Crisis Intervention in Integrated Care

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BOX 26.1
KEY POINTS

- A crisis occurs when a person feels overwhelmed, becomes dysfunctional, and is unable to adequately manage or resolve life stressors.
- A stressor may be a new life event, an interpersonal problem, an internal conflict, or a developmental problem.
- Crises are self-limited and result in three possible outcomes: (1) improved functioning, (2) recovery to the previous level of functioning, or (3) stabilization at a lower level of functioning.
- All members of the integrated health team play a role in recognizing the patient in crisis.
- Primary care providers begin the evaluation and treatment of the patient in crisis and refer the patient to an appropriate team member and for the appropriate level of care.
- Patients in an integrated health system are monitored for crises in the tracking registry.
- The behavioral health specialist provides time-limited, targeted crisis intervention treatment. All members of the integrated health team support the therapist and patient throughout the course of treatment.
- A timeline, social network map, and wheel-and-spoke diagram are tools for evaluation and treatment planning for the patient in crisis.
- Crisis intervention treatment may help a patient realize personal growth and improved functioning.

INTRODUCTION
This chapter describes how to identify persons in crisis, determine an initial level of psychiatric care, and deliver crisis intervention treatment within an integrated primary care and behavioral health practice. See Box 26.1 for an overview of key points in understanding the crisis intervention approach.

A crisis occurs when a person feels overwhelmed, becomes dysfunctional, and is unable to adequately cope, manage, or resolve a life situation. People in crisis experience overwhelming, paralyzing anxiety that leaves them feeling powerless to use their usual social supports, personal strengths, and coping skills to solve a problem at hand. Crises are universal phenomena: Everyone is vulnerable!

ORIGINS OF A CRISIS
A crisis may be precipitated by any stressful life event, including interpersonal problems, medical illness, internal conflicts and psychological events, or a developmental issue. The stress caused by a life event reflects the nature of the event as well as the patient’s reaction.

Stressful Life Events
A crisis may be precipitated by the intrinsic distress of a traumatic life event, such as a fire or an assault.
BOX 26.2
STRESS RANKING OF SELECTED LIFE EVENTS

1. Death of spouse/mate.
2. Death of close family member.
3. Major injury/illness to self.
4. Detention in jail or other institution.
5. Major injury/illness to close family member.
6. Foreclosure.
7. Divorce.
8. Infidelity.
9. Surviving a disaster.
10. Assuming responsibility for sick or elderly loved one.
13. Spouse/mate begins/ceases work outside the home.
14. Change in residence.
15. Retirement.

Adapted with permission from Hobson’s (1998) list of 51 events on the Social Readjustment Rating Scale—Revised.

The onset of a crisis after an event is often immediate but may be delayed up to six weeks. The Social Readjustment Rating Scale—Revised ranks a range of external stressful life events reflecting the course of human life, for example the death of a spouse, medical illness, or retirement, as detailed in Box 26.2. Similarly, trauma survivors experience predictable stages of grief, functional impairment, and crisis.

Interpersonal Crisis
Crises in this domain are usually precipitated by conflicts between two people. These conflicts may arise in a marriage (e.g., affair, sickness, role reversal) or at work (e.g., between a boss and an employee). When these conflicts arise, the ability of both parties to actively communicate their feelings and behave civilly is impaired; the resulting dysfunctional dyad cannot resolve disputes or solve problems.

Internal Conflict or Psychological Event
Sometimes the precipitating event of a crisis can be obscured because the event is an internal experience that needs to be described by the patient. Psychological events, such as a disturbing thought, an impulse to hurt oneself or another, or a disturbing dream as reported by patients who have posttraumatic stress disorder, can precipitate a crisis. Internal crises can precipitate symptoms of anxiety or depression or more dramatic symptoms such as non-epileptic seizures (see Chapter 29: Integrative Care Model for Neurology and Psychiatry: Non-Epileptic Seizures Project) and conversion disorders. Psychological events may also relate to internal reactions and meaning attributed to a stressful life event or interpersonal crisis.

Developmental Crises
Erik Erikson observed that people routinely experience developmental crises as they advance through life’s developmental stages and the age-related tasks that accompany those stages, from childhood to retirement. Failure to master the tasks of an earlier developmental stage is a potential source of crisis that may interrupt future development in the next stage; for example, a failure to negotiate the role and identity confusion of adolescence may prevent successful transition into adulthood. In young adulthood, persons need to cope with either intimacy or isolation. Later they may face a crisis of stagnation if they fail to realize the generativity of middle adulthood.

The responses to stressful events, trauma, and developmental issues are considered “generic,” since they are experienced similarly and ubiquitously in Western cultures.
Personalized Meaning of the Stressor

Events affect individuals differently. Patients often ascribe personal meaning to events, and may magnify or deny the impact of a current problem or situation. Perhaps a crisis evokes a patient's prior memory or emotionally traumatizing life experience. Perhaps a patient's inability to manage a present crisis reinforces a preexisting maladaptive belief that the crisis and resulting dysfunction are beyond control. These associations add significant meaning to a situation even though they are often unconscious or unappreciated by the patient. By looking for past patterns that are similar to the current crisis, primary care providers can help the patient recognize a crisis and the context through which a current situation is being experienced. From this position, the provider can help the patient develop more adaptive responses.

