Effective Crisis Planning with Families

Sponsored by MBHP in collaboration with the MassHealth Managed Care Entities

Speaker: Kappy Madenwald, MSW

April 11, 2011: Holiday Inn, Marlboro MA
April 13, 2011: Holiday Inn, Woburn MA
Goals for Today

• Use of the new Crisis Planning Tools
  – Safety Plan
  – Advance Communication to Treatment Provider
  – Crisis Planning Supplements

• Guiding children, families and young adults in the development of effective Safety Plans

• Developing Safety Plans that promote REAL risk reduction

• Developing “Crisis Systems of Care”

• Understanding your role in the “Community Crisis Continuum”
Vision for Crisis Planning Tools

• Address feedback and suggestions from families and providers related to
  – Language
  – Flexibility of use
  – Purpose

• Improve alignment with Wraparound Principles of Care

• Emphasize plan “usability” and “authenticity”

• Expand array of “Crisis Planning Tools”
Crisis Planning Tools

- The Crisis Planning Tools consist of three primary components for use by children, families, and young adults.
- There is nothing hierarchical about the tools.
- They can be used separately or in some combination that is useful to the person/family.
COMPONENT I: SAFETY PLAN
COMPONENT I: SAFETY PLAN

• Quick Summary:
  – This is an *in-community, in-the-moment* tool used by children, young adults, or parents to reduce or manage worsening symptoms, promote wanted behaviors, prevent or reduce the risk of harm or to diffuse dangerous situations.
  – The specifics of the Safety Plan MUST be meaningful to and actionable by the person/family.
COMPONENT I: SAFETY PLAN

– As the family chooses, the Safety Plan can be filed with the ESP/MCI team or others who might provide crisis support or intervention in the future.

– Sharing the plan promotes the "future" providers' awareness of and ability to support the strategies being used by the person/family.
COMPONENT I: SAFETY PLAN

• Description:
  – The Safety Plan template is two-sided.
  – One side has a simple structure that captures Contacts and Resources, the Goal of the Safety Plan, and Actions.
  – The other side is an open format.
  – The child, parent(s)/guardian(s), or young adult builds the plan on the side that suits them best.
COMPONENT I: SAFETY PLAN

• When to use it:
  – Any time the family does not have an existing Safety Plan
  – For many persons/families the Safety Plan will often be the only Crisis Planning Tool that is used…
    • those experiencing a "first" or infrequent crisis episode
    • Those who are addressing behaviors in the home that are unlikely to rise to the level of emergency services
COMPONENT I: SAFETY PLAN

– For families working with a CSA, IHT, or other CBHI service, this one-page form can be used to develop the initial Safety Plan.

– As treatment unfolds and the family develops a more comprehensive plan, it can replace this initial plan.
SAFETY PLAN: What it is NOT

• It is not a risk assessment tool—but it is informed by risk assessment
• It is not a care-planning tool—but its purpose may align with some parts of the care plan
• It is not a "contract for safety"—though harm prevention/reduction is a very high priority
SAFETY PLAN: What it is **NOT**

- It is not developed for the benefit of the provider—though the provider’s awareness of and ability to support the family 24/7 in plan implementation is clearly a benefit
- It is not “one size fits all”—100 families, 100 unique plans
COMPONENT II: ADVANCE COMMUNICATION TO TREATMENT PROVIDER
(ADVANCE COMMUNICATION)

<table>
<thead>
<tr>
<th>What I experience when I am in crisis</th>
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<tbody>
<tr>
<td>My priorities in a crisis</td>
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<tr>
<td>What helps me in a crisis</td>
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<tr>
<td>Treatment I prefer (specific programs, medications, types of intervention, alternatives to hospitalization, involvement of friends and family)</td>
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<tr>
<td>Treatment I prefer NOT to receive</td>
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<tr>
<td>If I am admitted to a facility, I need to plan for the following (pet, child, housing, car, job, school, etc)</td>
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<tr>
<td>Additional information, needs or requests</td>
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</tbody>
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<table>
<thead>
<tr>
<th>How my/our child looks and acts when in crisis</th>
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<tbody>
<tr>
<td>My/our priorities when my/our child is in crisis</td>
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<tr>
<td>What helps my/our child during crisis support/intervention</td>
</tr>
<tr>
<td>Treatment I/we prefer for my/our child</td>
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<tr>
<td>Treatment I/we prefer my/our child NOT receive</td>
</tr>
<tr>
<td>If I/we cannot be immediately reached if child is in crisis, please:</td>
</tr>
<tr>
<td>Additional information, needs or requests</td>
</tr>
</tbody>
</table>

[Table for medical provider information]
COMPONENT II: ADVANCE COMMUNICATION

• Quick Summary:
  – The Advance Communication tool provides a method for persons or parents/guardians to communicate in advance and in writing to potential future providers of crisis support or intervention.
  – It paves the way for future episodes of crisis support or intervention to more closely align with the needs of the person/family.
COMPONENT II: ADVANCE COMMUNICATION

– It is a way for a person/family to share information with, and make advance requests to a future treatment provider.

– In essence, it communicates the following: "If you see me/my child in crisis, here is how I/we would like to be treated, here are the types of interventions I/we prefer, and here is what is important to me/our family."

– This is a tool that promotes the consideration of personal/family voice and choice and the practice of “Shared Decision-Making".
COMPONENT II: ADVANCE COMMUNICATION

– The Advance Communication is not a legal document, the treatment provider is not bound by the requests made on the form, but its use can simplify communication and allow those requests to be considered.

• For an introduction to “Shared Decision-Making" in mental health care, go to http://www.samhsa.gov/consumersurvivor/shared.asp
COMPONENT II: ADVANCE COMMUNICATION

• **Description:**
  
  – The Advance Communication is two-sided.
  
