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Chapter Eighteen

Managing Crises Step-by-Step

Luisa Garcia, a 28-year-old Latina female, is attending her regular psychotherapy session with Katherine Mahoney, a mental health trainee. Luisa tells Katherine that she has been thinking about suicide.

Robert Moore, a 25-year-old White male, comes to the intake clinic. He tells the intake worker, Shane Abel, a mental health trainee, that he needs treatment since he is thinking about killing his brother over a financial disagreement.

Ryan Fernandes, a 55-year-old East Indian male, is brought to the clinic by his elderly parents. All of them are Catholic and first-generation immigrants. The intake worker, Brandi Williams, a mental health trainee, reviews the chart and sees that Ryan has a long history of schizophrenia. His parents tell Brandi that Ryan has been pacing all night for the past several nights and that he is talking to himself.

The focus of this chapter is to assist you in conceptualizing the overall process of crisis management. These three detailed vignettes are elaborated throughout the chapter to illustrate the steps in crisis management with very different clients as well as the process of interacting effectively with the crisis client. The chapter also focuses on common issues that occur with all crisis clients, such as deciding whether to hospitalize, formulating a crisis management plan, and documenting appropriately. Specific issues that are pertinent to particular crises are discussed in subsequent chapters.

Managing crises is the most anxiety-provoking work that psychotherapists do. Here are the steps in doing so:

- Establish rapport
- Assess

  - The current situation
  - Historical and demographic risk factors
- Plan and implement
  - Give and elicit feedback
  - Consult supervisor
  - Consider whether hospitalization is appropriate
  - Make a crisis management plan and secure client's verbal agreement
  - Implement plan
- Document

Throughout, you will need to figure out how to cope effectively with the crisis. You should consult with other professionals as needed throughout this entire process.

ESTABLISHING RAPPORT: COPING WITH CRISES AND THE THERAPIST'S EMOTIONS

Katherine feels very anxious about talking with Luisa about her suicidal thoughts. She has never actually assessed a real client for suicidality before, although she has done role plays in class. Katherine takes a deep breath and reminds herself that she does know how to do this. She also reminds herself that more experienced staff are available to help her at any time if she needs to ask for help. She makes reassuring statements: "Luisa, it was very wise of you to come in and ask for help. I can see that you understand that these suicidal ideas mean that you need help right away." She tells Luisa what they will be doing in a reassuring manner and communicates to Luisa that the situation is under control: "What I'd like to do is get a better understanding of how you are doing right now so that we can make a plan that will help you as soon as possible. How does that sound to you?"

Even highly experienced therapists can become anxious when they are working with crisis clients. There is nothing wrong with feeling anxious; it shows that you care. Keep in mind how the client is feeling. The client feels that his or her problems are unmanageable and that help is desperately needed. Your calm reassurances will help. The client doesn't feel in control right now, but being with someone else who does know how to manage the situation will be reassuring.

Try to contain your own anxiety during the assessment. You must keep your cool even if you feel nervous. Take a few deep breaths if you need to. Remind yourself that the client is here to get help and will feel better soon. If you are calm though clearly concerned, the client will feel reassured. I can assure you that once you understand the situation and help the client get assistance, the client's emotional distress will be eased, and both of you will feel relieved. Remember that, at any time, you can walk the client to the office of your supervisor or another more experienced colleague and ask for help.

Once the crisis has been resolved, discuss what happened thoroughly with your supervisor. Increasing your understanding and confidence about how to address crisis situations is the best way to reduce the stress and anxiety of coping with them.

ASSESS: THE CURRENT SITUATION

Katherine asks Luisa how long she has been thinking about suicide. Luisa says that she has been thinking about it constantly for the past 5 days. Katherine asks more about Luisa's suicidal ideas. Luisa reveals that she is thinking about jumping off a bridge near her house and that she has walked by the spot several times thinking about jumping. Katherine asks whether Luisa thinks she can control herself and not jump. Luisa is unsure.

