should be given as appropriate. Help the patient understand that crisis is a normal event which may occur to any of us at various times in our lives. Feelings of hopelessness on the part of the patient may be alleviated when he understands that the crisis state is time limited and a sense of equilibrium will return. Emphasizing a patient's strengths and support systems may help restore lost confidence.

The crisis is viewed by the counselor as a problem to be solved, rather than as an illness. As Nelson and Mowry state

The crisis intervention model tends to ignore the deviant aspects and concentrates on problem solving. It is more

[21] J. James, " Crisis Intervention, " South Carolina Journal of Mental Health 6 (Fall 1972): 13.

acceptable to work on solving problems than it is to
be deviant. For the client there is the message that
though work is to be done, he does not have to deal
with an illness but must instead look at differnt
ways of solving the present crisis. [22]

Timing of crisis intervention cannot be stressed enough. If a
client comes for help when he is still in the midst of an active
crisis, his chances of resolving the crisis in a positive, growth-
producing fashion are far higher than if he obtains treatment after
the active crisis state. At this point, the " maladaptive aftereffects "
will be far more difficult to rectify. [23] " A relatively minor force
acting for a relatively short time can switch the whole balance from
one side to the other--to the side of mental health or to the side of
mental ill health. " [24]

[22]Zane P. Nelson and Dwight D. Mowry, " Contracting in Crisis
Intervention," Community Mental Health Journal 12 (January 1976): 43.

[23]Golan, " Crisis Theory, " p. 447.

[24]Parad, " Brief Ego-Oriented Casework with Families in Crisis," p.147.

CHAPTER II

SIGNS, SYMPTOMS, AND CERTAIN TREATMENT INDICATIONS OF SOME

EMERGENCY ROOM CRISES

Although each patient you work with will be unique and will require individualized treatment, generalizations can be made about certain types of crises. In this chapter will be presented many of the most common types of crises you may expect to encounter in the emergency room and some guidelines for treatment. These presentations are not meant to tell you everything you need to do in specific instances but rather they are meant to indicate what should not be omitted from the information gathering and counseling process related to certain problem areas. This is of course beyond the information you will require for the social evaluation and use of the standard counseling techniques mentioned elsewhere.

A. SUICIDE

Suicide is responsible for more than 20,000 deaths each year in the United States. [25] Each year in this country, there are some 200,000 suicide attempts. [26] This makes suicide the tenth leading cause of death in the U.S. For adolescents and college students, it is

[25]Joseph Mendels, Concepts of Depression (New York: John Wiley and Sons, 1970), p. 12.

[26]W.D. Zieverink and Kent E. Neff, " Guidelines in Evaluation and Management of the Suicidal Patient, " Medical Staff of Providence Medical Center, Portland, Oregon, 1976, p. 1. (Mimeographed.)

[27]Ibid., p. 1.

the second major cause of death. [28]

As an emergency room social worker, you may expect to encounter numerous cases where a patient has attempted suicide. It is therefore important for you to know how to evaluate suicidal potential and what to do when this potential is detected.

1. Assessing suicidal potential

    a. Sex and Age

        1.) More women than men attempt suicide. [29]

        2.) More men than women are successful at committing suicide. [30]

        3.) Suicidal potential increases with advanced age. [31]

    b. Suicidal plan

        1.) The more lethal the intended method for committing suicide, the greater the potential for success. [32]

        2.) The more available the means for committing suicide, the greater potential for success. [33]

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[28] Norman Farberow and Robert E. Litman, " Suicide Prevention," Emergency Psychiatric Care: The Management Of The Mental Health Crisis by H.L.P. Resnik and Harvey C. Rubin (Charles Press, 1975); reprinted ed., The National Institute of Mental Health, 1975, p. 105.

[29] Ibid., p. 108.

[30] Ibid., p. 108.

[31] Zieverink and Neff, " Guidelines in Evaluation and Management of the Suicidal Patient, " p. 2.

[32] Farberow and Litman, " Suicide Prevention," p. 108.

[33] Ibid., p. 108.

15

3.) The more concrete the plan for committing suicide, the greater the potential for success. [34]

c. Stress

1.) Recent major life changes may precipitate suicidal behavior, particularly where loss is involved. [35]

d. Symptoms

1.) Suicide risk increases when depression is present. [36]

2.) Suicide risk increases greatly when the depressed patient is also agitated. [37]

3.) Suicide risk increases if the patient is experiencing delusions, hallucinations, loss of contact, or diorientation. [38]

e. Other factors which increase suicidal potential.

