Crisis Prevention and Management Tool

A written crisis plan is an effective tool for all involved in the care of an individual to clarify the triggers that can lead to a crisis, the stages of crisis, the appropriate responses at each stage and how to prevent more intrusive emergency involvement (e.g. 911, visit to the emergency room, unplanned changes in medication). This tool is also an important communication device when intrusive emergency involvement does occur. A tool such as this is part of a process with the individual, their family and paid caregivers to determine the best proactive and preventative approach to planning ahead.

This tool has been in a variety of ways including:

- Internal to an agency that is continuously updated – for communication among staff groups, across shifts or for on-call managers to provide support to staff during evenings and weekends
- With an inter-agency team to bring together multiple providers supporting an individual with complex needs
- A discussion tool to complete with clients and families
- A tool to share with the local crisis provider and Emergency Department
- Can also be used early on in a complex situation, as a way of identifying what is known and what is not known. When there are a lot of crises occurring it provides a framework for bringing everyone to the same page. Updating through regular meetins with the inter-agency team can occur as more becomes known

This is an example of one tool which is quite extensive – providers may have different versions of this, some simpler than others. The categories listed here do not always fit each situation and sometimes need to be adjusted. However the key underlying principle embedded in this tool is that the structure of the crisis plan should bring to life the biopsychosocial approach - by capturing the significant biological, psychological and environmental/social elements of the persons life that are relevant to preventing crisis.

For more information contact Susan_Morris@camh.net

Crisis Prevention and Management Tool
SAMPLE

Date of Plan: September 15, 2009
This Plan is for: Moe **Date of Birth:** March 17, 1988

Address: Peterborough, Ontario
Phone Number: (905) XXX

Closest family relationship **Contact number:**
XXXXX (Mother) (h) (905)XXX
(c) 416 XXX
(w) 905-XXX
XXXXX@xxx

Other significant personal supports **Contact number:**
XXXXX (Sister) 905 XXXXXX

Agency providing primary support **Worker:** Angela
Association for Community Living **Worker number:**

Current Medical Practitioner(s) **Contact number:**

(GP)

(Community Psychiatrist)

Diagnoses:

Psychiatric:	**Intellectual Disability**
Date given: August 13, 1992 By whom: Dr. Axis I: Autism Axis II: Severe MR Axis III: Constipation Axis IV:	Date diagnosed: August 13, 1992 By Whom: ❑ Mild Mental Retardation ❑ Moderate Mental Retardation X Severe Mental Retardation ❑ Other Diagnoses: Specify:

Significant Medical Information or Diagnoses

- H. Pylori was treated with medications in April 2009
- No significant medical concerns at the time of discharge

Dental
- 9 cavities filled and 3 extractions July 2009

Hospital Preference

Please bring to: Civic Hospital Phone Number: Address:

Current Medication

Medication	Dose	Frequency	As of	Purpose
Clonazepam	1 mg	8:00 am 12:00 pm 8:00 pm	Mar. 11/09	Anxiety
Celexa	20 mg	8:00 am	Mar. 11/09	Anti-Depressant
Loxapine	5 mg	8:00 am	Aug. 29/ 09	Agitation/Anti-psychotic
	10 mg	9:00 pm or bedtime	Sept. 10/09	
PRN: Olanzapine	7.5 mg	PRN/as needed *Maximum 2 doses within 24hrs, at least 2 hours between doses	May 22/09	Insomnia/Sleeping
PRN: Lorazepam (Ativan)	2mg	PRN /as needed *Maximum 3 doses within 24hrs, 1 dose every 4hrs.	Mar. 20/09	Agitation (see Level 2 of Personal Support Plan below)

Overview of Individual and Situation

Living Situation

X lives with family
☐ lives alone with supports
Describe:
☐ lives in Group Home
Describe:
☐ lives alone
☐ Other. Describe:

Environment

Lives within family home
- Home is 3 stories, basement, main floor and top floor
- room is located on the top floor, has a back yard without fencing

-Lives with:
- Biological Mother
- Step-Father

- Biological Sister- Moe's older sister
- Step-Sister - age 9
- Step Sister - age 11

-Other family:

- Biological Sister - older sister
- Biological Father – Not involved

Current Service Providers

Agency	Contact (include name & number for each)
- Crisis Network	
- Behaviour Services	Behaviour Therapist
- Community Living	Case Manager
- Autism Service	Autism Consultant
- Staffing Agency	Manager

