NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

THE DMHDDSUS CRISIS PREVENTION AND INTERVENTION PLAN

yale program for recovery and community health

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NC DMHDDSUS PCP Initiative
August 15th, 2024

Person-Centered Tools and Strategies to Maximize Choice and Promote Safety

Housekeeping

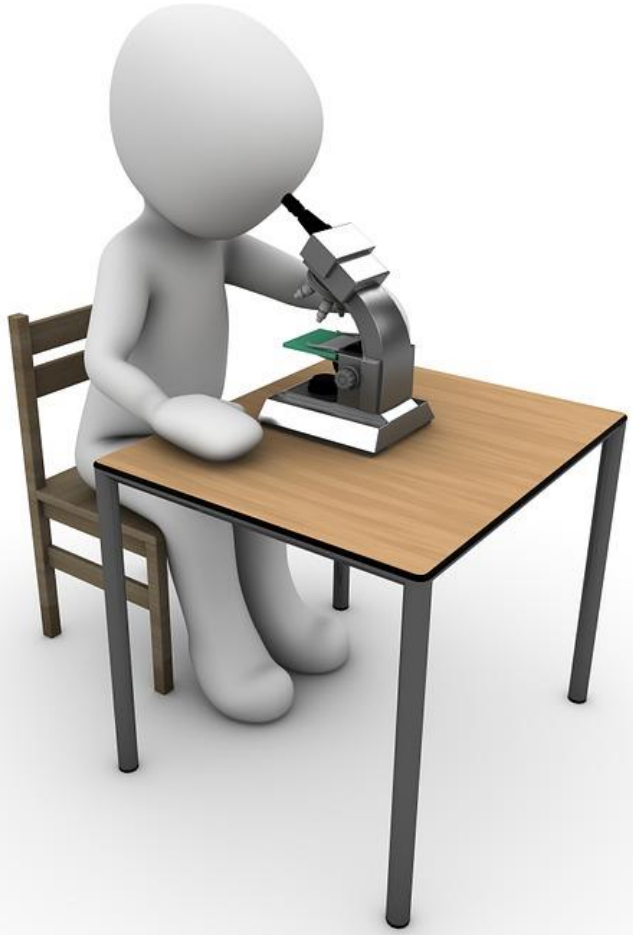
- **E-mail will be the primary method of communication** for post-training communications, including the distribution of Certificates of Completion.
- Attendance for the **full duration of today's webinar is necessary to be eligible for a Certificate of Completion.**
- **A brief training evaluation form is required** for your Certificate of Completion. A link to the evaluation will be provided at the end of this training and sent again via email approximately 1 week from today. Please be sure to follow all prompts, including the final link to enter your name and email address to receive your Certificate.
  - Note that the required survey will close 2 week's from today's training. **If you do not complete the survey within 2 weeks, you will lose the opportunity to receive NBCC credit.**
  - The Certificate will come from a **sender named "Certifier."** Please check junk/spam mail prior to **contacting Anita Allen** (anita.allen1213@gmail.com) **if your Certificate has not arrived within 3 weeks.**
  - If you have any **difficulties accessing/downloading your Certificate** or if corrections need to be made, please use link provided in the survey or **email** anita.allen1213@gmail.com
- Reminder to **mute audio** to reduce interference. If we mute all, you will have the ability to unmute as needed
- For **technical issues** with audio, video, zoom, **please direct questions in chat to Ingrid Padgett.** troubleshoot
- Have **access to your chat box** for exercises and to post questions! We want to hear from you ☺

History of PCP Development in NC

- Early 1990s, implementation of person centered approaches in supporting Thomas S. class members
- The NC PCP Manual was updated in 2010. Since that time, a lot has changed in the world of “recovery”.
  - Went from maintenance and stabilization, to thriving and community integration
  - Increased focus on strengths-based approach
  - Individualized goals
  - Improvement in quality of life, across all domains
  - Employment

DMH/DD/SUS 2020 Desk Reviews of PCP

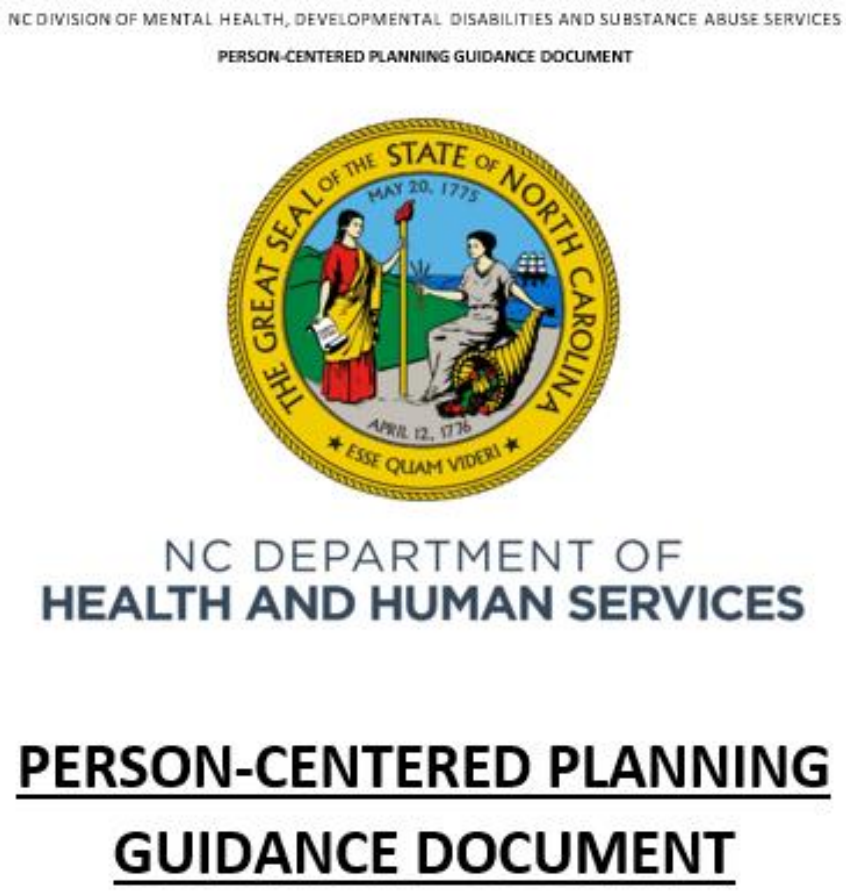
- Findings:
  - individuals voiced an interest in employment, but did not have an employment goal
  - “cookie cutter” goals and interventions that were not individualized or meaningful
  - goals were more about decreasing symptoms than learning skills (e.g., medication compliance, staying out of the hospital)
  - Crisis Plans were not guided by the person; not individualized, did not include the use of natural supports, and did not specify individual preferences when more restrictive interventions are required



PCP Manual & Template Workgroup

Review observations led to the establishment of a diverse statewide workgroup:

- Focus was more on philosophy behind person-centered planning and really identifying what is most important to the individual
- The NC Person-Centered Planning Guidance Document was created and went into effect November 1, 2023
- * DHHS contracted with Dr. Janis Tondora to develop a standardized PCP Training on the PCP Guidance Document for providers across all age groups, disabilities, and services.