Shane asks Robert more about his violent thoughts. Robert says that whenever he sees his brother, he thinks about "jumping him." They have been living in a small apartment together with their mother, and tensions have been running high. When Robert is out of the house, he doesn't think about his brother or their disagreement. He said that he has been trying not to act on the violent impulses since he knows he would regret it later.

Brandi asks Ryan about his thoughts. Ryan says that God has been talking to him and tells him that he needs to spread the Word to the heathens in the neighborhood. (They live in a mostly Hindu Indian neighborhood.)

Whenever you have any concern that a crisis may be developing or anyone may be at physical risk, you must ask about this (Packman, Pennuto, Bongar, & Orthwein, 2004). Not asking may put your client or someone else in danger. Not asking will not protect you legally from not knowing and, in fact, will put you at greater professional risk (Packman, Pennuto et al., 2004). You'll want to thoroughly understand your client's thought process, level of intent, and plans regarding the risky situation (Simon, 2004).

You might want to interview the client individually, or you might want to involve whatever family members came in with the client. If the client is less functional, family members will provide valuable information. In addition, consider that certain cultural groups (such as Ryan's) may have more intergenerational involvement and may conceptualize problems more in the context of the family than the individual (Gonzalez, 1995). Generally, it is helpful to ask the family whether they want to come in to your office together, and

take your cue from their response. You can always ask some people to step out briefly later if you think it will be helpful.

ASSESS: HISTORICAL AND DEMOGRAPHIC FACTORS

Katherine knows from Luisa's chart that Luisa has been diagnosed for years with borderline personality disorder and chronic major depression. She also knows that last year, Luisa took an overdose of pills, had her stomach pumped, and was hospitalized for 2 weeks. She knows that Luisa has a history of three other previous attempts of varying lethality. After each attempt, Luisa was hospitalized. Luisa also reports about five other hospitalizations for severe depression and suicidal ideation.

Shane asks Robert if he has been violent before. Robert reveals that he is a recovering alcoholic. He has been abstinent for 15 months. When he used to drink, he was often violent, but he has not been violent since he has been sober. He denied ever getting into any legal trouble because of his violent behavior in the past, and, as far as he knows, no one has ever been in the hospital after a fight with him. With Robert's approval, Shane calls Robert's drug and alcohol counselor, Ms. Patterson, to get her input. She says that Robert has been very compliant with his recovery program and that, to her knowledge, he has not been hostile toward anyone since becoming sober. She feels that he is very motivated to continue to improve and can be trusted to follow through on a crisis intervention plan. She said that she would be happy to see Robert if he could come in for an appointment tomorrow.

Brandi has reviewed the chart and sees that, as far as the clinic knows, Ryan has never done anything to harm himself or others. She asks his parents about this, and they confirm it. He has had several past episodes when he stopped taking his medications, became psychotic, and had to be briefly hospitalized. When Brandi asks the family about his medications, she finds that they have been coping with a medical crisis in a grandchild and have not been monitoring his medications as closely as they often do. Ryan himself insists that he has been taking his medication, but he clearly has a thought disorder and may be too confused to remember his medications; Brandi knows that his insistence is more likely a statement indicating that he has been intending to take his medications rather than an indication that he has actually done so. Ryan wandered off by himself in the middle of the night about 2 years ago, and his family found him in his pajamas wandering about the neighborhood the next morning. They voice their concern that this might happen again.

Has this same crisis situation occurred in the past with this client? If so, that is an indication that the likelihood of its happening again is greater. For example, a history of multiple suicide attempts is the best predictor that a client is at heightened risk of future attempts (Joiner, Walker, Rudd, & Jobes, 1999).

In what situations has the crisis situation occurred? Are these situations the same today or different? For example, if the client has been violent toward family when drunk in the past and has just relapsed on alcohol, the risk is greater. If the client has never been violent when sober and has been reliably sober for several years, the risk is less.

Consider what you know about the client. Ask the client what has or has not worked in past crisis situations. Consider what other professionals have to say verbally and/or in the chart.