Communication Style – Primary Language

- Receptive language skills appears to be better than expressive language skills
- To make a request he points or takes the desired item
- Responds to simple one to two-step instructions. (E.g. if – then), may require additional time to process information and it may be necessary to repeat the request more than once

-Communicates by:

-pointing, gesturing or by guiding (pulling the individual by the arm)
-saying, "yes" or "no"
-using signs: washroom, more, thank you, please

Strengths/Skills

- Benefits from positive social attention e.g. verbal praise
- Enjoys socializing with staff
- Able to make choices when provided with 2 options
- Benefits from structure and consistency in his daily life
- Does well with 1:1 supervision
- Enjoys going out for walks, swimming, being read to and watching streetcars
- Responds well to a sensory diet of calming activities
- Likes watching T.V. HGTV, CP 24 and the food network
- Will smile, laugh and make 'happy sounds' when in a good mood or excited

Behaviour

- **Self-injury:** is described as Moe attempting to or successfully banging of his head on any hard surface or biting his arms or hands. Moe will most often bang his head on walls, doors and tables. Self-injury may vary greatly in intensity, sometimes causing no apparent injury and other times causing bumps, cuts and/or bleeding. When beginning to escalate he will slap the back of his head.

- **Aggression**: is described as Moe attempting to or successfully biting, scratching or pinching another person.
- **Property Destruction**: is described as Moe attempting to or successfully damaging property. Moe will usually hit windows, tear up clothing or objects in the environment or turn over furniture.
- **Self-Stimulatory Behaviour:** is described as Moe flicking his fingers in front of his eyes, rocking his body at a slow pace, making repetitive vocalizations while smiling or laughing, making humming noises and/or tapping small objects on his teeth.

Moe has learned to use self-injury, aggression and property destruction to gain staff attention and to escape staff demands. These behaviours have also been observed (less frequently) when he is denied an item or activity.

These behaviours occur more frequently and/or more intensely when Moe has not slept well (e.g. less than 4hrs a night) or when he is in physical pain or discomfort (e.g. cold, cough, injury).

Stressors/Triggers

- Being physically unwell or uncomfortable: hungry, tired, new medication, cold etc.
- Changes in his physical environment: furniture being moved, personal items being misplaced etc.
- Being denied activities or food
- Transitions from one activity to another
- Decreased staff attention and/or engagement (e.g. 15 or more minutes)
- Noisy or crowded environments: malls, amusement parks

Personal Support Plan

Observable Behaviour	Recommended Responses
Level 0: Calm / Baseline ▪ Will smile and laugh to himself, make quiet vocalizations and engage in rhythmic, quiet self-stimulatory behaviour ▪ Pacing ▪ Enjoys: TV (esp. HGTV, CP24 and the food network), being read to, swimming, walking, and streetcars.	**Prevention** ▪ Moe manages well with planned structure including frequent breaks and rests. ▪ Use first ___ then ___ to communicate the sequence of events. ▪ Reinforce/attend to adaptive behaviour: waiting for demands to be met, absence of challenging behaviour (e.g. “Moe, good safe hands”) ▪ Look for physical signs that Moe may be unwell and take action immediately. ▪ Monitor sleep and bowel movements daily and take necessary action immediately (e.g. doctor, PRN for sleep, high fibre diet etc.)