A "crisis" is often not centered around diagnoses codified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). Indeed, patients in crisis only sometimes fit the DSM-5's recognized diagnoses. Many patients in crisis may not have a history of mental illness or substance abuse. The closest DSM-5 diagnoses to a crisis are either trauma-related diagnoses or an adjustment disorder, whose relationship to the older concept of crisis is debated. However, sometimes a DSM-5 diagnosis, like major depression or an anxiety disorder, may precipitate the crisis or be discovered in the course of a crisis. Patients with personality disorders struggle with poor problem solving and experience recurrent crises (See Chapter 17: Working with Personality Disorders in an Integrated Care Setting). When a DSM-5 diagnosis is present, the clinician can apply crisis treatment principles to the treatment of the disorder or can treat according to the best practices described elsewhere in this book.

**Course of a Crisis**

People employ coping skills, defense mechanisms, interpersonal relationships, and environmental supports to manage life's inherent stress; choices of coping skills reflect upbringing, temperament, innate strengths, and the cultural influences. Certain personal characteristics (e.g., resilience, optimism, and self-efficacy) further enable effective management of a stressful situation. Optimal anxiety management can enhance performance and productivity, as when studying for an exam or completing a project on deadline. The successful maintenance of a stressor-coping equilibrium enables patients to complete and enjoy the activities of life (e.g., working, building relationships, starting families). Culture often provides individuals with traditions designed to manage crises, such as the cultural rituals around death, sickness, or divorce. Figure 26.1 illustrates the development, process, and potential outcomes of a crisis.

A crisis begins with a stressor that disrupts a stable equilibrium. A patient's failure to manage a stressor precipitates a state of crisis and a feeling of being overwhelmed, which may manifest as anxiety, depression, or a sense of panic or incompetence. Other environmental factors may compound this.

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**Figure 26.1** Crisis: development, process, and outcomes
stress. For example, the death of a spouse may rob the survivor of both an income and the emotional support of a close confidant. The most intense anxiety may not be experienced immediately after the precipitant. Many persons initially deny, avoid, or “recoil” from dealing with an acute stressor. Only about 25% of patients can identify a crisis on the day of the stressor; 25% will realize the severity of the problem, usually with symptoms, after a week. The remaining 50% may take up to six weeks to recognize the precipitants of a crisis and related symptoms.

Most crises resolve over six weeks as the intensity of the precipitants diminishes or the patient copes independently. But while a new equilibrium will be found, there is no guarantee that functioning will improve. There are three typical outcomes for crisis:

1. Ideally, someone will navigate the crisis and emerge with novel coping skills and an enhanced sense of mastery; thus a crisis becomes an opportunity for personal growth.
2. More commonly, the crisis will be managed and the pre-crisis level of functioning returns.
3. Some crises are incompletely or maladaptively resolved. The patient only partially copes and stabilizes at a lower level of functioning; some patients struggle with ongoing anxiety or other symptoms. Other patients accept a resolution of the crisis that is only a compromise. For instance, a patient may remain in a dysfunctional relationship to avoid the pain of separation. This type of patient remains vulnerable to the recurrence of future crises and may fail to return to his or her previous functioning.

INTEGRATED CARE AND CRISIS INTERVENTION TREATMENT

Integrated behavioral health draws on the unique skills and positions of every primary care team member. Table 26.1 reviews potential roles of each integrated team member in crisis intervention treatment.

Each of these clinicians maintains a distinct relationship with the patient, in which different opportunities exist to recognize and treat a patient in crisis. The success of any one team member improves the capabilities of the others: for example, a care manager following up with patients within one week of an emergency department visit, improves rates of access to primary care, insurance coverage, and patient functioning. Outreach by behavioral health specialists increases appointment attendance and patients’ satisfaction.

Patients in an integrated health system should be monitored in a registry, which is typically managed by a health coach, behavioral health specialist (BHS), or other trained personnel and actively monitored by the BHS, consulting psychiatrist, or other members of the health care team. A registry can be used to track crises, problems, symptoms (e.g., depression and anxiety rating scales), functional measures (e.g., Clinical Global Impression Scale or World Health Organization Disability Assessment Schedule), medication doses, information on the last visit, and details on the frequency of a patient’s contact with specialists or use of community resources. A well-designed registry allows the integrated team members to quickly identify patients who are not improving and intervene.

Epidemiologic merits of a registry include monitoring population health across a practice, identifying populations at high risk of psychiatric and medical comorbidity, and evaluating the effectiveness of practice innovations.

An integrated behavioral health team should maintain regular communication about the patient’s care and progress. Ideally, the team should have a standing meeting as a group to review cases at a frequency determined by the practice. Ad hoc communication about particular patients is common and useful. Each team member should share his or her preferred method of communication (e.g., e-mail, pager, cellphone) and develop a standardized process to ensure that referrals to BHSSs are tracked, that cases are entered into the population registry, and that primary providers receive updates on the patient’s treatment. A registry accessible by all members of the integrated health team facilitates regular communication.

