Managing Crisis in an EIS

Wicked problems, principles, procedures

Srihari & Sykes, Aug 2021

Crises: Scenarios (and variations):

1. Risk for **suicide** or **violence** in the community: safety for our patients and the community
    - Poor connection to clinic
    - Involvement of police
    - Living situation (family, alone, supervised, homeless)
    - ....
2. Risk for **violence** in the clinic: safety for ourselves
3. .....

Suicide

PREMISES

- A Behavior (goal-directed, subject to several influences)
- But usually related to mental illness or substance use
- Actuarial approaches to prediction are of very limited clinical utility
- We (clinicians) are better at reducing risk than predicting it!

Suicide

HEURISTICS/ PRINCIPLES

- Embrace risk: known and emerging, and continuously address risk factors (e.g. access to means (guns, medications), hopelessness, CAH)
- When it comes to SUD, bracket out prior probabilities, "EtOH can lubricate any (bad) impulse toward action"
- Share the uncertainty of risk - with family, other caregivers, colleagues BUT take responsibility for (re)solution!
- Don't worry alone: share risk assessments/plans with your clinical team
- Beware 'group think' and invite diverse/opposing opinions to revisit your approach within and across scenarios
- Develop tools for common scenarios (e.g. printed list of coping strategies)

Jack is a 21-year-old high school student who was recently asked to leave his college dormitory (in MA) after repeatedly threatening his roommate who he accused of "spying on his thoughts" by "using radio waves." He initially refused to inform his parents and lived in a series of homeless shelters for more than a year before returning to live at home in Hamden, CT. Shortly after his arrival home, his Mother brings him to the YNHH ER after he acknowledged cutting his left wrist in response to a command auditory hallucination.

… three months after admission to STEP he appears markedly less disorganized, and more forthcoming during his visits to his primary clinician when he reports that he intermittently hears a single voice addressing him directly. While this voice is not telling him to end his life, Jack has been trying to figure out what the message means - and to do this, he has been going to the upper most floor of a local parking garage. He reports that standing under the open sky (and near the low protective wall, helps him listen better. He denies any intent to end his life, but does not rule out the possibility that if commanded to do so again, he might comply.

‘Wicked Problems’*

- Problem framing, not problem solving is often the main task.
- No stopping rule: limits are resources aimed at “good enough” responses.
- (Re)solutions are not true/false but good/bad.
- There are no “permissible” limits on what is worth trying.
- Every wicked problem is unique: real but limited transfer of processes across cases.
- A problem may not be solved (in a generalizable manner) but rather “resolved” within a community of stakeholders and may need to be revisited as conditions or priorities change.

Adapted from Rittel and Webber (1973)

Wicked Problems & Complex Interventions

Table 12.2 Comparing simple, complicated, and complex problems. Adapted from Glouberman and Zimmerman (2002).

Simple: Following a Recipe	Complicated: Sending a Rocket to the Moon	Complex: Raising a Child
The recipe is essential	Formulae are critical and necessary	Formulae have a limited application
Recipes are tested to assure easy replication	Sending one rocket increases assurance that the next will be OK	Raising one child provides experience but no assurance of success with the next
No particular expertise is required. But cooking expertise increases success rate	High levels of expertise in a variety of fields are necessary for success	Expertise can contribute but is neither necessary nor sufficient to assure success
Recipes produce standardized products	Rockets are similar in critical ways	Every child is unique and must be understood as an individual
The best recipes give good results every time	There is a high degree of certainty of outcome	Uncertainty of outcome remains
Optimistic approach to problem possible	Optimistic approach to problem possible	Optimistic approach to problem possible

Managing Crises in a specialty team

A multi-modality approach

Simple	Complicated	Complex
Remove firearms, limit medication supply	SOPs to coordinate care amongst several providers (e.g. AM Huddle)	Build treatment alliance with patient
Medicate depression / psychosis to remission	Address environmental factors (e.g. basic needs, unemployment)	Share risk with family/ friends
	Develop crisis plans for family/housing staff	Balance autonomy vs. paternalism
	Develop a ‘post-vention’ approach for your team	
	Implement screening & monitoring procedures	

Recommended Reading

Suicide. Chapter 6 in Havens LL: A Safe Place: Laying the Groundwork of Psychotherapy. Cambridge, Mass., Harvard University Press, 1989
There is much written on the subject of suicide and mental illness and there is much important research yet to be done, but I have read nothing that gets as close to the heart of the matter for front-line clinicians who routinely address this very daunting challenge in the outpatient setting.

Cole-King A. (2013). Suicide mitigation: A compassionate approach to suicide prevention. Advances in Psychiatric Treatment, 19(4), 276–83 & Cole-King A, Lepping P. (2010). Suicide mitigation: time for a more realistic approach. Br J Gen Pract, 60(570), 3–4. *A sensible approach to reducing risk and a reminder of the paradox that we are far better are reducing risk for suicide than predicting this risk.*