

**EMERGENCY PROCEDURES
MANUAL**

**NORTHFIELDS
PSYCHOLOGY CLINIC
UNIVERSITY OF WOLLONGONG**

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INTRODUCTION

Normally the key to emergency situations is to avoid them either by not accepting very high-risk clients (acutely psychotic, strong history of violence etc) or to defuse the situation.

All emergencies which occur in the Clinic, or in relation to the Clinic in any way, must be brought to the attention of the Clinical Supervision Director or Clinic Director as soon as feasible. Detailed reporting of all such incidents is essential.

It is best to involve the Clinical Supervision Director or Clinic Director before an emergency develops and talk to them or have them see the person in question (see "walk ins").

WALK INS

A "walk in" is a person who attends the Clinic without an appointment. Although this is discouraged (we seek to see people on an appointment basis), these incidents do arise and in most cases the person is unusually agitated. Accordingly, such people are to be treated as high risk and should be screened by the Clinical Supervision Director or Clinic Director.

On days when the Clinic is open, the person is asked to take a seat and the Clinical Supervision Director or Clinic Director is summoned.

SUICIDE

Suicide is a major external cause of death and it is the second leading cause of death in the 15-19 year age group. Although the risk of suicide amongst clients attending the Clinic is expected to be low, it remains a distinct possibility.

All Clinic trainees and Supervisors have a duty of care to the public. This should ensure that when assistance is sought to deal with suicidal behaviour, the response is prompt, efficient and effective. The assessment of risk of suicide is a core clinical skill.

RESPONSE TO REFERRALS

All referrals, which involve any indication of suicidal potential, must be referred immediately to the Clinic Director, Clinical Supervision Director or to the Supervisor assigned to provide cover in the Clinic at the time of the referral.

Requests for assistance with people at risk of suicide may come from individuals, families or friends. They are to be given clear and concise information about available services and the available options for treatment. They are to be directed to their nearest and most accessible service, i.e. Hospital, Emergency Service or Mobile Mental Health Team.

Contact must be made with the service to whom the person at risk has been referred and a relevant contact person in that service identified, who has accepted ongoing responsibility. The name of this person, and the date and time of the call, must be documented.

RISK FACTORS

SOCIODEMOGRAPHIC FACTORS

Factors, which have been shown to have a statistical relationship with suicide, are:

- Lack of supports (eg no relationship)
- Male Sex
- Significant Isolation
- Antisocial Behaviour and Conduct Disorder
- Drug and Alcohol Abuse (high rates of intoxication at the time of death have been noted)
- Previous Suicide Attempt and Impulsivity
- History of Physical or Sexual Abuse
- Family History of Suicidal Behaviour, Depression or Parental Absence
- Family Turmoil
- Chronic Medical Illness - (Note Epilepsy is relevant)
- Major Psychiatric Disorder, Including Affective Disorder, Psychosis, Personality Disorder and Substance Abuse.

Studies show that the majority of people who complete suicide had verbally expressed suicidal intent within the previous 24 hours, and one third had previously attempted suicide. In studies of young people who complete suicide, nearly one half of boys and one third of girls had shown some anti-social behaviour in the year before their suicide.

PSYCHOLOGICAL FACTORS

- Depressed mood
- Hopelessness and helplessness
- Negativity and the expectation of negative events
- Estimation of a reasonable chance of successful completion of suicide
- Inability to contingency plan for future situations, which may provoke suicidal thoughts.

SUICIDAL ACTIVITY

- Frequent, Intense or Prolonged Suicidal Ideation
- Previous Suicide Attempts
- The Suicide has been Planned and Engineered in such a way that Rescue is Unlikely
- The Client Expresses an Unambiguous Wish to Die
- Access to Means of Suicide is readily available.

ACUTE PRECIPITANTS

- Disciplinary crisis at work or school
- Acute Disruption or Loss of a Key Relationship
- Contagion Events
- Anniversary Events
- Social Isolation.

THE ASSESSMENT OF SUICIDAL RISK

Detecting suicidal ideation in the interview situation is extremely challenging. Understanding that suicidal clients may be ambivalent and perhaps reluctant to admit ideas of self-destruction, managing the client's distress, anger, and possibly provocative behaviour, apart from typical features of depression, and understanding the role of impulse and opportunity are all important.

Once suicidal ideation has been detected, identify your concerns to the client and tell them that you are required to contact the Supervisor on duty in the Clinic.

BRIEF GUIDE TO SUICIDE RISK ASSESSMENT

Any expressions of suicidal preoccupation should be taken seriously and fully explored. Having detected suicidal ideation it is necessary to evaluate its precise meaning, intensity, the likelihood of it being acted out and the risk to others. The Supervisor on duty in the Clinic will take over, or sit in on, the interview with the client.