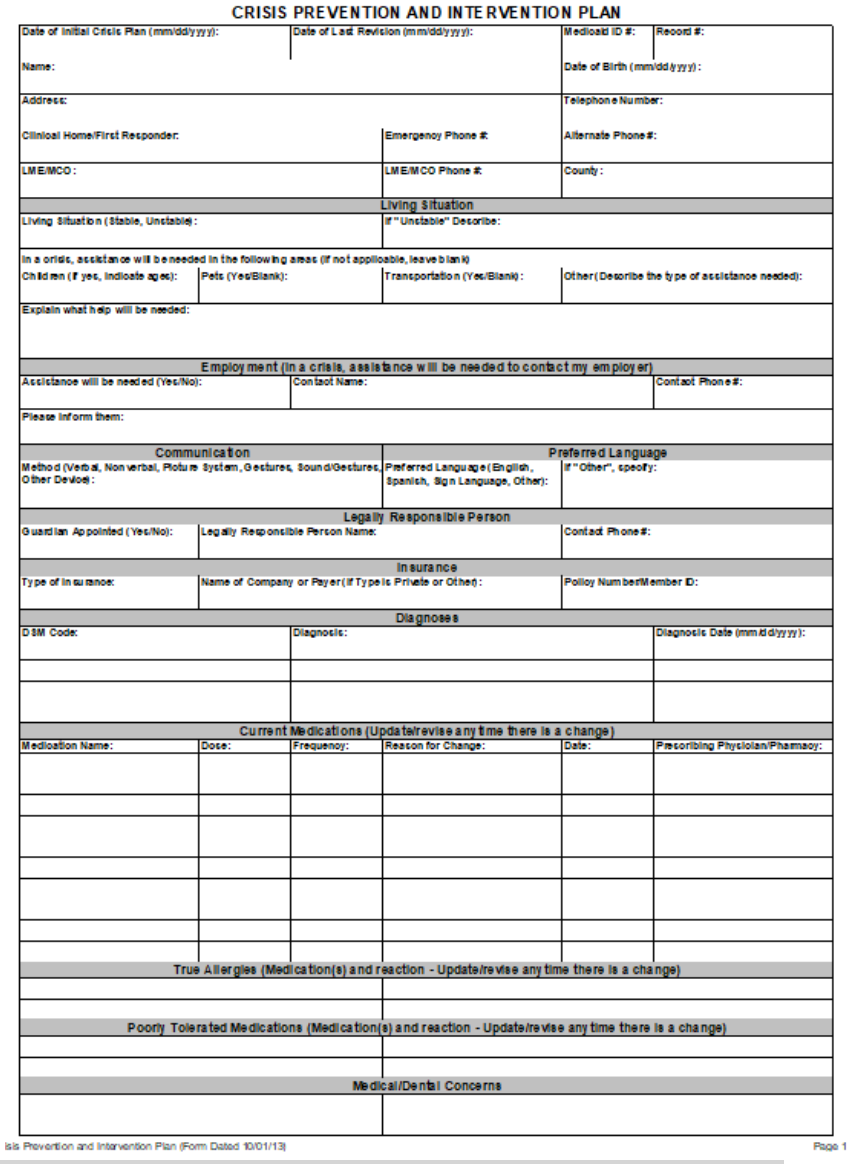


The introductory training is ALREADY available on UNC Behavioral Health Springboard and can be accessed HERE if needed ☺

PCP Crisis Plan Requirements

Effective November 1, 2023, all PCPs must include the full 3-page Crisis Plan

- Previously, the 3-page Enhanced Crisis Plan was only required for Enhanced Service Providers
  - (e.g., Assertive Community Treatment Team, Community Support Team, etc.)
  - other service providers were only required to complete the last page of the Crisis Plan
- The workgroup recommended this change because they believed that the more detailed crisis plan would be beneficial for all individuals.



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, Non verbal, 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 any time there is a change)					
Medication Name:	Dose:	Frequency:	Reason for Change:	Date:	Prescribing Physician/Pharmacy:

True Allergies (Medication(s) and reaction - Update/revise any time there is a change)	

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

Medical/Dental Concerns	

isis Prevention and Intervention Plan (Form Dated 10/01/13) Page 1

Facilitators

Let's Start with YOU!

- Audience Participant Poll (Multiple Hats Allowed)
- In CHAT: Please tell us, if you could share meal and conversation with any ONE person (current or historical), who would that be?

*A note on our use of terms: Person, *service user, participant, client, person in recovery, patient, person with a disability, psychiatric survivor, person with lived experience, person in distress, consumer.* ***Always honor individual preferences and when in doubt, ASK!***

Janis Tondora

Janis Tondora, Psy.D., (she/her), is an Associate Professor at the Yale School of Medicine. Her work involves supporting the implementation of person-centered practices that help people with behavioral health concerns and other disabilities to get more control over decisions about their services so they can live a good life as they define it. She has provided training and consultation to over 25 states seeking to implement Person-Centered Recovery Planning and has shared her work with the field in dozens of publications, including her 2014 book, *Partnering for Recovery in Mental Health: A Practical Guide to Person-Centered Planning.* Outside of work, you may find Janis enjoying the great outdoors with her family (human and furry!) on a paddleboard, in the mountains, or at the beach.

Plan for the Webinar

- Welcome/Housekeeping
- Brief History of the NC PCP Initiative
  - Including the expansion of requirements around the “Crisis Plan”
- The NC PC Crisis Plan:
  - **Janis**: Framing the problem; Why are crisis plans important; Key resources; Core Values
  - **Leigh Ann:** How to engage with the person; Common challenges; Supported decision making; Complementary tools
    Amy: A lived-experience perspective on the power of person-centered crisis plans
- Putting it all together: Review of Roma and Fred (Janis & Leigh Ann)
- Closing Q&A and evaluation

A Reminder:

Diverse PCP models/tools to meet diverse needs and preferences …

But with SHARED vision and values

There is no ONE “right tool to create a PCP or a person-centered crisis plan!

tlc the learning community for person centered practices

nwic National Wraparound Implementation Center

Building Your Toolkit

- *Starting with your "home grown resource"*

- ***Training Elements/Instructions***
  - Tab 1 of Crisis Plan Template
  - Comprehensive guidance around essential values, FAQs, and "step-by step" pointers
  - When in doubt, refer back!

Crisis Plan Template (FINAL 8.30.22).xlsx

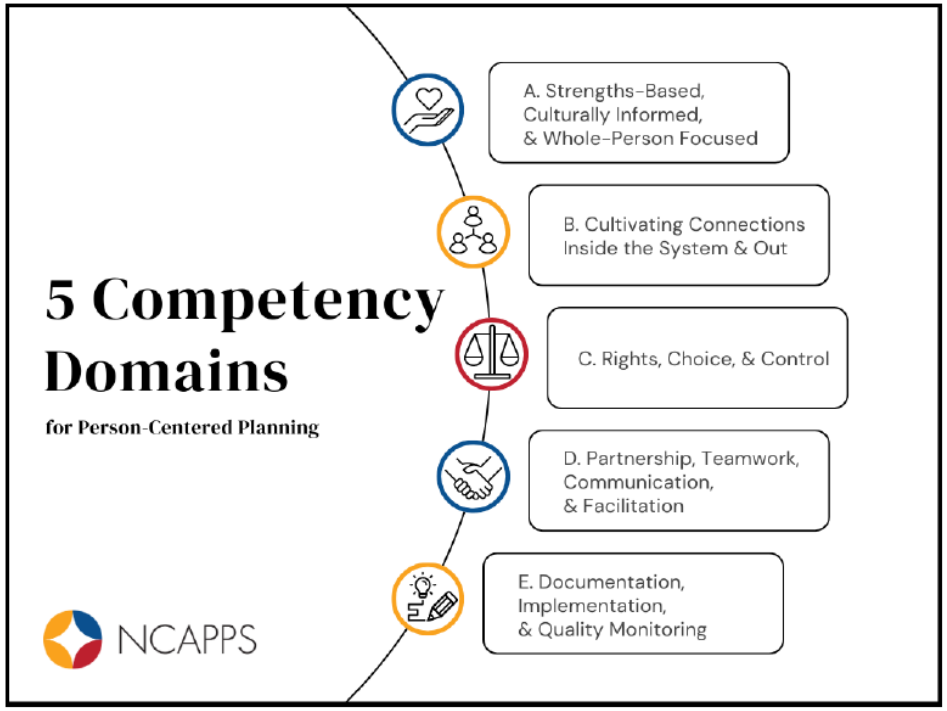
CRISIS PREVENTION AND INTERVENTION PLAN TRAINING