OVERVIEW OF CRISIS INTERVENTION TREATMENT

Crisis intervention is a therapeutic approach to help patients resolve a crisis. In contrast to other psychotherapy models, crisis intervention is designed to be time-limited and to be focused on resolution.
<table>
<thead>
<tr>
<th>Initial Visit</th>
<th>Weeks 1 and 2</th>
<th>Weeks 3 and 4</th>
<th>Weeks 5 and 6</th>
<th>Weeks 7 and 8</th>
<th>Termination and Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
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<td></td>
<td>1. Review therapist's formulation of crisis.</td>
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<tr>
<td>Provider/</td>
<td></td>
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<td></td>
<td>2. Chart &quot;red flags&quot; of crisis for future reference.</td>
</tr>
<tr>
<td>Advanced</td>
<td>1. Identify crisis.</td>
<td>1. Schedule brief follow-up appointment.</td>
<td>1. Follow active medical issues, as necessary.</td>
<td>1. Review progress.</td>
<td></td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>2. Begin formulation.</td>
<td>2. Reinforce positive changes.</td>
<td>2. Reinforce positive change and use of social supports.</td>
<td>2. Review solutions and successes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Assess for safety.</td>
<td>3. Solicit feedback on initial therapy referral.</td>
<td>3. Reinforce nonpharmacologic anxiety management.</td>
<td>3. Reflect on challenges of therapy.</td>
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</tr>
<tr>
<td></td>
<td>5. Encourage follow-up with integrated care team.</td>
<td>5. Anticipate medical complications from crisis (e.g., medication nonadherence).</td>
<td>5. Administer screens.</td>
<td>5. Anticipate future challenges.</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Be alert for &quot;red flags&quot; of new crisis.</td>
</tr>
<tr>
<td>Assistant,</td>
<td>1. Help identify the crisis.</td>
<td>As needed</td>
<td>As needed</td>
<td>As needed</td>
<td>3. Advise about administration of screens, periodically.</td>
</tr>
<tr>
<td>Nurse, and</td>
<td>2. Administer mental health screens before the appointment.</td>
<td></td>
<td></td>
<td></td>
<td>1. Share formulation with primary provider and staff.</td>
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<tr>
<td>Staff</td>
<td>3. Alert primary care provider to core issues.</td>
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<td></td>
<td></td>
<td>2. Share &quot;red flags&quot; with other providers.</td>
</tr>
<tr>
<td>BHS/Therapist</td>
<td>4. Enhance motivation to engage in therapy.</td>
<td></td>
<td></td>
<td></td>
<td>3. Summarize case with consulting psychiatrist and remove from caseload.</td>
</tr>
<tr>
<td></td>
<td>2. Complete formulation.</td>
<td>2. Teach anxiety coping skills, if necessary.</td>
<td>2. Review solutions and successes.</td>
<td></td>
<td>(continued)</td>
</tr>
<tr>
<td></td>
<td>3. Assess safety and mitigate risks.</td>
<td>3. Reinforce nonpharmacologic anxiety management.</td>
<td>3. Reflect on challenges of therapy.</td>
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<tr>
<td></td>
<td>4. Develop a timeline.</td>
<td>4. Pursue and find solutions to problems.</td>
<td>4. Reflect on crisis precipitants.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>5. Assess social network.</td>
<td>5. Administer screens.</td>
<td>5. Anticipate future challenges.</td>
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<tr>
<td></td>
<td>9. Update registry.</td>
<td></td>
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<tr>
<td>Initial Visit</td>
<td>Weeks 1 and 2</td>
<td>Weeks 3 and 4</td>
<td>Weeks 5 and 6</td>
<td>Weeks 7 and 8</td>
<td>Termination and Follow-up</td>
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<tr>
<td><strong>Health Coach, if available</strong></td>
<td>1. Review wellness needs as recommended by primary care provider.</td>
<td>1. Follow progress in registry.</td>
<td>1. Follow progress in registry.</td>
<td>1. Follow progress in registry.</td>
<td>As needed</td>
</tr>
<tr>
<td>2. Input information into registry.</td>
<td>2. Assess needs related to nutrition, weight, exercise, sleep, harm</td>
<td>2. Update wellness plan, as needed.</td>
<td>2. Update wellness plan, as needed.</td>
<td>2. Update wellness plan, as needed.</td>
<td>Refer to community resources for ongoing care, if indicated.</td>
</tr>
<tr>
<td>3. Implement wellness plan with goals and outcome measures.</td>
<td>3. Provide feedback to BHS.</td>
<td>3. Provide feedback to BHS.</td>
<td>3. Provide feedback to BHS.</td>
<td>3. Provide feedback to BHS.</td>
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<tr>
<td><strong>Care Coordinator/Case Manager</strong></td>
<td>Meet patient and determine needs for care coordination.</td>
<td>Outreach the patient (as necessary) to aid in follow-up</td>
<td>As needed</td>
<td>As needed</td>
<td></td>
</tr>
<tr>
<td><strong>Consulting Psychiatrist</strong></td>
<td>1. Aid in triage to appropriate level of care.</td>
<td>1. Review progress of treatment with therapist.</td>
<td>1. Review progress of treatment with therapist.</td>
<td>1. Review progress of treatment with therapist.</td>
<td></td>
</tr>
<tr>
<td>2. Assess for dangerousness, if needed.</td>
<td>2. Consult on initial formulation.</td>
<td>2. Consider pharmacotherapy.</td>
<td>2. Consider role for pharmacotherapy.</td>
<td>2. Consider role for pharmacotherapy.</td>
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<tr>
<td>5. Finalise formulation with therapist and primary care provider.</td>
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</table>
BOX 26.3

