Personality Disorder
Integrated Care Pathway

(PD–ICP)

5: Crisis Management

July 2015
Acknowledgements

This document was produced by a partnership of NHS Highland staff, volunteers, service users and staff from other public and third sector organisations.

The NHS Highland Personality Disorder Service will coordinate future reviews and updates of this document.

NHS Highland would like to thank everyone involved in the creation of this document.

July 2015
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5. Crisis Management

5.1 Introduction

For the purposes of this section a “crisis” can be usefully defined as a brief acute, non-illness impairment of functioning characterised by behavioural disorganisation and increased emotional dysregulation with escalating dysphoria. The specific clinical features of a crisis will vary according to the precipitating situation and the personality structure of the individual.

While a crisis is not a clinical disorder, one can contribute to the other. An emergency is more than a crisis and requires a different type of response. Crises may be triggered by stress related to a range of internal or external factors. Frequently interpersonal or social system factors are important contributors. The duration of crisis episodes can vary significantly, but it would be untypical for an acute crisis episode to last beyond 72 hours. However, crises may occur in a connected series.

Many evolving crises will not require specific input from mental health services, especially if the patient has prepared a crisis self-management plan. A distinction can usefully be drawn between a crisis self-management plan and a clinical crisis care plan. A crisis self-management plan is developed by the patient, often with the support of a clinician, and essentially provides a description of a crisis and its early indicators, options and resources which have proved useful in previous crises, things which have previously proved unhelpful when in crisis and which should be avoided, and an outline plan of action for the next evolving crisis. This can be especially useful as problem solving and cognitive flexibility is typically impaired with escalating emotional arousal. In contrast, a clinical crisis care plan is developed by the treating team with the collaboration of the patient to provide a plan outlining how the team aims to respond to the patient’s next crisis.

When intervention by services is indicated, the aim is to enable the patient to return to their usual level of functioning as soon as possible. Clinicians should avoid trying to achieve too much during crisis episodes and keep goals and interventions as simple as possible. Only once the acute crisis has resolved should longer term goals be addressed. In terms of the ‘phase-based approach’ to the treatment of people with personality disorder, crisis management represents Phase 1 (stabilisation) work, with the initial emphasis on safety and containment, although work to promote self-regulation is likely to follow shortly after.

Risk assessment is important in crisis episodes, especially of risk of suicide, although other risks should also be considered. During risk assessment, it is important to draw the distinction between chronic (longstanding) and acute (newly increased) risk. Many people with personality disorder have chronic thoughts that life is not worth living or frank suicidal thoughts. Two principal factors which can contribute to an acute increase in risk of suicide are increased intent and increased impulsivity.

5.2 Crisis planning

Crisis planning is an important part of the care and treatment of people with personality disorder. Both patients and clinicians have important roles to play in the process.

The patient’s crisis self-management plan and the clinical crisis care plan should both be seen as dynamic documents to be reviewed and amended as the patient’s self-knowledge and skills develop. In addition, review and update of both plans should occur at the earliest opportunity
5.3 Patient’s crisis (self-management) plan

In assisting a patient to develop their own crisis self-management plan, clinicians support self-management by highlighting the strengths and responsibilities of the patient. The format of a patient’s crisis plan can vary, but will generally include individualised information on crisis indicators, what has helped in the past, what has been unhelpful, useful contacts and specific plans for self-management of future crises. Examples of template crisis self-management plans are available in the appendix for this section.

Patient’s crisis self-management plans should be developed as early as possible in the treatment process, ideally from the point of assessment and diagnosis. It is important that the plan should be developed at a time when the patient is not in acute crisis and can draw upon their baseline capacity for planning and problem solving. The clinician should support the patient to take responsibility for developing their own plan and avoid providing “the answers” as far as possible. The process itself should be a validating one, promoting the patient’s role of primary responsibility in their own recovery and highlighting their ability to at least attempt to resolve what may seem to be overwhelming problems.

In keeping with the principle of self-management, the finished document remains the property of the patient for them to refer to when necessary. Clearly, for the plan to be useful in the process of self-management, it should be kept in a readily accessible place, ideally carried by the patient at all times. It is of particular importance for the patient to be able to locate the document as easily as possible, as the ability to find the document when a crisis is evolving is likely to be much reduced.

While it is important that it is recognised that the patient retains ownership of the document, it is recommended that the patient shares it with those involved in their care. Clinicians can then make the important information in the crisis plan accessible to other treating clinicians, for example by keeping a copy in the patient’s medical notes, attaching a copy to clinic letters so that it can be placed in SCI store or scanned into the patient record in Primary Care, encouraging GPs to consider using the ‘Special Notes’ system for NHS24 contacts or similar.

5.4 Clinical crisis care plan

A clinical crisis care plan is developed by the treating team with the collaboration of the patient to provide a plan on how the team aims to respond to the patient’s next crisis. Such a crisis care plan may form part of standard care planning but for patients with more severe presentations, the Care Programme Approach documentation may prove useful. The patient’s crisis self-management plan is likely to complement a crisis care plan and consideration should be given to keeping a copy of the crisis self-management plan with the crisis care plan or CPA.

5.5 Indicators of a Crisis

A crisis can be identified by acute changes in a range of domains. It is important to assess for the presence of co-occurring mental state disorders such as psychosis or affective disorder which may sometimes present with similar features.

Affective changes may include:
- Increased emotional lability
- Panic and anxiety
- Escalating dysphoria
- Low mood
- Anger

Behavioural changes may include:
- Parasuicidal behaviour (includes suicidal gestures and attempts, and non-suicidal self-injury)
- Increased impulsivity

Cognitive / perceptual changes may include:
- Dissociation or transient psychotic features
- Reduced cognitive processing ability including reduced ability to cope and utilise resources, to think logically and to problem solve.
- Reduced ability to retain awareness of the internal processes of oneself and others

Presence of these features can lead to worsening of difficulties regarding self, others and society. Interpersonal stress is frequently a precipitating or perpetuating factor for crisis episodes.