REQUIRED CORE ELEMENTS	
1. WHAT is a crisis plan?	A crisis plan is a document designed to: > provide all the information necessary to support and give direction to help prevent a crises from occurring, > to respond effectively when they occur, and > to plan for their successful resolution.
2. WHO should receive a crisis plan?	Person-Centered Comprehensive Crisis Plan: > The revised Comprehensive Crisis Plan will be required for any individual who is receiving a service that requires a Person-Centered Plan.
3. WHY are crisis plans important?	> Ensure a more comprehensive approach, with an emphasis on promotion, prevention, treatment, rehabilitation, care and recovery. > Can avert danger to the individual or other's health and well-being. > Can reduce the need for expensive resources, such as emergency room treatment or psychiatric hospitalization, thereby saving costs. > Can prevent setbacks to a 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. 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 repeated psychotic episodes or mental health crises. o various other setbacks.
4. WHO should have access to an individual's Crisis Prevention and Intervention Plan?	With the individual and/or guardian's permission, the crisis plans should be uploaded to a computer and a paper or electronic copy made available to: (NOTE: A good crisis plan needs to be available to ALL who will need it in a crisis.) > 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. (NOTE: The Service Provider is to maintain a current file of the Person-Centered Plan/Crisis Plan for all individuals receiving Enhanced Services and/or individuals deemed to be at risk and in need of a crisis plan). > LME-MCO Call Center (day-time and after-hours) Personnel. The call centers are staffed by trained workers who can assist callers with their crisis event, make referrals and contact emergency services or first responders if deemed necessary. > Emergency room personnel and the individual's physicians. > Legal Guardian(s)/Family. > Residential providers. > Law Enforcement. > LME – MCO staff (Care Coordinators). > 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).*

Building Your Person-Centered Toolkit

Practitioners support people in having control and discovering their voice in all aspects of plan co-creation, implementation, and review.

- ***Five Competency Domains for Staff Who Facilitate Person-Centered Planning*** **(NCAPPS, 2023)**



C: Rights, Choice, and Control	• Integrated Support Star for Supported Decision Making[1] • Decision making profile[3] • Decision making agreement[3] • Important To/Important For[3] • Psychiatric Advanced Directives[6] • Driver's Seat Toolkit for people with behavioral health conditions[7] • This Is Your Life: Creating Your Self-Directed Life Plan[12] • Considering the Role of Antipsychotic Medications in My Recovery Plan[14]

Framing the Problem

Why are person-centered crisis planning tools necessary?

- Tendency toward involuntary/restrictive solutions without fully utilizing our person-centered approaches/tools
- Involuntary/restrictive solutions are experienced as traumatizing; They can do irreparable harm
- Person-centered strategies are needed at all times, but are perhaps MOST crucial in collaboratively navigating crisis situations

Dynamics Which Complicate Crisis Planning

- Overall risk-aversion among providers (and others who care about the person!)
- A genuine desire for people not to come to harm; fear and past trauma
- No clear definition or SHARED understanding of what constitutes a “crisis”
  - Our view versus the person’s view
  - What we perceive as “not in their best interest” or inappropriate/maladaptive…
- Liability
- Lack of tools/guidance/training for staff resulting in under use of best practices and a default to more restrictive measures

Benefits of Person-Centered Crisis Plans

- Crisis Prevention and Intervention Plan
  - Proactively avoid/minimize risk of escalation to crisis
- Increase safety and reduce harm (due to the crisis itself OR how it is managed)
- Avert consequences of crisis – emotional, practical, interpersonal, health
- Potentially reduce the need for high intensity services such as ER visits, hospitalization, etc. Positive HUMAN and FISCAL benefits

Keep in Mind Core Values

- Shared responsibility; partnership and blend of “voice” in the CP
- Plan as a living document; need to revisit AFTER the crisis has resolved; what did we LEARN
- Using a whole person, strengths-based approach

Accessing/Sharing the Plan When Needed

- In order for the plan to be effective, the plan needs to be available to all who need it in a crisis!
- Who should have access?
- Secure necessary ROIs at the time of completion
- Facilitate access by sharing for the person (with their permission) or providing copies for them to distribute

Leigh Ann Kingsbury

Leigh Ann Kingsbury, MPA, Gerontologist (she/her), is the Principal Consultant of InLeadS Consulting. For more than 30 years she has used best practices in person centered approaches to support people who live with disabilities, including psychiatric diagnoses, intellectual/developmental disabilities, and people living with dementias. She has published widely on the topic of person-centered practices and has consulted across the US, Canada and the UK on using person centered practices to facilitate healthcare decisions and advance care planning. She is the author of People Planning Ahead: A Guide to Communicating Healthcare and End of Life Wishes. Outside of work, Leigh Ann loves to spend time outdoors with plants and flowers and she has a 30-year passion for rescuing Persian cats.

Completing the Crisis Plan

- Presume competence and engage with shared responsibility and decision making
- Be clear about what other strategies and tools exist, such as a supported decision-making agreement, power of attorney, or authorized representative agreement
- Clarify what the person expects from their supporters
- Who is the point person during crisis? If hospitalized, who is visiting?

Common Challenges

1

Supporting people who don’t use speech for communication

2

Supporting people who have labels of challenging behavior

3

Engaging with people for whom information is sparse, or who have few (if any) unpaid supports

Supporting People Who Do Not Use Speech for Communication

Speech is motor; language is cognitive
Not talking/not using speech does not equal “not understanding”
Presume competence, ask permission
Engage with the person first and always; use their name often; use eye contact; explain that you’ll talk with their supporter to get specific answers if they are unable to answer
Take your time – allow time for the person to process
You must find others who care about/like/love the person (NOT simply “know” them)