PLAN: GIVE AND ELICIT FEEDBACK

Katherine tells Luisa, "I'm concerned about what you're telling me. It was wise of you to come in and talk to me about this. I hear that you can't be sure you'd ask for help if the suicidal feelings get strong again, and you are unsure whether you can control yourself. I suspect you're talking to me about this because you know you'd be safer in the hospital." Luisa responds to Katherine that she does understand that she needs to be in the hospital.

Shane tells Robert, "I see that you are worried about these violent thoughts, and I am as well. But I'm not exactly sure what our plan should be. It sounds to me as if you have been able to control your impulses much better since you have been sober. Is that true? Do you think you and your brother would be safer if you weren't around him right now?" Robert replies to Shane that he feels uncertain about being able to control his violent impulses right now, but he thinks that as long as he avoids his brother, he will be fine. Shane says, "I can think of a few plans that might work for you, and I'd like us to discuss them. One might be to stay with a friend and avoid all contact with your brother for now. We could also consider admitting you to the hospital or to a partial hospitalization program. What do you think?" Robert says that if he can avoid his brother, he knows he won't be violent. Shane feels that Robert is sincere and motivated not to harm his brother, so a less restrictive alternative is appropriate.

Brandi tells Ryan and his parents, "I'm concerned that you will end up in the hospital again. It sounds like, even though you sincerely want to take your medication, you may have been missing some doses lately. [Turning to his parents] It's likely that he will improve soon, if he can regularly get his medication over the next several days. I'm wondering if you feel you can manage him at home or

if you are too worried that he might do something unsafe like wander off at night." Ryan's parents worry that he may roam the neighborhood at night again. They think that they can get him to take his medications, but they are worried about what he will do before he stabilizes. Ryan says he thinks he would be okay outside the hospital, then talks again about his intent to convert the heathens. He is observed during this discussion to be looking around the room.

You should give the client feedback—your professional opinion about the situation. Be honest and tactful, if possible. For example, if you believe that the client feels great because she is getting manic, say so. If you are worried about the client's suicidal impulses and think hospitalization would be safer, say so.

Sometimes the situation is fairly cut and dried, such as that of Luisa, and you have specific recommendations. The crisis management plan may be clear to both the therapist and the client. Here, Luisa has been in this situation before and knows what is needed.

Eliciting feedback is important as well. The client's feedback about plans is invaluable. Several possible dispositions might be appropriate, depending on the client's (and family's, if present) interests and motivations. As with Robert and Ryan, in the previous vignettes, you will want to get input from the client (and possibly the family) about the options before a plan is finalized jointly.

Sometimes the input of the family is necessary. In the case of Ryan, the clinician sees that the family has valid worries that he will be unsafe. Since he has a history of wandering about disoriented at night, he has the potential to be a danger to himself. His poor judgment could lead him into dangerous situations, or he could be distracted by hallucinations, wander into the street, and be killed by a vehicle. For his own safety, both the clinician and the family feel that he will be safer in the hospital until he is stable.

PLAN: CONSULT SUPERVISOR

Katherine is uncertain whether she can trust Luisa to wait in the waiting room while she consults her supervisor. They have been working together for only 2 months, and Katherine knows that Luisa is very impulsive. Katherine asks Luisa, "Can you give me a minute to call my supervisor? I need to consult with him briefly." Luisa asks if she should step out, but Katherine assures her that it is fine for her to stay in the office. Katherine calls her supervisor to ask him to come to the office. Her supervisor does not pick up the phone. Katherine then calls a fellow trainee who agrees to go to the supervisor's office and asks him to come to Katherine's office. The supervisor, Ezra Stone, knocks on the door about 5 minutes later. Luisa has met Ezra before. Ezra comes into the office and sits with them while Katherine summarizes Luisa's situation. Ezra agrees with the plan.

Shane feels that Robert can be relied on to wait in the waiting room. He asks Robert to do so, then goes to consult with his supervisor and returns after a few minutes.

