Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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WPPNT Reminders

How to join the Zoom webinar

- **Online:** https://dhswi.zoom.us/j/82980742956(link is external)
- **Phone:** 301-715-8592
  - Enter the Webinar ID: 829 8074 2956#.
  - Press # again to join. (There is no participant ID)

Reminders for participants

- Join online or by phone by 11 a.m. Central and wait for the host to start the webinar. Your camera and audio/microphone are disabled.
- Download or view the presentation materials. The evaluation survey opens at 11:59 a.m. the day of the presentation.
- Ask questions to the presenter(s) in the Zoom Q&A window. Each presenter will decide when to address questions. People who join by phone cannot ask questions.
- Use Zoom chat messages to communicate with the host or to share information related to the presentation.

- Participate live or view the recording to earn continuing education hours (CEHs). Complete the evaluation survey within two weeks of the live presentation and confirmation of your CEH will be returned by email.
- A link to the video recording of the presentation is posted within four business days of the presentation.
- Presentation materials, evaluations, and video recordings are on the WPPNT webpage: https://www.dhs.wisconsin.gov/wppnt/2021.htm.

Essential Principles of Crisis Intervention:

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APPROACHING THE CRISIS SITUATION

- TAKE A BREATH!
- MAKE SURE EVERYONE IS SAFE, AT LEAST FOR THE MOMENT!
- DO NO TRY TO SOLVE A PROBLEM BEFORE YOU UNDERSTAND WHAT THE PROBLEM IS!

SUGGESTIONS FOR-THE CRISIS CLINICIAN (CONT)

1. BE ACTIVE
2. BE WILLING TO TAKE CALCULATED RISKS.
3. APPEAR CALM AND IN CONTROL--WHETHER YOU ARE OR NOT.
4. MAKE SURE YOU HAVE YOUR OWN SUPPORT SYSTEM.
    - VIOLENT PATIENT--HELP NEEDS TO BE READILY AVAILABLE
    - HIGH-RISK PATIENT--SHARE THE RISK
    - BURN-OUT PRODUCING PATIENT
5. KNOW YOUR GOALS--CLINICAL, PROGRAMMATIC, OR POLITICAL.

RULES FOR CRISIS INTERVENTION

1. LEAST IS BEST: DO WHAT IS NEEDED BUT NOT MORE.

   COROLLARY TO 1: UNLESS THERE IS A REASON TO HOSPITALIZE, OUTPATIENT MANAGEMENT IS PREFERRED.

2. THE NEEDS OF THE ENTIRE SOCIAL SYSTEM ARE CRITICAL;

   FAMILY, POLICE, ER STAFF, LANDLORD, ETC.

A. INITIAL APPROACH TO THE CRISIS SITUATION

1. LISTEN TO THE HISTORY OF THE CRISIS FROM ALL THE PEOPLE INVOLVED.

   - HISTORY TAKING CAN HELP PROVIDE A SENSE OF STRUCTURE AND ORGANIZATION
   - CAN DECREASE CHAOS
   - CAN PROVIDE CRITICAL INFORMATION

B. INITIAL APPROACH TO THE CRISIS SITUATION

2. ASSESS RISK
   - PAY PARTICULAR ATTENTION TO ISSUES OF DANGEROUSNESS, EITHER SUICIDAL OR HOMICIDAL.

3. OBTAIN INFORMATION FROM AS MANY COLLATERAL SOURCES AS POSSIBLE.

4. EVALUATE AND MAXIMIZE DEGREE OF COOPERATIVENESS FROM BOTH PATIENT AND SIGNIFICANT OTHERS.

C. INITIAL QUESTIONS THAT HELP TO ORGANIZE THE CRISIS

1. WHAT IS THE CRISIS?
2. WHO IS INVOLVED?
3. WHOM IS THIS A CRISIS FOR?

D. DEVELOP THE CONTEXT OF THE EPISODE:

1. WHAT ARE THE PRECIPITANTS OR STRESSES THAT LED TO THE EPISODE?
2. WHAT IS THE HISTORY OF THE EPISODE?
    - HOW DID IT DEVELOP?
    - WHAT HAPPENED?
3. HOW DOES IT FIT INTO THE PERSON'S LIFE?
    - WHAT OTHER SIMILAR EPISODES HAS THE PERSON HAD?
    - HOW WERE THEY HANDLED?
    - WHAT ARE THE PATIENTS STRENGTHS AND USUAL COPING MECHANISMS?

