

**Arizona Department of Health Services  
Division of Behavioral Health Services  
PROVIDER MANUAL  
Community Partnership of Southern Arizona (CPSA Edition)**

**Section 10.14** Crisis Planning and Risk Assessment

**I. Purpose**

- A. To ensure that CPSA enrolled members have a crisis plan in place that anticipates future crises and appropriately plans for them.
- B. To ensure assessment of a CPSA Member's overall ability to be safe in the community and to assess the need for immediate interaction.

Adults and children receiving behavioral health services have complex needs and challenging behaviors and therefore can be at higher risk for crisis. Every individual and family receiving behavioral health services should therefore have a crisis plan that anticipates future crises and appropriately plans for them. Proactive planning for crises ensures that plans are designed when the Adult Recovery Team (ART) or the Child and Family Team (CFT) are capable of their most creative and best thinking. This planning should include both crisis prevention and crisis management.

It is important to recognize that crisis is self-defined by the person and/or his or her family experiencing the event. What is perceived as crisis for one person may not be perceived as a crisis for another person. The following are guidelines for assisting individuals with developing their individualized crisis plans. Guidelines serve as a framework and are most useful when used in the spirit of member directed care. A crisis plan developed without the active involvement of the member, his or her family or chosen supports is not beneficial.

**II. Targeted Population/Scope**

CPSA enrolled members who are enrolled and assigned with a Comprehensive Service Network (Network).

**III. Definitions**

- A. Crisis management: A process that serves to prevent crises from escalating to the point at which crisis intervention needs to occur. Effective crisis management occurs at the beginning phase of the crisis cycle, when emotional intensity is relatively low.
- B. Crisis intervention (or stabilization): A process that occurs when a crisis has escalated to the extent that emotional intensity is so high, it causes a state of disequilibrium. Crisis intervention serves to resolve the member and/or family's immediate needs and restores them to the optimal level of functioning possible.

**IV. Special Considerations**

- A. For children and youth, the crisis may be related to a placement stabilization issue. It is important in the crisis planning process to understand that a change in placement may trigger a crisis event for children and youth. Therefore, it is important for children, youth and their families to address the possibility of placement change within the context of the Child and Family Team as a preventative measure.
- B. Children and adults with developmental disabilities are to be viewed within the context of their cognitive and developmental age and should be included in the Adult Recovery

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and/or Child and Family Team process whenever possible. Children with developmental disabilities tend to be particularly sensitive to change. Transitions, especially the transition to adulthood, need to be carefully planned to reduce the negative impact of any change.

**V. Guidelines**

A meeting to develop the crisis plan should be held in a timeframe based on clinical need but no longer than 90 days from the point of first service. In some cases a crisis plan will be developed before the service plan has been finalized. The steps of this process are fluid and should meet the needs of the member, his or her chosen supports and/or family.

Crisis planning is most effective when conducted within the context of an Adult Recovery Team (ART) and/or Child and Family Team (CFT). The team facilitator's task is to lead the team through the crisis planning process. Crisis plans address the question, "What things could happen to provoke a precipitous disruption in the service plan, or in the member's current level of functioning and what can be done to both prevent and respond to these potential occurrences?"

Crisis plans are to be developed as soon as clinically possible. They are to be signed by as many members of the Adult Recovery and/or Child and Family teams as feasible. It is suggested that all team members have a copy of the crisis plan for quick reference and that it is reviewed with the team members to ensure that everyone understands the member's needs as they are related to the crisis plan. This process is particularly important for individuals who may not know the member well and/or are new to the ART/CFT process.

