CRISIS PREVENTION AND INTERVENTION PLAN TRAINING

REQUIRED CORE ELEMENTS	
1. WHAT is a crisis plan?	A crisis plan is a document designed to: > provide all the information necessary to help prevent a crisis from occurring, > provide information to guide an effective response when a crisis does occur, and > make a plan for successful crisis resolution.
2. WHO should receive a Comprehensive Prevention & Intervention Crisis Plan?	1. The Comprehensive Crisis Prevention & Intervention Plan is designed to be one section of a Person-Centered Plan that can also be easily extracted as a stand-alone document for the purpose of easy distribution. **ALL Person Centered Plans MUST include the Comprehensive Crisis Plan.** 2. In addition, the Comprehensive Crisis Prevention & Intervention Plan is **RECOMMENDED** for all consumers who are at significant risk of crisis events - including those in basic benefit services. This would include persons who have, within the past year, been psychiatrically hospitalized or received inpatient treatment for a substance use disorder, who have been arrested, attempted suicide, or used crisis services (i.e., mobile crisis team, facility-based crisis or non-hospital detox unit, walk-in crisis, NC START, or use of a hospital's emergency department for reasons related to psychiatric illness or substance use).
3. WHICH provider working with a consumer should lead the process of developing the Comprehensive Crisis Plan?	The Comprehensive Crisis Plan should be developed by the primary clinician or provider who completes the Person Centered Plan (PCP), in collaboration with the consumer, and perhaps with input from others who know the consumer well. Developing a comprehensive crisis plan requires a good working relationship with the consumer, and the in-depth knowledge of the consumer that a primary provider would have. Please note that general characteristics / preferences section of the crisis plan should not reflect only the views of the consumer or only the opinion of the clinician, but should be completed in a truly collaborative fashion, reflecting both the preferences of the consumer ***and*** the best clinical judgment and expertise of the clinician. **NOTES:** > Although mobile crisis teams are responsible for developing abbreviated one-page crisis plans, or "hot sheets," mobile crisis teams should not be charged with developing comprehensive crisis plans with consumers, unless the mobile crisis team is the typical and most constant provider of service for the consumer. > Likewise, professionals in FBCs, inpatient psychiatric hospitals or emergency rooms should not have responsibility for developing comprehensive crisis plans.
4. WHEN should the Comprehensive Crisis Plan be constructed?	Constructing a Comprehensive Crisis Plan requires careful thought and knowledge of the person for whom it is being developed. The Comprehensive Crisis Plan should not be developed when the consumer is in the midst of a crisis, as thoughtful planning is often difficult to accomplish at such times. Although it does not need to be developed at the initial intake meeting with the consumer, it should be completed early in the treatment process, and if possible, within a month of intake. The Comprehensive Crisis Plan should be updated on the same schedule as the PCP, AND/OR shortly after any crisis episode occurs, AND/OR anytime there is a significant change in the course of treatment -- including medication changes.
5. WHY are crisis plans important?	Effective crisis plans help to: > Avert danger to the consumer or other's health and well-being. > Prevent setbacks to an individual's recovery that results from the aftermath of a crisis, such as: o loss of confidence and self-esteem. o loss of a job.

