"Family Medicine and Crisis intervention specialists - importance of their cooperation in the prevention of suicidal behavior"

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Summary:

Research title: Family medicine and crisis intervention specialists - importance of cooperation in the prevention of suicidal behavior.

The aim of this work is to analyze the family doctors and crisis intervention specialists cooperation characteristics and, additionally, the impact and the outcome on the patient that is undergoing a crisis and that is experiencing suicidal thoughts and/or ideas of containment.

The main objectives of the investigation are to:

1) analyze the patient's opinion of the family medicine physicians, evaluate the information they receive about the crisis intervention centers and to accelerate the problem-solving ability.

2) To evaluate the peculiarities of patients treatment in Crisis Intervention Centers

3) To identify further opportunities for cooperation between the crisis intervention centers and family doctors and the continuation of the crisis survival continuity of care;

Results: When statistically comparing both groups, we conclude that the control group has a shown, overall, better results.

The individuals belonging to the control group have a better outcome (lower risk for anxiety relapse and suicidal ideations) when compared to the research group, leading to a better the prognosis. This occurs because, when the cooperation between both specialties exists and is efficient, the patient crisis is detected in early stages and the treatment and management plan are traced promptly and accurately, leading to shortening of the crisis duration and lowering the probability of its relapse.
**Conflict of interest:** The author reports no conflicts of interest.
Abbreviations:

FP – Family physician
GP – General practitioner
CI – Crisis intervention
CIC – Crisis intervention center
WHO – World Health Organization
LUHS – Lithuanian University of health sciences
HCM – Health care ministry
HIM – High income countries
LMIC – Low and middle income countries
IASP – International association for suicide prevention
EU – European union
UN – United Nations
NGO – non governmental organizations
AAFP – American Academy of Family Physicians
SMH – State mental health
PH – Public Health
CFPC – College of family physicians of Canada
PHC – Primary health care
LR – Lithuanian republic
**Introduction:**

Everyone has psychological crisis and it can be solved completely with or without extreme measures: from humorous approach to it or it can result in suicide or attempt to end ones life.

Not all of us have a strong personality and an innate ability to look beyond a crisis moment or to try to handle it intuitively. Nowadays, in times where the society is overflowing with information and technology has evolved exponentialey, on the other hand, interpersonal relationships and communication is given less attention and importance, what leads to individuals in crisis to consider extreme ways for its resolution and desperate measures, as suicide.

Lithuania is a country that, for at least 2 decades, is among the leaders in the field of suicide, so our study has taken the initiative to analyze the outcome and benefits when there is a cooperation between the family doctors and the psychiatrists. For that matter, in Lithuania were opened 5 crisis intervention centers, which have, as main goal, the prevention of potential suicidal behaviour (however there was shown other medical specialties reluctance to cooperate with these centers).

Our researchers, have taken the initiative to actively promote the cooperation opportunities between both family medicine specialists and crisis intervention center psychiatrists. The advantages of this cooperation shall be granted and analyzes the opinion of patients who have agreed to participate.

It is believed that the cooperation between family doctors and crisis intervention psychiatrists could help significantly and result in a better and faster way to lower suicide incidence in patients in a crisis situation. It is also believed that it will speed up patient hospitalization, shorten the active treatment period and the continuation of a previously adequate treatment regimen once the patient returns to the Family Doctor, could become one of the prevention measures to reduce Lithuania Suicide numbers.
The study will be carried out using the questionnaire survey method followed by a statistical analysis of clinical data of random anonymous individuals which have agreed to participate in the study, are in need of psychological crisis management and have 18 years old or more.

The aim is to analyze the family doctors and crisis intervention specialists cooperation characteristics and their impact on the crisis in the patient experiencing suicidal thoughts and ideas of containment.

**Aim and Objectives:**

**Aim:** Analyze the Family doctors and Crisis intervention specialists cooperation characteristics and their impact on patient in crisis experiencing suicidal thoughts and ideas of containment.