Given what Brandi has observed about the family relationships, she feels that Ryan's family can keep him in her office for a few minutes. Brandi asks them if she can step out for a few minutes to consult with her supervisor. She asks, "Can I rely on you to wait here until I get back in about 5 minutes?" They assure her that this is fine.

If you are inexperienced at assessing crises, you will want to consult with a supervisor before giving feedback. Alternatively, if you are more experienced, it may be clear what you need to do, and you will just give your supervisor a quick call to update him or her on the situation at an appropriate point.

If the client has been cooperative and agrees not to leave the facility, you and your supervisor may be able to discuss the case while the client waits in the waiting area or in your office, as with Robert and Ryan in the previous vignettes. However, if you have any concerns about the client's ability to follow through with waiting for 10 to 15 minutes while you consult, as Katherine has concerns about Luisa, your supervisor can join you in the office with the client as you summarize your observations.

If you are afraid that your client will hurt him- or herself, run off, or engage in any risky behavior and you need to step out of the office to find a supervisor, you must ask another staff person to look after the client, or you must take the client to the emergency room if the facility you're working in has one. If your facility has police or security personnel, you may need to call them to escort the client.

PLAN: CONSIDER WHETHER HOSPITALIZATION IS APPROPRIATE

After discussing her situation with Katherine, Luisa agrees to the plan to go to the inpatient unit.

Brandi tells Ryan and his family that she is worried about his safety and thinks it would be wise for him to be in the hospital. Ryan agrees because he sees that this is what his parents want him to do.

Clients with acute symptoms of psychosis or mania may or may not need to be hospitalized. Each case should be considered on an individual basis. Here are some of the questions you will want to ask yourself regarding the client to determine whether to hospitalize or treat as an outpatient:

- Does the client have insight into own mental illness?
- Can the client be calm and comprehend instructions?
- Does the client verbalize an intention to get and take medications?
- Do you think that the client can be relied on to follow instructions and take medication?
- If psychotic, does the client have sufficient understanding of what is real and what isn't, and can she act appropriately on this knowledge?
- Will the client agree to attend an appointment soon?
- Will the client agree to seek help if worse?
- Can the client or the client's family reliably identify if the client is worse and seek help appropriately?
- Is the family supportive and reliable?
- Is there any risk of harm to self or others?

The client can be managed as an outpatient when the client is engaged well in treatment, has good insight about symptoms, and can be trusted to follow through on appointments and any changes in medication. If there are some deficits in the client's comprehension or follow-though but the client is cooperative and the family is involved, supportive, and reliable, the client may also be able to be treated as an outpatient. If the client can be involved in an intensive partial hospitalization program rather than the more restrictive environment of the inpatient unit, the client and family are more likely to be satisfied with the care (Horvitz-Lennon, Normand, Gaccione, & Frank, 2001).

Sometimes the plan will be to hospitalize the client. Although particular details vary from state to state (Simon, 2004), clients are generally hospitalized when they are a danger to self or others or if they are so mentally ill that they are unable to adequately care for their own needs. In the previous vignette, Ryan cannot keep himself reliably safe because of an exacerbation of his mental illness, so he is considered appropriate for hospitalization.

PLAN: MAKE A CRISIS MANAGEMENT PLAN AND SECURE CLIENT'S VERBAL AGREEMENT

Shane asks Robert if he has a friend he can stay with for a few days. He thinks his friend Tony will let him sleep on his couch.

Finalize a crisis management plan by synthesizing your assessment with the feedback of the client and, if appropriate, the client's family. Get the client's verbal agreement to comply with the plan. (In some settings, there may be a preference for written agreements instead.) Observe the client carefully for signs of insincerity (e.g., hesitancy or sarcastic tone) and reconsider the plan if necessary.