Supporting People Who Have a "Challenging Behavior" Label

Stop talking, stop moving, be still, and listen more

Presume competence, assume trauma

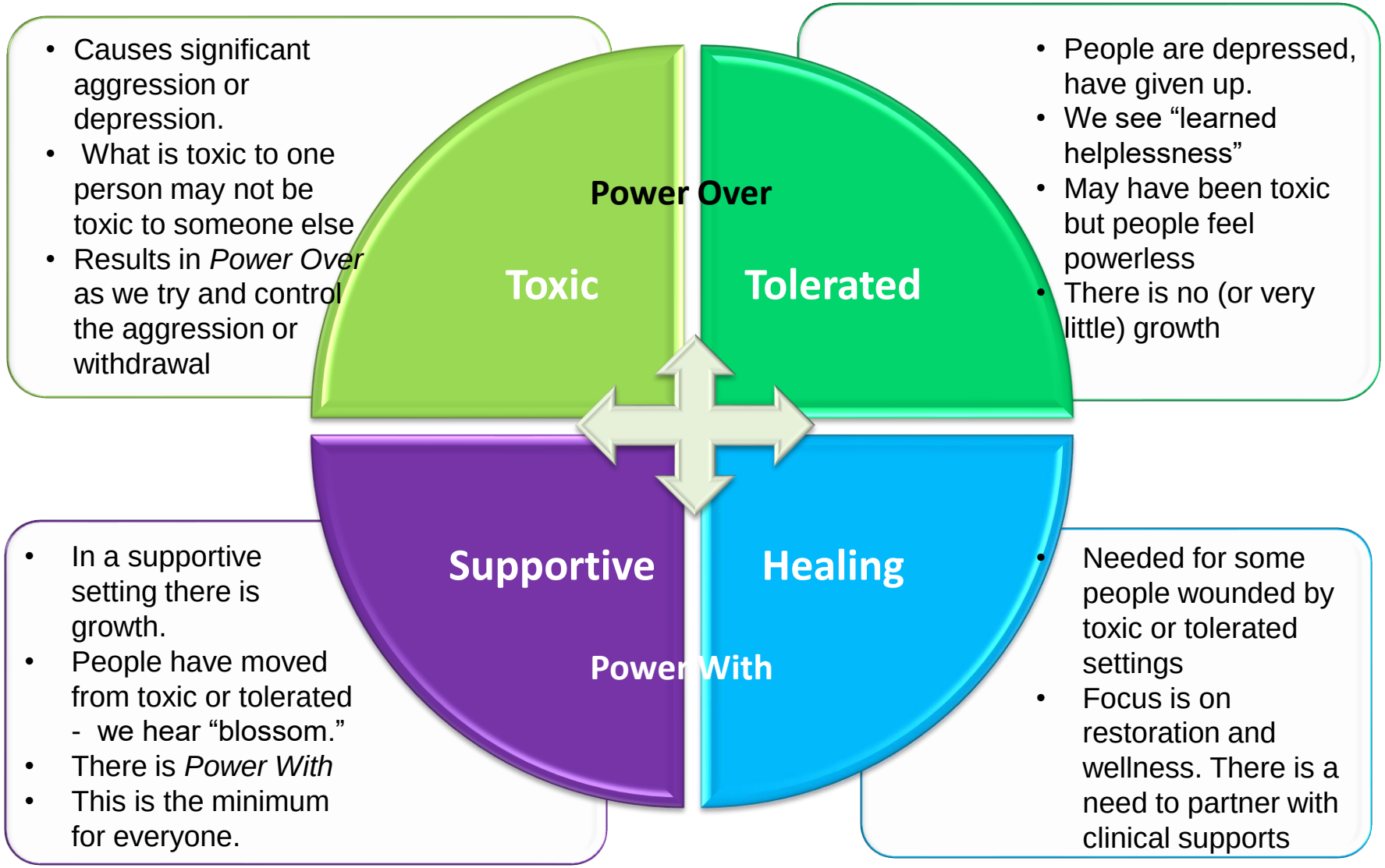
Do not assume you need to "stop" the behavior (you might, but you might not)

Look at both – depth and breadth of the person's life – what can you learn?

Look for ways to give back control to the person and share power

Consider where and how the person spends time: Toxic to them? Barely tolerable? Supportive? Healing?

The Role and Importance of Environments



- Causes significant aggression or depression.
- What is toxic to one person may not be toxic to someone else
- Results in *Power Over* as we try and control the aggression or withdrawal

- People are depressed, have given up.
- We see “learned helplessness”
- May have been toxic but people feel powerless
- There is no (or very little) growth

- In a supportive setting there is growth.
- People have moved from toxic or tolerated - we hear “blossom.”
- There is *Power With*
- This is the minimum for everyone.

- Needed for some people wounded by toxic or tolerated settings
- Focus is on restoration and wellness. There is a need to partner with clinical supports

Supporting People When Information is Sparse

You may be the first person to truly listen and acknowledge – do not underestimate the impact you may have

If the person has a history of actions that are hurtful to others, understand the lens through which information comes

It can be hard to see someone's gifts and talents when you dislike them

When we do not like someone, when someone annoys us, we tend to lead with snark and disdain, not empathy or compassion

Supported Decision Making

- A legally recognized decision-support process where a person chooses *specific supporters* to help them with *specific decisions*
- Supporters are identified in a Supported Decision-Making Agreement (SDMA)
- At minimum, typical SDMAs include:
  - Name of supporter, and their specific role
  - Consent/agreement from person and supporter
  - Start and end date of agreement, and/or “check-in” date
  - Witness or notary
- Supporters ***are not*** decision makers, nor acting as an agent of the person. They provide support only, as defined by the person
- SDM meets NC law’s requirements (SB 615) for trying a less-restrictive alternative before applying for guardianship

The Plan Should be Informed by OTHER PC Tools (as available)

- Opportunity to start with strategies the person/their circle know work best
- Core value of lived-experience-informed

29	Additional Planning Documents (Indicate if the individual has any of the following documents. If "Yes", attach the document to the Crisis Plan)	
30		Yes/No
31	Individual Behavior Plan	
32	Suicide Prevention and Intervention Plan	
33	WRAP Plan	
34	Futures Plan (youth in transition/young adult)	
35	Advanced Directives	
36	Living Will	

Helpful Tools

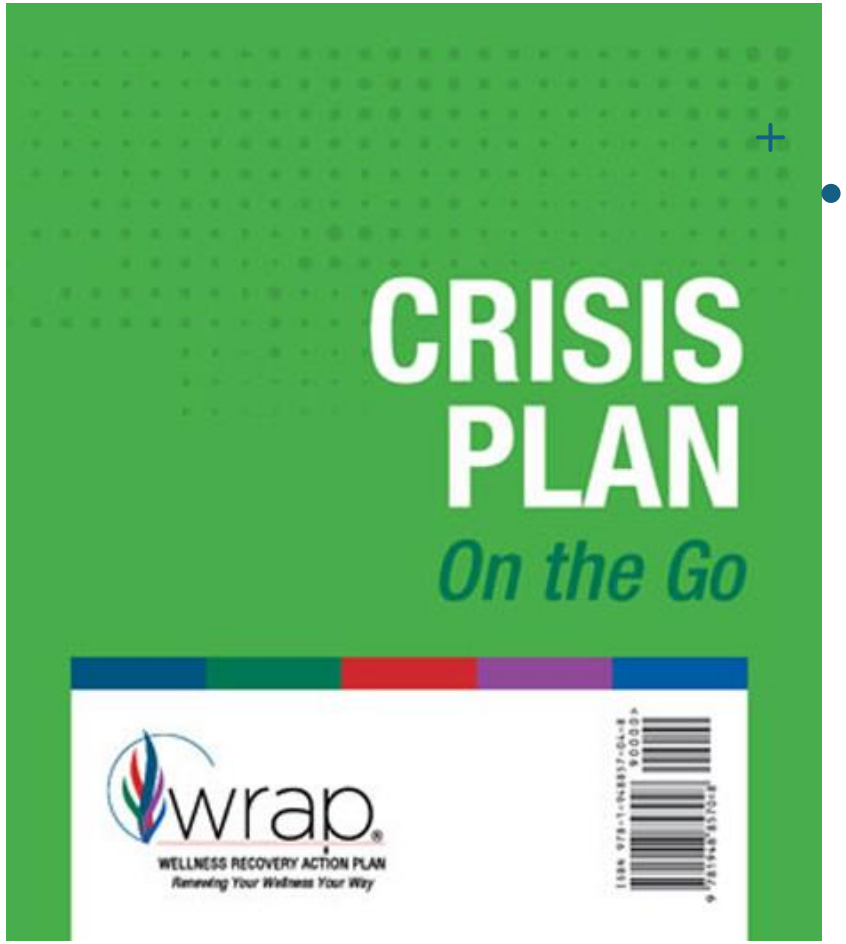
- Person-Centered Thinking tools
  - Communication Charts (should *always* accompany a behavior plan)
  - Debriefs:
    - Immediate and short-term learning: 4+1 tool
    - Long-term learning: Learning Logs
  - Matching
  - From the person's point of view: "If I could, I would…"
- Charting the Life Course tools
- Inclusion Press
- North Carolina: Rethinking Guardianship
- The National Resource Center for Supported Decision Making
- The National Guardianship Association (look for Standards of Practice and Position Statements)
- Young adults and transitioning youth: Center on Youth Voice Youth Choice
- National Resource Center on Psychiatric Advance Directives
- Wrap Crisis Plan on the Go