Any assessment of Suicide risk should include the following:

Current suicidal ideation

- Has the person been feeling so bad that they wish they were dead?
- Has the client ever thought of killing him or herself?
- Has this happened recently?
- What has happened to make them feel like this? (acute precipitants)
- How long have they been considering it? How often in the past week? (duration, recency).
- How strongly do they wish to die? What would stop them? Is there any other way to solve their problems? (intensity, hopelessness/helplessness, negativity).
- How else can they manage suicidal thoughts and feelings? (contingency planning).

Plan

- Has the client a plan to commit suicide? What is it? How effective is it likely to be?
- Does the client have access to the method? (e.g. a gun).
- When would they do it? Where would they do it?

Previous Suicide Attempts

- Has the client attempted to kill or harm him or herself before?
- How often? (frequency).
- When? (recency).
- What methods were used (how lethal)?
- What happened at these times? (preventative factors).

Social Support

Does the client have a parent, spouse, good friend who could be contacted to help keep the client safe?

A Mental Status Examination

Including Appearance, Attitude and Activity, Mood and Affect, Speech and Language, Thought Content, Thought Process and Perception, Cognition, Insight and Judgement.

Evaluation

If a client has current suicidal ideation, a feasible plan and the means to carry out the plan, they are considered to be at risk. If the client has attempted suicide before and/or has few social supports, the client is considered to be at increased risk of suicide. If the client has experienced severely depressed mood for some time, is presenting with psychotic features or poor judgement they are at extremely acute risk of suicide.

ACTION TO BE TAKEN

Several immediate options are available, depending on the seriousness of the risk of suicide. The following are some options, which can be used depending on the urgency and degree of risk:

Obtain the client's undertaking that they will not make an attempt before your next session. Ensure that the client has a list of contact numbers to use in the event of a suicide crisis.

Begin cognitive therapy (eg):

- talking about suicide is a sign of desire for help
- the desire for help indicates ambivalence

- what is sought is an end to the “pain”
- death can have negative effects on others
- challenge hopelessness.

Arrange to ring the client between sessions to evaluate the degree of risk and offer support.

Call the client’s family/significant others and request that they come to the Clinic to collect the client. The person/s called should be capable of providing care and support.

Stay with the client until they arrive and explain the situation to them. Ensure that they have a list of contact numbers to use in the event of a suicide crisis.

If during business hours, a client is considered to be at acute risk of suicide, escort the client to the Wollongong Hospital after discussing the matter with the duty registrar.

While any risk of suicide remains, the person should be seen by other professionals in order to increase the client’s access to resources in the event of a suicide crisis.

IF THE CLIENT ABSCONDS WHILE YOU ARE SEEKING ASSISTANCE AND THERE IS A REAL RISK OF A SUICIDE ATTEMPT CALL:

MOBILE CONTACT CHRIS ALLAN 0408 446 239
MOBILE CONTACT JOHN FREESTONE 0413 933 990
MENTAL HEALTH NORTHERN TEAM: 4254 1500
MENTAL HEALTH SOUTHERN TEAM: 4223 8001
MENTAL HEALTH AFTER HOURS: 1300 55 22 89
SHOALHAVEN MENTAL HEALTH TEAM 4422 8111
POLICE: 0 000
UNIVERSITY SECURITY: 4900

If client is in immediate danger within or after leaving clinic the contact Police or University Security.

If client needs acute assessment and follow-up within 24 hours contact the appropriate mental health team.

If client needs monitoring over the week i.e. follow-up phone call contact clinic director or supervision director.

If client is assessed as being in no immediate danger the instigate no suicide contract.

DOCUMENTATION

As with all psychological work, careful notes should be kept in the client's file, of the circumstances, decisions made and actions taken. Record the name, agency and time of call of any other person, agency or professional contacted. Where confidentiality has been breached, record the reason/s for this.

Make a full record of all actions taken concerning the matter in the client's file. Both the trainee and Supervisor should sign this record.

It should also be noted that in the event of a death a coronial enquiry is likely. These often take place 2 years after the event – making immediate accurate records a must.

VIOLENCE OR AGGRESSION

The risk of physical violence or aggression in the Clinic is considered to be extremely low. However, there is always a possibility that unforeseen situations may arise where safety is at risk. In these situations, **the guiding principles are for protection and safety**. The safety of every person in the Clinic, including the aggressive or violent person, is of paramount importance.

Risk should be able to be anticipated. The trainee and supervisor should have an opinion about risk for known clients. Where this is so and there is a risk, then a decision can be made before hand about monitoring (by video), jointly seeing the client or the trainee carrying the duress alarm.