1.) History of suicidal behavior. [39]

2.) General lack of resources. [40]

3.) Alcoholism. [41]

Of the above factors for assessing suicidal potential, the most critical are concreteness of suicidal plan and lethality of suicide

[34]Ibid., p. 108.

[35]Zieverink and Neff, " Guidelines in Evaluation and Management of the Suicidal Patient, " p. 2.

[36]Farberow and Litman, " Suicide Prevention," p. 108.

[37]Ibid., p. 108.

[38]Zieverink and.Neff, " Guidelines," p. 2.

[39]Ibid., p. 2.

[40]Farberow and Litman, " Suicide Prevention," p. 109.

[41]Barry Maletzky, " Workshop '77 On Understanding and Preventing Suicide," Providence Medical Center's Clinical Pastoral Education Program and Northwest Counseling Associates, Thursday, April 28, 1977, p.7.

method. [42]

The determination of the degree of suicidal potential is difficult. Studies may show us who is most likely to commit suicide but they do not tell us that less likely candidates never attempt or commit suicide. Until the emergency room social worker becomes highly proficient in assessing a patient's risk to himself, it is better to err on the conservative side rather than incorrectly assume a patient is not in danger.

Besides crisis counseling, treatment of patients with high suicidal potential should include appropriate precautions to prevent suicide attempts. [43]

> I know of practically no one who tried to kill himself six months ago who isn't glad today he didn't. Depressions and their coincident suicidal ideations are time-limited: a person will improve almost always, even if absolutely nothing is done to help him. It thus makes sense to identify the potentially suicidal patient early and treat him vigorously, thereby giving him the time he needs to save his own life. [44]

[42] Farberow and Litman, " Suicide Prevention," p. 111.

[43] Ibid., p. 116.

[44] Maletzky, " On Understanding and Preventing Suicide," p. 8.

B. DEPRESSION

Identifying the existence, severity, and duration of a depression
in a patient is important. Symptoms of depression often coincide with
a crisis. Knowing how long the depression has lasted tells the social
worker if the depression is crisis related. If it is short term, then
the depression may be amenable to crisis intervention techniques. If
the depression is long term (ie., more than six weeks or so), then
the patient may require ongoing treatment for this problem after the
immediate crisis has been treated. If the depression is quite severe,
then the patient should be evaluated for the possibility of suicidal
ideation or behavior. This is particularly true when the patient is
both depressed and agitated. [45]

The following list represents signs and symptoms of depression
to watch for and to gather information about:

1. Mood

   Sad, unhappy, crying spells

2. Thought

   Poor self-image, ideas of guilt or worthlessness, feelings of
   helplessness, withdrawal from social relationships, diminished
   efficiency and ability to concentrate

3. Behavior and appearance

   Patient appears slowed down and may neglect personal appearance.
   Agitation

[45] Farberow and Litman, " Suicide Prevention," p. 108.

18

4. Somatic symptoms

   Decrease or loss of appetite, weight loss, sleep pattern

   disturbance, decrease or loss of interest in sexual matters,

   multiple somatic complaints, constipation, mentrual changes.

5. Anxiety

   Tension, numerous concerns, fear, confusion

6. Suicidal ideation and behavior [46]

[46]Joseph Mendels, Concepts of Depression, pp. 6-20.

C.   PSYCHIATRIC EMERGENCIES

Occasionally you will work with a patient whose inappropriate-
ness or extreme behavior may result in that patient being dangerous
to himself or others or being unable to care for his own basic needs.[47]
If you suspect a patient is experiencing a mental health crisis, you
will want to conduct a mental status examination [*] to learn the
extent and severity of the crisis. Characteristics of a psychiatric
emergency include:

1. Fear

2. Anxiety

3. Depression

4. Mania, the opposite of depression

    The patient in a manic state is unrealistically optimistic

    and freely communicates this optimism to others.

5. Inappropriate anger

6. Marked confusion

7. Loss of reality contact

8. Withdrawal from social relationships and loss of interest in

    events or objects previously important to the patient

9. Deviant or impulsive behavior

10. Somatic complaints [48]

[47]Kent Neff and William Zieverink, " Emergency Department Psych-
iatric Checklist," Emergency Department, Providence Medical Center,
Portland, Oregon, 1976, p. 1. (Mimeographed.)

[*] See Social Evaluation

[48]Dimeco, " Psychiatric Emergencies," pp. 2-5.