**Objectives:**
1. Analyze the patient's opinion about the family medicine physicians, evaluate the information they receive about the crisis intervention centers and to accelerate the problem-solving ability.
2. To evaluate the peculiarities and characteristics of patients treatment in Crisis Intervention Centers
3. To identify further opportunities for cooperation between the crisis intervention centers and family doctors and to the continuation of the crisis survival continuity of care.
Literature review

Nowadays, crisis inducing events and crisis episodes are very common.

**Definition:** A crisis is the perception of a sudden event that arises from situational, developmental, biological, psychological, socio-cultural and/or spiritual factors and that is causing disturbance in the individual’s homeostasis mechanisms. This event is understood as an intolerable difficulty where, the usual coping mechanisms are not helping in the problem resolution. It can lead to major disorganization within the individual (1)

**Causes/ Types of crisis:**
This emotional upset occurs after we face particular stressors. Some of the possible causes are biological, psychological (the majority of patients, experiencing crisis, are very susceptible emotionally and have low self esteem or self worth values), crisis of anticipated life transitions, crisis resulting from traumatic stress, social crisis, economic causes (2)

There are some specific definitions that should be mentioned before starting to define “crisis”.
Because each individual is different, individuals that have big amount of stressors in their lives only remain in the state of stress and, in some way, manage to cope and/or adapt with them. As emphasized by Den Bergh (1,2), there are 3 possible outcomes for a crisis:

1. Stress: is understood as a cognitive, physiological, behavioral and emotional sensation where the external or internal factors are capable to shake off the individuals way to deal and overcome situations/events.

2. Coping: it is defined as the mechanism of each individual to overcome and defeat the sensations brought by stress. Some known coping mechanisms include: thinking about the problem in a different way, try to find the advantages and what could be learned from it, try to change ones behavior and, if needed, impose a change in routine.
There are 3 ways of coping:
- Biological
- Psychological: coping mechanism that is focusing on the problem itself or on the emotions triggered by it.
  The first one is normally adopted when the distressing situation is possible to change by behaving in a certain way. The second option, occur when the external situation cannot be changed so, the remaining option, is to change our own way to think according to it.
- Relational

3. Adaptation: Normally occurs once the individual has identified his/her suitable ways of dealing with the situation and the next step is to get used to the new situation.

**Characteristics of a crisis:**

There are some important characteristics that should be mentioned when talking about crisis. Nowadays, the whole definition of crisis is sometimes misunderstood – who is affected by it, what the person is feeling and how to manage it. When discussing about crisis, there are some things that should be cleared out:

1. Crisis are universal and idiosyncratic (3)
   This means that they occur to all the individuals at some point in their lives and is not always correlated with mental illness.
   It is considered as “universal” event and no one is immune to it.

2. Episodes of crisis are triggered by specific identifiable events leading to a unique personal response (4)

3. Crises are sudden and short lasting events. They are solved in a brief period (normally after 6-8 weeks). They do not turn out to become chronic although, if intervention is not promptly made, this situation can lead to the individual’s psychological growth or deterioration (3)

4. As stated by Brammer et. al (5), they are complex and hard to figure out.
5. Crisis obliges individuals to make choices and decisions (5). Either the patient decides to take action and try to overcome this situation or simply leave everything in a “stand by” mode and hope that it will fade soon.

Roberts (6) stated that crisis contain 5 components:
1. A hazardous or traumatic situation
2. A vulnerable or unbalanced state
3. A precipitating factor
4. Active crisis state based on person perception
5. Crisis resolution

Phases of a Crisis:
For a better understanding and intervention, it is important to analyze how crisis are developing and, since we are not immune to it and we all are permanently exposed to this stressors, identifying the development of a crisis, can lead to its better prevention.