  – One side is intended for young adults (though it may be suitable for some children) and the other side is intended for parents and guardians.
  
  – Any or all of the sections can be completed as the person completing the form chooses.
COMPONENT II: ADVANCE COMMUNICATION

• When to use it:
  – In general, the Advance Communication is useful when a person/family has experienced crisis episodes in the past and
  • expects that there will be more, or
  • when communication is difficult during a crisis.
COMPONENT II: ADVANCE COMMUNICATION

- Many persons/families will not find it necessary to complete an Advance Communication because they don't anticipate using crisis services in the future.

- Some persons/families don’t find it problematic to communicate their needs at the time of the crisis event.

- Persons/families who have been reluctant to use ESP/MCI services might be more interested in trying the service if they can file an Advance Communication ahead of time.
Advance Communication—What it is **NOT**

- It is not a plan to be implemented by the family.
- It is not intended for existing treatment providers—they have already incorporated family voice, choice, priorities into the care plan.
- It is not a substitute for engaging in Shared Decision-Making with families—but it aids communication in a crisis situation.
Advance Communication—What it is NOT

• It is not a legal document—it is a additional method of communicating preferences

• It is not answered by somebody else on a persons behalf—it is developed in the words of the young adult, child and/or parent/guardian
COMPONENT III: SUPPLEMENTS TO THE ADVANCE COMMUNICATION OR SAFETY PLAN

<table>
<thead>
<tr>
<th>Health Conditions or Concerns</th>
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<tr>
<td>Physical Health</td>
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<td>Mental Health</td>
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<td>Substance Use</td>
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<tr>
<td>Development</td>
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Notes:

List any special accommodations required due to physical condition or communication barrier:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Current or Discontinued</th>
<th>Prescribed by</th>
<th>Note</th>
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<th>Medications</th>
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<th>Summary of Hospitalizations/Out of Home Treatment</th>
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<td>Date of Admission</td>
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<th>Summary of Outpatient Treatment Services (from first to most recent)</th>
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<tr>
<td>Date Treatment Began</td>
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<th>Allergies (Medication, Food, other)</th>
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<td>List Allergens</td>
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Developed by:

This is a summary of information about:

Date Completed / / Initial Revision

Other Information, needs, requests, accommodations

For one Day:

For one Day:

<table>
<thead>
<tr>
<th>Summary of Prior Treatment</th>
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<tr>
<td>Date Treatment Began</td>
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This is a summary of information about:

Date Completed / / Initial Revision

Other Information, needs, requests, accommodations

For one Day:

For one Day:

Developed by:

This is a summary of information about:

Date Completed / / Initial Revision

Other Information, needs, requests, accommodations

For one Day:

For one Day:
COMPONENT III: SUPPLEMENTS TO THE ADVANCE COMMUNICATION OR SAFETY PLAN

### Personal Demographic Information
- **Address:** 
- **City:** 
- **State:** 
- **Zip:** 
- **Home Ph:** 
- **Cell Ph:** 
- **Work Ph:** 
- **Type of Living Arrangement:** 
- **Date of Birth:** / / 
- **Gender:** 
- **SSN:** / / 
- **Notes/Alerts:**

### Information about Parent(s), Guardian(s) or Spouse/Significant Other
- **Not applicable**
- **Name:** 
- **Relationship:** 
- **City:** 
- **State:** 
- **Zip:** 
- **Home Ph:** 
- **Cell Ph:** 
- **Work Ph:**

### Information about Friends, Advocates, or other supportive people
- **Not applicable**
- **Name:** 
- **Relationship:** 
- **Living with? Y/N:** 
- **City:** 
- **State:** 
- **Zip:** 
- **Home Ph:** 
- **Cell Ph:** 
- **Work Ph:**

### Summary of Current Services, School and/or Work
- **Provider:** 
- **Agency/Business:** 
- **Ph#:** 
- **Address:** 
- **City:** 
- **State:** 
- **Zip:** 
- **Type of Service:** 
- **Physical Health:** 
- **Mental Health:** 
- **Substance Use:** 
- **Pharmacy:** 
- **DD/DS:** 
- **DMH:**

### Information about School
- **Not applicable**
- **Do not contact**
- **School Name:**
- **Grade:**
- **Program:**
- **Type:**

### Information about Work
- **Not applicable**
- **Do not contact**
- **Name of Business:**
- **Job Title:**
- **Preferred Contact:**
- **Title:**
- **Ph#:**
- **Parent/Guardian:**
- **Ph#:**

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*This is a summary of information about:*
Component III: Supplements

• **Quick Summary:**
  
  – These are pre-formatted supplemental documents that persons/families may find useful in organizing and efficiently communicating information that is commonly sought by treatment providers.
  
  – Children, parent(s)/guardian(s), and young people could choose to complete any or all of the sections, and add any or all of the sheets to their Safety Plan or Advance Communication.
Component III: Supplements

• **Description:** There are four topic-specific, one-page sheets:
  – Personal Demographic Information
  – Summary of Prior Treatment
  – Summary of Medical Information
  – Summary of Current Services, School, and Work
Component III: Supplements

• When to use it:
  – The various supplements may become useful to a person/family when there is a need to communicate demographic and current/historic treatment information—particularly when there is a considerable volume to share.
  – Rather than having to remember it all and repeat it each time, the information can be readily communicated in writing to a provider either in advance or at the time of an intervention.
Supplements: What they are NOT

• The tools are not intended for use by existing treatment providers—existing providers have already gathered much of this information

• The tools are not intended to be redundant for a person/family—a person/family might already organize medical records and demographic information in a meaningful fashion
Routing Boxes