Amy Pierce:
The Power of a Person-Centered Crisis Plan: A Personal Example

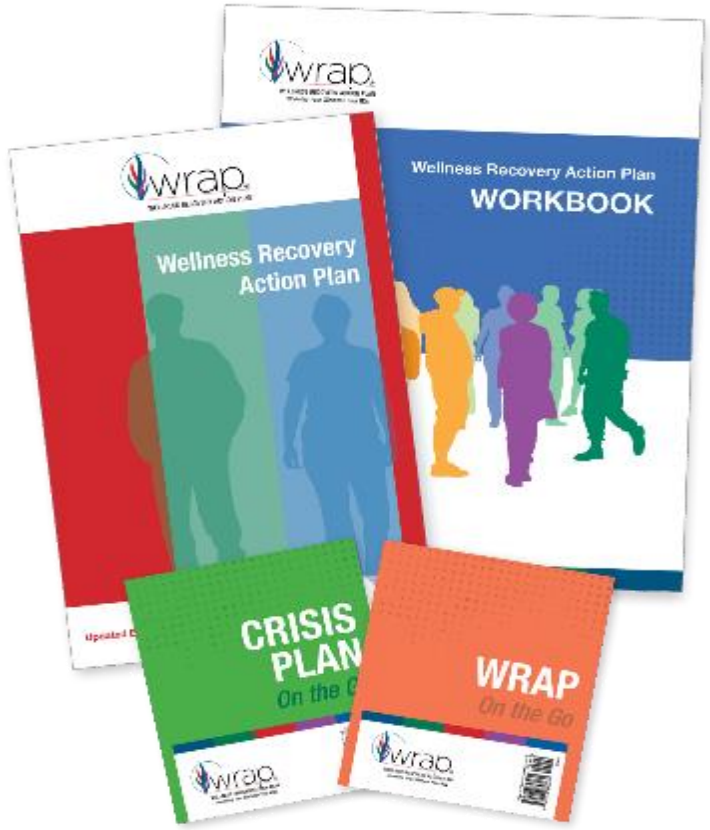
Amy Pierce, MHPS, PSS, ALF (she/her) is an international trainer and consultant and has been working in the Peer Movement in the state of Texas for over two decades. She has extensive experience in the peer support sector, having started the first peer support program in the state hospitals in Texas, working as a peer support worker in a community mental health agency, and the Program Coordinator for a transitional peer residential housing project. Amy also enjoys reading secondhand books in the pool, watching birds in the bay, and being a jungle gym to her two energetic nieces.

WRAP® Crisis Planning & Post-crisis Planning

- This is the only part of WRAP® that we talk about that needs be to shared with others to work.
- Crisis is defined by the individual: We can use this part of the planning process for any life issue and include direction for our treatment of medical issues.
- It is always a plan that we choose: who supports us; what supports we want and do not want; how we are supported by others including medical professionals.
- Wrap Crisis Plan on the Go



Structure of the WRAP® Crisis Plan (EBP)



Part 1	What I'm like when I'm feeling well
Part 2	Signs I need supporters to step in
Part 3	Supporters
Part 4	Medications/supplements/health care
Part 5	Treatments and complimentary therapies
Part 6	Home care/ community care respite
Part 7	Hospital or other treatment facilities
Part 8	Help from others
Part 9	Inactivating the plan

General Structure of the WRAP Crisis Plan

Part 1	What I look like when I am well
Part 2	Signs I need my supporters to follow this plan
Part 3	At this time, I want my supporters to
Part 4	If my supporters disagree on a course of action, I want them to settle the dispute in this way
Part 5	I want the following people to support me in these ways
Part 6	People who should not be involved in supporting me or making decisions on my behalf
Part 7	Things to support me feel better and get back to wellness and things, which do not support me and would make things much worse
Part 8	When I'm in a crisis, these are the tasks to be taken care of, and who I want to do them
Part 9	These are the signs that will let my supporters know it's time to stop using this crisis plan

Common Pitfalls When Only Using the Crisis Plan

- It often can be called “Crap WRAP”
  - “Good” crisis planning is about prevention and wellness as much as crisis!
- It remains a “flat piece of paper” or something that only exists in an EHR
- Persons do not feel it is voluntary in nature and often answer the questions quickly and provide responses that they believe persons are looking for
- “I’ve worked the worksheet with many people and think of WRAP as a crisis plan. But I don’t want to help people plan for their next hospitalization”-peer specialist

When a WRAP Crisis Plan is Created using the Values and Ethics of WRAP….

- It builds upon the other sections of WRAP including the Key Concepts and that work helps a person thoughtfully create a Plan that is uniquely their own
- Persons begin to take agency into their own wellbeing
- This plan allows a person to maintain some degree of control over their lives even when it feels like everything is out of control.
- It will take time to complete.
- Often persons will never have to activate the plan and if they do often times the period of “crisis” is shorter and persons come through it with less life impact
- Crisis is not something to be feared, and provides opportunity for learning and growth
- A Crisis Plan will also support a person’s supporters/care providers
- **IT CAN CREATE A FOUNDATION THAT SUPPORTS AN INDIVIDUAL TO REACH FOR THEIR OWN DREAMS**