The individual is exposed to a precipitating stressor. Considering that we are all different individuals there are 3 possible ways to deal with such events:

- **The growth pattern**, as stated by Dixon et. al (7), the person uses internal and external mechanisms, manages to cope, and develop strength/new skills on how to deal with similar problems in the future
- **Equilibrium pattern**: According to Frankl et. al (8) the person goes through this events, but even though he/she “survive”, the event leaves a causes a big impact in the person life and makes him/her remain scarred in some way
- **Frozen crisis**: Proposed by Lantz et. al (9), the person suffers a psychological breakdown. In situations like this, anxiety and tension build up and increase to such level, that major disorganization of the individual psychological state occur and high risk fatal outcomes appear. Some of the feeling/actions verified in this stage are withdrawal, suicidal ideations and violent behaviour towards others or oneself.
Prevention of a crisis:

Austin Community College (1) advocates that exist 3 types of crisis prevention, which should be discussed:

Primary Prevention: Avoids developing of illness
Secondary Prevention: important for early diagnosis and immediate treatment
Tertiary Prevention: responsible for making the patient achieve the highest level of wellness possible.

Goals of crisis intervention:

As Gladding et. al (10) mentioned, there are 6 goals of crisis intervention:
1. Support suffering individuals and their families.
2. Improve the communication and partnership with psychiatrist and family medicine doctor.
3. Prompt intervention and resolution of the crisis.
4. Promotion of physical and mental health. Crisis intervention focuses on the recognition of the signs of danger and consequent prevention of deterioration of individuals mental health and/or progression to suicidal idealizations
5. Offers the patients the possibility to adopt new ways of perceiving, coping and solving their current problem.
6. Encourage patient to vent out emotions and psychological distress

Management of a crisis: Crisis Intervention

Crisis intervention is understood as a type of to aid patients going through a crisis, and to accelerate its resolution and general improvement of the patients feelings.

This resolution is done using personal, social and environmental resources.

Unfortunately, not everyone is able and the most indicated to assess patients with crisis so, first of all we must indicate who can be an crisis counselor and which characteristics are required when helping a patient on crisis (10) :
1. The counselor should be mature, with an understandable and assertive personality.
2. Must be a person with a wide range of life experiences.
3. The counselor should have level of energy and basic helping skills.
4. Must be an individual with many quick mental resources.
5. The abilities of keeping him/herself calm in high stress environments and self-confidence are necessary
6. It is indispensable that the counselor focuses on present problem of the does not dwell his past traumas.
7. The counselor should have an adventurous attitude.
8. The counselor should be flexible and creative.
9. The ability for information management is necessary.

**The seven-stage CI model:**

This model is very important and well known when it comes to crisis intervention. It is very useful because it aids the clinician in intervening and assessing, in a effecting and fast way, what is the patient situation (6). A crisis intervention scheme makes the treatment plan and intervention more successful and easy.

This model is capable of:
- Assessing the problems and resources
- Defining the goals of treatment
- Finding alternative methods through which the patient can cope with his current situation
- Build clients strengths.

Doctors must act promptly to the challenges that their patients in crisis present. This fast action is indispensable because it can be the first time the patient goes through such crisis, so this feelings of despair are totally new to the patient or, in less fortunate cases, the individuals interpersonal conflict is unbearable and this might be his/her last attempt to try to change something.

Given that, clinicians have the duty to address the individual in a logical and orderly process.
This model, identified by Roberts et.al (6), is composed by 7 critical stages:

- Stage I: Psychosocial and lethality assessment
- Stage II: Rapidly establish rapport
- Stage III: Identify the major problems or crisis precipitants
- Stage IV: Deal with feelings and emotions
- Stage V: Generate and explore alternatives
- Stage VI: Implement an action plan
- Stage VII: Follow up and booster sessions

It is important for a counselor to understand what is the interpretation that the patient is giving to the crisis or how is he/she resuming his/her emotions.