STEPS OF CRISIS INTERVENTION

1. Identify the stressor or precipitant (e.g., external event, interpersonal problem, medical illness, psychological event, or developmental issue).
2. Characterize the patient's reactions to the crisis.
3. Understand the personal meanings of the event for the patient.
4. Develop a timeline of the crisis to understand the "Why now?"
5. Collect a social history including occupational, interpersonal, developmental, and psychiatric and substance use history to understand events influencing the current crisis.
6. Screen for other life problems that may exacerbate the crisis (e.g., medical conditions, legal issues, or substance abuse).
7. Build a social network map that includes the patient's family members and other sources of support.
8. Identify and prioritize problems contributing to the crisis.
9. Integrate biological, psychiatric, social, and cultural elements into a case formulation.
10. List potential solutions with the patient.
11. Assess less adaptive coping styles and teach more adaptive coping styles.
12. Support the patient in using the team and proposed solutions to resolve the crisis.
13. As the crisis resolves, provide anticipatory guidance.

of the acute crisis. In most cases, crisis intervention therapy is delivered over one to eight individual sessions with a BHS.15.20 Crisis intervention treatment proceeds through the stages described in Box 26.3.

We present a model of crisis intervention adapted to the integrated care setting. A medical assistant may conduct primary screening for a crisis; the primary provider conducts an initial assessment and subsequently uses the integrated care team, including a health coach, BHS, consulting psychiatrist, and care manager, to facilitate treatment. Telehealth consultation may be used if a psychiatrist or other members of the team are not readily available.

Recognition of the Crisis

Identifying the presence of a crisis and determining the precipitating stressor are the first steps of crisis intervention. Patients in crisis often feel confused and disorganized; they may be unable to recognize their own crisis state. In a collaborative care environment, every team member must be attuned to the signs of a patient in crisis. Many warning signs might suggest a patient is in crisis: He or she may unexpectedly miss appointments, feel easily frustrated upon checking in or when interacting with the medical assistant or nurses, or a patient may confide distress to a favorite staff member. Some patients may not renew or fill prescriptions while accumulating several emergency department visits. Patients may also share new, medically unexplained somatic symptoms12 or screen positive on mood and anxiety screeners.

The opportunity for crisis intervention and treatment may be lost if clinicians fail to recognize and investigate changes in symptoms and functioning. When a patient appears distressed, being open about the patient's behavior and affect will invite a conversation. There are multiple moments during an office visit when a patient can be approached about stressful life events. Every integrated care team member should feel empowered to open a conversation with the patient. For example:

SCHEMULE: "It has been a long time since you missed an appointment without calling. I hope nothing serious is happening?"
(Next step: Alert care manager or nurse that patient may need additional outreach.)

NURSE: "You seem upset today; I don't usually see you like this. How are you feeling lately?" (Next step: Provide a self-report screening instrument and alert the provider.)
PRIMARY CARE PROVIDER: "It is unlike you to not take your medication regularly. What might be going on?" (Next step: Assess for the presence of crisis.)

**Formulation of the Crisis**

Identifying the stressor precipitating the crisis can be challenging for people whose intense distress leaves them unable to navigate the events driving their crisis. Moreover, the stressor is also likely to have occurred in the six weeks before the person presents for care. Some information may be available to the primary care provider from previous records or collateral informants. However, most likely, it will be the primary care provider who will obtain the initial history of the crisis. The provider's inquiries may be prompted by the concerns of other staff members or by the patient's family members. Family members can participate in the crisis intervention interview and treatment (see Chapter 27: Best Practice for Family-Centered Health Care: A Three-Step Model).

The interview can start by asking, "Why now?" What was happening on the day the patient reached out for help? The interview should then focus on the immediate precipitants of a crisis. Developing a six-week timeline of recent events, related to the crisis, focuses the interview and explores for sources of distress, as Figure 26.2 illustrates. The interview can progress to open-ended questions, exploring other stressors, the nature and duration of symptoms, changes in functioning or daily routines, and how the patient is doing generally.

Consider external events, interpersonal conflicts, internal conflicts, and developmental issues as common sources of a crisis. Discussing changes in these domains may also provide clues to the timing and nature of the stressor. "When was the last time things were going well" is a helpful question that may further elucidate the onset of the crisis state.