GENERAL CONSIDERATIONS IN CRISIS INTERVENTION:

- BE INTERESTED IN ANY RECENT CHANGE
- BE ACTIVE
- GET A DETAILED STORY OF WHAT HAPPENED WHEN
  - HELPS ORGANIZE THE SENSE OF CHAOS
  - PROVIDES CRITICAL INFORMATION
- LISTEN AND GIVE THE PATIENT PERMISSION TO TALK
- MAKE SURE EVERYONE ELSE ALSO HAS A CHANCE TO TELL THEIR STORY

ASSESSING SUICIDAL EVENTS (AND IDEATION)

WHY NOW? WHAT WAS THE FINAL STRAW?

SPECIFICS OF PLAN, WHAT, WHEN, HOW

RISK-RATING: LETHALITY, DISCOVERABILITY

ACTION TAKEN

ALCOHOL, SUBSTANCE USE, IMPULSIVITY

DEGREE OF HOPELESSNESS

WHAT STOPPED THE PERSON/HOW WERE THEY FOUND

ATTITUDE NOW OF BEING FOUND/ALIVE

ADAPTED FROM SHAWN SHEA 1998

WHAT DOES THE PERSON WANT?

ASSUMPTION:

EVERYONE WANTS SOMETHING

GIVING PEOPLE WHAT THEY WANT

- WHAT PART OF WHAT THE PERSON WANTS CAN YOU GIVE?
- WHAT ELSE CAN YOU DO TO DEMONSTRATE THAT YOU ARE HELPFUL?
- HOW CAN YOU DEMONSTRATE THAT YOU ARE "ON THE PERSON'S SIDE"?

E. ASSESS CLIENT'S SUPPORT SYSTEM

- PEOPLE IN CRISIS OFTEN FAIL TO ACCESS THEIR SUPPORT SYSTEM

- DIAMOND'S DICTUM

WHEN STUCK, ENLARGE THE FIELD

F. SUPPORT CLIENT'S STRENGTHS

- HOW HAVE THEY COPED WITH THIS KIND OF PROBLEM IN THE PAST?
- WHAT PART OF THE CLIENT'S LIFE IS GOING WELL, OR AT LEAST BETTER?
- WHAT DOES THE CLIENT DO WELL?
- LOOK FOR WAYS TO REINFORCE PRO-SOCIAL COPING

G. CONSIDER SUBSTANCE USE AND WITHDRAWAL:

Opioid Intoxication	Alcohol intoxication
•Drowsiness •Slurred speech •Memory impairment •Shallow and slow respiration •Pupil constriction •Coma	• Confusion • Slurred speech • Lack of coordination • Flushed face • Nystagmus

H. CONSIDER MEDICAL DISEASE:

1. IF YOU DO NOT LOOK FOR IT YOU WILL NOT FIND IT.
2. CONSIDER POSSIBILITY OF ORGANIC DISEASE EVEN IF PATIENT IS "MEDICALLY CLEARED" BY ER
3. IS THIS BEHAVIOR IN KEEPING WITH THIS PERSON'S HISTORY, OR IS IT VERY DIFFERENT
4. IS THIS PERSON CONFUSED, DOES NOT KNOW WHERE OR WHEN THEY ARE, HAS IMPAIRED MEMORY, WALKS OR MOVES ODDLY OR SEEMS ILL?