There are some possibilities:

- The crisis is seen like a challenge
- Rapoport (11) stated that some people see it as a loss and punishment
- A gain, if the individual has this perception, it is a good prognostic factor (5)
- A reality

When a crisis can’t be prevented, or when the mechanisms during crisis intervention were not effective or safe, the patient risk for negative thoughts and ideas of containment increase, increasing also the possibility for suicide to occur.

**Suicide**

**Definition and epidemiology:**

As evidenced by Schwartz-Lifshitz (12), suicide is defined as the act that leads the individual to kill himself. This action is started and carried out by an individual, that is totally aware of the risks and fatal outcome.

When analyzing suicide at a global level, its concluded that the global rate is of 16 suicides per 100,000 inhabitants: 18 per 100,000 are males and 11 in 100,000 are females. (13)

In the majority of the countries, was proved that suicide predominate in white males and in young population, which now turned into major risk group. Also in people that
are socially isolated, not married and without religious involvement or affiliation was noted that suicide risk was increased (14).
It is proved that behind every suicide, are 50 suicide attempts.

**Risk factors/ risk groups:**

Schwartz-Lifshitz et al. (12) have appointed some of the factors or groups of people that more often commit suicide and this include:

- Aggressive, impulsive and hostile people: this features are seen more often among suicide attempters than non-attempters.
- Hopelessness
- Heredity (this behavior is believed to have strict genetical correlations)
- Childhood trauma (researches believe that childhood trauma is inversely proportional to first attempt for suicide)
- Suicide attempt in the past

**How to approach the suicidal patient**

Family physicians are normally the first ones to face patients with suicidal ideations so suicide prevention measures must start from them. It is proved that ½ of people that have committed suicide, saw the physician in the preceding month.

If the family physician has suspicion of high suicide risk, he must directly ask the patient about his suicidal thoughts.

According to Stovall et. al (14) direct questions are crucial for the family physician to picture the patients situation and to identify promptly, if the patient has intentions to commit suicide or not: Does he have a gun? Has the patient been hoarding pills? Ask about the mood, presence of anxiety, indication of substance abuse.

Carrigan et al (15, 16) suggested that, before managing every suicidal patient, he should be characterized according to risk level ( high, moderate, mild)
After risk stratification is performed, the appropriated management is chosen. First of all, priority should be given to establishment of safety. After so is done, some options are available:

1. High risk → hospitalization + access emergency psychiatric services
2. Moderate risk (no imminent) → pharmacotherapy and psychotherapy.
3. Mild risk → start treatment immediately

The family physician at the same time, although very important, can not take care of a patient with suicidal ideations alone. He requires a multidisciplinary team where a psychiatrist, family physician and psychotherapist are involved.

**Cooperation between family physicians and psychiatrists**

Characteristics of Primary Health Care:
1. Generality: The provider should have a competence/skills to be able to evaluate the problem. He should be able to identify how acute is the situation and what is the situation and what to do)
2. Accessibility: Primary health care and its representatives should be accessible and available to all the population. The unselected health care problems are managed regardless certain categories of the population: gender, age, social class, ethnicity, religion, it must be accepted.
3. Integration: The PHC includes all the curative, rehabilitation and health promotion.
4. Continuity: The family physician is responsible for providing continuity in patients disease. He is responsible for:
   - Foreseeing future consultation
   - Choose the adequate diagnostic methods
   - Prescription of medications
   - Goal planning and making sure that they are achieved
   - Prevention of disease progression or further relapses or development of another diseases
5. Team approach: Family physicians should not work alone. They should be ready to work with other medical, health and social care providers (multidisciplinary team) that contains a nurse, occupational therapist,
psychologist and psychiatrists. Family physicians are responsible for delegating them the care of their patients, contribute to and participate in the MD care and must be prepared to exercise leadership of the team.

6. Hollistic approach: The individual health problems should be evaluated from the physical, psychological and social approach.

