Mental Health Clinicians' Role in Responding to Critical Incidents in the Community

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A critical incident is a situation involving an individual who is threatening to commit suicide immediately using a means that is readily available. Examples include situations in which a person threatens to jump from a height or is barricaded in a building with a gun.

Given the prevalence of mental illness in the community, mental health professionals may be called on to assist in such incidents. The role of mental health professionals as members of a negotiating team during a critical incident is a subject of debate. Opinions vary, from the view that they have no role to the view that volunteers trained by mental health professionals can be responsible for conducting negotiations (1–7). The model described by Ebert (5) outlines complementary roles for law enforcement and mental health professionals.

This column highlights practical issues mental health professionals should keep in mind when responding to a call for assistance with a critical incident, particularly those involving a person barricaded with a gun, and offers strategies for dealing with life-and-death situations.

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Steps in addressing critical incidents

The initial call. Psychiatrists and other mental health professionals, mobile crisis units, and even lone practitioners may be called on to provide assistance in a critical incident. It should be noted that all actions taken by the clinician should be thoroughly documented for both clinical and legal purposes.

The first step is to assess the current situation. If possible, before going to the scene the clinician should obtain basic information, such as the name of the person, the location and a description of the scene, types of weapons known to be present, the location of safe access routes, the names of the person's primary contacts such as friends and family members, and any information on the person's medical, psychiatric, and substance abuse history. If the clinician receives information that the police are not at the scene, they should be contacted according to procedures that should have been previously established by the clinician and the local law enforcement agency.

The clinician must develop an understanding of the emotional stress experienced by the person in crisis in order to conceptualize the dynamics of a situation and to direct clinical approaches (1,2,7–11). Assessment in a rapidly changing environment often depends on collateral information provided by the person's family members and friends.

Traveling to the scene. At least two clinicians should respond. If two clinicians are not available, the responding mental health professional should team up with a responder who has received crisis training or hostage negotiation training. En route to the scene, the responders should clarify their roles in the upcoming negotiation and should continue gathering information using cellular telephones. Before arriving at the scene, the clinicians must find out if verbal contact with the person in crisis has been established. If it has not, the clinicians should get the approval of law enforcement officials before attempting to contact the person.

Arrival at the scene. The primary concern at the scene is safety. Any mental health professional on site must report to the commanding law enforcement officer. The arrival and input of a mental health professional can help decrease the police's sense of urgency and perceived need to act. Final responsibility for public safety and on-scene operations rests with the commanding officer (1,2,5,7,12). If a strong alliance with the person in crisis has been established by someone already on the scene, that person should continue as a negotiator. The clinician can serve as consultant or coach.

Negotiating the alliance phase. The initial step to a positive outcome is to establish contact with the person in crisis (1,2,8,11). If the person is resistant, a useful strategy is to offer a choice of negotiators for the person to talk to, including mental health clinicians, police, emergency medical service technicians, or police

chaplains. Sometimes multiple contacts are required before communication is established. Use of a bull horn or a special telephone to project the negotiator's voice may be necessary. Individuals who have precipitated the person's agitation or who may do so should not be involved in the negotiation process (9, 10,12,13).

Initially, the barricaded person may make the negotiator feel helpless. People who have suffered narcissistic injuries often devalue others to elevate their own self-esteem (9, 10,14,15). The negotiator should allow the person to externalize his or her feelings and project helplessness or rage.

Threatening questions should not be answered directly. A question such as "Have you ever seen someone cut his throat?" has no simple answer. The clinician can best answer such questions by reflecting perceptions in a way that shows concern. For example, the clinician may say, "Your question scares me, and I don't know how to respond. But I can help you if you let me."

The barricaded person needs to feel a sense of control initially. He or she must be assured that the clinician is trying to understand what has caused the crisis. Most incidents have a precipitating event, and its context must be understood. The person may be able to identify a psychological trauma.

In addition, information from family members, friends, observers at the scene, treating professionals, or hospitals may be used. Knowledge about current drug or alcohol use is helpful, because an intoxicated individual may in time become sober and more open to negotiation. However, because of concerns about the confidentiality of information patients provide to treating professionals and hospitals, it may be difficult to gain information from those sources. The clinician should speak to an administrator if necessary, because a life-and-death situation will almost always allow one to circumvent the need for confidentiality.

In negotiating with the person in crisis, the clinician should be empathic, not patronizing. He or she should not lie but should not feel forced to tell the whole truth. The clinician may choose to avoid learning certain information, such as whether a person injured by a barricaded subject is alive or dead. At times the clinician may find it better to say, "I don't know" (13).