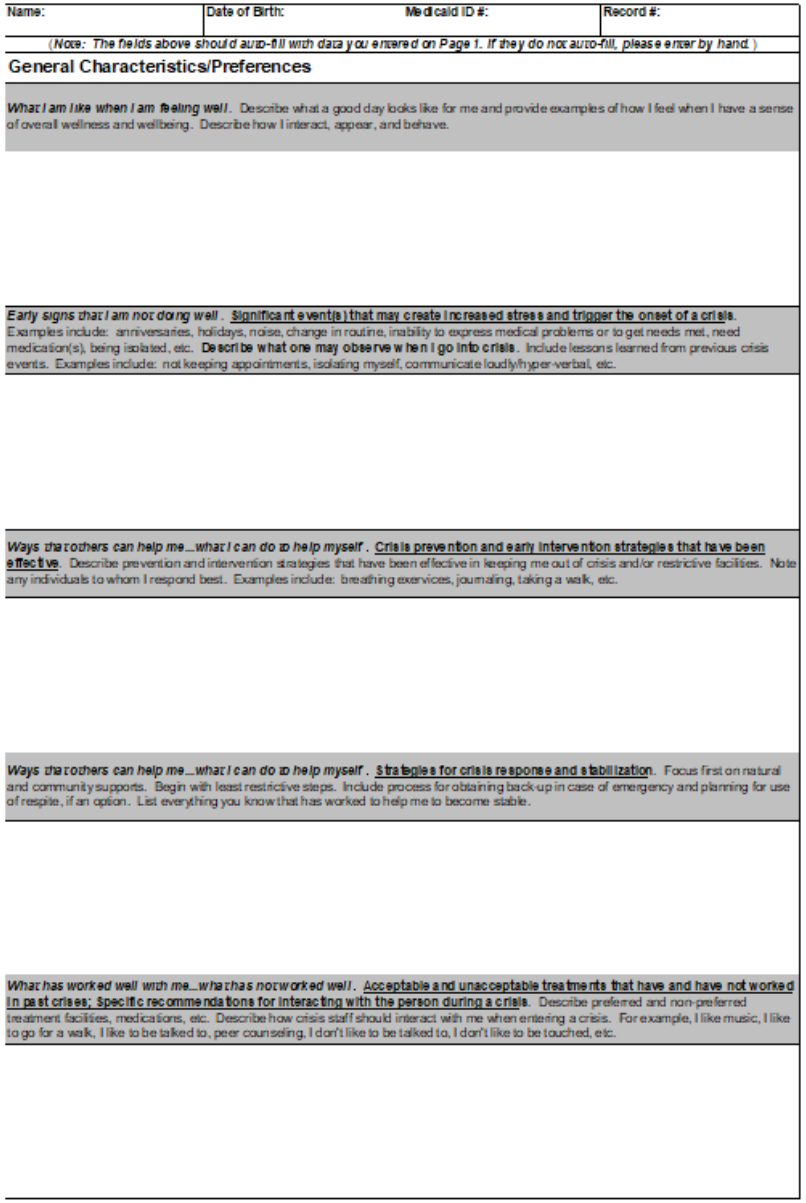
- *These plans may inform our Advanced Directive/PAD – which is a separate legal process defined by state laws and regulations.

So, what does a “good” crisis look like?

- Key Reflection Questions:
  - Is there sufficient direction or guidance to be truly helpful to the person in a crisis?
  - Is the crisis plan truly an individualized plan?
  - Is the crisis plan up-to-date?
- Let’s illustrate with a few samples…

Crisis Plan P. 3: Preferences & Characteristics

- What I am like when I am feeling well.
- Early signs that I am not doing well.
  - Significant event(s) that may create increased stress and trigger the onset of a crisis.
- Ways that others can help me...what I can do to help myself.
  - Crisis prevention and early intervention strategies that have been effective.
- Ways that others can help me...what I can do to help myself.
  - Strategies for. crisis response and stabilization
- What has worked well with me...what has not worked well.
  - Acceptable and unacceptable treatments; Specific recommendations for interacting with the person during a crisis.



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

What I am like when I am feeling well. Describe what a good day looks like for me and provide examples of how I feel when I have a sense of overall wellness and wellbeing. Describe how I interact, appear, and behave.

Early signs that I am not doing well. **Significant event(s) that may create increased 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, need medication(s), being isolated, etc. **Describe what one may observe when I go into crisis.** Include lessons learned from previous crisis events. Examples include: not keeping appointments, isolating myself, communicate loudly/hyper-verbal, etc.

Ways that others can help me...what I can do to help myself. **Crisis prevention and early intervention strategies that have been effective.** Describe prevention and intervention strategies that have been effective in keeping me out of crisis and/or restrictive facilities. Note any individuals to whom I respond best. Examples include: breathing exercises, journaling, taking a walk, etc.

Ways that others can help me...what I can do to help myself. **Strategies for crisis response and stabilization.** Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help me to become stable.

What has worked well with me...what has not worked well. **Acceptable and unacceptable treatments that have and have not worked in past crises; Specific recommendations for interacting with the person during a crisis.** Describe preferred and non-preferred treatment facilities, medications, etc. Describe how crisis staff should interact with me when entering a crisis. For example, I like music, I like to go for a walk, I like to be talked to, peer counseling, I don't like to be talked to, I don't like to be touched, etc.

Roma's Story

- 29-year-old Puerto Rican female and loving mom of 2 teens
- Many strengths, including her supportive cousin, creativity, work history
- Survivor of childhood abuse and multiple Adverse Childhood Experiences (ACEs)
- Long history of polysubstance use, major depression, and Post-Traumatic Stress Disorder
- Medical issues (Hep C) but "refuses" to go to the doctor
- Intermittently unhoused; history of incarceration
- Released from prison 6 months ago
- Began living with a cousin who had temporary custody of her children
- Asked to leave 1 month ago due to verbal and physical "blowouts" with daughter and concern re: substance use
- Clinician referred Roma to a local transitional shelter with behavioral health services
- Doing well volunteering in reception but admits to "slips" with drinking
- Roma is open to services and highly motivated to get her kids back

Roma: Person-Centered Summary

Roma is a 29-year-old Puerto Rican woman, and a deeply loving mother. Through the years, she has had the support of a cousin to help provide for her minor age children as she struggled to manage a serious trauma history and subsequent medical and behavioral health issues (hepatitis C, major depression, PTSD, poly-substance use). She was recently referred to a Community Support Team (CST) by a representative from Child Protective Services after she was asked to leave her cousin's apartment, with whom she had been living, due to frequent volatile arguments with her 14-year-old daughter and a possible relapse on alcohol. Roma's daughter is currently at the same age that Roma was when she became pregnant with her as a result of sexual abuse at the hands of her own father. Unresolved trauma issues appear to be triggering an increase in symptoms and making it particularly difficult for Roma to parent her daughter and manage her recovery. In addition, Roma has been reluctant to follow-up on treatment for her hepatitis C which may be due to her trauma history and discomfort with male providers.

Roma is living in a Transitional Shelter, and while she is feeling very overwhelmed and distressed by her situation, she is hopeful regarding the program and has made it clear that her priority goal is to work toward re-gaining custody of her children. She is in the action stage of change and is motivated to work with her providers in order to develop the stability and skills needed to be the best mother she can be. This includes Roma's expressed desire to give up drinking and work toward abstinence. She may benefit from connection to trauma-informed care and specialty medical and substance use services as well as the development of parenting and communication skills, symptom management/coping skills, and independent living skills associated with household management (e.g., budgeting).

Roma has a number of strengths and interests to draw upon in her recovery. She is a devoted mother who has demonstrated significant resilience having survived multiple traumatic experiences in her life. Consistent with her culture of origin, she places a high value on family support, has benefitted from a close relationship with her cousin, and may prefer natural supports to formal treatment services. Roma is highly creative and artistic and has found refuge in painting and poetry, which she uses as a coping skill.