- At the bottom of each of the templates is a routing box. It is used to communicate information to treatment providers/entities that receive copies of all or part of the Safety Plan or other tools and to assure some plan uniformity so that receiving agencies can file the plans.
- In addition in the right-hand side of the footer, the order and number of pages can be documented.
INDIVIDUALIZED ALTERNATIVES

The Crisis Planning Tools are designed to be flexibly used, but will not meet the needs of everyone. In these instances it is acceptable to develop and use an alternative format or a more comprehensive plan that works for the person/family.
INDIVIDUALIZED ALTERNATIVES

Examples of an alternate plan:

– The product of more comprehensive safety planning, such as
  • Functional Behavioral Assessment
  • Wellness Recovery Action (WRAP) Plan
– Electronic in nature—and kept in cell phone/PDA
– A wallet-size, laminated card
– In a language other than English
– Pictures rather than words
Guiding Children, Families and Young Adults in the Development of Effective Safety Plans
In your packet is a copy of the Safety Plan tool.

– The Safety Plan tool includes a 1-page tear away top sheet that might help guide the conversation.

– There are sample questions for each of the three components of the Safety plan.
Guiding the Development of Effective Safety Plans

- If the Safety Plan achieves its promise of being person/family-centered, the content will be a good reflection of where the person/family is right now and where they want to be heading.
  - Where the family is on its “journey"
  - Where the person is on his/her recovery “journey”
Guiding the Development of Effective Safety Plans

And it will be consistent with:

– Stage of *readiness for change*/degree of insight into behavior
– Family's self-defined priorities
– Natural ecology and culture
– Degree of comfort and success that has been achieved in managing crisis situations
– Family's interest in use of formal systems
– Family's interest in use of natural supports
Safety Plan Exercise

Scan the Safety Plan. What does it tell you about…

– Where the family is on their “journey”?
– Where the person is on his/her "recovery" journey?
– Stage of readiness for change/degree of insight into behavior?
– Family's self-defined priorities?
– Person/family natural ecology and culture?
– Degree of comfort and success that has been achieved in managing crisis situations?
– Family's interest in use of formal systems?
– Family's interest in use of natural supports?

How would it be useful to you to have a copy of this Safety Plan in advance of a crisis?
Sample Safety Plan: Jackson

Contacts and Resources

- Best Friend/Support Person: ___________ #________
- Lola/babysitter: ___________ #________
- MCI team: ___________ #________

Team daytime number: ___________ #________
Team 24/7 on-call pager: ___________ #________

Name/role: ___________ phone: ___________ Name/role: ___________ phone: ___________

Notes:

Goal of Plan

I (dad) want to notice when Jackson’s physical behavior is getting worse, try new techniques, and use outside help sooner.

Actions

IF THIS HAPPENS
If he gives mean looks, slams doors, stomps loudly—
Try this:
Give calm reminders.
Remind him he “knows how to keep it together”.
Help him find an acceptable activity.

If he threatens to hit or harm or throws things around—
Give a short and clear warning.

If the warning doesn’t work—use a brief timeout
Tell him to wait in his room while I (dad)
* calm down or call a support person
* call team member for coaching
Ask (sister) to play in a different space

If he hurt himself or someone else or damages property—
Try an extended timeout
Call for in-home support by team
Call for MCI
Arrange a caregiver for (sister)

Developed by:
Jefferson S.

Date Completed: 06/06/11 Initial: X Revision:

Filed With:
- North MCI Team
- Parent/Guardian

This plan is for:
Jackson
Sample

Date of Birth: ______ First Name: ______ Last Name: ______
Jackson does not have contact with his mother. His father has full custody.
(username, address, phone, etc.)

Jefferson S. ph: _________ ph: _________
Parent/Guardian

Parent/Guardian

36
Sample Safety Plan:
Tyler

Contact and Resources

- Pastor Marshall/Friend of family: #617-111-1111
- Aunt Sara: #617-111-1111
- Susan/Babysitter: #617-111-1111
- Jose/Friend: #617-111-1111
- MCI Team: 

Phone:

Name/role:

Notes: Aunt Sara works Tuesdays and Thursdays—cannot do overnights on those days

Goal of Plan

1. We all agree to focus on improving things during the times of the day/week when things are the worst
2. We want to keep police from coming to the house and charges from being filed by working together

Actions

Whole Family: We will remind each other what is at stake—we know we can figure it out ourselves without getting loud.

Tyler: I will have a plan of something to do outside of the house most days Monday-Friday from 3-6 pm. Some options:

- YMCA open gym Mondays and Thursdays
- Look for afternoon job
- Library media room open every day
- Can do up to 6 hours of yard work a week at home for $10/hr
- Can use car to run family errands when needed (grocery shopping, get gas)

Parents: Stay out of power struggle, don't make idle threats, back each other—don't add it to it by fighting with each other.

Tyler can use car on Saturdays when week goes well.

To get a break, Tyler can spend the night at (friend) Jose's if okay with his parents or Aunt Sara's twice a week.

Parents/Tyler: Consider calling Pastor Marshall to help talk it through by phone if we are having a hard time working it through on our own.

Parents/Tyler: Consider calling MCI. Can talk by phone, have them come to home or going to MCI office if it feels like the fight is going to get too big to manage ourselves

Developed by:

Date Completed: 

Filed With:

This plan is for:

Date of Birth

Other information, needs, requests:

Joan S. ph. ph. ph.

Lars S. is legally blind

Parent/Guardian

Lars S. ph. ph.

Parent/Guardian
Sample Safety Plan: Miguel

Miguel was not interested in completing a written safety plan—he says he would not keep it around where other people might see it. He has not told very many people that he has had suicidal thoughts.