WHEN YOU AND CLIENT DO NOT AGREE ON PLAN

You might have definite ideas about what the plan should be but the client does not like your plan. In this case, carefully explain your concerns and your reasoning to the client and ask for feedback. Then find out what the client's concerns are and do the best you can to address them:

> Therapist: "I'm very concerned. You've told me that you can't be sure that you'd call 911 or go to the emergency room if you feel more suicidal. You've come in for help with this, and it's very important to me to take some action to help keep you safe. The only thing I know of that will keep you safe under these circumstances is for you to be in the hospital. Yet you're telling me you don't want to go. What do you suggest that we do under these circumstances?"
>
> Client: "Just let me go. I'll be okay."
>
> Therapist: "Do you have any concerns about being in the hospital?"
>
> Client: "I've seen the movies. I know that psych hospitals are full of dangerous psychos."
>
> Therapist: "Actually, what's in the movies is overly sensationalized. I've visited the unit before, and I can assure you it's a very safe place. The people who are there are seeking help for their problems, just like you are."
>
> Client: "Will you come see me there?"
>
> Therapist: "I can't do that because I need to be here in the intake clinic seeing other people who are in crisis."
>
> Client: "How long will I be there? Can they keep me for weeks?"
>
> Therapist: "They will probably discharge you within a week. And as soon as you aren't suicidal anymore, you can ask to leave at any time, and they can't keep you."
>
> Client: "Okay, I'll go."

When you address the client's concerns, most of the time the client will agree to go to the hospital. In very rare instances, you may have to involuntarily hospitalize a client. Be sure to ask your supervisor what the criteria are for involuntary hospitalization and how this is done in your setting so that you are prepared.

IMPLEMENT PLAN

Luisa expresses some concern about her cats, as she hasn't made any arrangements for them, so Katherine lets her call her mother from the office and ask her to feed the cats while Luisa is in the hospital. Then Katherine escorts Luisa to the emergency room for admission. When in the emergency room, Katherine calls Luisa's psychiatrist to give her an update on the situation. The psychiatrist will need to come to the emergency room to write an admit order.

Robert calls his friend Tony from Shane's office, and Tony tells him that he can stay as long as he needs to. Robert doesn't have any of his clothes or toiletries with him and agrees to ask his mother to bring them over to Tony's. He agrees to stay at Tony's at least until his next appointment with his alcohol counselor, when he can discuss this issue in more detail. Shane suggests that if he does see his brother accidentally before then, he should turn around and leave immediately. Robert readily agrees to do so but thinks this is unlikely. Robert again verbalizes his intent not to hurt his brother despite these impulses. Shane suggests that Robert call his mother as well and update her on these plans. Robert calls his mother from the office, and when he gets off the phone, he says that his mother was relieved and happy to hear that he had taken some steps to get help and resolve this situation. His mother volunteered to bring some of his clothes by his friend's house tonight.

Since the clinic does not have an inpatient unit on-site, Brandi talks to Ryan's parents about where he has been hospitalized before. They have been satisfied with the care he received at St. Joseph's. She recommends that they take him to the emergency room there. She gets a signed release from Ryan to communicate with St. Joseph's. She makes a copy of the release and prints out her progress note about her evaluation of Ryan. She puts these in an envelope and gives them to Ryan's parents with the instructions that they give the envelope to the clinician at the hospital. She puts her supervisor's pager number in the progress note in case hospital staff have any questions. Ryan and his family believe that he will be cooperative in the ride to the hospital, and they agree to take him directly there.

Do whatever you can to implement the plan right then. If you are in a medical center, walk the client from your office to the emergency room for admission. If the client is staying with a friend, have him call the friend from your office and make a plan to get to the friend's house. If the client remains an outpatient, be sure there is an outpatient follow-up appointment made and secure the client's agreement to attend.