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	o loss of housing or placement. o stress and burn out of family or care givers. o damage to health of self or others. o neurological damage resulting from repeated psychotic episodes or mental health crises. > Reduce the need for expensive resources, such as emergency room treatment or psychiatric hospitalization, thereby saving costs.
6. WHO should have access to an individual's Crisis Prevention and Intervention Plan?	With the individual and/or guardian's permission, the crisis plan should be uploaded to a computer and a paper or electronic copy made available to anyone likely to support the individual during a crisis episode: > Individual for whom the plan was developed. > Service Providers, including, but not limited to: Peer Support Specialists, First Responders, Mobile Crisis Teams, NC Start, etc. > LME-MCO Care Coordinators. > Emergency room personnel and the individual's physicians. > Legal Guardian(s)/Family. > Residential providers. > Law Enforcement. > Others as needed. * *For individuals with a substance abuse diagnosis, the consent must meet the requirements set forth in 42 CFR Part II (Subpart C § 2.31).*
7. ESSENTIAL VALUES AND PRINCIPLES in developing an effective crisis plan and responding to a crisis event.	The specific elements of a good crisis plan are contained in the attached Crisis Prevention and Intervention Plan template (as developed by a group of stakeholders including individuals with service needs, LME-MCO representatives, Provider Organizations, the NC Hospital Association, DSOHF, DMH/DD/SAS, and various others). In addition Essential Values include, but are not limited to, the following: (Reference: www.SAMHSA.gov) > Intervening in Person-Centered Ways - Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated in the crisis response. > Shared Responsibility - An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in, rather than a passive recipient of services. > Addressing Trauma - It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. There is also a dual responsibility relating to the individual's relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making this crucial information available. > Establishing Feelings of Personal Safety - Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (this should be included in the crisis plan) and what interventions increase feelings of vulnerability (ie. confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual's needs and latitude to address these needs creatively. > Based on Strengths - An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.

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	> The Whole Person – The individual may have multiple needs (ie. Behavioral and/or medical) and an adequate understanding of the crisis means not being limited by services that are compartmentalized according to healthcare specialty. > The Person as Credible Source – It is important for Responders to view the individual in crisis as a credible source of information—factual or emotional, rather than to be dismissive. It is important to understand the person's strengths and needs. Guiding Principles include, but are not limited to: (Reference: www.SAMHSA.gov) > Access to supports and services is timely. > Services are provided in the least restrictive manner. > Peer support is available. > Adequate time is spent with the individual in crisis. > Plans are strengths-based. > Emergency interventions consider the context of the individual's overall plan of services. > Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene with the problems being presented. > Individuals in a self-defined crisis are not turned away. > Interveners have a comprehensive understanding of the crisis. > Helping the individual to regain a sense of control is a priority. > Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served. > Rights are respected. > Services are trauma-informed. > Recurring crises signal problems in assessment or care. > Meaningful measures are taken to reduce the likelihood of future emergencies.
8. STEPS to writing a crisis plan.	Writing a good crisis plan is a step-by-step process. Those specific steps are delineated below. **However, it is most essential that the crisis plan be constructed with the individual. The process must be a joint responsibility, and never carried out in the individual's absence or without his or her input.** The specific steps for developing a crisis plan are as follows: **(Step 1).** Write the Date of the Initial Crisis Plan or the Date of the last Revision. (Page 1 of the Plan) **(Step 2).** Write Basic Essential Information about the Individual, including: (Page 1 of the Plan) > Identify the person needing a crisis plan. > Date of Birth. > Address and phone number. > LME-MCO information. > Living situation. > Employment information/assistance. > Communication barriers, language, preferences. > Legally Responsible Person information. > Insurance information. > Diagnoses > Medications (including dosages, frequency, reason for change, date of prescription, the prescriber, and the pharmacy). > Medical problems and allergies, if any. **(Step 3).** Identify the Supports for the Individual. (Page 2 of the Plan)