He did choose, however, to add a new contact to his cell phone called “Information.” He listed names and numbers of three people he could call if he is “feeling stressed” and wants to talk to somebody.

He also listed the number for the national suicide hotline and the MCI team.
Guiding the Development of Effective Safety Plans

• It will be created with the understanding that safety planning is not a one-time event
  – It is a developmental process
  – Person/family competency, mastery, instinct, insight, increase through experience and honing of strategies
Guiding the Development of Effective Safety Plans

• And an understanding that there are a wide range of ways…
  – to decrease unwanted behaviors,
  – to improve management of a crisis, and
  – to reduce risk of harm
Guiding the Development of Effective Safety Plans

• In each family, the words like "crisis," "safety," or "risk" mean different things.
  – It is important to use the family's own definition of what might place them at risk or be identified as a ‘crisis’.
  – We may be surprised when it is not what we assumed it to be.
  – Family identification of the "crisis" or "risk" is the first step to helping the family develop a Safety Plan that they can actually own and will want to use.
Guiding the Development of Effective Safety Plans

- Ask if the person/family already has any kind of safety or crisis plan, how it was developed and if it is working.
  - Take care to not supplant a working plan
Guiding the Development of Effective Safety Plans

• Think strategically about who is actively involved in developing the Safety Plan
  – How involved would the child like to be? Roll with resistance and acknowledge that it is his or her choice.
  – Sometimes a child does not agree that their behaviors that are unsafe or problematic and his/her involvement may be counterproductive
  – How involved should the parent(s)/guardian(s) be? Is the desired outcome enhanced or diminished by the level/type of involvement
Guiding the Development of Effective Safety Plans

• That some plans focus solely on actions of the parent(s) does not in any way suggest that they are to blame.
  – The parents may simply be ready for action while their child is not.
  – As the parents make strategic changes in their behaviors or responses or take other actions, the child may change in the direction of the desired behaviors as well.
Guiding the Development of Effective Safety Plans

• It diminishes the authority of the parent and the credibility of the plan to have it filled with actions that a child (or anyone else) is unlikely to take.

• Attempts to implement this kind of plan may actually escalate the household rather than reduce risk or unwanted behaviors.
Guiding the Development of Effective Safety Plans

- Focus on do-able
- Focus on controllable
- Focus on consensus
- Focus on areas of least-resistance
- Focus on normal and natural, areas of strength and enjoyed activities
Guiding the Development of Effective Safety Plans

– If a family is not ready for much, the plan should not be much.
– The choice is theirs to make.
– Build an authentic relationship that respects where they are now.
– When they are ready for more, we are ready too.
Guiding the Development of Effective Safety Plans

- Culture, beliefs, readiness for change, strengths, barriers, and prior experience will all come into play in the event of a crisis and must be taken into account when creating a usable Safety Plan.

- Plans that are filled with things that "we" (the provider) would do give "us" (providers) a false sense of confidence that the risk of harm is reduced.

- If the family won't do it in a crisis, it does not reduce risk of harm and it should not be on the plan.
Guiding the Development of Effective Safety Plans

– Don't drag anyone to the table. A power struggle is not productive.

– This is a living, evolving Safety Plan and there are future opportunities to engage those family members who may be disinterested now.

– If the whole family is reluctant—figure out what it means. Realign the planning process so that it is a match to what the family is ready for now. Ask the family about it—what is not working about this?
Guiding the Development of Effective Safety Plans

What might be behind reluctance or resistance to developing a Safety Plan?
Guiding the Development of Effective Safety Plans

• Develop a plan that is sensitive to timing and circumstances for the child/family.
• Identify what the family feels is hierarchically important in safety planning.
• The plan cannot be what "we" (the provider) would do in the family's shoes, but what the family members can actually commit to trying or doing.
Guiding the Development of Effective Safety Plans

• We all know from personal experience that having a “problem” and knowing how/being ready to address it are very different things.

• As providers, it is easy for us to be in ACTION mode—we are ready for families to solve the problem, and for children to stop the behavior NOW.

• But, families may be ambivalent, have questions about their ability to change, not have an acceptable alternative or have different priorities.

• We will feel the RESISTANCE if we are pushing someone into something they are not ready for—we need to adjust.
Guiding the Development of Effective Safety Plans

If a person/family is not ready for CHANGE, focus could be on:

1. Reducing harm from the behavior
2. Resolving ambivalence
3. Reducing exposure to things that lead to crisis
4. Focusing on self-identified priorities

*We must readjust from where “we are” (often in “action” mode) to where the person/family is in order to see real change and promote healthier choices.*
Guiding the Development of Effective Safety Plans

• Often in the field of mental health, providers are oriented towards the use of formal services to solve mental health problems.

• However, families have unique preferences when it comes to managing a crisis and our understanding in this regard is important since an authentic plan will generally reflect those preferences.
What are reasons that a family might choose not to call 911?
Guiding the Development of Effective Safety Plans

What are reasons that a family might choose not to call an MCI Team?
Guiding the Development of Effective Safety Plans

• Get a sense of general preferences when it comes to using resources.
  – Does the family lean towards those that are formal or informal?
  – Do they prefer to self-manage family crises?
  – Don’t make assumptions about what a family might be willing to do in a crisis
Four Examples of Family Styles

Preference for FORMAL services

Preference for a mix of FORMAL Services and INFORMAL supports

Preference for a mix of INFORMAL supports and Self-Management

Preference for Self-Management
Intervening with Families in Individualized Ways

Can a family solve a serious mental health crisis without us?
360° Action Strategies