Clinicians must also consider the presence of new medical conditions, primary mental illness, or substance abuse among patients in crisis. The relationship between crisis and psychiatric/medical disorder is bidirectional. By their nature, some medical, mood, anxiety, psychotic, and substance use disorders can occur without a life stressor. These illnesses can result in substantial functional impairment that drives ancillary stressors, hinders patients' use of effective coping strategies, and results in a crisis. In the other direction, stressful life events are often significant risk factors or precipitants for depression and substance use. 22-24 Screening instruments such as the Patient Health Questionnaire-9 (PHQ-9) 25,26 Generalized Anxiety Disorder-7 (GAD-7),27 and Alcohol Use Disorders Identification Test (AUDIT) 28 or the QPD (see chapter 10 Automated Mental Health Assessment for Integrated Care: The Quick PsychoDiagnostics Panel (QPD) Meets Real-World Clinical Needs) can be administered to patients by staff before appointments and aid the clinician's evaluation of the crisis and its resolution.

![FIGURE 26.2 Six-week timeline](image-url)
The primary care provider may use the triage assessment system (TAS) to identify maladaptive psychological reactions to crisis. The TAS is a framework that briefly formulates the patient's reaction to a stressor and identifies maladaptive coping. In the TAS, the crisis state is described as an interaction among emotional, behavioral, and cognitive reactions. The primary emotional reaction is often clear and described by the patient: sadness, anger, guilt, or loneliness. These emotions often relate to the patient's crisis behaviors. These behaviors are most often (1) immobility or inability to solve the crisis, (2) avoidance of the relevant stressors, or (3) an adaptive "approach" reaction by which the patient works to resolve the crisis. Finally, cognitive reactions characterize the perception of the crisis. The crisis event can be perceived as (1) an irrevocable loss, (2) a transgression, or an offense against the patient, or (3) a threat that will bring future catastrophe. The synthesis of these emotional, behavioral, and cognitive reactions describes the patient's impairment and the effect of the crisis on social relationships, work, well-being, and self-perception. The presence of maladaptive behavioral and cognitive responses suggests the need for more intensive treatment by the integrated team or referral.

Although an adept primary care provider may be able to identify the stressor, complete the formulation, and deliver some brief suggestions within a medical appointment, the primary care provider is more likely to refer the patient for brief treatment with a "warm handoff" to the BHS. The BHS can spend more time exploring the crisis, its meaning, and the process by which the patient's individual strengths may allow crisis resolution. The process of building and working in a therapeutic relationship can reinvigorate the patient's commitment to his or her social network, an important step in resolving the crisis state.

**Determination of the Level of Care**

Not all patients can be safely managed in the office. Figure 26.3 demonstrates levels of care that may be available to a practice.

Patients may need to transition to other levels of care over time. Some patients may "step down" their care, as when graduating from intensive outpatient substance treatment to weekly therapy sessions or to community resources (e.g., Alcoholics Anonymous). Other patients may need a "step up" in care, as when hospitalization is required for acute suicidality.

All initial assessments of crisis states must address whether the patient is a danger to himself or herself, a danger to other persons, or so impaired as to be unable to maintain his or her essential activities of daily living (often called grave disability). Frank
suicidal or homicidal ideation is always of concern; it should be evaluated with input from a BHS and/or a psychiatrist and may result in the patient’s need for inpatient care. Risk assessment is discussed in detail in Chapter 18: Violence and Suicide. Other less dangerous considerations include concurrent psychiatric illness, the presence of psychosis or substance use, and past behaviors.  

For the patient requiring immediate transfer to a higher level of care, established protocols should exist for monitoring the patient while in the office and completing a warm handoff to the BHS or a care coordinator who might facilitate referral to a crisis center or emergency department. A phone call and sharing of records from the primary care office is vital so that emergency providers understand the patient’s full presentation as well as resources available to build a potential discharge plan. Some patients referred to a crisis center or emergency department will be admitted to inpatient treatment; others may be referred from the emergency department to an outpatient community mental health or substance treatment setting. In an integrated care environment, a care manager or other team member should follow up with the patient within one week after an emergency department visit to encourage re-engagement with the practice or connection to other recommended services.  

Referral to Specialty Care  
An initial formulation of the crisis may suggest that the precipitant is an exacerbation of a chronic or severe mental illness or relapse of a substance use disorder. In these cases, specialty treatment outside the integrated care office may be indicated.  

Patients with serious chronic mental illness and substantial social work needs may benefit from specialized care from a community mental health center, assertive community treatment team, or mobile crisis team, if available. These services offer intensive psychiatric case management, crisis resources, medications, and peer support. For these patients, primary care offices can provide ongoing medical care and health maintenance in coordination with a patient’s primary mental health provider or a care manager.  

Patients with moderate to severe substance use disorders may require intensive outpatient, residential, or inpatient detoxification services. Indications for these services include failure to achieve abstinence with less intensive treatment, high risk of complicated withdrawal, and significant social impairment (e.g., homelessness) that complicates efforts to achieve sobriety. Patients who need substance use treatment in the community should also be followed by the integrated care team within a medical home. The team should continue to review the patient’s progress in treatment, monitor medical complications of substance use and treatment, and reinforce adherence to his or her treatment plan.  