I. DIFFERENTIAL DIAGNOSIS OF PSYCHIATRIC DISORDER

1. IS THIS AN ACUTE EPISODE, OR PART OF A CHRONIC PICTURE?
2. DO NOT OVER-DIAGNOSE:
   EX. DIAGNOSIS OF SCHIZOPHRENIA REQUIRES A HISTORY OF LEAST SIX MONTHS
3. DIFFERENTIAL DIAGNOSIS IN THE ACUTE SITUATION IS USEFUL ONLY AS FAR AS IT CHANGES IMMEDIATE TREATMENT

J. CONSIDER WHAT NEEDED INFORMATION IS NEEDED BUT NOT YET OBTAINED

- MEDICAL, SOCIAL, PSYCHOLOGICAL, OR HISTORICAL
- FLAG GAPS IN THE DATA BASE

ONLY THINK ABOUT A SOLUTION TO A PROBLEM ONLY AFTER YOU FULLY UNDERSTAND THE PROBLEM

Decisions to initiate a commitment, start a medication, or hospitalize are solutions.

- Do we fully understand the problem we are trying to solve
- How will this solution help or hurt in the short term.
- How will this solution help or hurt a year from now.

A BEGIN TO DEVELOP AN INITIAL TREATMENT PLAN
WHAT DOES THIS PERSON NEED NOW

1. AN ENVIRONMENT

   HOW MUCH PROTECTION IS NEEDED TO PREVENT THE PERSON FROM HARMING SELF OR OTHERS, AND FOR HOW LONG?

2. STRUCTURE

3. OBSERVATION

4. WHAT SETTINGS PROVIDE THIS DEGREE OF PROTECTION, STRUCTURE AND OBSERVATION IN OUR COMMUNITY?

B. WHAT CAN WE DO RAPIDLY TO RESOLVE THE IMMEDIATE CRISIS?

- CRISIS CBT: WHAT ASSUMPTIONS IS THE PERSON MAKING THAT CAN BE REDIRECTED?
- ENVIRONMENTAL INTERVENTION: PLACE TO LIVE, FOOD TO EAT
- STRESS REDUCTION: INTERVENE WITH FAMILY OR ROOMMATE ISSUE, HELP WITH WORK STRESS, PROBLEM SOLVE AN OVERWHELMING ISSUE
- A "TIME OUT", EITHER WITH FAMILY, HOTEL, HOSPITAL ALTERNATIVE, OR HOSPITAL

C. CONSIDER THE USE OF MEDICATION

WHAT IS THE GOAL OF USING MEDICATION AT THIS TIME?

- CLIENT REQUEST, STAFF HOPING TO ESTABLISH CONTROL, NEED TO "DO SOMETHING"
- HOW LONG WILL A MEDICATION TAKE TO BE EFFECTIVE
- WHAT EFFECT WILL INITIATING MEDICATION NOW HAVE A YEAR FROM NOW. WILL IT HELP OR MAKE CONNECTION TO MEDICATION AND TREATMENT MORE DIFFICULT?

D. CONSIDER WHOM TO GET INVOLVED AND WHEN.

FAMILY, EMPLOYERS, LANDLORDS, ETC.,

- IF NOT IN THE ER THEN EARLY IN THE RESTABILIZATION PROCESS.
- IMPORTANT TO BALANCE TREATMENT NEEDS WITH THE CLIENT'S RIGHTS TO PRIVACY AND CONFIDENTIALITY

E. CONSIDER THE USE OF THE HOSPITAL:

HOSPITALIZATIONS TYPICALLY OCCUR DURING SOME PERIOD OF CRISIS, STRESS OR CHAOS.

IT IS TEMPTING TO IMMEDIATELY RESPOND TO THE CRISIS BY ASKING WHETHER THE PERSON SHOULD BE HOSPITALIZED.

AVOID THIS TEMPTATION!

