



PRACTITIONER GUIDANCE FOR CRISIS, RELAPSE AND CONTINGENCY PLANNING

Why has this guidance been developed?

To provide practitioners with baseline information on the processes involved in the development, implementation and evaluation of crisis, relapse and contingency plans.

Who is it meant for?

All practitioners who undertake, or contribute to, care coordination, care planning and evaluations (reviews) of care. Everyone who receives a service from AWP will have a crisis, relapse and contingency plan.

Does it contain everything I need to know?

This guidance covers the fundamental, or essential, elements of crisis, relapse and contingency planning. It is not an exhaustive guide to the subject.

What does it contain?

An outline of the core components of a standard crisis, relapse and contingency plan, with specific guidance regarding developing a crisis plan, identification of the person's relapse indicators/warning signs which may precipitate a crisis, and how to construct and record a contingency plan.

Where should I record the information?

In the relevant part of the care planning section of RiO – this is titled “Crisis, Relapse and Contingency Plan” and is separated into the following headings:

- Constructing the crisis plan
- Who will be caring for any dependent children
- Relapse indicators/warning signs
- Contingency plan

Complete the free-text boxes systematically.

What do these terms mean?

Crisis Plan – this is a ‘service user-focused’ plan that identifies details of self-management and social network support(s) aimed at preventing or reducing the likelihood of a relapse of the person's illness, or a deterioration in their mental state and the elevation of any risks associated with this.

Dependent children – any individual under the age of 18 years for who the person has permanent,

partial or intermittent parental and/or care-giving responsibilities.

Relapse indicators or early warning signs – the signs (things that are observable to other people) which, based on the person’s individual history, are most likely to indicate that some form of crisis or relapse is likely to occur. It is the use of this personal historical information to plan person-centred care.

Contingency plan – this is a ‘service-focused’ plan which details the actions, responses or interventions from any one or more of the services involved in the delivery of care and treatment to the service user. This identifies who will do what, where, when, how and with whom should a crisis occur. This plan would usually come into effect if the person’s crisis plan has failed to prevent a deterioration in their mental state or an elevation in the levels of risk.

What information supports this guidance?

The references for this guidance are:

- [Good practice guide to care planning](#) – AWP guidance (2013)
- [Refocusing the Care Programme Approach](#) (Department of Health guidance 2008)

Where can I obtain further information?

You should access further information from the following sources:

1. Your clinical/professional supervisor and/or line manager.
2. Your professional organisation – eg: BMA, RCN, etc. – and check whether they have published guidance for their members.
3. A useful video made by the Institute of Psychiatry and in association with Rethink Mental Illness, on the principles of care coordination and the role of the care coordinator is accessible here: [Care coordinators and care planning](#)

When was this guidance produced?

It was developed throughout 2013 and approved for use on 09/12/2013

When will it be reviewed?

On a three yearly cycle (2016), or earlier if necessary

Who developed this guidance?

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Introduction

An important aspect of planning care is formulating actions to be taken in the event of a deterioration in the person’s mental health and/or their disengagement from mental health services. This planning should be

undertaken, wherever possible, before a crisis occurs. The service user, their carer/s, their care team and any other relevant party should collaborate in formulating and agreeing the plan.

The two main aims of the plan are to support the person and carers to have an active role in maintaining their mental health at an optimum level, and to clearly communicate the actions for people to take if a relapse appears to be occurring.

Everyone receiving a service from AWP will have a Crisis, Relapse and Contingency Plan. If you are a care coordinator, it is your responsibility to ensure that this planning takes place.



The Crisis, Relapse and Contingency Plan is recorded in RiO in the care planning section. It is split into four sections, as follows:

1. Crisis Plan
2. Who will be caring for any dependent children
3. Relapse Indicators/Warning Signs
4. Contingency Plan



The 'crisis plan'

This section should focus on recording details of self-management and social network support to prevent relapse, at the point when the first early warning signs are noticed. These early warning signs are usually first noticed by the person themselves, or someone significant in their social network. This section should also record in great detail how the person keeps themselves mentally healthy, their skills and interests, their social contacts, their coping strategies, etc.

An example of one aspect of self-management for this section is given below:

'From your experience you have learned that losing sleep is often followed by a deterioration in your mental health. Loss of sleep has always been the very first sign of relapse that either you or your partner have been able to identify with hindsight, before a relapse occurs. You have learned that losing one night's sleep followed by a night of good sleep is unlikely to cause a relapse. More than one consecutive night's loss of sleep has usually led to a relapse. In the past when you have had a poor sleep you have been happy to let your partner know, and subsequently plan together for a better night's sleep the following day. This has included the following;

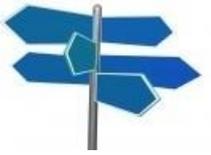
- a. Thoughtful meal planning for the day – your partner has agreed to help buy the food that you need.
- b. Planned activity in the evening so that you do not feel bored, but that excludes stimulating television, and limits your time on your PC to a maximum of 30 minutes each evening after 5pm.
- c. A minimum of 20 minutes moderate physical exercise in the afternoon – your favourite is going for a walk to the local shops of Dennington Road and then back home.'