• Behavior change is difficult and it is often unrealistic to address it head on or to expect all unwanted behavior to cease.
• It is useful to take an indirect approach (that may be met with far less resistance) and to use solutions that are comfortable and natural.
360° Action Strategies

• Brainstorm ways to:
  – Reduce harm from the behavior
  – Take action after the behavior happens (prevention is often not realistic)
  – Change how others in the home react to the behavior
  – Reduce exposure to circumstances that precipitate behavior (i.e. increase structure or supervision or reduce access)
  – Build on strengths and engage in activities of interest (change the venue or focus during times of peak difficulty)
  – Move in the direction of the long-term goal. Think of it as going from "A to D" instead of "A to Z."
360° Action Strategies

Behavior being addressed
360° Action Strategies

Scenario 1

Goal of Safety Plan: "We want to reduce the physical altercations between 14 year old Jake and his 8 year old brother that happen almost every day after school."
360° Action Strategies

Scenario 2
Goal of Safety Plan: “We expect periodic crises as a part of Tyrell’s illness. We want to develop a routine for managing crises so that things don’t feel so out of control when one happens.”
Testing Plan Authenticity

Sample questions:

"Picture a crisis unfolding. Are all of the right names and numbers at your fingertips?"

"Do the goals listed match your priorities in a crisis situation?"

– If not, let's modify.

“Can you see yourself taking each of the actions that you have identified?”

– If not, what seems more doable that takes you in the direction of your overall goal?”
Testing Plan Authenticity

On a scale of 1-10:

– “how likely is it that you will use this plan?”
– “how confident are you that the plan will be useful during a crisis?”
– “how confident are you that you can manage any future crisis with no one getting hurt?”
Advance Communication Tool

• In your packet is a copy of the Advance Communication tool

• The Advance Communication tool includes a 1-page tear away top sheet that explains how to complete the document.
Advance Communication Tool

• Some individuals and families have developed a clear sense of what is useful to them in a crisis situation.
• They have learned through experience what calms and what escalates.
• They have preferences for treatment facilities based on location, program style, effectiveness of previous treatment, or other reasons that are meaningful to them.
Advance Communication Tool

• As parents/children/young adults gain insight and clarity on some of these points, they might find it useful to complete an Advance Communication tool.

• The Advance Communication tool is a vehicle for sharing in advance person/family-specific information, to indicate preferences, what has worked or not worked, and any other information or request that is important to the person or parent/guardian.
Advance Communication Tool

• This is a tool that promotes the consideration of personal/family voice and choice and the practice of “Shared Decision-Making.”

• The Advance Communication is not a legal document and the treatment provider is not bound by the requests made on the form.

• However, its use can simplify communication and allow those requests to be considered.
Advance Communication Tool

• For those persons/families who use crisis services, but have not been willing to develop a Safety Plan, see if they are interested in completing an Advance Communication.

• There are instances when a family or individual thinks that "a Safety Plan won't work," when they see the process or document as "stupid/lame/useless" or when they otherwise do not want to engage in safety planning.
Advance Communication Tool

• But the same person/family might see value in writing an Advance Communication so that in the event of another crisis episode, they are "treated more fairly" or "get what they need" or "don't have to repeat everything over again."
What I experience when I am in crisis
The problem is usually that I have been angry or feeling sorry for myself and I start drinking. Then I start thinking about killing myself. When people try to help me, I shut down at first—it isn’t personal. I just need time to get my words together.

My priorities in a crisis
STAYING OUT OF THE HOSPITAL! I can pull it back together pretty quickly and I know the point when I need to call crisis. Also, I just started a new job that I really like and I cannot miss any shifts for the first three months or I will be fired.

What helps me in a crisis
Give me some space and then I will be ready to talk. Don’t just come in asking all of your questions all at once. I want to keep my cell phone with me so I can call a friend or my aunt at some point. I am not going to go into details about the abuse—look at the old files if you want to know, but don’t ask me. It is in the past and I am done talking about it.

Treatment I prefer (specific programs, medications, types of intervention, alternatives to hospitalization, involvement of friends and family)
I am done going to treatment. Maybe someday, but not now. I am trying it on my own and am doing ok so far. My focus is my career and my friends and enjoying the GOOD instead of talking about the BAD. I can use crisis if I slip.

Treatment I prefer NOT to receive
NO MEDICATIONS.

If I am admitted to a facility, I need to plan for the following (pet, child, housing, car, job, school, etc)
I SHOULDN’T be admitted anywhere, but IF I EVER AM, call my aunt Jasmine at ###. She has a key and will pick up my dog and watch my place.

Additional information, needs or requests
Do not call my mother—she is not in my life anymore and I do not want her to have any information.
Jasmine

In reading this Advance Communication

• What do you think about...
  – Where Jasmine is on her recovery “journey”?
  – Her readiness for active treatment?
  – How to best “join” with her during this crisis intervention?
  – the potential pathways to crisis resolution?

• What are the considerations if someone recommended inpatient hospitalization?

• How helpful is it to see this Advance Communication from Jasmine?
Sample: Completed by Lara’s parents

How my/our child looks and acts when in crisis
Lara does not want to be a burden so she often tells the crisis team that she is fine even when she is really upset inside and is having thoughts of hurting herself.

My/our priorities when my/our child is in crisis
She is very embarrassed that she has to get help—privacy and discretion are very important to us.

What helps my/our child during crisis support/intervention
1. It is usually difficult for her to open up to men—if a woman is available, it would probably go better.
2. She may want one of us to stay with her while she is being interviewed. Please respect her wishes.
3. She carries a sketchpad and pen and uses it when she is upset. Please let her keep it with her.