THIS QUESTION SHOULD BE AT THE END OF THE CRISIS ASSESSMENT, NOT AT THE BEGINNING.

THE HOSPITAL IS A PLACE WHERE TREATMENT CAN OCCUR, IT IS NOT TREATMENT IN ITSELF.

1. THE HOSPITAL IS A PLACE WHERE RESOURCES (PEOPLE) ARE CONCENTRATED.
   - CONSIDER OTHER WAYS TO ORGANIZE NEEDED RESOURCES.
2. ONE SHOULD USE HOSPITAL BECAUSE SOME TREATMENT CAN OCCUR THERE THAN CAN NOT OCCUR ELSEWHERE
   - USE HOSPITAL AS A SOLUTION TO A PROBLEM RATHER THAN A RESPONSE TO A PROBLEM

CONSIDER THE USE OF HOSPITAL ALTERNATIVES

A. WHAT IS AVAILABLE IN THE AREA? CRISIS HOMES, HOTELS, FRIENDS, FAMILY, PHONE CALLS, OTHER NATURAL SUPPORTS

B. WHAT IS NEEDED TO MAKE THIS SAFE AND EFFECTIVE?

C. WHAT ARE THE ADVANTAGES AND DISADVANTAGES OF THESE ALTERNATIVES?

BE CLEAR ABOUT WHAT YOU WANT TO HAVE HAPPEN IN THE HOSPITAL

A. WHAT ARE THE GOALS FOR THIS HOSPITALIZATION

B. HOW WILL YOU AND THE CLIENT KNOW WHEN THESE GOALS HAVE BEEN MET.

C. WHAT NEEDS TO HAPPEN IN THE HOSPITAL FOR THESE GOALS TO BE MET

D. HOW LONG IS THIS EXPECTED TO OCCUR.

IF PATIENT HOSPITALIZED, DISCHARGE PLANNING SHOULD BEGIN AT ADMISSION

BEGIN INITIAL THINKING ABOUT WHAT THIS PATIENT WILL LIKELY NEED IN TERMS OF LIVING SITUATION, TREATMENT, DAILY STRUCTURE, ETC.