Level 1: Anxiety ▪ Self-stimulatory behaviour more intense: rocking more quickly, exaggerated movements. ▪ Flat or grimacing affect ▪ Less likely to engage in tasks ▪ May bang head bang lightly but can be easily verbally re-directed	**Supportive** ▪ Reduce environmental stimuli: bring Moe to a quiet(er) area, turn off lights, TV, remove others from the environment. ▪ Engage Moe in calming activities e.g. read a book, listen to soft music. ▪ Reduce demands ▪ Provide food (meal or snack) every 2.5 hours ▪ Provide attention every 15 minutes ▪ Praise Moe for any calm behaviours (absence of challenging behaviour, following directions etc.) Praise should include: 1) The use of Moe's name 2) Physical contact 3) 1 minute of positive interaction/attention
Level 2: Defensive ▪ More exaggerated movements, pacing more quickly, flickering fingers in front of face more intensely and quickly. Rocking for long periods of time (e.g. 10-15 min. straight) ▪ Physically appears more frantic: moving more quickly, eyes darting/looking up and around. ▪ Mild property destruction: may throw things around the room. ▪ May attempt to scratch, pinch or bite anyone who is near him.	**Directive** ▪ When not self-injuring or aggressing provide him with reassurance, "Moe's ok." ▪ Keep distance and remove peers from the area. ▪ Reduce demands ▪ Provide one brief direction e.g. "hands down", "no pinching" Do not engage in lengthy verbal de-escalation, as this will reinforce the behaviour and cause it to happen more frequently. ▪ **Give him a PRN, if he does not calm with the above strategies within 5 minutes of intervention** *see medication section
Level 3: Acting Out ▪ Head bang and bite arms and hands with great intensity and multiple times. Causing redness and possibly cutting upper forehead, arms or hands. ▪ Actively seek out people to scratch, pinch or bite. ▪ Wave arms around quickly while making loud high pitch vocalizations. Intense rocking. ▪ Property destruction will intensify: over turning furniture, shaking banisters, slamming doors, tearing up objects. ▪ Behaviours at this level can last for a short time but has, historically, lasted up to hours in duration	**Non Violent Crises Intervention** ▪ Keep distance and remove peers from the area immediately. ▪ Provide one brief direction e.g. "hands down", "no scratching" Do not engage in lengthy verbal de-escalation, as this will reinforce the behaviour and cause it to happen more frequently. ▪ Restrict Moe to a safe area and prevent attempts to leave area. ▪ Do not provide reinforcing items or activities for at least 15 minutes following an episode of SIB or aggression. Reinforcing items include: food, drinks, puzzles. ▪ Block attempts to aggress as per CPI. ▪ Physically intervene to prevent serious self-injury and only if it is safe to do so. **If serious risk of harm call emergency services.**

Level 4: Tension Reduction	Therapeutic Rapport
▪ Moe may cry or fall asleep after an episode. ▪ Self-stimulatory behaviour will continue at milder intensity and more slowly.	▪ Once Moe has calmed then return to his routine ▪ Praise for adaptive behaviour e.g. no SIB or aggression, following staff direction etc. ▪ Keep demands low and give Moe space

Hospitalization Precipitants

Moe has been hospitalized a number of times because of intense and dangerous self-injury and aggression. Two of these incidents were precipitated by significant changes in Moe's life: starting a new day program and a favorite staff leaving the program. Other significant precipitants have included Moe having a urinary tract infection and having medication changes, both of which were likely causing physical pain or discomfort that Moe was unable to communicate to care providers.

Resources that have Worked in the Past

Inpatient at the Centre for Addiction and Mental Health, Dual Diagnosis Program from.. to ... Prior to this admission, has historically had a series of admissions in the community to General Hospital. Moe has done well in safe beds and respite specializing in Autism.

Backup Protocol

**Note: Crisis protocol will be ongoing through collaboration with Crisis Network, Staffing Agency, Autism Service, Behavioural Service and Centre for Addiction and Mental Health.

1. Support providers are to follow **Personal Support Plan**. A more comprehensive Behaviour Support plan can be found in behaviour section in binder.
2. Consult with mother regarding the use of PRN. See Medication Chart for PRN use.
3. In the event that he is ***not*** responsive to staff re-direction and the intensity and/or frequency of self-injurious behaviour is escalating, and there is risk of safety to him or others staff to act in accordance with their own agency's policy.
4. a) If staff are unable to manage risk to self and/or others, call emergency services (911) and identify crisis. Support providers to liaise with family.
   b) If staff are not in the home and the behavior present risk to himself or others family will call 911 or Mobile Crisis for assistance with process at 905-278-9036
5. Post crisis– Support providers to provide a detailed description within the communication book. Information regarding event to be shared with all support agencies.

This tool developed jointly by **Cota Dual Diagnosis Case Management Team**, **The Dual Diagnosis Resource Service** and **The Griffin Community Support Network**, September 2005

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Allergies/Alerts	

Formulation/Understanding

Significant Medical Information or Diagnoses

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Agency	Contact

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Strengths/Skills

Behaviour

Stressors/Triggers

Personal Support Plan

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Level 1: Anxiety ▪	**Supportive**
Level 2: Defensive ▪	**Directive** ▪
Level 3: Acting Out ▪	**Non Violent Crises Intervention**
Level 4: Tension Reduction ▪ .	**Therapeutic Rapport** ▪

Hospitalization Precipitants

Resources that have Worked in the Past

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