Treatment Within the Integrated Care Medical Home  
The medical appointment itself should not be forgotten as an opportunity for the primary care provider to deliver brief counseling. Compassionate listening and empathizing are powerful acts of healing. Crises evolve in a setting of poor social connectedness; clinicians provide a positive relationship in which to validate the patient’s distress, the complexity of a situation, and remind the patient of personal strengths. Providers can also make use of this healing relationship to deliver brief therapeutic techniques, for example, patients with significant anxiety may benefit from brief teaching of mindfulness meditation. Some patients with medical illness experience demoralization; the sensation of incompetence and hopelessness. Engaging these patients in a short discussion of the meaning of their illness, hopes for the future, sources of support, and likely treatment options may ameliorate demoralization.  

Motivational interviewing is another useful technique that can be applied during a medical appointment by a primary care provider (with ability, interest, and time) or a BHS. Motivational interviewing is a therapeutic method in which the clinician and patient explore the positive and negative aspects to behavioral change in a collaborative fashion (See Chapter 25: Health Coaching for Integrated Care). This method is particularly useful for patients who are ambivalent about reducing their problematic substance use or making healthy behavioral choices. Patients who are already actively working toward sobriety may benefit from a reminder of strategies for managing cravings, advice on avoiding triggers for use, and reinforcement of healthy decisions.  

Integrated BHSs will be able to briefly address many crises in the primary care setting, particularly for patients whose crisis results from a clear external stressor, who have mild or moderate substance use disorders, or who cannot access specialty care. The
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severity of illness that can be handled in a primary care setting depends on the comfort, skills, and capacity of the practitioners and the team within the care system. For instance, models exist for managing actively suicidal patients, borderline personality disorder, and serious chronic mental illness in outpatient therapy, but delivering these treatments may not be feasible for most primary care practices.

Crisis Intervention Therapy

After deciding that crisis therapy is indicated, the primary care provider may encourage and arrange for crisis intervention treatment. Many patients in crisis are seeking help and are hopeful that treatment will be beneficial. Yet some patients may be reluctant to pursue therapy, feeling it is unnecessary or unlikely to be helpful. The crisis state perturbs a person’s sense of self-worth and self-efficacy so that the idea of relying on others, or even admitting there is a problem, may be challenging. Patients may minimize their struggles or avoid stressors despite evidence of profound functional impairment. Other patients express an interest in therapy but feel overwhelmed at the idea of pursuing more care and more appointments.

There are several strategies for the primary care provider and BHS to help the patient begin treatment. Motivational interviewing by the primary care provider can help guide the patient’s decision to participate in therapy. Another helpful strategy is to facilitate a warm handoff to the BHS while in the office. As in-person introduction “breaks the ice,” humanizes the experience of therapy, and conveys the provider’s trust in the BHS. The BHS, in the presence of the primary care provider, also has an opportunity to solicit a personal commitment from the patient to begin crisis treatment. If a face-to-face introduction is not possible, the primary care provider can provide an overview of the therapeutic process and have the care coordinator schedule the first therapy appointment. If an appointment cannot be scheduled before the patient leaves, the care coordinator or the BHS should actively contact the patient to schedule treatment. Thus the collaboration among the integrated care team begins at the first visit and continues throughout crisis treatment.

After referral to the therapist, the primary care provider should also schedule a follow-up medical appointment in several weeks to ensure that the patient has begun therapy. A subsequent visit provides an opportunity for feedback from the patient on his or her initial therapy visits. This feedback may help anticipate hurdles to the patient’s therapy, including difficulties with adherence and motivation. Table 26.1 outlines the tasks that care team members perform throughout the process of crisis therapy; team members’ specific work will vary somewhat based on the provider’s expertise and among different care systems.

Having begun the crisis assessment during the first medical appointment, the primary care provider should share with the BHS an initial formulation of the crisis, including an understanding of the precipitant and its personal meaning to the patient. The provider shares a safety assessment and the status of medical issues and prognoses pertinent to the patient’s ongoing crisis. An objective understanding of the patient’s medical illness helps the therapist recognize a patient’s tendencies toward catastrophic thinking; for example, the therapist could help a patient who ruminates on “worst case” scenarios of an upcoming surgery. Also, nurses and other staff can offer encouragement and validate the patient’s decision to pursue therapy.

Therapy with a BHS

Therapy with a BHS begins with the therapist eliciting both the “Why now?” and a detailed developmental and social history relevant to the acute crisis. The history of prior crises and the resolution of those crises offer the therapist clues as to how the patient will successfully navigate the present episode. The process of gathering this history helps the patient and therapist build rapport that is essential for productive therapy.

Therapist’s Assessment of the Social System

As therapy begins, the therapist should evaluate the patient’s social support system. The BHS may use a social system map to visualize important relationships and sources of support in the patient’s life (Fig. 26.4).