Roma's Crisis Prevention Plan, P. 3

General Characteristics/Preferences
What I am like when I am feeling well. Describe what a good day looks like for me and provide examples of how I feel when I have a sense of overall wellness and wellbeing. Describe how I interact, appear, and behave.
My best days are when I have good visits with my kids. I get up, put on something nice, I'm hanging out socially with the people at the shelter. When we get together, me, my cousin and the kids, we laugh and talk and do something fun. It gives me hope and I feel calm and peaceful. When I am not with my kids I feel best when I am doing something creative or useful. I like to paint or read or write poetry and it feels good when I am helping out around the shelter. People tell me I am kind and funny and that makes me feel good. I like to finish up a good day by going to a meeting (AA). I don't always talk, but now that I haven"t drank in a while, it makes me feel like I am making progress and I speak up more.
Early signs that I am not doing well. **Significant event(s) that may create increased 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, need medication(s), being isolated, etc. **Describe what one may observe when I go into crisis**. Include lessons learned from previous crisis events. Examples include: not keeping appointments, isolating myself, communicate loudly/hyper-verbal, etc.
The thing that sets me off the most is when something messes up my visits with my kids and they get canceled. Or when we do get together, if we end up fighitng or they don't really believe I'm doing well. When that happens, it reminds me I haven't always been there for them the way I should have. I sometimes get flooded with bad memories when I am really stressed out or upset. I try to escape from the world and just stay away from everyone. I have a hard time taking care of myself. I have difficulty sleeping and might end up staying in bed all day if nightmares had me up all night. I forget about bills and I can't find the energy to take care of the basic stuff I know I need to - like taking a shower or changing my clothes. Then the biggest sign I'm struggling is when I start drinking again. I might start blowing off meetings and blowing off my shifts helpling at the front desk. And I'm really on edge, I'll be getting into it with people at the shelter and start yelling and lose control if they are getting on me about drinking. Then I feel terrible about it after and stay away from everyone even more. Its a BAD cycle. Certain times of the year are also really hard for me. I tend to get really depressed in the Spring becasue my grandmother died in May and she was the only adult who ever really did right by me... And then, the holidays are tough, particularly if I am apart from the kids. Christmas and Thanksgiving are probably the worst. I already missed enough holidays with them, I just want my life to be different sometimes.

***Ways that others can help me...what I can do to help myself*.** **Crisis prevention and early intervention strategies that have been effective.** Describe prevention and intervention strategies that have been effective in keeping me out of crisis and/or restrictive facilities. Note any individuals to whom I respond best. Examples include: breathing exervices, journaling, taking a walk, etc.

When I can't handle things, I try to relax by writing in my journal, painting or reading. People always said I was "artsy," and that helps some. Even though I sometimes don't want to, going to the AA meetings really does help. Just being around people who are trying to get better makes me understand what I am going through and reminds me I'm not the only one. I also try to use the relaxation and mindfullness exercises that Sally has been teaching me in therapy. I like to practice gratitude and I'll sit quietly in the morning and make a mental list of things I'm grateful for. I have so much anger about the past but practicing gratitude helps me let go of it some. Deep breathing can also be helpful but I don't like to do it with my eyes closed because I get very anxious. Sometimes talking to my kids calms me down, just knowing that they are OK. I've got things to live for and that helps me keep going to stay on the right track.

***Ways that others can help me...what I can do to help myself*.** **Strategies for crisis response and stabilization**. Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help me to become stable.

Right now I feel like there are a lot of people in my life I could call if I am feeling overwhelmed. My cousin (919-876-0743), my sponsor (984-323-5000), my peer specialist Audrey (984-323-7612), the Community Support Team (984-356-0903) and the staff at the shelter (919-251-7754) have all been very supportive. Its not like I need advice, sometimes I just have to get things off my chest and be heard and I feel better. When things are going bad, I could probably use some extra contact - maybe more visits with Audrey. If I am isolating, it does help when people take the initiative to reach out to me. Right now, I don't have responsibility for my kids, but if I do need to go to the hospital I want to make sure my cousin knows, so she can tell my kids and know what's going on.

***What has worked well with me...what has not worked well*.** **Acceptable and unacceptable treatments that have and have not worked in past crises; Specific recommendations for interacting with the person during a crisis.** Describe preferred and non-preferred treatment facilities, medications, etc. Describe how crisis staff should interact with me when entering a crisis. For example, I like music, I like to go for a walk, I like to be talked to, peer counseling, I don't like to be talked to, I don't like to be touched, etc.

When I am in crisis and especially if I am getting worked up, I need some space and sometimes the quiet room is helpful. Or just taking a walk with a staff person - not necessarily talking, but getting a break from the chaos on the unit, that can help me calm down. If possible, I have a strong preference for female female caretakers, therapists and doctors. One person talking to me at a time is better than a group. If I do have to go to the hospital I would prefer to be taken to Central Regional. I had a pretty good experience there. I got involved in the Peer Support groups and feel like the staff there know me pretty well. But one time Central didn't have a bed and I got sent to Broughton. It was hours away from my family and I didn't get to see my kids for a month and it was awful. If I am in the hospital and things are getting out of control, sometimes a prn med like Ativan will help. But I react very badly to being touched, especially by men. Please avoid restraints at all costs. It brings back the worst memories and will really set me off. My current medications have been working well and I trust my doctor. Please do not make changes to my meds without talking to her. In the past I had a really bad experience with Prozac. My heart was racing and I felt like I couldn't breathe.

Fred's Story

- Fred is a funny, kind man who lives at home with his parents, and younger brother, Eric. Fred loves to help others – and rarely turns away when someone asks for his help. Other people who know and care about Fred describe him as "never met a stranger", has an eye for details, an animal lover, and "a really kind human."

- Fred does not generally use speech for communication, though will occasionally call his brother by name, and frequently points out common animals he knows (dog, cat, bird).

- Fred's father and brother are commercial airline pilots and as such, have non-traditional working hours. They leave home and are gone for multiple days – and then come home and are home for several days at a stretch. Fred's mom does not work outside the home on a regular basis, but does volunteer a couple places and is involved in other community organizations (local gym, maintaining a community garden).

- Fred loves being outside, and in particular, really enjoys work that involves doing something physical outside. He has worked for several years for a local landscaping company. He doesn't usually need paid support any longer, as several of the employees agreed to provide work support as needed. Fred seems to enjoy spending time with his co-workers, and on a couple of occasions they have invited him to go to the movies or grab a beer after work. He seemed thrilled with these invitations.

- The challenge for Fred is he seems to struggle to understand that his job requires he get up and leave the house on work days by about 7am – and no one else in his house does this! He also seems to get anxious when his dad and brother are gone and he can't figure out where they are.

- Sometimes going to work and doing something physical can help Fred with his anxiety. But other times, it just increases his frustration and anxiety. Some days he won't leave the house. Usually, Fred loves to help – so when a coworker (or his mom) asks for his assistance, he jumps right in. But if he's experiencing anxiety or worry, he will often refuse and storm off; and if pressed on the issue, he may pick up something nearby and throw it, hard. Fred has broken a few pieces of equipment and more than one easy-to-grab flowerpot or planter.

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What I am like when I am feeling well . Describe what a good day looks like for me and provide examples of how I feel when I have a sense of overall wellness and wellbeing. Describe how I interact, appear, and behave.

When Fred feels well, when he is having a good day, he is silly, funny and playful. He enjoys helping his mom with gardening, chores around the house, errands, etc. His mom says he likes being given "important" jobs to do."
Fred is helpful and will typically do chores and other tasks that are his responsibility, as a member of his household.
Fred likes to be busy. He seems to get bored when he just sits around. He likes being included in whatever is going on --even if it seems mundane to others.

