Clinicians on the front lines in psychiatric emergency departments (EDs) make life and death decisions under conditions of chaos and uncertainty. People in crisis along with their families or friends arrive at the ED because they were looking for solutions to acute problems or were sent there by force against their will. Clinicians and the people who arrive at the ED (who may not yet be patients) have to construct a narrative of what happened and find acute solutions. After gathering as much information as possible from all credible sources, clinicians must make critical decisions. Admit to the inpatient unit? Hold overnight to evaluate and observe? Discharge for outpatient follow-up if necessary? Or discharge to home without any need for follow-up? Clinicians make these difficult decisions by estimating risk and probability.

In general, most people are not great at estimating risk and probability. If you would like to be enlightened and humbled, read *Thinking Fast and Slow* by Daniel Kahnemann,\(^1\) the Nobel Prize winning psychologist who helped establish behavioral economics with the late Amos Tversky (as told in *The Undoing Project* by Michael Lewis\(^2\)). One of the important concepts discussed by Kahnemann is that we tend to be overconfident in our abilities to predict outcomes. He tells a story of when he worked for the Israeli army where they used interviews to figure out which soldiers should get certain positions. He realized that they had never followed up to see if their predictions were true. So, they did a study to discover the outcomes and, lo and behold, their predictions were terrible and the interviews were worthless. A similar story is told in another book by Lewis, *Moneyball: The Art of Winning an Unfair Game*.\(^3\) Baseball recruiters would use their “gut” to decide who was worth hiring for positions on professional teams with the risk of spending millions of dollars. The young men who became members of teams frequently did much worse or much better than predicted, but the recruiters never bothered to see if their predictions were true. The Oakland Athletics used a different method to systematically gather data and crunch the numbers to find the relevant variables to reduce risk and get better outcomes.\(^3\) They used that data to hire unknown prospects and build a great team.

Thus, the path to better decisions and outcomes in the psychiatric ED is by getting better data, assessing outcomes, and then testing interventions. A great example of this process was published by Miller et al.\(^4\) who tested an intervention to reduce completed suicides for people who had been in the ED. They found that the Coping Long Term with Active Suicide Program (CLASP),\(^5\) which uses individual psychotherapy, case management, and involves significant others, reduced suicide attempts by 30%. As stated by the authors, this outcome is a modest but important result. The challenge now is to disseminate the CLASP protocol to EDs around the country.

It is time for mental health and ED clinicians to collaborate to get

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doi 10.3928/00485713-20171205-03
the data and test interventions for better outcomes. The infrastructure to do this is starting to emerge from the Patient Centered Outcomes Research Network (www.PCORnet.org) and an initiative to build a learning health care system. Stay tuned.

REFERENCES