Once you have determined that the patient is a danger to himself or others or is unable to care for his own basic needs, you will then want to review treatment possibilities. Obviously the patient will need to be cared for for a time. This may, and usually does, require inpatient psychiatric hospitalization. If that is the case, follow these steps:

1. Review voluntary and involuntary commitment procedures for your community

2. Consult with a psychiatrist if possible

3. Make a vigorous attempt to secure cooperation from the patient for inpatient psychiatric hospitalization

D. ALCOHOL

The prevalence of alcohol related problems in this country does
not need to be repeated here. For the chronic alcoholic who is moti-
vated to seek treatment, you will undoubtedly have resources available
of offer. Physical effects of alcohol consumption will be observed
and treated by emergency room staff. The job of the emergency room
social worker is to ascertain the relationship between alcohol consump-
tion and crisis. The patient in crisis may use alcohol to alleviate
his symptoms. On the other hand, consumption of alcohol may precipi-
tate the crisis in which the patient finds himself.

To determine the relationship between alcohol and crisis, the
emergency room social worker should obtain the following information:

1. Does the patient have a history of excessive drinking

2. When did the present drinking episode begin

3. When did the patient take his last drink

4. What precipitated the present drinking episode [49]

Alcohol complicates the crisis interview in several ways. The
intoxicated patient may not be very coherent. The patient's behavior
may be inappropriate and difficult to manage. Emergency room staff
and significant others may react negatively to the intoxicated patient.
Whatever the case may be, the intoxicated patient should if possible
be seen again by someone after the intoxicated state has passed. An
appropriate referral for treatment could result in the patient learning

[49]H.L.P. Resnik and Harvey L. Rubin, Emergency Psychiatric Care,
The Management Of The Mental Health Crisis (Charles Press, 1975),
pp. 66-77.

more healthy coping methods for dealing with stress and crisis than consumption of alcohol.

E.   DRUGS

As with alcohol, drug abuse may precipitate a crisis in an
individual. Further, information gathered from the patient under the
influence of certain drugs as well as signs and symptoms observed in
the patient during the interview should be suspect. " Cases in which
drug taking is suspected may give rise to considerable diagnostic
problems for other psychiatric conditions may be simulated and per-
plexing clinical presentations encountered. " [50] " The elation, excite-
ment, delusions, and hallucinations that are often seen may suggest the
presence of hypomania or schizophrenia. " [51]

In each psychiatric emergency involving adolescents and young
adults, the emergency room social worker would do well to look for the
possibility that drugs are involved. When it is found that the patient
in crisis has abused drugs, the following information should be gathered:

1. History of drug abuse. Is the crisis due to drug experimentation
   or perhaps a complication of drug addiction?

2. What types of drugs are involved and in what quantity? This
   information should be shared with the emergency room physician
   treating the patient. The physician can tell you the effects of
   the drug in question and he or she can respond to the possible
   medical problems generated by the drug abuse. (It is worth
   noting that non-pharmaceutical drugs and drugs taken in combin-
   ation may further complicate assessment of the situation since

[50]P.F. Bridges, Psychiatric Emergencies: Diagnosis and Management
(Springfield, Ill.: Charles C. Thomas, 1971), p. 57.

[51]Ibid., p. 57.

possible effects may be unknown.)

Again, as with alcohol, the patient's behavior may be inappro-
priate and difficult to manage. The patient influenced by drugs should
be seen again by someone after the drug-induced state has passed. It
is helpful to gather information from significant others to help you
gain a clearer picture of the patient before you refer the patient for
treatment.

F.   CHILD ABUSE

When a child is brought to the emergency room and you suspect the child may have been physically abused, you should immediately contact the emergency room physician. The physician will examine the child and further confirm or disconfirm your suspicions. Treatment should involve the entire family and may require that you notify the police department or other agency in your community responsible for investigating possible child abuse.

Physical abuse or physical neglect may be apparent in the child. Emaciation, multiple bruises and contusions, and broken bones will be evident when the child is examined by the emergency room physician. Other forms of abuse may be less obvious. These are sexual abuse, verbal abuse, emotional neglect and emotional abuse. [52]

Signs which may indicate child abuse should be considered, include the following:

1. Contradictory history presented when more than one person is interviewed regarding the child, and information gathered from each is vastly different

2. Child's injury appears not to have been caused in the manner described by parents

3. Child brought in for care long after injury occurred

4. History of repeated injury

5. Parent shows detachment or is overly protective

[52]Providence Medical Center Administration, "General Operational Policy regarding Child Abuse," Accession No. 79, Code No. 104.061, Portland, Oregon, 1975, p. 3.