A social system map identifies all the patient’s significant relationships, including family, friends, coworkers, medical providers, cultural and community supports. Patients’ appreciation of these relationships alleviates the sense of loneliness imposed by the crisis state while beginning to remove the self-imposed pressure of solving the problem on their own. For patients who have lost a key member of their support system, a therapist might consider how other persons in the social system can
fill the support needs left by a loss. The evaluation of the patient’s support network may reveal that the patient’s experience is inducing similar anxiety and tension among their supportive relationships. Perhaps in the past, the patient’s anxiety served to solicit help from their social environment."**

Consultation with Psychiatry
The BHS or primary care provider can consult with a psychiatrist either live or via telehealth (see Chapter 9: Telehealth in an Integrated Care Environment). Psychiatric consultation can be used for therapeutic advice, new recommendations for refractory patients, indications for additional medical workup, psychopharmacotherapy, or for a focused brief psychotherapy targeting symptoms or the crisis. Patients should be followed in a tracking registry. The consulting psychiatrist is positioned as a supportive and helpful team player, not exclusively as a supervisory figure.**

A psychiatrist may contribute to the initial formulation and safety assessment. For high-risk or particularly difficult cases, the psychiatrist may treat the patient directly or via telehealth. After several weeks, the psychiatrist should review the tracking registry of patients in crisis with members of the integrated team in order to assess their progress. A failure to make progress as anticipated or the discovery of new information may require reassessment of the diagnosis, case formulation, treatment offered, or a change in the level of care. Challenging cases may be highlighted in the registry for consultation. A population-based review may suggest the use of algorithms or standards of care for subpopulations of patients in crisis.

Development of Solutions by Patient and Therapist
Identifying the stressor, understanding the crisis, and assessing the patient’s social network allow the patient and therapist to define the problem and begin to seek solutions. Within the context of the patient’s life, the therapist can help the patient understand maladaptive coping, sources of impairment, and possible solutions to the crisis. Organizing this active behavioral approach can be done with a ‘wheel-and-spoke’ treatment plan shown in Figure 26.5.
Crisis Intervention in Integrated Care

1. Suicide and safety planning
   - History of suicidal ideation
   - a. Remove weapons from home
   - b. Develop a safety plan
   - c. Involve partner in the safety plan
   - d. Provide local crisis hot-line number

2. Interpersonal conflicts
   - Conflict with partner over spending
   - a. Help patient involve partner in developing a budget

3. Prior history
   - Financial and social crises after prior job losses
   - a. Reframe negative thought distortions stemming from past experiences
   - b. Focus on present through crisis

4. Interpersonal conflicts
   - Conflict with partner over financial stress
   - a. Involve partner in therapy session
   - b. Consider other sources of emotional support (crisis therapy, family member, clergy)

5. Precipitants of crisis
   - Threatened job loss
   - Possible solutions:
     - a. Clarify situation with employer
     - b. Review finances
     - c. Prepare résumé
     - d. Begin searching for new job

FIGURE 26.5 List the core problem in the wheel center, prioritize contributing problems by numbering them, and list possible solutions.

In the center of the wheel, the crisis, problem, or diagnosis is defined. If the crisis involves suicide or violence risk, then this issue becomes the center of the wheel and the focus of crisis treatment (see Chapter 18: Violence and Suicide). Otherwise, the focus of crisis treatment is typically a problem or diagnosis mutually decided between the patient and provider. The "spokes" describe problems contributing to the crisis, and these problems are prioritized by numbers. Under each problem are potential solutions.

The patient and BHS brainstorm solutions to contributing problems. Ideas for solutions often come from the patient's past experiences in resolving difficult situations. The BHS can review the patient's maladaptive coping styles and suggest more adaptive approaches described in Box 26.4.

The BHS provides feedback and steers the patient toward solutions that reflect the patient's positive psychological traits and values, reaction style, new coping strategies, use of the social network, and environmental supports. In constructing solutions, the therapist must be entirely focused on resolution of the acute crisis.

This process of defining the crisis as induced by a stressor, describing available social supports, and listing a menu of solutions pulls from many theories of psychotherapy. The act of empathizing and active listening are core tenets of all types of psychotherapy, while formulation of the personal meaning of a stressor based on a patient's prior experiences evokes a more psychodynamic approach. Primary care providers and office staff may use motivational interviewing to help reluctant patients engage in treatment. Family therapy is often used to resolve interpersonal or familial conflicts in the social network or develop systemic interventions. Crisis intervention's persistent emphasis on trying possible solutions employs solution-focused problem-solving therapy. Reminding patients of mindfulness and anxiolytic techniques like deep breathing are classic cognitive-behavioral interventions. Therapeutic strategies typically reflect the patient's needs and capabilities and the therapist's predilections, training, and assessments of the patient's responses.