7. Personal: includes consultation reason and trying to find out patient expectations (are they real or unreasonable?)

8. Family oriented: it is important to educate family mainly when the patient needs support, regular check ups.

9. Community oriented: the community should be oriented in order to prevent and promote health promotion.

10. Coordination: Family physicians are the main representations of the patient. It is important to advice, reconsider the situation, ask for 2nd opinion and to encourage the patient. They should ensure appropriate and timely referral of the patient to specialist services.

11. Confidentiality

Unfortunately, the relationship between the primary health care physicians and the psychiatrists is commonly based on poor communication, inappropriate personal contact and not very based on respect.

Nowadays, for an adequate assessment, treatment and prevention of crisis in patients, both specialties understood the urge to come close and reach a level on understanding.

As noticed by Herman et. al (18, 19), family doctors are normally the first ones to consult patients with crisis and due to that, they have a big importance in patient’s evaluation and treatment.

Although, mental health care from FP is not always done because:

- requires a significant amount of time in his working day.
- end up in FP frustration due to the lack of from psychiatrists and the inability to access psychiatric resources.

This leads to a worrisome lack of collaboration between both groups.
Because the collaboration between FP and psychiatrists is so important, many ways have been suggested to improve. The McMaster approach, as suggested by Kates et. al, is the most common and used nowadays. Its main goals are to increase the comfort and expertise of family physicians when it comes to dealing with problems, involving the psychiatrists actively in their patient's care after a referral, and offering relevant services that supplement those of the family physician, while monitoring and correcting problems that can arise when the two specialties work together.

Family physicians mentioned that they received little information from psychiatric teams. FP were asked how could they improve the collaboration “what could be done to improve the relationship with psychiatrists?”

It is concluded that there are 3 mains ways to improve the collaboration between specialists:

1. Communication improvement
2. Continuous medical education (CME) in psychiatric topics for FP
3. Access to consulting psychiatrists.

1. It is agreed by both specialties that communication in written terms is the favorite. It would be better if the FP would request relevant elements of patients clinical history including
   - Diagnostic impression
   - Therapeutic approaches that were done until now
   - Physical health problems
   - Previous psychiatric contacts
   - Goal of consultation

   and psychiatrists should focus mainly in diagnosis and therapeutic plan.

   Telephone communication is another option and is indicated in case of a quick exchange of information. It is preferred between FP and psychiatrists who are coworkers. Should be performed when both have time to talk.
2. It should include reviews from FP on what it is necessary for them to learn in order to improve the quality of their work with psychiatrics. Also, brief sharing of information with the psychiatrist on the telephone could aid doing so.

   The CME activities comprise:
   - Regular meetings to discuss cases and review relevant educational materials
   - Lunch or dinner lecture
   - Workshops

The collaboration between FP and psychiatrists, should receive appropriate administrative and financial support.

3. The psychiatrists showed interest in collaborating with FP. Their main concern was not having too much time and inappropriate remuneration.

On the other hand, FP showed satisfaction when psychiatrists where visiting the PHC services and one conclusion was achieved: it would be very helpful if one psychiatrist would be connected to one or many FP and would take presence in the facility 1 time a week.
Research methodology and methods

Research planning (organization): The research was carried in VSI Respublikine Kauno Ligonine Crisis Intervention centre, performing interviews and communicating with the patients during the period of time from November 2015 until till December 2016. The research permit was issued by LUHS biomedical and ethics committee (No.BEC-MF-470)
The goals of study, confidentiality and anonymity were explained to the research respondents. The study sample was based on 270 patients where 59, 26% were females and 40,74 % males. The age varies from 18 until 58 years old. Results were collected using a questionnaire. The test consisted in about 32 questions to the patients. This questions were focused on the patient data and evaluation of the inquires psychological status. The main goal is, to analyse the family doctor and crisis intervention specialists’ cooperation characteristics, and their impact in the prevention of suicide and evolution of patients’ crisis.