6. Parent is hesitant to provide information

7. Child is unusually fearful [53]

You may notice many other indications that the parent-child relationship is unhealthy. When less obvious forms of child abuse such as emotional neglect, emotional abuse, and verbal abuse are observed, your primary objective is " to help and prevent damaging relationships between parents and their children " [54] through crisis intervention techniques if appropriate or by referral for treatment. When physical neglect or physical abuse are obvious and of a relatively severe nature, your primary objective is to protect the child from further abuse and secondarily to treat the family. Protecting the child may require immediate hospitalization and will require you contact the proper authorities.

[53]Ibid., pp. 8-11.

[54]Parents Anonymous, " To Whom It May Concern," Portland, Oregon, 1976, p. 2. (Mimeographed.)

G.   THE BATTERED WIFE

More and more it has come to our attention that the battered woman, be she wife or living partner, represents a very large problem in our society. Battered women frequently seek emergency medical treatment in hospital emergency rooms. The emergency room social worker should always intervene in this crisis. The primary objective of treatment is to prevent further physical abuse. In some cases the battering may be so severe as to indicate the woman is in peril of losing her life if she returns to her living partner.

In many communities, sheltered living situations exist to provide immediate santuary for the battered woman. The long range goal is to help the woman separate from her living partner and live independently. Other forms of immediate relief may include short term inpatient hospitalization and involvement of the proper authorities. Many battered women may be resistant to leave their living partner no matter how extreme the situation. They may believe their husbands or living partners will reform; they may be afraid they cannot cope in the world alone, either emotionally or financially; they may require child support; or they may see themselves so negatively that they believe they have nothing to offer to another person. [55] Some women may even believe the beatings are somewhat deserved.

In less extreme situations where the couple want to work things out and in extreme situations where the woman refuses to leave her living partner, the couple should be referred for treatment. Whether they

[55]Joseph N. Bell, " Rescuing the Battered Wife," Human Behavior
(June 1977) : 22.

receive treatment as a couple and whether or not treatment is success-
ful will depend in large part on the living partner's motivation to
seek and use help.

Currently there has been some publicity regarding the battered
husband. Because it is degrading for a man to be physically weaker than
a woman, few men will admit to the situation. The emergency room social
worker should be alert to the possibility of the battered husband and
deal with him in a similar fashion to that of the battered wife, being
especially sensitive to the social implications the situations has for
the man.

H. DEVELOPMENTAL CRISIS

Some authors have pointed out that each person faces different tasks at each stage in his or her chronological development. [56] When young adulthood begins and childhood and youth ends, there are expectations for choosing a career, seeking employment, and socializing with the opposite sex. [57] Adulthood usually involves marriage and assumption of parental responsibilities. [58] Late adulthood brings menopausal changes for women at around the age of forty-five. [59] For both men and women, late adulthood, at around the age of fifty, brings with it the reality of advancing years and the reality that options for life pattern changes may no longer be open. Old age may be accompanied by losses caused by retirement, death of spouse, physical decline, and increasing dependence on others. [60]

Each stage in life requires that the individual reorganize his life. Each transitional phase carries with it the potential for crisis as well as the potential for growth.

[56]D.C. Aguilera, et al., Crisis Intervention Theory and Methodology (St. Louis: C.V. Mosby Co., 1970) and

Gail Sheehy, Passages (New York: E.P. Dutton & Co., Inc., 1974.)

[57]Aguilera, Crisis Intervention Theory and Methodology, p. 120.

[58]Ibid., p. 124.

[59]Ibid., p. 129.

[60]Ibid., pp. 134-137.

CHAPTER III

FORMS AND DOCUMENTATION

In this chapter, I will present outlines for various types of documentation. You may already have forms for some of the purposes listed. If they are somewhat different from those in this manual and you are not yet used to them, you may want to generate your own outlines to help you know what information each question in each form is aimed at getting.

The amount of documentation you choose to do on services you provide will be related to your personal preferences and agency demands for information. In this era of accountability, demands for information tend to be excessive at times. If you find one hour of direct service requires two hours of documentation and requires filling out a dozen or so forms (a situation I found myself in at one point in time), you should review the functions of each form you must complete and weigh these against the time they require you to absent yourself from direct service.

If, on the other hand, you work somewhere where important information is omitted because no form exists on which to record that information, then you may want to develop a new form or new methods of record keeping. Some of the outlines I will provide here may help you in this effort.

It is not expected you will need to use all the forms outlined in this chapter at all times. Some are presented simply to give you an idea of what types of documentation you could do should you feel a need.