What helps my/our family during crisis support/intervention
1. We want to be a part of decisions rather than being told what the plan is—we have a lot of experience in knowing what works.
2. Our other children feel overlooked by the crisis team. They are scared for their sister. If you can take a few minutes to ask them how they are doing or if they have questions they really appreciate it.

Treatment I/we prefer for my/our child
1. We have a lot of family members and friends who will help out at home and if we can keep him safely in the home, that is our choice.
2. We only want referrals to providers that are experts in trauma and will tell us about their trauma training and experience.

Treatment I/we prefer my/our child NOT receive
Anything that is overnight—we do not think she could bear it and she has been very upset when crisis staff have talked to her about it before. Unless it is a life or death situation, we will keep her at home.

If I/we cannot be immediately reached if child is in crisis, please:
If the crisis is at school, talk to Mrs. Washington, the adjustment counselor. Also, any time you cannot reach us call Aunt Martha at ### to see if she can come to be with Lara

Additional information, needs or requests
If you come to our home, please pull in to the back of the driveway and use the side door
Lara

In reading this Advance Communication

• What do you think about…
  – Where the family is on their “journey”?  
  – Their experience in managing crises? 
  – How to best “join” with the family? 
  – The potential pathways to crisis resolution?

• What are the considerations if someone recommends inpatient hospitalization?

• How helpful is it to see this Advance Communication from Lara’s parents?
Developing Crisis Systems of Care
Characteristics of Effective Crisis Systems of Care

• Have well established community-based urgent treatment services as an upstream alternative to emergent services
  – Crisis Intervention in the community rather than in the ED
  – Invitation to seek services earlier in the crisis episode
  – Crisis provider facilitates a ‘step-up’ to a higher level of care when needed
Characteristics of Effective Crisis Systems of Care

• The delivered crisis service is a course of intervention rather than a prescreen for admission or a level of care determination
  – In Massachusetts Mobile Crisis Intervention is a treatment level of care
  – Crisis intervention is a level-of-care service unto itself
  – How a person/family responds to the intervention informs the eventual disposition
  – Change/crisis resolution is anticipated
Characteristics of Effective Crisis Systems of Care

• The intervention is resolution-focused in an effort to reduce the need for restrictive, out of home treatment such as hospitalization
  – The intervention is generally pragmatic, problem-solving, consultative and collaborative
  – Often involves use of motivational interviewing, solution-focused treatment and other cognitive therapies to aid in crisis resolution and restoration of functioning
  – Person in crisis/family know what is most likely to work and will often come up with the best plan
Characteristics of Effective Crisis Systems of Care

- Care is delivered in a **least restrictive** (consistent with treatment and safety) manner
  - Voluntary
  - Least intensive
  - Least intrusive
  - In the community (near home)
  - Brief in duration
  - Individualized (person-centered vs. program-centered care)
Characteristics of Effective Crisis Systems of Care

- Emphasis is on identifying strengths rather than pathology
  - A ‘crisis state’ is a temporary (widely varying in length) period of disequilibrium and overwhelming events or emotions
  - A return to a higher level of functioning (from which a person can then tap into his/her repository of coping skills) is a key goal
  - Best solutions are in keeping with a person’s strengths, preferences and natural resources
Characteristics of Effective Crisis Systems of Care

• Ownership is by the broader system rather than solely the crisis provider(s)
  – System-wide philosophy of crisis care
  – Systemic outcomes are measured in addition to provider-specific outcomes
  – Formal means of interface are established
    • Mutual referral protocols
    • Means of communication
    • Shared information
    • Shared outcomes
  – Systemic approach is taken in ongoing efforts to strengthen the community safety net
Characteristics of Effective Crisis Systems of Care

• The community crisis continuum—the full array of services and supports to persons in crisis—is inclusive of less-traditional crisis partners:
  – Outpatient treatment providers
  – Peer and Family-operated service providers
  – Law-enforcement agencies
  – PCP’s/Primary Health Clinics
  – Housing providers
  – Employment providers
  – Residential centers
  – Schools
Limitations of Traditional Emergency Services

• Interventions are time-limited
• Knowledge of the circumstances is limited
• Assessment is often limited to imminent need
• Crisis provider does not generally know the person’s unique:
  – History
  – Risks
  – Strengths
Limitations of Traditional Emergency Services (cont)

• The disposition may be **MORE** conservative than the person in crisis needs
• The disposition may to **LESS** conservative than the person in crisis needs
• **MOST IMPORTANTLY:**
  – Opportunities to prevent or de-escalate early in the crisis no longer exist.
  – The person in crisis is no longer in a community setting
  – When a person is in the **MOST** restrictive service, there are fewer opportunities for him/her to reassume control
And to others

To the client…

And the cost…

So does the risk…

As a crisis escalates…
Crisis Continuum

• Ask community stakeholders (including treatment providers) to list the “crisis services” that are available in a typical community and the short list is likely to include hospital emergency rooms, community-based crisis facilities and the subsequent inpatient treatment facilities.

• Even within one comprehensive treatment agency, particular programs might be tagged as being responsible for crisis services while others are not.
Crisis Continuum

Phase I
Prevention

Phase II
Early Intervention

Phase III
Acute Intervention

Phase IV
Crisis Treatment

Phase V
Recovery and Reintegration
Crisis Continuum

- Consider the primary providers of behavioral health crisis services in Massachusetts
  - When you look at the crisis continuum, in what stage of a crisis do these providers have the most leverage?
Crisis Continuum:

- Traditional crisis providers tend to get involved after:
  - The person/family has lost control
  - The need for crisis service has already been identified and most likely documented
  - The coping skills of the person in crisis have already been compromised
  - Actual injury to person in crisis or others may have occurred
  - Caregivers and support systems may be scared, angry, exhausted or overwhelmed
  - Steps towards eviction from housing or programs may be underway
  - A criminal act may have been committed
  - Consumer and/or community expectancy for a “safe” (inpatient) outcome is high
Crisis Continuum

<table>
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<tr>
<th>Phase I</th>
<th>Prevention</th>
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<tr>
<td>Phase II</td>
<td>Early Intervention</td>
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</tbody>
</table>

• The goal of Crisis Systems of Care is to expand and strengthen the crisis continuum to represent the essential skills and services of a broad-base of persons/entities that are either currently engaged or likely to become engaged with persons who might experience a crisis.