Object of study: Patients from VŠĮ Kaunas Psychiatry Hospital Crisis Intervention Centre of Aleksotas that are in crisis and/or have expressed suicidal thoughts/ ideas.

Participant selection: The patients that will fill the anonymous questionnaires should meet a certain number of characteristics that will be described below.

- 18 years of age and older
- Consent to participate in the study.
-Need for psychological crisis management and voiced suicidal thoughts or actions
- Consent to check hospital information after 6 months (if the patient was admitted to the hospital during this period, the nature of psychiatric hospital) through e-health database.
Method and methods of data analysis:

The selection will be carried out in a random (randomized) method.

A study will be carried out using the questionnaire survey method and further statistical analysis of clinical data;

The survey form is anonymous.

Subjects confidentiality is ensure and such study translates no additional risks or harm for patients physical or psychological health.

Results and Discussion of Results:

After doing the analysis of the previous results, we can distinguish two groups in this study: the “Control group” and the “Research group”.

The “Control group” includes all the patients that took less than 7 days since the development of the crisis, to visit the Family practitioner and being redirected to the CIC. The second group, comprises the people that took more than 7 days from the development of the crisis until the family doctor consulted them and finally went to the Crisis Intervention Centre.

In the following table, we will evaluate the sociodemographic aspects of control and research group.
<table>
<thead>
<tr>
<th></th>
<th>Control group &lt; 7 d</th>
<th>Research group &gt; 7d</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>67</td>
<td>93</td>
<td>59,26%</td>
</tr>
<tr>
<td>Men</td>
<td>34</td>
<td>76</td>
<td>40,74%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>47,2 +/- 7</td>
<td>45,2 +/- 12</td>
<td></td>
</tr>
<tr>
<td><strong>Place of living</strong></td>
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<tr>
<td>City</td>
<td>80</td>
<td>60</td>
<td>51,85%</td>
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<tr>
<td>Rural areas</td>
<td>21</td>
<td>109</td>
<td>48,15%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
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<tr>
<td>- Married</td>
<td>48</td>
<td>45</td>
<td>34,4%</td>
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<tr>
<td>Single</td>
<td>59</td>
<td>118</td>
<td>65,6%</td>
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<tr>
<td><strong>Working status</strong></td>
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<tr>
<td>- Employed</td>
<td>90</td>
<td>80</td>
<td>63%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>11</td>
<td>89</td>
<td>37%</td>
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<tr>
<td>&gt; 12th grade</td>
<td>97</td>
<td>60</td>
<td>58,15%</td>
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<tr>
<td>&lt; 12th grade</td>
<td>4</td>
<td>109</td>
<td>41,85%</td>
</tr>
</tbody>
</table>
Evaluating the previous data, we can conclude that:

When focusing on the sex of the evaluated patients, we observe that bigger percentage of female population was investigated when compared to males. Also, can be noticed that, when compared to male population, woman more often had a tendency to seek for help and to be referred to CIC in a period of less than 1 week.

In terms of population age, is noted that, the control group is slightly older than the research group.

The majority of interviewed patients are living in the city (51.85%) and this majority is also the one that searched for help faster when compared to inhabitants of rural areas. This is believed to be so because the people living in urban areas have an increased facility and access to health care services, transportation methods and all sorts of information (internet access, TV), which leads them to prompt awareness and concern about their health, with consequent help search.

Examining the marital status of the interview patients, we conclude that, the index of single individuals is higher than the married ones (65.6%). After careful analysis of the table, is noted that singles took in average, more than a week since the beginning of their crisis, to search for help when compared to married people. Married people, are less likely to feel alone and /or have the possibility to “vent” with a trustworthy partner and, at the same time those partners notice changes in behaviour quite early. All this factors, increase the awareness of the patient and his will to solve the crisis they are going through.