Similarly, if the client (new or ongoing) appears agitated, very angry or psychotic a decision can be made how to best manage the risk.

This would include sitting nearest the door and letting the Supervisor know you are seeing a difficult client. The supervisor should be called in for very agitated clients.

DURESS ALARM

A duress button has now been introduced at the clinic. Duress buttons will be taken into the consulting room each time you see an adult or adolescent client. They are to be returned at the end of the session to the drawer in the reception area. It is rarely if ever that you will need to use the button. You will only use it when you feel unable to handle a threatening situation that has arisen in the consulting room, where the guidelines in this procedure manual have not enabled you to bring the situation under control.

After pressing the button you are to leave the room if possible and inform reception of the circumstances. If no one is at reception ring security and contact the Clinic Director or Clinical Supervision Director.

If you are unable to leave the room you will wait there until Security arrives and continue to calm the client.

GUIDELINES IN THERAPY

One of the most difficult skills for therapists to master is the ability to over-ride instinctive responses and unconscious reactions, such as when we are faced with threat of violence and are 'programmed' to respond with fight or flight. Instead of these natural reactions:

- It is important to remain calm (use self-talk to help).
- A calm and reassuring voice is important.
- Try to breathe evenly.
- Respect personal space. There is some evidence to suggest that people experiencing high tension need greater interpersonal distance than others.
- Early on, get the person to agree to something, either in word or action, thus initiating co-operation.
- Listen with empathy and concern to the person, ensure that they feel heard by going over what they are saying and clarifying **their** perceptions of issues and events, which led up to the outburst.
- Do not present any alternative view or interpretation of events until the client is calm and receptive. It is difficult to process adequately when overwhelmed by anger and your interpretations can result in the person feeling invalidated and misunderstood and increase their sense of alienation and anger.
- Let them know that you understand what they are saying and feeling.
- Deal with the current issues.
- Speak Adult to Adult, not Adult to Child.
- Avoid making promises or guarantees that cannot be kept or are beyond your control.
- During periods of rage minimise interactions other than to provide clear, short instructions.

RISK OF HARM TO PERSONS OR DAMAGE TO PROPERTY

- Evasive self-defence strategies are the most appropriate response.
- Remove yourself to a place of safety.
- Notify the Clinic Director or Clinical Supervision Director.
- Alert others in the Clinic to the risk.
- Call security on 4900 (or if justified, the police, 0 000).

DOCUMENTATION

Document all instances of aggressiveness, violence, damage to property or harm to others in detail in the client's file. Give times and the sequence of events, from prior to the onset of the behaviour until after its conclusion. Detail all action taken by you and your Supervisor.

DEBRIEF AND FOLLOW UP

If there is an incident the duty supervisor / Director would be responsible for immediate debrief.

Incidents would be followed up under occupation, health and safety requirements and modifications to responses and procedures made.

ABUSE OR NEGLECT OF A CHILD OR ADOLESCENT

Where physical, sexual or emotional abuse of a child or adolescent is disclosed to you by the child/adolescent, or where the child/adolescent presents with physical injuries, e.g. burn marks, bruising etc., or with evidence of being neglected, e.g. not being fed, dirty or unkempt, it is important that you:

Listen to the child/adolescent. Your role is to listen, but NOT to conduct an investigation. Obtain information that the child/adolescent is willing to give, but do not push for information.

Tell the child/adolescent that they have done the right thing in telling you. Acknowledge that it is a difficult thing to do. Remain calm and be reassuring to the child/adolescent. Emphasise that what has happened is not their fault.

Where the child/adolescent asks that this be kept confidential, you must make it very clear that **this is a promise you cannot make**. You need to let them know that because of your concern about them and their safety, you will be discussing what you have been told with the Supervisor on duty, so that you can decide the best way to keep them safe. **CONTACT THE SUPERVISOR ON DUTY.**

The Supervisor on duty will help you decide the best course of action to take.

Where injuries are suggestive of non-accidental causes or there is sufficient concern that the child/adolescent has been abused or neglected from the disclosures made, a notification must be made to Department of Community Services (DoCS) wherever abuse or neglect of a child or adolescent is suspected.

*When making a notification it is important that you make it clear that it is a **PRIORITY** notification, and that it is accepted as such by the DoCS officer, if the child/adolescent is in an environment where the abuse or neglect is likely to re-occur.*

If you do not make it understood that it is a **priority** notification it is unlikely that DoCS will intervene to assess the situation in anything under 10-14 days.

Department of Community Services: 4254 0411 or 13 2111

If you are unable to contact a DoCS worker or cannot convey fully the information then obtain the form:

Recording Form for the Report of Suspected Risk of Harm Related to the Abuse or Neglect of a Child or Young Person

From the office, complete this and fax to the numbers on the form.