**VI. Procedures**

Basic Crisis Planning Steps:

An effective crisis plan begins with a detailed functional assessment including things identified by the person as potential obstacles. Once a functional assessment is done, the following simple three step process for crisis planning are useful:

- A. Predict: Facilitator begins by assisting the ART/CFT in predicting obstacles to the behavioral health goals of the individual and/or family. The ART/CFT answers the question, "What could happen that might lead to a crisis? What is the worst thing that could go wrong?"
- B. Functional Assessment: (See [CPSA PM Form 10.14.1](#)) What events, behaviors or behavior sequences are associated with the initial, middle and ending phases of the crisis? The Functional Assessment:
  1. Summarizes what is known about past crises and how future crises may evolve:
    - a. What specifically happens during a crisis?
    - b. How often does it happen?
    - c. How long does it last?
    - d. Where does the behavior occur?
    - e. Who is involved? How are they involved?
  2. Determines what happens before the crisis.

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- a. What are the triggers?
  - b. Does the crisis happen more frequently with certain people, at certain times or locations?
3. Determines what happens after the crisis.
- a. What are the consequences of the crisis?
  - b. How do people feel?
4. Looks for exceptions, i.e., identify the components of wellness and effective coping for this particular individual.
- a. How do the person and/or family know when they are doing well?
  - b. What self-care (crisis prevention) strategies are the person and/or family implementing?
  - c. What are the circumstances that create optimal functioning for the person and or family?
5. Determines the most likely reason why the crisis is occurring?
6. Identifies alternative (crisis prevention and crisis management) or replacement behaviors.
- a. What behaviors have not worked in the past?
  - b. What behaviors have worked in the past?
- C. Prevent: The facilitator uses the information obtained through discussion with the individual and/or family as the foundation for developing options drawn from community and individual strengths to prevent the events, behaviors, and sequences of behavior that lead to the crisis.
- D. Plan: (see [CPSA PM Form 10.14.2](#)). The facilitator partners with the individual, family, and other members of the ART/CFT to develop steps for the management of the crisis should a crisis occur despite the prevention efforts of the ART/CFT. Clearly defined steps crafted in advance detailing how to manage the crisis when it occurs makes it much easier to handle, and will often lessen the intensity of the crisis as well as risk level of the crisis. The plan for managing the crisis provides direction to the individual and his or her natural supports when they are least able to problem solve due to the emotional affects of the crisis when it is occurring. The members of the ART/CFT know what to do and what not to do during the crisis. This step specifically describes who will do what, when, and where? Crisis Plans should include specific names and phone numbers, as well as contingencies.

Crisis planning can provide an appropriate opportunity to introduce, explore and document Advanced Directives for all adult members. For adult members who may in the future be prone to involuntary psychiatric commitment or treatment, an Advanced Directive for Mental Health Decision Making should be discussed in advance to express the member's desires and choices about treatment and can be included in the Crisis Planning process.

As members that are dually enrolled in DDD and CPSA and who are residing in out of home placements may have special needs in the midst of a crisis, the Developmental

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Disabilities/Behavioral Health Emergency Information and Crisis Plan ([CPSA PM Form 10.14.5](#)) should be used in lieu of [CPSA PM Form 10.14.2](#).

Although highly recommended, the use of [CPSA PM Form 10.14.1](#), [CPSA PM Form 10.14.2](#), and [CPSA PM Form 10.14.4](#) are not mandated. All Comprehensive Service Networks must utilize a Crisis Plan Form that includes all the elements found in [CPSA PM Form 10.14.2](#). [CPSA PM Form 10.14.5](#) must be used for all DDD-enrolled members.