• This does not automatically imply that new services must be created—it is first and foremost about cataloging existing resources and perhaps seeing those resources in a different light.
Crisis Continuum

• The first step in doing this is to introduce the concept of a broad and inclusive crisis continuum in which all treatment providers, partners in other systems, private facilities like hospitals and law enforcement agencies:
  – Begin to identify their place on the continuum
  – Identify the essential role they play in seeking opportunities for crisis diversion or resolution at the earliest stage on the continuum, and
  – Achieve the competency required to be successful in this work.
Crisis Continuum

• As other segments of the crisis continuum are strengthened, the emphasis begins to shift away from the acute portion of a crisis and the course of care (including hospitalization) that may follow.
Crisis Continuum

• It’s possible to achieve **breadth** within the crisis continuum by strategically attending to all phases of a crisis episode.
Crisis Continuum

- **Depth** is maximized by considering the causal factors of crisis and capturing antidotes and remedies in addition to classic crisis interventions and treatment services within the continuum in the form of plan elements.
Crisis-Specific Performance Specifications for MassHealth Providers

By level of care, there are crisis-specific Performance Specifications related to:

– Access
– Responsibility for providing intervention
– Continuity of Care
– System Collaboration
– Post-hospital services

Source: Provider Manual
Crisis-Specific Performance Specifications: Outpatient Services

Components of Service

3. Outpatient Service providers provide emergency services 24 hours per day, seven days per week to all Members enrolled in the outpatient program/clinic/practice. These services are intended to be the first level of crisis intervention whenever needed by the Member.
Crisis-Specific Performance Specifications: Outpatient Services

a. During operating hours, these services are provided by phone and face-to-face through emergency appointments as warranted by the Member’s clinical presentation.

b. After hours, the program provides an emergency phone number that accesses a clinician either directly or via an answering service.

c. Any call that is identified as an emergency by the caller is immediately triaged to a clinician.
Crisis-Specific Performance Specifications: Outpatient Services

a. A clinician must respond to emergency calls within 15 minutes. This clinician provides a brief assessment and intervention minimally by phone.

b. Based upon these emergency services conducted by the provider both during operating hours and after hours, the provider may refer the Member, if needed, to an Emergency Services Program (ESP) for an emergency behavioral health evaluation.

c. An answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital emergency department (ED), is not sufficient.
Crisis-Specific Performance Specifications: Outpatient Services

Service, Community, and Collateral Linkages

1. In an effort to improve continuity of care, outpatient providers will have strong working relationships with Emergency Service Providers (ESPs), Inpatient, ICBAT/CBAT, and providers of other diversionary or 24-hour levels-of-care. They will have this documented through written affiliation agreements, minutes of regularly scheduled meetings, and/or evidence of collaboration in Members’ medical records.
Crisis-Specific Performance Specifications: Outpatient Services

Process Specifications: Access

1. Members who are not in crisis and do not require immediate services, but present with an urgent request for services, will be scheduled for an outpatient therapy appointment within 48 hours, and they will be given the after-hours telephone number with appropriate emergency instructions.
Crisis-Specific Performance Specifications: Outpatient Services

3. Members referred from an inpatient unit will be scheduled for an outpatient therapy appointment within seven days from the date of discharge from the inpatient unit.

4. Members referred from an inpatient unit will be scheduled for a psychopharmacological appointment as soon as clinically indicated, but no longer than 14 business days post-discharge.
Crisis-Specific Performance Specifications: Outpatient Services

Process Specifications: Assessment and Treatment Planning

1. When a Member in outpatient treatment is evaluated by an Emergency Services Program (ESP) and/or admitted to Inpatient, ICBAT, CBAT, or any 24-hour level of care and/or when Members are being referred to the outpatient provider from the inpatient/ICBAT/CBAT unit the outpatient provider will:
Crisis-Specific Performance Specifications for Outpatient Services

a. receive and return phone calls from Emergency Services Providers (ESP) and providers of inpatient or other 24-hour levels-of-care who are servicing the clinician’s outpatient client within one business day;

b. provide information and consultation, with appropriate consent, in order to inform the assessment of the Member by the ESP and/or 24-hour level-of-care;

c. make every effort to participate, face-to-face or by phone, in the facility treatment and discharge-planning process;
Crisis-Specific Performance Specifications: Outpatient Services

d. provide Bridge appointments for Members on inpatient units whenever possible;

e. facilitate the aftercare plan by ensuring access to an outpatient appointment that meet the access standards above; and

f. support the Member in implementing his or her aftercare.
Crisis-Specific Performance Specifications: In-Home Therapy Services

Components of Service


g. Phone and face-to-face coordination with collateral providers, state agencies, ESP/Mobile Crisis Intervention, and other individuals or entities that may impact the youth’s treatment plan, subject to required consent.

i. Coaching in support of decision-making in both crisis and non-crisis situations
Crisis-Specific Performance Specifications: In-Home Therapy Services