Lithuanian unemployed population statistically accounts for fewer amounts of individuals than the employed ones. Analysing the table, the employed individuals more often searched for help and reached the CIC within one week. It can be interpreted by the fact that, even though, the employed sector is less likely to feel depressed, when situations of crisis occur, the latter acts more promptly due to the high impact it will have on their professional, personal and social life.
Education was also evaluated as an important parameter. As it can be noticed, the rate of high school education within our participants was 58.15% and this were also the ones that visited the GP in less than 7 days. Educated individuals are more often concerned about their health status and more aware of small alterations, due to their easy access to health information nowadays.

Depression, anxiety and suicidal ideations, were measured from the case reports, separately. In the patients’ questionnaire, there was a section where it was required that they measure their level of crisis, in a scale from 0-10 at admission, at the beginning of the treatment and at discharge. Was observed that the patients that seeked for help of the GP in less than 7 days and were, later on, redirected to the CIC, had a small percentage of anxiety and depression at admission (4.6) during treatment and at discharge (2.26), when compared with the remaining group that for various reasons, met the GP more than a week later of the symptoms onset and was observed that the level of crisis was bigger at admission (6.20) and at discharge (5.92).
Comparison of crisis level between both groups:

When statistically comparing both groups, we conclude that the control group has shown, overall, better results.

The individuals belonging to the control group have a better outcome (reduced risk for anxiety relapse and suicidal ideations) when compared to the research group, leading to a better the prognosis. This occurs because, when the cooperation between both specialties exists and is efficient, the patient crisis is detected in early stages and the treatment and management plan are traced promptly and accurately, leading to
shortening of the crisis duration and lowering the probability of its relapse. At the same time, within the research group, some common data was verified: there was an increased level of depression, anxiety at admission and at time of discharge, longer hospital stay and overall crisis level.

Woman and men show the same suicidal ideation but it is proven that, more often, males attempted suicide, which in general, leads to a higher percentage of male mortality.

Also, in the questionnaire, were included 3 questions. The patient opinion, regarding this questions, is illustrated below:

**1. Did you participate in particular classes in CIC in how to overcome the crisis?**
2. Is the continuation of the treatment, started in CIC, necessary by GP?

3. Is the communication between CIC' and GP necessary?
Recommendations:

1. GP should be more involved in CI treatment options
2. General Practitioners should also have a basic psychiatric knowledge: by the mandatory presence in conferences or small courses organized regularly.
3. Telephone numbers and addresses of Crisis Intervention Centers must be well spread and known by GP’s.
4. CIC could adopt measures and promote them by providing more information

Conclusions:

1) After our study, we can conclude that there is a tendency for the patients to delay their visit to the doctor. The majority doesn’t have a very detailed knowledge in how the FP can help them and about CIC existence and their functioning.

2) Consist in institutions, formed by multi-disciplinary team of specialists (psychiatrists, nurses, occupational therapist, social workers, psychologists), that constantly follow up the patients by often communication and daily evaluation of their emotions and behaviour. In the CIC of Aleksotas, where the research was carried out, there are areas where the patient can express him/herself by means of art (by painting or drawing) and by means of music. Common rooms, are also present, and allow communication and integration with other patients. Areas where the patient can relax and watch TV or enjoy the nature are another free time option.

3) The cooperation between General Practitioners and Psychiatrists in crisis management, is essential, and the better it is, the better will be the patient’s prognosis. All measures should be done in order to improve this relationship and are recommended: mandatory presence of GP in conferences or small courses organized regularly by psychiatrists were most common red flags and main management
methods are shared. CIC could also adopt measures and promote themselves by providing more information via panflets, internet and other communication methods.

Despite the findings, more research data is necessary to get more exhaustive information concerning communication between GP and Psychiatrists.
Ethics Committee Clearance:

Title: "Family Medicine and crisis intervention specialists - importance of cooperation in the prevention of suicidal behaviour."

Number: BEC-MF-470

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