A. SOCIAL EVALUATION [61]

The social evaluation is a form which becomes a part of the patient's medical record. On it is recorded the pertinent information you gather from and about the patient. Sources for this information are the patient, significant others, old charts, emergency room staff, other professionals with whom you consult, and information from whatever other sources you may contact. The following information is recorded:

1. Date

2. Identifying Data

   a. Name

   b. Age

   c. Sex

   d. Referral Source

3. Background Information

   a. Presenting Problem

   b. Medical History if applicable

   c. Developmental History if applicable

   d. Family History if applicable

   e. Previous Treatment, especially related to presenting problem

   f. Present Treatment, especially related to presenting problem

4. Resources

   a. Financial

[61] adapted from the Department of Social Work " Social Work Report," Providence Medical Center, 741-08D, Rev. 12/76, Portland, Oregon, 1976.

b. Social

    1.) Home

    2.) Work

    3.) Other

c. Family Constellation

5. Reactions related to presenting problem and life situation

    a. Patient's feelings about present state or condition

    b. Patient's attitude toward self and social milieu

    c. Patient's motivation for coping with present state

6. Mental Status if appropriate [62]

    a. Appearance

    b. Affect

    c. Orientation (name, time, date, situation)

    d. Thought Process

    e. Thought Content

    f. Intelligence

7. Assessment

8. Plan

9. Progress Notes for follow up

[62]For further readings on Mental Status Examination:

    Bridges, Psychiatric Emergencies: Diagnosis and Management, pp.15-19. and

    J. Lieb and A. Slaby, The Crisis Team. A Handbook For The Mental Health Professional (New York: Harper & Row, Inc., 1973), pp.158-9,52-8.

B. FLOW SHEET [63]

When a patient is admitted to the emergency room, a chart is immediately begun and deposited in the chart rack. When the emergency room social worker finds a client in need of counseling or accepts a referral from emergency room staff, he may immediately want to start a flow sheet.

The flow sheet indicates that the social worker is working with a particular patient. It is located on top of that patient's chart. The flow sheet serves several purposes. First, by alerting emergency room staff that you are working with a certain patient, those staff who feel they have pertinent information to offer on that patient may contact you. Second, the flow sheet shows when you are actually with the patient. This can help to avoid numerous interruptions. Third, because the flow sheet stays with the patient's chart, it shows that the patient has received emergency room counseling. (The Social Evaluation also becomes a permanent part of the patient's chart but you may be unable to complete the Social Evaluation Form before the patient is transferred to another unit in the hospital or to another institution.) The following information is recorded:

1. Patient's name

2. Date

3. Time case was referred to you

4. Time you began interviewing patient

[63]Adapted from:

Emergency Department, " Emergency Services Department Flow Sheet," 678.30D, Providence Medical Center, Portland, Oregon, 1973.

C.   REFERRAL LOG RECORD [64]

The Referral Log Record is simply a device for keeping you aware
of cases which are still pending. It is most likely that you will provide
some sort of follow-up for each patient you counsel in the emergency
room. To be sure you have not forgotten someone, it is helpful to keep
for your files a record with the following information:

1. Patient's name

2. Date you first interviewed the patient

3. Date case closed _____

[64] Adapted from the Emergency Room, Social Service, " Referral Log
Record," 741.04D, Providence Medical Center, Portland, Oregon, April 1975.

D. REFERRAL INFORMATION FOR COMMUNITY AGENCIES [65]

When referring a patient to a community agency, you may want to send either with the patient or separately, some information to that agency regarding the nature of the referral. Following is information you may include:

1. Name, address, and phone number of the hospital where you work

2. Date

3. Your name

4. Patient's name, address, phone number, age, and hospital number

5. Date patient visited the emergency room

6. Patient's presenting problem

7. Patient's discharge recommendations

8. Reasons you are referring the patient to agency

9. Phone number to call for further information

[65]Adapted from the Emergency Room, Social Service, " Referral Information For Community Agencies," Providence Medical Center, Portland, Oregon.

E.   EMERGENCY ROOM COVERAGE [66]

The emergency room coverage sheet lists the hours that social workers are on duty in the emergency room. It shows which social workers are on duty at specified times. Copies can be given to emergency room staff and emergency room social workers.

Two purposes are served by this form, First, if social workers are not on duty in the emergency room seven days a week around the clock, it lets the emergency room staff know when to expect coverage. If a patient's need for crisis counseling is not so extreme that someone must be called in, emergency room staff may have a patient wait until a social worker is scheduled to be on duty or they may suggest the patient leave the hospital and call the social worker for a counseling appointment at the time the social worker is expected to arrive. Secondly, a patient may want to see a particular social worker in the emergency room. Emergency room staff can inform the patient about that particular social worker's schedule by referring to the emergency room coverage sheet.