6. The In-Home Therapy Services provider has 24-hour urgent response accessible by phone to the youth and family, 365 days a year. In the event of an emergency, the In-Home Therapy Services provider engages the ESP/Mobile Crisis Intervention (24 hours a day, 365 days a year) and supports the Mobile Crisis Intervention team to implement efficacious intervention. An answering machine or answering service directing callers to call 911, ESP/Mobile Crisis Team, or to go to a hospital emergency department (ED), is not acceptable.
Crisis-Specific Performance Specifications: In-Home Therapy Services

Service, Community, and Collateral Linkages

1. The In-Home Therapy Services team maintains a linkage and working relationship with the local ESP/Mobile Crisis Intervention team in their area in order to provide youth and their families with seamless and prompt access to In-Home Therapy Services upon referral from a Mobile Crisis Team following a crisis period or to ESP/ Mobile Crisis Intervention team in an emergency.
Crisis-Specific Performance Specifications: In-Home Therapy Services

• 3. If referral to a higher level of care (e.g., Crisis Stabilization, CBAT, IP) is necessary, the In-Home Therapy Services team provides a focused treatment plan to help guide and expedite treatment by the provider of the higher level of care.
The In-Home Therapy Services provider is available 24 hours a day, seven days a week, 365 days a year to take referrals. The provider responds telephonically to all referrals within one business day. During daytime operating hours (8 a.m. to 8 p.m.), the In-Home Therapy Services provider responds by offering a face-to-face encounter to referrals within 24 hours. Providers are required to engage in assertive outreach regarding engaging in the service, track the outreach, and follow-up.
Crisis-Specific Performance Specifications: In-Home Therapy Services

2. The In-Home Therapy Services provider participates in discharge planning at the referring treating facility/provider location. If the referral is initiated as a diversion by a Mobile Crisis Team in an effort to divert out of home placement or psychiatric hospitalization, the In-Home Therapy Services provider makes every effort to meet with the youth and parent/guardian/caregiver and the Mobile Crisis Team clinician at the time of referral or as soon as possible thereafter.
Crisis-Specific Performance Specifications: In-Home Therapy Services

3. With the youth’s and parent/guardian/caregiver’s consent, the In-Home Therapy Services team will visit the youth and family in any safe setting within 24 hours of the referral if referred from an inpatient unit/CBAT/Crisis Stabilization. If referred from a Mobile Crisis Team, the first In-Home Therapy meeting will be offered within 24 hours of the initial referral or as negotiated with the youth and parent/guardian/caregiver and the Mobile Crisis Team in any safe setting. Initial treatment goals and planning will be initiated at this meeting.
4. The ICC provider must be available by phone and staff on-call pagers to monitor the need for ESP/Mobile Crisis Intervention services and assist with access to those services for the youth and their families 24 hours a day, 365 days a year. An answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital emergency department (ED), is not acceptable.
Crisis-Specific Performance Specifications: Intensive Care Coordination

Service, Community, and Collateral Linkages

- 7. The ICC provider maintains linkages and working relationships with the local ESP/Mobile Crisis Intervention provider in their service area in order to facilitate referrals from the Mobile Crisis Intervention provider and to ensure care is properly coordinated for youth and families served by ICC and ESP/Mobile Crisis Intervention....
Crisis-Specific Performance Specifications: Intensive Care Coordination

...With consent from the parent/guardian/caregiver, if required, when a youth and family involved in ICC is in need of intervention from ESP/Mobile Crisis Intervention, as determined by the ICC provider, family and the ESP provider, the care coordinator is in contact with the ESP/Mobile Crisis Intervention staff at the time of referral (or if not, the referral source immediately upon learning of referral to ESP/Mobile Crisis Intervention) to provide relevant information, assistance, and recommendation for how ESP can best intervene to the ESP/Mobile Crisis Intervention staff.
Crisis-Specific Performance Specifications: Intensive Care Coordination

9. With consent, if a youth is admitted to a 24-hour behavioral health level of care (e.g., Crisis Stabilization, inpatient hospital, CBAT, PHP), the care coordinator contacts the facility at the time of referral and provides preliminary treatment recommendations to initiate and guide treatment, and schedules a CPT meeting at the facility within two (2) days for care coordination and disposition planning. The CPT meeting includes the participation of the family and facility staff. The ICC provider and facility staff communicates and collaborate on a youth’s treatment throughout his/her admission to develop, in concert with the family, a disposition plan that is consistent with his/her ICP...
Crisis-Specific Performance Specifications: Intensive Care Coordination

Process Specifications: Treatment Planning and Documentation

16. The ICC provider is available to provide support by phone or staff on-call pager to the youth and the family 24 hours a day, 365 days a year. During business hours (M-F, 8 a.m. - 8 p.m.), the ICC provider provides phone and face-to-face assessment of the need for ESP/Mobile Crisis Intervention or emergency services and assistance with access to such services, including mobilizing to the home or community settings (e.g., school) to assess the youth’s needs and coordinate responses to emergency situations…
Crisis-Specific Performance Specifications: Intensive Care Coordination

...After hours (i.e., between 8 p.m. and 8 a.m. and on weekends), the ICC assesses the youth’s need for crisis services and provides crisis support by phone. If, based upon the ICC’s clinical assessment of the youth’s needs, Mobile Crisis Intervention is required, or in the event of an emergency, the ICC provider shall engage the ESP/Mobile Crisis Intervention. ICC providers shall remain actively involved in monitoring and assessing the youth’s need for services during the course of Mobile Crisis Intervention. An answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital emergency department (ED), is not acceptable.
Developing Crisis Systems of Care

• The crisis-specific Performance Specifications establish a floor of expectations among providers

• As with broader Systems of Care initiatives, the opportunities to strengthen and enrich the community safety net are endless
## Community Crisis Continuum

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Closing Remarks