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	> List the individuals that should be called in the event of a crisis, indicate the calling order, provide contact information, and indicate if a consent to release information to that person exists. **(Step 4).** Crisis Follow Up Planning. (Page 2 of the Plan) > Include which team member is the primary contact to coordinate care. > Indicate who will be visiting the individual in the hospital (this should be the person's preference). > Indicate who will organize and lead a review/debriefing following the **(Step 5).** Identify Additional Planning Documents. (Page 2 of the Plan) > If it is indicated that the individual has any of the planning documents, attach the document(s) to the crisis plan.
	(Step 6). Identify the General Characteristics/Preferences to include: (Page 3 of the Plan) **A description of what the individual is like when feeling well.** o Ask the individual what a good day looks like for him/her and provide examples of how he/she feels when they have a sense of overall wellness and wellbeing. o Describe how they interact, appear and behave when doing well. **A description of situations and/or events that may be crisis triggers for the individual.** Make certain to include the person's perceptions of what causes him or her to be in crisis. (Examples may include): o Noise. o Change in routine. o Alcohol and/or drug abuse. o Non-compliance with medications or inability to express medical problems. o Family / marital conflict. o Particular environmental stresses such as noise, isolation. **A description of the person's observable behavioral changes when s/he is entering a crisis episode**, such as: o Not keeping appointments. o Change in hygiene/self-care. o Loud or rapid speech. **A description of crisis prevention and early intervention strategies** that have been effective. (NOTE: Describe ways that others can help the individual and what he/she can do to help him/herself.) o Focus on preventing the targeted behaviors. o Focus on the least restrictive measures. o Match the strategy to the behavior. o Consider what occurs just before, during, and after crises. o Be specific about relapse prevention strategy. **A description of strategies for crisis response and stabilization.** (NOTE: Describe ways that others can help the individual and what he/she can do to help him/herself.) o Describe how staff should interact with the individual when entering a crisis. For example: listening to music, going for a walk, having a conversation, not having a conversation, peer counseling, being touched, not being touched, etc. o Match the response to the level of behavior. o Focus on the least restrictive measures. o Make certain the strategy reflects the person's preference for intervention. o Include who should be notified of the crisis (guardians, family, etc).

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	o Consider the array of available responses (ie. Back-up support, crisis respite, etc.) o Be sure to consider alternatives to hospitalization. o Consider and include (if appropriate) provision of support while inpatient, and coordination strategies with the inpatient team. o Include development of discharge plans. Plan this ahead, if possible. o Describe preferred and non-preferred treatment facilities. o Describe preferred and non-preferred medications.
9. Final questions to ask about your crisis plans.	> Is there sufficient direction or guidance to be truly helpful to the person in a crisis? > Is the crisis plan truly an individualized plan that reflects the specific needs, preferences, strengths and challenges of that particular person? Probably the biggest temptation in developing crisis plans is to cut corners and develop “cookie cutter” plans that are generic and non-specific. To be useful, a crisis plan needs to fit the individual and his or her situation. > Is the crisis plan up-to-date? People move, medications change, living situations and providers also change over time. Crisis plans need to be updated frequently so the information they contain remains relevant and useful.

CRISIS PREVENTION AND INTERVENTION PLAN

Date of Initial Crisis Plan (mm/dd/yyyy):	Date of Last Revision (mm/dd/yyyy):	Medicaid ID #:	Record #:
Name:		Date of Birth (mm/dd/yyyy):	
Address:		Telephone Number:	
Clinical Home/First Responder:	Emergency Phone #:	Alternate Phone #:	
LME-MCO:	LME-MCO Phone #:	County:	

Living Situation

Living Situation (Stable, Unstable):	If "Unstable" Describe:

In a crisis, assistance will be needed in the following areas (if not applicable, leave blank)

Children (if yes, indicate ages):	Pets (Yes/Blank):	Transportation (Yes/Blank):	Other (Describe the type of assistance needed):

Explain what help will be needed:

Employment (In a crisis, assistance will be needed to contact my employer)

Assistance will be needed (Yes/No):	Contact Name:	Contact Phone #:

Please inform them:

Communication	Preferred Language	
Method (Verbal, Nonverbal, Picture System, Gestures, Sound/Gestures, Other Device):	Preferred Language (English, Spanish, Sign Language, Other):	If "Other", specify:

Legally Responsible Person

Guardian Appointed (Yes/No):	Legally Responsible Person Name:	Contact Phone #:

Insurance

Type of Insurance:	Name of Company or Payer (If Type is Private or Other):	Policy Number/Member ID:

Diagnoses

DSM Code:	Diagnosis:	Diagnosis Date (mm/dd/yyyy):

Current Medications (Update/revise anytime there is a change)