DOCUMENTATION

As the first person hearing a disclosure, or making observations which suggest the child is being abused or neglected, you must remember that the notes you make may well be subpoenaed to Court or be used in writing legal reports. The following must be recorded legibly in the client's file:

- Accurately indicate the time and date and your title.
- Indicate who was present at the time of disclosure or observations, the events that led up to the disclosure or observations.
- As accurately as possible write down the questions asked and the child/adolescent's answers in a verbatim report.
- Make comments on the child/adolescent's affect and non-verbal behaviour.
- Accurately document when confidentiality has been requested and what you said in response.

- Document the involvement of the Supervisor.

DOMESTIC VIOLENCE

While referrals for treatment of domestic violence are not normally accepted in the Clinic, the issue may arise in the context of treatment for other issues.

Domestic Violence is a range of abusive behaviours, perpetrated by one partner upon the other to gain and maintain control. Domestic assault is a crime which occurs across all cultural and socio-economic groups. Much domestic violence goes unreported for fear and safety reasons. The safety and ongoing protection of women and children are paramount considerations in any response (95% of perpetrators are men).

Domestic Violence falls into the following categories:

Physical assault includes slapping, pushing, kicking, choking or the use of weapons to inflict injury. All acts of physical assault are criminal offences. All threats should be taken seriously. They may lead to murder or suicide.

Psychological/emotional/verbal abuse is the use of words, language, actions or other strategies to threaten, insult, abuse, denigrate or degrade the partner.

Social abuse refers to social isolation imposed upon a partner, which impedes or curtails access to family, friends and community agencies. This may include geographic isolation.

Economic abuse refers to the controlling and withholding of access to family resources, including money and ownership of goods and property.

Sexual assault is a criminal offence. It includes a range of sexually abusive and exploitative behaviours including rape, indecent assault and forced viewing of pornography.

Should victims of domestic violence present to the Clinic, the Supervisor on duty must be contacted.

If the client is seriously hurt, medical treatment should be sought through Wollongong Hospital. The police must be contacted where serious assault has occurred.

If a client has been assaulted (physically or sexually), or is afraid they will be, they should be encouraged to call the police. The trainee or Supervisor may offer to call for them.

If the client does not consent to police contact, and the assault has not been serious, ensure that the client is informed of their legal rights, and that in the event of an emergency, the police should be called on 000. They may arrest the offender, and keep him [sic] in jail until he can be seen by a magistrate if there is a risk that the offender may inflict further harm.

Access to appropriate support services needs to be offered.

RESOURCES AND SUPPORT SERVICES

The following support services are available:

- Domestic Violence Helpline (1800 800098) which offers a free 24-hour Crisis Phone Line, free counselling, assessment and referral.
- Local Women's Shelters
- Local Court
- Police
- Department of Housing
- Community Health Centres
- Department of Social Security
- Hospital Social Work Departments
- Various legal centres e.g., The Legal Services Commission.

DOCUMENTATION

The following should be documented in the client's file:

- The time of arrival.

- All observed and reported injuries, even minor injuries, due to actual or suspected Domestic Violence must be carefully documented. Where required, medical help should be sought to assess injury.
- The explanation given for the injury and whether this appears feasible.
- If there have been previous instances of Domestic Violence.
- The fears expressed by the woman.
- The mental state of the client.
- All action taken.
- The names of all people involved (trainee, Supervisor, police, family members in attendance).

It is important to be aware that the documentation of injuries may provide medico-legal evidence for court.

DOCUMENTATION REQUIRED FOR ANY INCIDENT OCCURRING WITHIN THE UNIVERSITY

An OHS form must be completed for any incident that occurs in the clinic. This form is available at http://staff.uow.edu.au/ohs/reporting/OHS002-Hazard-Incident_Report_Form.pdf.

This form must then be taken to the clinic director for completion.

ISSUES FOR THOSE MANAGING EMERGENCY SITUATIONS

Dealing with emergency situations may raise strong feelings in those exposed to and attempting to manage the situation, such as anger, fear, revulsion, disbelief and sadness. It is necessary that you contain and manage those feelings when in the situation and with the people concerned, but that you find an appropriate venue later to address them. Suitable venues for debriefing include making time with your Supervisor, the Clinic Director or another Supervisor from the Clinic.

How you react to a child, adolescent or adult who discloses abuse will affect them. It is important to remain calm and supportive and avoid both verbal and non-verbal expression of your own feelings at this time.

Bear in mind that in the case of abuse, but particularly sexual abuse, the person may have been threatened, coerced or bribed into secrecy and will require repeated reassurances that your intervention will keep them safe.