WHAT DIFFICULTIES SHOULD ONE EXPECT AND TRY TO PREPARE FOR FOLLOWING DISCHARGE

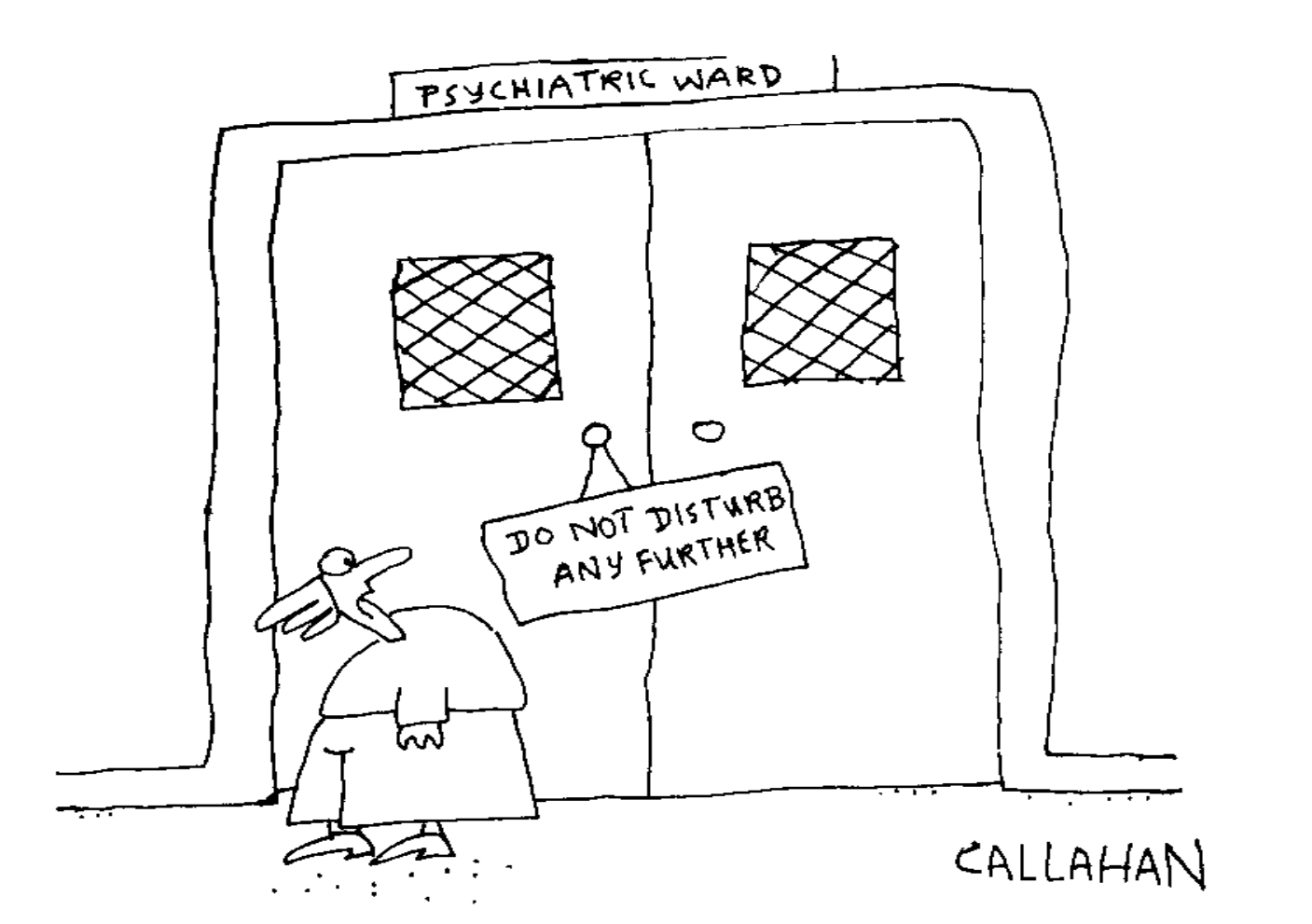
- NOT SHOWING UP FOR APPOINTMENTS
- "UNMOTIVATED" AND "TREATMENT RESISTANT"
- REFUSING MEDICATION

THINK ABOUT HOW WHAT YOU DO NOW WILL MAKE THINGS BETTER, OR WORSE A YEAR FROM NOW.

- MOST PEOPLE WE SEE IN CRISIS HAVE AN ONGOING ILLNESS. HOW WILL WHAT WE DO NOT MAKE IT MORE, OR LESS LIKELY THAT THEY WILL BE WILLING TO COME IN FOR HELP IN THE FUTURE, ENGAGE IN TREATMENT, OR TAKE MEDICATION
- IF WE CAN HELP THE PERSON, EVEN A LITTLE, STABILIZE THEIR LIFE OR GET ONGOING HELP, WE HAVE BEEN USEFUL.
- IF WHAT WE DO MAKE IT LESS LIKELY THE PERSON WILL BE IN TREATMENT IN THE FUTURE, WE MAY HAVE CAUSED DAMAGE

IF WE WERE ON THE OTHER SIDE OF THE DESK:

- ARE WE TREATING THIS PERSON THE WAY WE WOULD LIKE TO BE TREATED?
- ARE WE LISTENED TO THIS PERSON IN CRISIS THE WAY WE WOULD LIKE TO BE LISTENED TO?
- ARE WE RESPECTING THIS PERSON'S WORLD VIEW AND DESIRES, EVEN IF WE DISAGREE, THEY WAY WE WOULD LIKE TO BE RESPECTED?


PSYCHIATRIC WARD
DO NOT DISTURB ANY FURTHER
CALLAHAN