**Crisis**Take the necessary time to assist patients in crisis, as they often present unexpectedly.Reassure that you are available to help. Commend them for seeking help and validate their experience. Establish rapport and use active-listening skills.

**Overview**

a. Initial supportive assessment and safe environment, validate experiencefocus on rapport, open communicationb. Evaluate medical (nutrition, injury related pain) needs and then psychiatric care (suicide, homicide)c. History taking: detailed history of events and previous traumatic events. Screen for comorbid depression and anxietyd. Develop action plan: include emotional stability and personal feelings of control of situation, have list of resources (personal and community)

e. Follow-up to assess progress. Resources for support can include internal ones (e.g., exploration of effective coping mechanisms and constructive thinking patterns.)

**Preparation**

Prepare your practice environment for possible crisis or disaster and include colleagues and staff in the planning for both medical and non-medical crises.Establish office policies for managing agitated/dangerous patientsPrepare for common emergencies encountered in the office setting (e.g. in general, asthma, anaphylaxis, shock, seizures, and cardiac arrest).Purchase equipment / medications for anticipated emergenciesFamiliarize all staff with equipment and local protocols

When dealing with an unanticipated medical crisis (e.g., seizure, shoulder dystocia):Assess the environment for needed resources (people, material).Assign roles / delegateAnticipate equipment needs.

**Management**

Be calm and methodical.ABC’s, vitals, etc.Reassess frequentlyCommunicate your assessments and thought process to teamUse closed-loop communication when giving ordersAsk for the help you need.

Offer appropriate community resources (e.g., counselor) as part of your ongoing management of patients with a crisis.If mental and psychiatric statuses are not stable, this may include psychiatric referral, hospitalization, or involuntary commitment.

Enquire about unhealthy coping methods (e.g., drugs, alcohol, eating, gambling, violence, sloth) in your patients facing crisis.

Ask your patient if there are others needing help as a consequence of the crisis.

 Assess suicidality in patients facing crisis:See priority topic *Suicide*

Thought of death, degree of intention, lethality of methodsAvailability of means (firearms)Prep attempts, nature, and family hex of suicideResponse to crisis may be self-harming behaviors

Homicidality?

Legally mandated duty to warn if there is a clear risk to identifiable person(s) that could cause serious and imminent harm.

Suspected child abuse?

Statutory requirement to report to public authorities

Victim of abuse?

Encourage them to remove themselves (and others) from dangerous situations.

**Medications:**

Use psychoactive medication rationally to assist patients in crisis.

Provide rx for physical pain or for sleepTake into account previous medications and responses to medications in the past and comorbid illnesses

No evidence in acute setting 0-72hrsAssessment of duration of crisis (once, cumulative or ongoing)Goal of medication is to

1. Decrease symptoms of re-experiencing, avoidance/numbness or hyper-arousal

2. Help with comorbid illness

3. Reduce suicidal, impulsive and aggressive behaviorFirst Line: SSRI for 8-12 weeks, first week reduction in anger/irritability, 2-4wk for rx effect, fluoxetine has been studied, fluvoxamine may have better sleep related improvementsTCA- some studies of effectiveness of amitriptyline in male combat veteransBenzodiazepines-help with anxiety and sleep, addictive potentialBeta-blockers- propranolol acutely may reduce later symptoms of post-traumatic stress disorder

**Follow-up**Reassess status/safety, reinforce positive effortsImmediacy should fit clinical scenario (seriousness of crisis, reliability of patient).Higher level of care indicated if failure to improve with current treatment.

**Things to Avoid**

Take care not to cross boundaries when treating patients in crisis Exchanging gifts, services, and money may cause feelings of obligation or imply a dual relationship.Appointments outside of regular hours (especially unchaperoned) are associated with additional boundary violations and cases of misconduct.Excessive self-disclosure can strain rapport.Physical contact (e.g. hugs, kisses, arm stroking, etc.) can be misinterpreted and blur relationship boundaries.