[66]Adapted from the Emergency Room, Social Service, " Social Work Department-Emergency Room Coverage," Providence Medical Center, Portland, Oregon, March 1977. (Mimeographed.)

F.   EMERGENCY DEPARTMENT CHECKLIST [67]

This is a form which lists all the activities a social worker
may be involved in while covering the emergency room. It is designed
to be filled out each shift.

One purpose of this checklist is to show the individual social
worker how he is using his time or, perhaps, which activities are de-
manding the greatest portions of his time. This can aid in setting
priorities for learning, recognizing limitations in the provision of
services, etc.

Another purpose of this checklist is justification of services
provided by emergency room social workers. Sometimes a social worker
may see only one or two patients in an eight hour period. He may
spend the bulk of one shift following up on patients seen previously,
providing training to emergency room staff, documenting services
provided, screening patients who may need counseling, etc. In other
words, he may be very productive while seeing few patients.

Since full time on-duty social workers in emergency rooms is a
relatively new concept, some justification for services may be needed.
Some education of those who finance emergency room crisis counseling
programs may be necessary. It might appear not very cost effective to
employ a social worker on a full time basis who sees only one or two
patients during the entirety of some eight hour shifts. On the other
hand, it may seem quite reasonable to employ a social worker who spends
" free time " casefinding, training emergency room staff, providing

[67]Adapted from Jack West, " Emergency Department Checklist,"
Emergency Room, Social Service, Providence Medical Center, Portland,
Oregon, 1977.

documentation of services provided, and so forth.

Following are the emergency department checklist activities.
For each activity, you may list the number of times during one shift
you engaged in that activity and total time spent per activity.

1. Case Consultation

   This refers to consultation with emergency room physicians,
   emergency room nurses, other emergency room staff, or community
   resources regarding a particular patient.

2. Inservice Consultation

   Refers to training you may provide others

3. Program Consultation

   You may consult with emergency room staff, other hospital
   staff, or administrators regarding the emergency room crisis
   counseling program.

4. Direct Service: Formal Contacts

   Formal contacts occur when emergency room patients and/or
   significant others are extensively interviewed and counseled.
   These contacts are always documented in depth by the social
   worker in the social evaluation which is included in the patient's
   medical chart.

5. Direct Services: Informal Contacts

   Informal contacts occur with patients in the emergency room and
   friends and relatives in the waiting room where contact is of a
   brief counseling nature and not otherwise documented.

6. Casework

   This includes casefinding and charting.

7. Other Documentation

G. CONSENT FOR RELEASE OF INFORMATION OR RECORDS [68]

It is likely that every hospital will have a supply of Release of Information forms. This form is signed by a patient and a witness when that patient agrees that his medical records and any other information may be sent to specified persons or agencies. Essentially this releases the hospital from liability related to releasing information about a particular patient. Further, because the patient must sign this form before information is released, he knows to whom his records will be sent.

This form is to be put in the patient's medical chart.

[68]Adapted from the Providence Medical Center, " Consent For Release Of Information Or Records," 768-25D, Portland, Oregon, June 1974.

H.   CONSENT TO RECORD INTERVIEW [69]

At times you may wish to tape record or videotape an interview with a patient. If you do, you should receive written consent from that patient.

A Consent To Record Interview form should contain the following information:

1. Purpose of the recording

2. Who, generally, will be allowed to hear or see the recording

3. Whether or not the recording will be kept permanently or erased after a specified period of time

[69]Adapted from the Emergency Room, Social Service, " Crisis Counseling Authorization For Permission To Tape Record Interview," Providence Medical Center, Portland, Oregon, April 1976.

I.   CASE CHECKLIST [70]

From the time a patient is referred to you to the time you close
that patient's case, you will need to follow a number of procedures.
The procedures in each emergency room will probably differ. Until these
procedures become " second nature " to you, it may be helpful for you
to develop a list of steps you must take with each case you encounter.

Suppose it is your first day on duty as an emergency room social
worker and an emergency room nurse asks you to see a patient who looks
upset. What do you do now? Following is an example of a checklist
you might develop to facilitate the process:

1. Get specifics

Ask the emergency room nurse what he or she sees as the problem.
Here is your opportunity to help a referral source become more
skilled at observing and reporting signs which indicate crisis
counseling may be appropriate.