Medication Name:	Dose:	Frequency:	Reason for Change:	Date:	Prescribing MD:	Pharmacy:

Allergies (Medication(s) and reaction - Update/revise anytime there is a change)

Poorly Tolerated Medications (Medication(s) and reaction - Update/revise anytime there is a change)

Medical/Dental Concerns

Name:	Date of Birth:	Medicaid ID #:	Record #:
(*Note: The fields above should auto-fill with data you entered on Page 1. If they do not auto-fill, please enter by hand.*)			

Supports For The Individual

Notification

List the individuals that should be called in the event of a crisis, indicate the calling order, provide contact information, and indicate if a consent to release information to that person exists.

Calling Order	Who	Agency	Name	Address	Phone #	Is there a valid consent to release (Yes/No)?
	Guardian/ Legally Responsible Person					
	Family Contact 1					
	Family Contact 2					
	Family Contact 3					
	Service Provider					
	Residential Program					
	Care Coordinator					
	Primary Therapist					
	Primary Care Physician					
	Psychiatrist					
	Other Physician					
	Peer Support Specialist					
	Other Support					
	Other Support					

Crisis Follow Up Planning

(Include contact number(s) if not provided above)

	Name	Contact #	Contact #
Who is the primary contact to coordinate care if the individual requires inpatient or other specialized care?			
Who will visit the individual while hospitalized? (This information should come from the individual and reflect the individual's preference)			

	Name	Timeframe
Who will lead a review/debriefing following a crisis? Within what timeframe?		

Additional Planning Documents

(Indicate if the individual has any of the following documents. If "Yes", attach the document to the Crisis Plan)

	Yes/No	Notes
Individual Behavior Plan		
Suicide Prevention and Intervention Plan		
WRAP Plan		
Futures Plan (youth in transition/young adult)		
Psychiatric Advance Directive (PAD). A PAD is a legal document allowing a consumer to direct his or her psychiatric treatment in the event that he or she becomes unable to make or communicate decisions about that treatment. To find out more information about PADs in North Carolina, go to http://www.nrc-pad.org/states/north-carolina-resources.		
Other Advance Directive or Living Will		

Name:	Date of Birth:	Medicaid ID #:	Record #:

(***Note: The fields above should auto-fill with data you entered on Page 1. If they do not auto-fill, please enter by hand.***)

General Characteristics/Preferences - as described in the individual's own words

What am I like when I am feeling well? Describe what a good day looks like for this person. Provide examples of how s/he interacts, behaves, appears and feels when s/he has an overall sense of wellness and wellbeing.

What are some events or situations that have caused me trouble in the past ? Outline significant events that may create or increase stress and trigger the onset of a crisis. (Examples include: anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, out of medication, being isolated, etc.)

What are the early warning signs that I am not doing well? What will others notice about my behavior, speech, and actions when I am not doing well? Describe what others observe when s/he is entering a crisis episode. Include lessons learned from previous crisis events. (Examples include: not keeping appointments, isolating himself, loud or hyper-verbal speech, not sleeping well, eating too much, etc.)

How can others help me and what can I do to help myself to address a crisis early on? Who is best able to assist me? Describe prevention and intervention strategies that have been effective in reducing stress, problem solving, and keeping the person from needing higher levels of care such as a trip to an emergency department or crisis center or inpatient hospitalization. (Examples include: breathing exercises, journaling, taking a walk, listening to music, calling a friend or family member or provider, etc.)

If I am in crisis, what are ways that others can help me and how can I help myself? What stra tegies do not work well for me? List everything that has worked well for the person in the past. Focus first on the least restrictive steps including natural and community supports. Describe how crisis staff should interact with the person in crisis. Describe preferred and non-preferred medications, treatment facilities, and options for respite. Include the person's preferred process for obtaining back-up in case of emergency. (Examples include: I like music, I like to go for a walk, I like to be talked to, call my sponsor, remind me of my PRN meds, I don't like to be talked to, I don't like to be touched, I prefer ABC hospital over XYZ hospital, etc.)