Body System: Psychogenic

Session Topic: Crisis Counseling

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• Physicians often report time pressure and lack of knowledge as a barrier to providing optimal mental health services to their patients. • Physicians often lack sufficient training to provide optimal crisis counseling. • Physician often lack an awareness of local, regional, and national tools and resources to help them support patients experiencing a crisis.	1. Develop a process to reassure and support a patient experiencing a crisis, with emphasis on evaluating the crisis severity, screening for depression and assessing the patient's status. 2. Develop a collaborative action plan that ensures the safety of the patient and others. 3. Establish follow-up protocols with patients who have experienced a crisis. 4. Identify local community, regional, and national resources for patients experiencing a crisis situation.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately

implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide recommendations for developing a process to reassure and support a patient experiencing a crisis, with emphasis on evaluating the crisis severity and assessing the patient's status.
- Provide recommendations for developing a collaborative action plan that ensures the safety of the patient and others.
- Provide recommendations for developing follow-up protocols with patients who have experienced a crisis.
- Provide strategies and resources for identifying local community, regional, and national resources for patients experiencing a crisis situation.
- Provide recommendations regarding guidelines for Medicare reimbursement.
- Provide recommendations to maximize office efficiency and guideline adherence to the management of patient crisis.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.

Needs Assessment:
Over half of all mental health services are provided by primary care physicians; however, family physicians often report time pressure and lack of knowledge as barriers.[1,2] Physicians often are required to assist patients in crisis. An estimated 4 percent of visits to primary care physicians involve psychiatric or social crises.[3]

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicates that family physicians may lack sufficient training to provide optimal crisis counseling.[4] More specifically, CME outcomes data from 2015 AAFP FMX *Crisis Counseling* sessions, suggest that physicians have knowledge and practice gaps with regard to developing a crisis plan for their practice; having a robust list of community resources to provide to patients; using appropriate coding/billing for reimbursement; utilizing safety agreements; integrating behavioral health into practice; and appropriately training office staff to assist in a crisis.[5] Approximately 45% of attendees from these sessions indicate that they experience a psychiatric crisis in their practice on a monthly basis.

Physicians may improve their care of patients experiencing a crisis by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[1,3,6-8]

- Patients who are experiencing a crisis should be assessed for suicidal and homicidal ideations.

- Patients who are suicidal and have comorbid psychiatric or medical problems, a history of violent or near-lethal suicide attempts, a poor response to outpatient treatment, or limited family or social support should be considered for inpatient hospital admission.
- Physicians must warn and protect intended victims of a patient.
- Physicians should help patients experiencing a crisis to stabilize acute distress, to explore options, to make a specific plan, and to commit to the plan.
- Selective serotonin reuptake inhibitors and other antidepressants are reasonable clinical interventions for patients with acute stress disorder or post-traumatic stress disorder.
- Primary care counseling leads to short-term benefits for psychiatric symptoms.
- Because there is no significant difference in performance among the different depression screening instruments, the most practical tool for the clinical setting should be used.
- Adults and adolescents 12 to 18 years of age should be screened for depression in clinical practices that have systems to ensure effective diagnosis, treatment, and follow-up.
- There is insufficient evidence to balance the benefits and harms of screening children seven to 11 years of age for depression.
- There is insufficient evidence to recommend for or against screening for suicide risk in the general population.
- The PHQ-2 is accurate for depression screening in adolescents, adults, and older adults.
- The PHQ-9 is a valid, quick screening instrument for depression that also can be used as a follow-up to a positive PHQ-2 result and to monitor treatment response.
- Depression screening in older adults can be accomplished with multiple instruments, including the PHQ-2, PHQ-9, and various Geriatric Depression Scales.
- Rapid screening for substance misuse or substance use disorders can be performed in the primary care setting with a validated single-question screening tool.
- Emergency contraception should be offered to all sexual assault survivors who are of childbearing potential and have a negative pregnancy test.
- All sexual assault survivors should be treated for the prevention of sexually transmitted infections.
- Physicians should discuss IPV and family violence with their patients in a routine, nonjudgmental manner.[9]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Additionally, physicians may want to consider the National Collaborating Centre for Mental Health. Borderline personality disorder: treatment and management for crisis management strategies.[10]

Physicians may need to quickly address a crisis situation during an office visit. There should be an established action plan for managing this impromptu crisis situation; including available resources, materials, and access to community resources. Physicians may even consider integrating a behavioral health specialist into practice to improve the delivery of psychiatric services to patients.[2] In fact, a Cochrane review indicates that a collaborative care model is effective for treating adults with depression and/or anxiety using a multi-professional approach to patient care, a structured management plan, scheduled patient follow-ups, and enhanced interprofessional communication.[11]

Sometimes family physicians may feel alone in handling this complex situation. What are some resources that would be available to help in crisis counseling?

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Realistic approaches to counseling in the office setting[1]
- A practical guide to crisis management[3]
- Integrating a behavioral health specialist into your practice[2]
- Screening for depression[6]
- A primary care approach to substance misuse[7]
- Collaborative care for depression and anxiety[11]
- Sexual assault of women[8]
- Intimate partner violence[9]
- Borderline personality disorder: treatment and management[10]
- Suicide (patient education)[12]
- United Way. 2-1-1 Information & Referral Search[13]
- United Way U.S. 2-1-1[14]

References

1. Searight R. Realistic approaches to counseling in the office setting. *American family physician.* Feb 15 2009;79(4):277-284.

2. Reitz R, Fifield P, Whistler P. Integrating a behavioral health specialist into your practice. *Family practice management.* Jan-Feb 2011;18(1):18-21.

3. Kavan MG, Guck TP, Barone EJ. A practical guide to crisis management. *American family physician.* Oct 1 2006;74(7):1159-1164.

4. AAFP. 2012 CME Needs Assessment: Clinical Topics. American Academy of Family Physicians; 2012.

5. American Academy of Family Physicians (AAFP). AAFP FMX CME Outcomes Report. Leawood KS: AAFP; 2015.

6. Maurer DM. Screening for depression. *American family physician.* Jan 15 2012;85(2):139-144.

7. Shapiro B, Coffa D, McCance-Katz EF. A primary care approach to substance misuse. *American family physician.* Jul 15 2013;88(2):113-121.

8. Luce H, Schrager S, Gilchrist V. Sexual assault of women. *American family physician.* Feb 15 2010;81(4):489-495.

9. Cronholm PF, Fogarty CT, Ambuel B, Harrison SL. Intimate partner violence. *American family physician.* May 15 2011;83(10):1165-1172.

10. National Guideline Clearinghouse. Borderline personality disorder: treatment and management. 2009; http://www.guideline.gov/content.aspx?id=14327. Accessed 7/15/2014.

11. Luxama C, Dreyfus D. Collaborative care for depression and anxiety. *American family physician.* Apr 1 2014;89(7):524-525.

12. FamilyDoctor.org. Suicide. 2000; http://familydoctor.org/familydoctor/en/teens/emotional-well-being/suicide.html. Accessed July, 2014.

13. United Way. 2-1-1 Information & Referral Search. 2014; http://www.211.org/. Accessed July, 2014.

14. United Way. United Way U.S. 2-1-1. 2014; http://211us.org/. Accessed July, 2014.