DOCUMENT

When documenting a crisis and how it was addressed, it is important to be as thorough as possible. This is the one time when you will want to err on the side of being overly inclusive in your progress note. It is important to do the following (adapted from Rivas-Vasquez, Blais, Rey, & Rivas-Vasquez, 2001):

- Describe the client and chief complaint
- List current symptoms and make appropriate diagnoses
- Summarize relevant historical information, including medical and substance abuse histories as well as prior mental health care
- If time allows, assess and document psychosocial history and family history of mental illness
- Document any consultations you made about the case
- Assess risk and protective factors
- Document client's agreement or disagreement with plan
- Document how the plan was implemented
- Describe, in detail, what your thought process and rationale were in assessing the situation and determining the plan

When you choose a less restrictive plan than hospitalization, be especially detailed about your thought process and rationale. You want the note to be fairly self-contained so that any mental health professional reading it will understand exactly why you made the choices that you did and agree that your choices were consistent with professional standards.

PROGRESS NOTE FOR LUISA

S/O. Luisa Garcia is a 28-year-old Latina female who has been in individual therapy with me for 2 months. Her diagnoses are borderline personality disorder and chronic major depression.

Ms. Garcia presents today with an exacerbation of depressive symptoms: poor eating and sleeping, feeling fatigued, and ruminating constantly about her problems. In addition, she has been thinking seriously about committing suicide and has a plan to jump off a bridge near her home. She states that she has been thinking about this constantly for the past 5 days and has been walking past the site thinking of jumping. She feels uncertain that she can control herself much longer.

Ms. Garcia has a history of suicidal behavior. Last year she took an overdose of her pills and had to have her stomach pumped. Additionally, she had three previous suicide attempts of varying lethality. She has a history of eight previous psychiatric hospitalizations for depression, suicide attempts, and suicidal ideation.

Ms. Garcia does not abuse substances, nor has this ever been an issue for her. She recently lost her mother, on whom she was very dependent, and has been despondent ever since.

A. Ms. Garcia is at significant risk of suicidal behavior given her inability to make a commitment to stay alive and her past history of numerous suicide attempts.

P. Ms. Garcia agreed to inpatient hospitalization at this medical center. She was walked to the emergency room and was medically cleared there, then was admitted to unit 2B.

[Signed] Katherine Mahoney, B.A.
Social Work Trainee
[Cosigned] Ezra Stone, L.C.S.W.

This progress note about Luisa is relatively brief for a crisis note. That is because it is a fairly cut-and-dried situation of acute suicidality in a client with a repeated history of suicidal behavior and because the client was placed in the restrictive environment of the inpatient unit, where they will follow standard procedure and put her on suicide watch.

PROGRESS NOTE FOR ROBERT

S/O. Robert Moore is a 25-year-old White male who presents at the intake clinic stating that he is thinking of killing his brother.

Mr. Moore has a long-standing history of substance abuse and has been treated by the addiction clinic at this facility. With his approval, his substance abuse counselor, Ms. Patterson, was contacted. She said that he has a 15-month history of abstinence, with negative toxicology screens done at random. His compliance with treatment is good, and he has not exhibited any violent or aggressive behavior while in treatment. She stated that she felt he could be counted on to cooperate with any agreed-on crisis management plan.

Mr. Moore admits to having a long history of violent altercations, all of which occurred while he was drunk. However, he states that no one was ever injured seriously, to his knowledge. Mr. Moore denied ever having been charged or convicted of any crimes, which is consistent with all chart documentation.

Mr. Moore stated that he and his brother have been living with their mother in a small one-bedroom apartment. They have been arguing about financial issues and can't get away from each other. He stated that, despite these violent thoughts, he does not want to hurt his brother, which is why he came to the clinic today. Mr. Moore said that as long as his brother is not around, he does not think about hurting him.

A. While Mr. Moore is having homicidal thoughts toward his brother, he showed good judgment coming to the clinic to get assistance in coping with this

crisis. He denies any intent to hurt his brother and states that he knows that if he did, he would regret it. He also stated that he wouldn't make his mother suffer like that. He has demonstrated excellent motivation and compliance with treatment over the past 15 months, and his substance abuse counselor has indicated that she trusts him to follow any crisis management plan. Given the above, my assessment is that as long as Robert stays away from his brother and continues to discuss these issues in treatment, he is not at risk of harming his brother.