The clinician should talk through any deadlines set by the person in crisis. Once rapport has been established, the mental health professional may step back from the negotiation to consult with a colleague, after first informing the person about the brief absence and assuring a quick return (11). If positive verbal communication is firmly established, a positive outcome is likely to result.

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Negotiating the middle phase. As the alliance builds and lethality diminishes, the clinician may begin discussing steps toward face-to-face contact. The clinician can offer the promise of future discussion to motivate the person toward safety. For example, the clinician may say, "If you agree to put down your gun, you, your wife, and I can talk together at the emergency department." The person in crisis commonly communicates in an angry, inflammatory manner. The clinician must allow the person's frustration and rage to be exhausted and must make an alliance with the side of the person that wishes no harm to self or others. The process should not be rushed or forced. The clinician may say, for example, "We can come out of this together."

An offer of a drink, food, or cigarettes can sometimes strengthen the negotiator's position and reassure the person in crisis through symbolic gestures of nurturance (13). Such offers must never be premature, however, and must be approved by the commanding officer. The clinician should ask for the person's trust. If the person is having difficulty trusting, the clinician can review the person's previous cooperation in the negotiating steps that have already occurred. A good technique is to give options, such as asking the person to put down the phone to take deep breaths or to place a weapon on the floor (10,13). Expressing concern about a person's physical or medical condition can help solidify an alliance and may encourage the person to move toward safety.

If weapons are involved, the person in crisis may be asked to relinquish them at a neutral location. This process will take time, and the clinician must not rush. Because more than one weapon may be present, the clinician should ask about other weapons and allow the person to feel comfortable with the decision to relinquish each one. As the person begins to share control with the negotiator, their alliance strengthens. Again, if the negotiator or the police try to rush this process and take control away too quickly, the person may become frightened and react by further escalating the crisis. Often, a step backward early in the negotiation process permits an ultimately quicker resolution than trying stubbornly to maintain every gain.

Resolution phase. When the time comes to move toward closure, the negotiating clinician must communicate clearly to the person in crisis how closure can take place (12,13). The person should be told to put down the gun or knife and to move away from danger. Concern for safety is paramount. The negotiator must be firm and supportive, capitalizing on both the person's fatigue and the alliance that has been built. An anti-

social or severely paranoid person may react idiosyncratically to directives. It is appropriate to back away if the response is aggressive.

A clear, specific plan about how to close the standoff should be developed in coordination with law enforcement officials. The plan must be clearly communicated to the person in crisis. For example, the person may be told, "You will open the front door, take two steps out, and lay the knife down. A police officer will search you, then you and I will sit on the steps and talk." The negotiator should make it clear that he or she will not meet with the person until all weapons are secured.

The negotiating clinician should ask the person in crisis to repeat the plan until all concerns are clear. The plan should permit the person to back off if he or she becomes uncomfortable. Often several attempts have to be made before surrender is possible (11–13). The person may find it too threatening to come out of a barricaded home. In that case, it may be possible for police to secure the person's weapons so that the negotiating team can enter. The person should be offered continuous assurance that no one will be harmed. When the person allows the standoff to end, he or she should be assured that the crisis team will be involved in the transition to follow-up care.

If negotiations fail. The best negotiators cannot always penetrate the barricade of fear, especially when the person in crisis is experiencing psychotic agitation. At these times, the role of the crisis team changes. Instead of interacting directly with the person, team members must provide support to police and emergency services personnel. When attempts at communication fail, tactical teams may have to take charge of the situation. The decision to use this strategy must be made by the commanding officer in light of the need to ensure the security of the person in crisis, the responding teams, and the community at large. Clinicians may offer suggestions, but they must remember that the police are ultimately responsible for the public's safety.

If police use tactical methods, it is best for crisis teams to leave the immediate area. A manic or psychotic person may be difficult to subdue. Tear gas or pepper spray may be temporarily incapacitating, but noxious chemicals should be used as a last resort, as no chance for alliance exists once they have been used. Often these chemicals may be ineffective with psychotic persons.

Another valuable role for the crisis team may be debriefing of officers, family members, and bystanders at a scene, particularly when the incident involves injury or death. In such rare cases, everyone should be encouraged to review actions taken during the critical incident. Crisis workers should be encouraged to discuss feelings of failure and sadness and to indulge in the second-guessing that normally occurs after a negative outcome. Police may need debriefing if physical force was necessary. Family members may need assistance in dealing with grief, confusion, and misunderstanding of what has occurred (4).

Finally, crisis teams and other agencies involved in responding to the incident should meet after a period of time to review the event and modify procedures as needed.

Conclusions

These procedures may require modification in individual communities. As the focus of psychiatric clinical care shifts away from hospital treatment to treatment in the community, awareness of these principles may prove useful to crisis teams who interface with law enforcement and other emergency services. ♦

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