Early signs that I am not doing well . **Significant event(s) that may create increased 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, need medication(s), being isolated, etc. **Describe what one may observe when I go into crisis**. Include lessons learned from previous crisis events. Examples include: not keeping appointments, isolating myself, communicate loudly/hyper-verbal, etc.

Fred lives with an IDD and anxiety disorder diagnosis. He takes Prozac and has had success with a daily dose helping to reduce his overall symptoms of anxiety.
Sometimes, Fred struggles to leave home when his Dad and brother Eric are not home. He has a hard time understanding why he has to go to work early in the morning (no one else in his home does this!), and he seems to have a "fear of missing out" on something that may take place while he's gone for the day.
Indicators that he is struggling include:
_his sleep patterns may change (up later, not sleeping well, getting up during the night, wanting to stay in bed in the morning)
_arguing with his mom about things he typically does not argue about (e.g., picking up after himself) ("arguing" looks like: refusal to do what mom asks, signing "no", pounding his fist; signing "dad" or "airplane" but appearing distressed when he does so)
_not getting up on time to go to work (he ordinarily does this on his own)
_refusing to leave the house when his ride arrives, or refusing to get out of the car when his mom drops him at work
_physically, he'll be antsy -- he may pace, he may make a lot of loud noises, he may have difficulty completing a task that is a routine part of his job; his supervisor reports he will have to ask Fred multiple times to start and finish a task, when ordinarily he can tell him once and Fred will be fine

***Ways that others can help me...what I can do to help myself*.** **<u>Crisis prevention and early intervention strategies that have been effective</u>**. Describe prevention and intervention strategies that have been effective in keeping me out of crisis and/or restrictive facilities. Note any individuals to whom I respond best. Examples include: breathing exercises, journaling, taking a walk, etc.

__Plan ahead when Dad and brother will be gone for FaceTime or Zoom, preferably early morning, or before Fred goes to bed
__Use a visual reminder of when his Dad and Eric are coming home, such as circling the date on a calendar that Fred can look at
__Fred likes airports and likes to know what airports his dad and brother are flying into -- using websites to look at those airports and showing those locations on a big world map help him "see" where his dad and brother are going; he has pictures of almost all major airports and looking through his pictures and pointing out where Dad and Eric are flying can be a good distraction for Fred
__One of the challenges is that most of the time Fred does not seem anxious when his dad and brother are gone; it can be a little hard to predict since most of the time he's fine. It is helpful to have a menu of activities Fred can choose from, or staff/co-workers can choose from, to quickly put into play if Fred becomes upset. (for example: corn hole-like beanbags are great for throwing; Fred likes to throw things to help himself calm down; keep a bucket of those in the car; if he's at work, using a rubber mallet to smash gravel, or bags of mulch, or broken clay pots).

***Ways that others can help me...what I can do to help myself*.** **<u>Strategies for crisis response and stabilization</u>**. Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help me to become stable.

__Focused one-on-one time with mom or friends; eating a meal together, going for a walk; going to the gym with mom; swimming
__If Fred seems anxious or you notice he seems antsy, ask him if he wants to take a walk with you; he likes to run sometimes if the person he is with is a runner; physical and sensory-input movements are particularly useful: swinging, stomping, hopping, pushing or pulling a heavy object (he once had a direct care professional who was a Cross Fit athlete, and Fred loved going to workouts with this woman)
__Look for ways to spend time with Fred without imposing any expectations; talk about Dad and Eric; use visual cues to remind him when one or both of them are coming home
__ Use a "harm reduction" approach -- for example, if we know that throwing things or smashing things helps Fred feel calmer, be prepared with options for him that are safe to throw or smash (see Q9 of his plan). Examples include cornhole beanbags, tennis balls if there is a safe place to throw them; tossing or throwing down medicine balls; smashing gravel or mulch bags (this works well at work)

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What works:

__ENGAGE WITH him.

____ Remember, he likes being included in almost all activities and tasks -- even if you think it's low key or boring or mundane, Fred really likes being "a part" of the activity

__Talk about Dad and Eric being gone. Remind him they will come home (even better if you can tell him when); don't ignore Fred's distress; lean into it and involve him in managing it.

__Ask him what will help. Sometimes he'll want to hold your hand; it's always worth a try to reach out and see if he wants to hold hands or be close to you. Not always, but sometimes he will just go outside and start walking, and he seems to enjoy it if others go with him (just be prepared to walk fast); or if he's at work, he may pound on a bag of mulch, or a pile of gravel -- support him to do this (join him in doing it....you may have fun!)

__Support Fred to get physical in some fashion -- jumping up and down (jumping jacks, hopping on one foot, then the other, then both; swinging his arms wide and back and forth; see if he'll hold your hands and then swing your arms up and down and around...act silly. Fred loves things that are funny and silly).

__Try throwing things outside, banging on things, running or stomping as hard and fast as he can, being loud in places where it's okay to be loud (to be clear, he doesn't yell as if he's being hurt or threatened; he just makes a lot of loud noises and sounds).

__When provided the chance to do something physical, Fred will not typically remain upset or overly anxious for very long. He will ordinarily calm down within 10-15 minutes. But, it's possible he could have 3 or 4 episodes of increased anxiety in one day.

What doesn't work

__Being demanding -- telling Fred to "get it together"

__Giving "orders"

__Ignoring what's happening

__Expecting him to just "snap out of it" and "get back to work!"

__Telling him to "stop" -- Fred knows what "stop" means, but if he's really anxious or upset, remember he can't rationalize -- so you need to engage his body

Medication and Hospitalization Information

__Fred has taken Prozac for many years and it works well for him. Prior to taking Prozac, Fred's mom reports he seemed anxious all the time. Lots of pacing, poor sleep, lots of hand rubbing, unable to sit still; he generally seemed "uncomfortable." And he was distraught when his dad and brother would leave for work. Fred's dad says "Prozac has helped Fred 'even out'. He enjoys going to work; and now there are things we can do that help when he seems to be getting upset. It's been a really positive change for him."

__At home, if he has trouble sleeping for several nights in a row, his mom will offer him a small dose of Klonopin and that also works well. He does not take Klonopin during the day because it makes him drowsy. Although Fred can't tell us "I don't like taking this medicine during the day", we know that Fred likes to be busy; we know that napping throughout the day is not how he enjoys spending his time; so, his mom believes he would prefer to not be drowsy during the day.

__Fred was hospitalized in 2018 for a severe kidney infection. Being hospitalized caused a lot of anxiety for him and he found it hard to be away from his home. The hospitalist prescribed Ativan to help Fred feel calmer and it didn't work for him. He was more antsy, he cried a lot, he didn't want to eat. **Fred and his parents do not want him to take Ativan again.**

Closing Q&A… Your Thoughts and Ideas

Evaluation And Certificates

- **REMINDER: You must complete a brief, anonymous training evaluation to receive credit for today's training.**
  - Access the evaluation via the link in chat OR the QR code on your screen
  - Link will also be emailed to you at the email address associated with your registration. Along with a recording link and copy of the slide deck used in today's presentation.
  - The evaluation will close after 2 weeks. If you do NOT complete it within that time frame, you will lose the opportunity for a Certificate of Completion.
  - Follow the prompt at the end to enter your name (as you would like it to appear on your certificate) and email address.
  - Certificate will be from a sender named "Certifier."
  - Expect your Certificate by email within approximately 3 weeks. Please check junk/spam mail prior to contacting anita.allen1213@gmail.com to inquire or to troubleshoot any technical difficulties downloading your Certificate.