5.6 Assessment and management of crises

In times of crisis, patients with personality disorder are ideally assessed and managed by those who know the patient and their background, although this may not always be possible. As far as possible, aim to conduct the assessment in a quiet area with as few interruptions as possible.

Each clinician will have their own approach to assessing a patient in crisis but assessment should be undertaken with some overarching principles. The principles of validation and collaboration are especially important.

Clinicians should adopt a calm, non-judgemental and non-confrontational approach. It is important that clinicians should actively listen to the story and reflect the patient’s perception of events back to them. It is important to validate the patient’s experience and avoid minimising, inappropriately reassuring, or jumping to premature problem solving. Interpretations or hypotheses about the reasons why a crisis occurred are likely to be of limited value at this stage and the focus should remain on containment as far as possible.

Patients often report that it feels more containing in a crisis to have the validating experience of feeling understood in the “here-and-now” in the context of recent (proximal) situational factors, rather than to understand the historical (distal) factors which may have led to the crisis. Distal factors are more usefully explored in depth after resolution of the acute crisis. In practice lengthy exploration during an acute crisis is unlikely to be helpful and may even contribute to further destabilisation. Where the patient is new or unknown to the assessor then background information on their psychiatric history and social context should be obtained if possible through medical notes or CPA records. This can help maintain focus on the ‘here and now’ or proximal factors during the crisis assessment. A picture of the current situation should be developed with a view to promoting a return to previous level of functioning as soon as possible by supporting a self-management and problem solving approach.

It is helpful to use validating language to clearly acknowledge the distress of the patient. Challenging the perspective of the patient on their own thoughts and feelings is likely to be perceived as invalidating and this can put the therapeutic relationship at risk. An exception to
this is if a pattern of invalidating negative self-judgement is noted. In such a case, self-
invalidation should be gently challenged by highlighting the difference between facts and
judgments.

The clinician, after actively listening and then reflecting their understanding of the situation back
to the patient, can explore solutions together with the patient in a collaborative manner using
formal problem solving or solution analysis. The assessor should:

- Draw on the patient’s own resources and skills
- Reflect on solutions and promote an alternative perspective to the patient
- Highlight the patient’s responsibility in their own recovery
- If appropriate, involve the patient’s social network

In general, when the patient has a crisis self-management plan and/or crisis care plan, these
should be utilised in the crisis management process.

- Crisis management should initially focus on safety and containment strategies. Work to
  promote self-regulation should be introduced as soon as possible.
- Crisis management should comprise simple short-term interventions focusing on the
  “here-and-now” rather than the past or the future, and aim for the minimum input
  necessary to enable the patient to return to their previous level of functioning.
- Medication may have a role in some situations but in general the principle is “as little as
  possible for a short a time as possible”. Prescribers should be aware of the risk of
  overdose in those presenting in crisis and in particular the potentially disinhibiting effects
  of benzodiazepines, see Medication Section.

5.7 Risk assessment and management in crisis

It is recommended that a detailed risk assessment be undertaken in patients presenting in
危机. This should be carried out in an empathic and non-judgmental manner, taking account of
risks to the patient but also identifying risks to others, including children and vulnerable adults.

Patients’ crisis self-management plans, CPA plans and clinical crisis care plans should be used
where available to assist with the risk management process.

Risk assessment should include history, mental state and situation as well as systematic
assessment of static and dynamic risk factors. Structured tools such as STORM (Skills Training
On Risk Management) may be helpful, see Appendix. STORM documentation can be found in
the STORM folder on the NHS Highland intranet O drive.

Clinically indicated positive risk taking following a risk-benefit analysis is an important com-
ponent of the care and treatment of patients with personality disorder. While safety must always
remain a primary consideration in such an analysis, it must be recognised that complete
elimination of risk is impossible. Risk management decisions should as far as possible be made
by the multidisciplinary team in collaboration with the patient. It is important to recognise that,
while the clinical team is responsible for providing a reasonable standard of care, the patient
retains responsibility for their behaviour and the consequences of that behaviour. A patient with
personality disorder should always be assumed to be a competent adult, able to make and
responsible for their own choices, unless there are compelling reasons to think otherwise, for
example severe mental state disorder. In good multidisciplinary working, clinical responsibility
for risk management decisions belongs to the whole multidisciplinary team rather than any
single clinician.
5.8 Community management of crisis

Most crises will not require the input of services and can be resolved by the resources available to the person in their social network. Self-help guides and information may be of value in supporting this process. When involvement of mental health services is indicated by reason of risk, severity or frequency of crises, relevant community services include:

- Community Mental Health Teams
- **Braeside Crisis and Intensive Treatment Service**, for Inverness sector patients who present significant risk to themselves or others and who would otherwise be considered for admission to hospital.

5.9 Hospital management of crisis

Acute in-patient management should be considered with the guidelines on in-patient management in the ICP in mind. Admission to hospital should usually not be considered when other options are appropriate.

5.10 After resolution of the crisis

At the earliest opportunity, the assessor should arrange that all clinicians involved in the patient’s care are informed of the details of the crisis and the current treatment plan. In addition, the patient’s crisis self-management plan and the clinical care plan should be updated at the earliest possible opportunity.

Crises are likely to recur unless a patient’s situation changes or their ability to cope with their situation changes. A crisis can therefore become a useful opportunity to open the discussion about longer term care and treatment options for personality disorder.
References


NICE. (2009). Borderline Personality Disorder Treatment and Management. NICE Clinical Guideline 78.