**VII. When Safety Concerns are Imminent**

**A. Assessing Risk Level**

1. A Risk Assessment is meant to determine an individual's overall ability to be safe in the community and to assess the need for immediate intervention balancing all known factors. Factors that must be considered include, but are not limited to,
  - a. psychiatric history;
  - b. suicidal or homicidal ideation;
  - c. available supports;
  - d. the availability of a safe and supportive environment;
  - e. the level of cognitive functioning;
  - f. the level of impairment from physical factors;
  - g. recent major stressful events;
  - h. the presence of substance abuse;
  - i. identification with high risk groups.
2. Each factor must be explored thoroughly, with probing questions providing the level of detail needed to determine risk level. For example, the presence of suicidal ideation must be considered in the context of
  - a. past suicidal ideation or attempts;
  - b. the intensity and frequency of thoughts;
  - c. the availability of means to follow through;
  - d. history of suicide attempts by family members or friends, etc.
3. The supports available to a member must be considered in the context of identified needs and the likelihood of those supports meeting those needs.
4. The level of impairment from physical factors must be weighed against the member's resiliency and ability to function in spite of them.
5. Ultimately, the assessment of risk level carefully balances all identified dangers with all mitigating factors. This balance must be carefully documented and explained in clinical terms, so any clinician or reviewer will understand which factors were considered, what weight has been given them, and the rationale that underlies the final determination.
6. Although sometimes useful in engaging the individual in working with the therapist or other team members to develop and adhere to the safety aspects of a service plan, the willingness of a member to sign a no-harm agreement should not in any way be considered a mitigating factor to risk factors and should not influence the risk level.

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B. Risk Assessment as a Continuing Process

The assessment of risk level must be an ongoing and constant process. As such, behavioral health staff must always be cognizant of the factors that may place a member in jeopardy and adjust the service plan and intensity of service provision appropriately. There is no advantage to requiring risk level determinations at set times (e.g. quarterly or semi-annually) as member needs and life challenges change frequently and are rarely determined by calendars. An assessment of risk must therefore be considered an essential clinical response to any and all significant changes in a member's life or symptom presentation.

C. Service Determination

CPSA is committed to services that are based on individualized care, and on the individual's and the family's unique needs, strengths, priorities and values. As such, established Risk Levels do not trigger pre-determined sets of services. The specific services, and the intensity, frequency and immediacy of provision must be proportionate to and appropriate for the defined needs in order to reduce risk and ensure safety and clinical improvement. The decisions reflected in the service plan must be clear, explicable and well documented. This does not mean that a provider could not, or should not, have guidelines established to inform a given clinician of the service options that may/should be considered in response to a determined Risk Level.

At all levels of risk, the following considerations should be made:

1. If there are any factors related to suicidality or ideations refer to [CPSA PM Attachment 10.14.3](#) - "Assessing Suicidal Risk - Technical Assistance Document #4" and utilize [CPSA PM Form 10.14.4 - Special Suicide Risk Assessment](#) form.
2. Is the member safe in his/her current environment or is a more restrictive placement indicated?
  - a. Level I acute or sub acute?
  - b. SAMHC Crisis Bed?
  - c. Level II residential placement?
  - d. Respite placement?
  - e. In home one-on-one?
3. Does the member require a pre-petition screening, or, if on court ordered treatment, a revocation?
4. What additional wrap around services are needed to keep the member safe and stable in the current environment?
  - a. Prevention plan development?
  - b. Revision of the Crisis Plan?
  - c. Intensified case management?
  - d. Individual therapy?
  - e. In home one-on-one supervision?
  - f. Day or intensive outpatient programming?
  - g. Face to face case management augmented by daily phone calls?
  - h. Peer or other natural supports?

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- i. Immediate Adult Recovery Team or Child and Family Team with evaluation of current services in place and consideration of enhanced service provision?
5. What level of involvement is required of the Medical Behavioral Health Professional (MBHP)?
  - a. More frequent appointments?
  - b. Reassessment of diagnosis?
  - c. Immediate medication assessment and adjustment by MBHP?
  - d. Assessment of medications by nurse and coordination with Medical Behavioral Health Professional?
  - e. Intensified coordination of care between the MBHP and the ART/CFT?
  - f. Intensified coordination of care between the MBHP and the PCP?
6. What level of reengagement is required at this point in time?
  - a. With the member?
  - b. With the member's family?
  - c. With other involved agencies?
7. Are there additional natural supports that can lessen the current risk level? How can these supports be incorporated into Service Plans, Crisis Plans and ongoing assessment and services?