Information you could obtain from the emergency room nurse
could include:

a. Why the patient is in the emergency room now. What is the
presenting problem?

b. Description of patient's behavior

c. Past history. Has the patient been treated in the emer-
gency room on previous occasions? What happened then?

d. Medications. Is the patient receiving medications for
psychiatric problems or physical problems? Is the patient

[70]Adapted from Jack West, " Case Checklist," Emergency Room, Social
Service, Providence Medical Center, Portland, Oregon, 1977. (Mimeographed)

taking illicit drugs? Which kind? How many? What about alcohol?

e. Impressions. What do you see as the problem? Does the patient appear to be a risk to himself or others at this time?

f. Significant others. Did the patient come to the emergency room by himself or accompanied by someone? If the patient came to the emergency room with others, this presents another valuable source of information to the social worker.

g. Additional information. Is there anything else you think I should know before seeing the patient?

h. Patient consent. Is the patient willing to see a social worker?

i. Physician consultation. Have you spoken with the emergency room physician as yet? What does he or she see as the problem? Has he or she been notified I will be seeing the patient?

2. Begin a flow sheet

The flow sheet shows what time a patient was referred to you and indicates that you are involved in that patient's case.*

3. Read patient's chart

A chart is immediately begun for each patient entering the emergency room. On this chart should be listed patient's name, address, age, presenting problem, current medications, etc. The

* See Flow Sheet

physician's findings are added to this chart after he or she sees the patient. You may be interviewing the patient before or after he sees the doctor.

4. Order patient's old charts and read them when and if they become available. Old charts are a patient's medical and other records from previous visits to the emergency room or previous inpatient treatment in the hospital in which you work. If the patient has been treated here previously, old charts can provide valuable background information.

5. Notify all available emergency room staff who are working with the patient referred to you that you will be seeing that patient. Confer with them if appropriate and time permits.

6. Interview patient*

Indicate on the flow sheet when you begin an interview and when the interview is completed.**

7. Interview significant others who may be in the waiting room if this seems appropriate. Sometimes you may need to call significant others on the telephone.

8. Consultation

If the patient with whom you are working is currently receiving or has previously received counseling, you may want to consult with his counselor before deciding upon a treatment plan. You may also wish to consult with other professionals or certain

*Chapter I, see Social Evaluation

**See Flow Sheet

emergency room staff before recommending a course of action for the patient.

Whenever you consult with someone regarding a particular case, you will need to be prepared to share what you see as the salient characteristics of that case. Information you gather from the patient in the interview which you will include in the Social Evaluation* should provide you with this data.

9. Provide the patient with a treatment plan

You may refer the patient to a community agency, to significant others, or, on occasion you may ask the patient to return to you for continued treatment at a later date. When making referrals to community agencies, you may simply provide a patient with information and a phone number. You might call a community agency for a patient. In some cases you could make all the referral arrangements for a patient including arranging transportation. The rule of thumb in making referrals is to have the patient take as much responsibility for what happens to him as is reasonably possible.

10. Complete the Social Evaluation for the patient's medical records.

11. Record patient's name and date of initial interview on the Referral Log Record.

12. Follow-up

Within one to three days after you have counseled a patient, you will want to obtain information about how that patient is doing. You may wish to get this information from the patient or from the

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*See Social Evaluation

resource to which you referred the patient. Information you need
to gather includes:

    a. Has the patient followed through with the treatment plan?

        1.) Did the patient contact the referral resource?

        2.) Did he make an appointment?

        3.) Has he received treatment?

        4.) Patient's reactions to treatment

        5.) If patient was referred to significant others, how
            are things going?

        6.) If patient has not followed through with the treatment
            plan, what are his reasons?

    b. Has the patient's condition improved or worsened since he
       received crisis counseling?

        1.) What has brought about this change?

        2.) Are there indications for altering the treatment plan?

    c. Other information

       Ask for any additional information which may be pertinent.
       In most cases, you will be gathering the above information
       from the patient. It is important to keep in mind that
       follow-up, like the interviewing process, is more than just
       an information gathering activity. You should follow the same
       steps in follow-up that you do in interviewing.

13. Record follow-up information in the progress notes section of
    the Social Evaluation.

14. If you do not plan to again involve yourself in the patient's
    treatment plan, note that the case is closed in the Referral
    Log Record.

CHAPTER IV

GENERATING A RESOURCE FILE

Resources will of course vary depending on the community and the
hospital in which the emergency room is situated. Over time, the social
worker will collect dozens of pamphlets, brochures, and possibly a
few more comprehensive resource lists describing agencies in his
locale. The job of the social worker is to find out what each agency
specifically provides, which type of patient is an appropriate referral
to each agency, and if several choices are available for one patient,
which agency offers the best treatment available for that patient.

If you are consistently referring the majority of patients you
see to a half dozen agencies, then it would be of value to you to visit
those agencies and observe the treatment provided. It would also be
helpful to discuss with your patients their opinions of the treatment
they received at these agencies.