Who will be caring for any dependent children

This section needs to detail the preferred arrangements that will need to be implemented if the person becomes unable to care for their child or children due to a mental health relapse. This may, for example, involve the parent requiring an admission into hospital and consequently needing their child(ren) to stay with relatives. Contact details of people to be involved, including daytime and evening contact information, and clarity about who has agreed to do what, needs to be recorded. Information such as who should be approached first, and then second, if the first person is unavailable, etc. should be included. Reference to any existing formal safeguarding arrangements and plans (with named contacts) should be included.



Relapse indicators/warning signs

This section is for recording what is likely to be observable to whom and what significance this is likely to carry. It is usually helpful to separate these out into:

1. Early noticeable signs – makes sense to record these and how they might be self-managed in the Crisis Plan section (see above)
2. Later signs – things observed by the person and others which may indicate a further deterioration in their mental state, level of functioning and/or an increase in risk(s)

It may make most sense to repeat some details of the above in both the Crisis Plan and Relapse indicators sections, respectively.

Relapse indicators/warning signs will vary from person to person, but their future relapse(s) are likely to present similarly to previous occasions. A clear description is needed of later relapse signs, which are known or expected to occur for the person, so that any deterioration can be accurately monitored and evaluated.



Relapse indicators/warning signs should be recorded using language which is clear, concise and meaningful to all involved. It should also be clear enough to be understood by others who may not have met the person before, but may be involved in their care during a crisis – eg: emergency department (ED) staff.

An example of one aspect of relapse indicators/warning signs for this section is given below:

‘You have learned from your previous relapses that if you are unable to improve your poor sleep once it deteriorates, then after the third or fourth night of poor sleep, you begin to feel, (especially with hindsight), that you are “out of control”, and other relapse indicators begin to appear. At this stage you are less aware of your relapse than other people around you. Your sister is the most likely person to bring to your attention that you are relapsing. At this stage you notice that your sister irritates you far more than usual. She also reports finding you to be short tempered with her as well as with others. Arguments, with raised voices



and doors being slammed, often occur. You describe feeling it is impossible to sit down and listen to your sister without interrupting her or walking away from her.'

The person's own words and phrases should be used in order for the plan to be most helpful to them. However, the plan should also be useful to any carer(s) that are involved, as well as staff members who may or may not know this individual when they present in a crisis. Therefore, some phrases may be improved by an explanation of what they mean, for the benefit of these other people.



Contingency plan

This section describes what should be done and by whom if the crisis plan and service user self-management and carer(s) input does not manage to avoid a relapse. The contingency plan should focus on what AWP and other services' input will be.

Whilst someone is receiving services from AWP, the contingency plan will usually focus on specific actions to be taken in the event of reduced engagement by the person with their CPA care plan. This could include missed appointments, or failed attempts attend face to face meetings.

When someone is working towards discharge from AWP services, then the contingency plan will be re-written as a re-access plan and will therefore be very different compared to when the person is receiving services.

Again, this section must be individualised and written in such a way that makes it useful for both the service user themselves, the people who know them, and also for staff who may need to act in a crisis, but who may have no prior knowledge of the person. It will be useful for the service user to understand why it is important that 'their' contingency plan is written in a way that is also useful to staff in other services.



This section should detail how the person and their carer(s) can access specific support from AWP services. Appropriate telephone numbers and times that specific services operate must be included. What to do outside of those operating times, including further contact details, may also be required. Specified staff names should be included and details of who should do what, where and when, etc. If any specific 'uploaded document' in RiO should be accessed, or an 'advance decision or statement' exists in the MCA section, then this must also be referenced.

It may be appropriate to specify the names of individuals and their relationship to the service user, for people who are most likely to contact AWP services on their behalf.

In addition to the contingency plan detailing actions to be taken once it is clear that a relapse has occurred, it can also address the period prior to this – ie: describe actions to be initiated if a full relapse has not yet occurred, but there is strong evidence or indications to suggest that a full relapse is likely if the contingency plan is not activated now.



An example of one part of a contingency plan for someone currently receiving a service from AWP, rather than a re-access plan is given below:

‘In the past, when your self-management has not succeeded in preventing a relapse, you have gone on to experience far more frequent, far more derogatory, and far more “intense” and “intrusive” voices. These affect you in various ways [detailed here].... At these times you have found that an increase in the dosage of your Olanzapine helps bring the voices back under your control. In the past you have arranged this increase via your GP, Dr Brown at Medcroft Surgery, Bristol (0117 919 0000) and also via your psychiatrist Dr Singh (0117 945 0000).



However, in the past, when you have been in the midst of these experiences you have often been unhappy to even take your usual medication.....Your Care Co-ordinator, Jill Smith is likely at this time to be trying to see you by calling your mobile and calling in to see you at your home. Jill is likely to also refer you to the Intensive Team to offer extra support. Your brother James Roberts (telephone 0777 9800000) is the person most likely to contact AWP staff at this stage because in the past, you have chosen to avoid all contact with any mental health staff. You have expressed a preference for staff to work hard to engage you at this stage because you recognise that the longer the length of time without help:

- the longer you have been unwell,
- you have stayed in hospital longer,
- been detained,
- damaged relationships with friends, family and neighbours.

Staff will work hard to engage you at this time and try to avoid a hospital admission under the Mental Health Act, but staff have to balance firm engagement with your stated preferences during this stage.’

Whilst too much unnecessary information will make the plan difficult for staff to find the most important parts, often the more specific the detail available, the more useful this plan becomes.