Implementation of Solutions
With a formulation, new coping styles, and possible solutions in hand, the patient and therapist implement the different proposed solutions and proceed through crisis intervention treatment as described.
BOX 26.4
COPING STYLES

MALADAPTIVE COPING STYLES
Deceptive/Antisocial: using dishonesty, lying, cheating, or stealing to solve a crisis
Suicidal: using the threat of suicide, or suicide attempts, to coerce someone or to solve a problem
Violent: using violence (threatened or actual) to establish control and solve problems
Impulsive: unpredictable or impulsive responses without anticipating possible outcomes
Random/Chaotic: an unproductive and extreme form of trial and error, an impulsive style often seen in prolonged psychotic states

ADAPTIVE COPING STYLES
Intuitive: using imagination, feelings, and perceptions to solve a problem
Logical/Rational: carefully reasoned, logical, deductive style
Trial and Error: trying a random solution, modifying it if it fails, and trying again
Help seeking: asking others for help
Informational: gathering information before deciding
Wait and See: allowing time or circumstance to determine the outcome
Action oriented: taking an action to immediately rectify the problem
Contemplative: quietly thinking over the problem before taking action
Spiritual: asking for God's direction
Emotional: using emotion such as tears, anger, or fear to help solve problems
Controlling: controlling people or oneself to gain the power to solve the problem
Manipulative: using a variety of manipulative styles to solve the problem

in Box 26.3. This working stage is the most challenging part of crisis intervention therapy. Flexibility is important for the BHS as well as for the patient. Many patients in crisis have come to rely on a single coping strategy, which may be ineffective or maladaptive. The process of pursuing different coping strategies (Box 26.4) and solutions to the crisis embodies the self-efficacy that the patient has lost through the intense anxiety of a crisis. The therapist helps the patient understand why certain solutions are unsuccessful, celebrates with the patient the success of other solutions, and realistically appraises the patient’s progress toward crisis resolution. Any regression to maladaptive coping styles—for example, avoidance of a stressor or recurrent substance use—is interpreted as a contributor to the crisis. Adaptive, positive work is reinforced with praise and the experience of successful problem solving.

As therapy proceeds, the therapist may leverage the resources of the integrated care team to monitor and engage the patient (see Table 26.1). Nurses, office staff, and the care coordinator help track missed appointments and reach out to the patient to aid a return to treatment. These providers may also readminister anxiety, depression, or the QPD screeners and offer feedback on the patient’s progress to the BHS. For instance, the patient may seem less irritable in interactions with scheduling staff or make a small joke walking from the waiting room. The BHS should communicate an enhanced formulation to the primary care provider to ensure that the level of care is safe and appropriate and that all team members are aware of updated treatment plans. The psychiatrist may monitor therapeutic progress through the registry and is available for consultation.

Resolution of the Crisis and Anticipatory Guidance
In the final stages of crisis intervention therapy, the patient reflects on his or her positive choices, new coping styles, and functional improvement. The therapist helps the patient recognize how particular
BOX 26.5
RELEVANT EVIDENCE

Strength of recommendation taxonomy (SOR A, B, or C)
- Motivational interviewing should be used to encourage healthy behavioral choices, including reducing substance misuse. (SOR A) 37
- A member of the integrated health team should follow up with patients after an emergency department visit. (SOR B) 13,34,35
- Mindfulness meditation improves patient anxiety. (SOR B) 36
- Standard depression and substance use screeners should be administered in primary care. (SOR B) 37,44
- Crisis intervention therapy facilitates crisis resolution and improves patient functioning. (SOR C) 6,13,14,16,44
- A social network map and wheel-and-spoke diagram assist in evaluation and treatment of the patient in crisis. (SOR C) 20
- A "warm handoff" should be made by the primary provider to the behavioral health specialist. (SOR C) 14
- Integrated health systems should use patient registries to track patients' treatment and improvement. (SOR C) 15,16
- Intensive outpatient or residential substance abuse treatment is indicated for patients with a high risk of complicated withdrawal, significant social impairment, or failure to achieve abstinence with less intensive treatment. (SOR C) 33

Solutions have improved the crisis. Improvement may also be reflected in reduced anxiety and depression as measured by outcome scales. The consulting psychiatrist and primary provider advise as to the continuation of psychiatric medications that may have been initiated.

Before the termination of therapy, the BHS, reinforced by the primary care provider, offers anticipatory guidance regarding future crises. "Red flags" that herald a relapse into crisis should be explicitly identified and shared with the primary care provider and integrated care team, who will continue to follow the patient after therapy ends. A plan should be made for routine monitoring of crisis symptoms in the future. Monitoring may be as straightforward as a routine inquiry about a troubled relationship or more frequent administration of a PHQ-9 depression screener. Keeping the patient's social system map and wheel-and-spoke solutions diagram in the medical record provides a lasting reminder of the supports and solutions available to the patient.

CONCLUSION
Crisis therapists are fond of the Chinese character for crisis, which combines the symbols for "danger" and "opportunity." Integrated behavioral health teams offering crisis intervention treatment help many patients grow and optimize their potential. Close communication among primary care providers, BHSs, care coordinators, staff, and the consulting psychiatrist is essential to ensure that the patient receives a thorough assessment at the appropriate level of care, aid necessary to resolve the acute crisis, and support in preventing future crises. See Box 26.5 for a summary of some of the evidence-based approaches that are used as part of the crisis intervention approach.

REFERENCES