If you are referring a patient to an agency of which you have
scant knowledge but which seems to be appropriate, you can call that
agency for more information. I have found, however, that a more satis-
factory method for gathering information about an agency for referral
purposes is to ask professionals who I know and whose opinions I
trust, what their impression is of the agency in question. Occasion-
ally that is impossible.

For each community resource you want to keep a file on, you will
need the following information:

Name of Agency:

Address:

Phone Number:

Hours:

Service provided:

Cost:

Comments:

An example:

Troutdale Family Services

2115 S.E. 89th   Troutdale, Oregon, 97060

381-4760

Hours: 9 A.M. - 5 P.M. Monday through Friday

Service provided: Provides part-time help with household tasks for
older people. Program designed to shorten, post-
pone, or prevent institutional care. Agency pro-
vides a social worker who evaluates client in home
to determine extent of need.

Guidelines for Referral: Older people who are unable to perform
household tasks without assistance.

Cost: Determined on a sliding fee scale on income but no one is re-
fused service because of inability to pay.

Comments: Several clients referred here. Generally all are satis-
fied with service provided. There is usually a
two to three week waiting period.

The above example could occur in your resource file under Resources for
the Elderly. Following are several other headings you may find useful in

generating your resource file. These can of course be modified and expanded as necessary.

Alcoholism

Child Abuse

Child Care

Crisis Centers

Drug Rehabilitation

Family Counseling

Job Counseling

Maternal Care/Abortion

Mental Health

Mentally Retarded

Physically Handicapped

Resources for Minority Groups

Resources for the Rape Victim

Extreme Emergencies

clothing

food

housing

transportation

CHAPTER V

FUNCTIONS OF THE EMERGENCY ROOM SOCIAL WORKER

The emergency room social worker is expected to be able to handle any non-medical crisis in a competent professional manner. His skills in counseling and knowledge of community resources are highly depended upon by emergency room patients and emergency room staff alike. He is expected to integrate special talents into the total care provided by the emergency room team. He must be able to evaluate the impact of crisis counseling in the emergency room; to show how and why emergency room social workers are preferable to any other available methods.

The emergency room social worker must be a crisis counselor par excellence. He must be familiar with the large body of research related to crisis theory and specifically with information about each problem area he may expect to encounter.

The emergency room social worker must be an educator. Emergency room physicians, nurses, and other emergency room staff are encouraged to refer patients to the social worker at any time they feel this appropriate. To do this task adequately, each member of the emergency room staff needs to know what signs to look for which seem to indicate treatment is needed. They need to be aware of the information you require before seeing a patient. Then instead of receiving a referral with the preferatory remark " This guy looks really disturbed. I think you should see him ", you will receive comments more like the following: " We have a 32 year old male with a history of several psychiatric admissions over the past three years. I've ordered the patient's old charts and they should be here shortly. The patient was released

from a psychiatric hospital three weeks ago and says he quit taking
his medications, Thorazine 100 mg. q.i.d., approximately one week
ago. He came here tonight complaining of hearing voices which are
telling him to kill himself. His parents are in the waiting room if
you need to talk to them. They say his psychiatrist is Dr. Jones. I
told the patient we have a social worker on duty and he said he would
be willing to talk with you. " There is obviously quite a difference
between the two referral statements above. That difference is a result
of training which the emergency room social worker can provide.

Another reason why the emergency room staff may provide better
care with greater knowledge of crisis counseling is because the social
worker may not always be available. Just as you may be required to lend
a hand in pushing stretchers or in minor medical procedures on the
rare occasion that a plethora of patients is admitted to the emergency
room at the same time, the emergency room staff may need to do some
crisis counseling or patient referral to other agencies when you be-
come overwhelmed with several patients in crisis at a certain point in
time.

A final reason for sharing knowledge with emergency room staff
is that it helps them to gain a more total picture of the patient.
They learn to respond more readily to extra-medical patient problems
and this can greatly enhance patient care.

It would be remiss of the social worker to take full responsibility
for all non-medical crises occurring in the emergency room.

The emergency room social worker should be a resource person. This
role includes everything from being able to answer questions other
staff members may ask regarding certain problem areas to providing in-

service training on subjects like preventive counseling, procedures
for psychiatric commitment, signs and symptoms of depression, etc.

The skilled emergency room social worker then, can have a pro-
found impact upon those he counsels at a time when they are most
amenable to change, and he can substantially upgrade emergency care
by providing, through intervention and education, a more comprehensive
approach to patient care.

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