P. In order to minimize any risk of an altercation, Mr. Moore agreed to call a friend from my office. The friend agreed to let Mr. Moore stay with him as long as he needs to. Mr. Moore agreed to go directly to the friend's house. He called his mother at work, and she agreed to bring some of his clothes and toiletries to his friend's house tonight. This arrangement will prevent him from any interactions with his brother. He agreed to follow up with his substance abuse counselor tomorrow, who will help him further explore these issues and discuss alternative housing options. Will alert Ms. Patterson regarding above.

[Signed] Shane Abel, M.D.
Psychiatry Resident

As you can see, this note is longer than the previous one. Since Robert will be treated as an outpatient, Shane has very carefully justified his decision-making process. He carefully documents Robert's intent not to harm his brother and Robert's reasons for not doing so. He has ensured that the plan is in place, as much as possible, before Robert leaves his office and documented that he has done so.

Note that there is no mention of Robert's brother being notified of Robert's homicidal thoughts against him—and, in fact, he was not. Why? First, Shane has carefully assessed Robert for homicidal intent and has seen, in fact, that Robert's intent is not to harm his brother. Second, Robert has shown good judgment in seeking help. Robert's reliability in treatment and his agreement to the plan indicate that Robert can be trusted to follow through appropriately. Finally, Shane's professional opinion is that the plan that he and Robert have devised has defused the situation.

PROGRESS NOTE FOR RYAN

S/O. Ryan Fernandes is a 55-year-old East Indian male brought to the clinic by his parents. They are all first-generation immigrants from India, and they are Catholic.

Mr. Fernandes has a long-standing history of schizophrenia. He has been treated for it at this outpatient clinic for 12 years and apparently has had symptoms and treatment since he was 21 years old. His parents report numerous previous hospitalizations, mostly when he stopped taking his medications.

Mr. Fernandes's parents report that he has been pacing all night and talking to himself. His functioning around the house has deteriorated markedly. They admit that they have been distracted lately with the illness of a grandchild and thus haven't been monitoring his medications as closely as they usually do. They also stated that when he has gotten more symptomatic in the past, he has wandered around the neighborhood in his pajamas, talking about "converting the heathens." Today, Mr. Fernandes says that God is telling him that he has been "anointed to convert the heathens." I also observed him looking around the room as if responding to internal stimuli. Mr. Fernandes states that he has been taking his medications, but his report may be unreliable because of current symptoms of thought disorder.

A. Mr. Fernandes is having an exacerbation of long-standing schizophrenia. There is significant risk that he could be a danger to himself by wandering the neighborhood at night when his parents are asleep. He is having auditory hallucinations, probable visual hallucinations, agitation, and delusions that he was anointed by God to convert the heathens. He has almost certainly been missing his medications. His parents do not feel that they can manage him at home at this time.

P. Because of the risk of self-harm through poor judgment, Mr. Fernandes will be taken for hospitalization to St. Joseph's Medical Center. Mr. Fernandes agreed to this plan, and his parents will drive him there. He signed a release of information, and they will bring a copy of this progress note with them for the emergency room staff. I consulted with Dr. Xavier about this plan, and he agreed to the disposition. His pager number is 312-555-0129 if further information is needed.

[Signed] Brandi Williams, M.A.
Psychology Practicum Student
[Cosigned] Thomas Xavier, Ph.D.
Staff Psychologist

Just because a client with schizophrenia is having an exacerbation of symptoms does not mean that the client needs hospitalization. However, in this case, because of the risk of harm through poor judgment, hospitalization is the wisest choice. Brandi makes this reasoning clear in the previous chart note.

RECOMMENDED READINGS

See chapters 19 to 21 for recommended readings on specific crisis assessment topics.

EXERCISES AND DISCUSSION QUESTIONS

1. What are the procedures for initiating voluntary hospitalization at your facility?
2. What are the procedures for involuntary hospitalization? What are the legal requirements to initiate involuntary hospitalization in your state?