FOR FIREFIGHTERS AND EMERGENCY MEDICAL SERVICES

Cooling the Flames

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Communication, Control, and De-escalation of Mentally Ill and Aggressive Patients

A Comprehensive Guidebook for

Firefighters and Emergency Medical Services

An Edgework Book
www.edgework.info

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CHAPTER 2

Safety In The Field

The Basic Emergency Call Process

Calls for assistance usually arrive at a Public Agency Answering Point (PSAP) located in the police or sheriff's department, or a consolidated call center containing both police and fire dispatchers. The PSAP will occasionally be located at the fire department itself. Regardless where the information is received, the call-taker must obtain essential information to ensure safety of both first responders and the subject of the call. This is especially important where there is a patient who may be at risk of harming themselves or others, or presents a known threat towards first responders.[6] However, the dispatcher may not be able to acquire this information, and the first responder will walk into a dangerous situation unaware. Therefore, you must always develop (and communicate) an exit strategy any time you enter a potentially volatile scene—and *any* emergency situation is volatile.

It is incumbent upon first responders to focus on their own safety, any non-involved individuals such as family members or bystanders, and as best as that can be accomplished, that of the patient. In many cases, this requires the assistance of additional personnel or law enforcement officers. Some regions also include mental health professionals who act as first responders when requested by police or fire departments in mental health emergencies.

Dealing with individuals with behavioral health issues often takes a time to resolve, not infrequently requiring one or two hours in the field. These are situations where you cannot "treat, load, and go," as you can in a medical emergency, due to the resistance of the patient. Once the scene is stable, therefore, it is important to communicate with the patient in a non-threatening manner. Patience, therefore, is a virtue for first responders.

Nonetheless, there must be a treatment plan formulated as quickly as possible, generally with the assistance of medical control and the patient's practitioner. Not infrequently, this may also require the use of 'overwhelming force' (by police or firefighters and EMTs) to get the patient loaded in the back of the ambulance (or other vehicle), and transported to a medical facility. Overwhelming force includes physical interventions, where you have enough hands available to make the patient helpless, or chemical restraints (both of which will be discussed later in this book) as methods of getting the patient to the hospital.

Figure 2.1 Responder safety is more than what occurs in the field

'Responder safety' does not only refer to what happens between firefighters and EMTs and the patient while on-scene. What you do or don't do can compromise your safety in other ways. For example, if you leave a patient home and they harm themselves or others, or even take their own life, not only was the patient and/or other citizens harmed, you can be sued for abandonment or depraved indifference.

In addition, a first responder can incur damaging psychological consequences, not only as an after-effect of violence, but also as a result of guilt at the failure to adequately protect yourself, your crew or your patient.

During the transport time, it is important is the patient is restrained in a physical position that does not inhibit his or her ability to breathe. Prior to transporting, reposition the patient to ensure an open airway and assess that the patient is actually breathing.

Violent episodes during transport can easily be mitigated with medications, administered by paramedics or other qualified practitioners. This is only possible if you have properly restraint and positioned the patient (See Appendixes A-C)

Your responsibility for the care of this patient usually ends upon arrival at the hospital or other treating facility. At this point, it is important that the patient is handed off to a qualified hospital practitioner, most likely a receiving nurse. The first responder must relay the medical information to the receiving nurse or other designated medical professional, including what occurred in the field, medications (if administered), and if restrained, the reasons for the restraints. Remember, the behaviorally disturbed patient is just as dangerous to the hospital staff as they may have been to you. Finally, good documentation of the event is required; if possible, complete that documentation prior to leaving the medical facility, or soon thereafter, if you need to respond to another emergency.

Don't Let the Abnormal Become Normal

Because firefighters and EMT are always working in the field, they must always consider potential danger. If you are already aware that a location is dangerous, of course you should secure police back-up, whenever possible. Sometimes, however, the danger is only apparent once you are in the middle of it. Don't let complacency cause career changing injuries. Be alert to the clues that something is not right.

We can't underscore how important it is to take note of and share your gut sense (physical intuition) that something is not right or dangerous with fellow firefighters and EMTs and, in many situations, with professionals outside the law enforcement arena. Not only should you be consulting with other responders

when you're concerned about a patient, but just as important, *consult when you should be concerned and aren't*. Some firefighters and EMTs become so familiar with medical or psychological pathology that the abnormal becomes normal. They no longer react in a natural way, tolerating or not even noticing covert aggression, or pre-assault indicators.

Consider those you see so often that you refer to them by first name or even a nickname. You can easily become complacent because you deal with this person so often ("Oh, I know that guy. He's all mouth."). Remember the adage, "There is nothing routine in work." Don't get so focused on accomplishing a task that you ignore or discount signs of danger. Your job requires you to get up-close-and-personal; even so, never forget how quickly and easily you can become a victim of violence.

Figure 2.2 Don't hand them a weapon

We've seen far too many firefighters and EMTs leaning over patients with 'sharps' (scissors, knives, etc) in a little holster on their belt or in their pockets, well within reach of the patient they are putting in restraints.

There are some in the firefighter/EMS industry calling for the ability of such first responders to actually carry weapons: handguns, stun guns or chemical defense weapons. As any police officer will tell you, this is a dangerous idea. One of the most important actions a police officer does if attacked or assaulted is to defend his or her weapons. They undergo extensive training in weapon-retention as well as deployment and use of weapons, neither of which is the primary duty of a firefighter or EMT. In general, assaults by patients are sudden and violent, and occur when you are primarily focused on rendering medical assistance, not like a police officer who goes into a scene anticipating and primarily prepared for the possibility of a violent attack. It is highly unlikely that you will have time to deploy any weapon system effectively, and it is more likely that whatever you are carrying will be used against you.

Lesson #4 – Stowing Potential Weapons Saves Lives

Before Going on a Response

Dispatch should have dangerous residences and individuals 'flagged,' whenever possible (Chapter 1). Calls regarding such a residence or individual should automatically activate police involvement and a warning of the potential dangers to firefighters and EMTs.

Approaching the Scene

As you approach the scene, you should be surveying your surroundings.

- You should look for escape routes, safe havens, and blind spots where you cannot see if someone is hiding.

- Listen for sounds of conflict both in the surrounding neighborhood and emanating from the scene.
- Look for people 'assessing' you. Distinguish between curiosity, hostility, and outright menace.

DO NOT talk yourself out of any feelings of trespass or danger. Your GUT feelings play an important role in your safety. If the situation seems unsafe, then do not continue to the patient's location without police!

At the Scene

1. Knock on the door or ring the doorbell with your safety in mind.
   - Whenever possible, we advise that you stand away from the center of the door as the unstable patient may slam it into you, or even shoot a firearm through the door.
   - Check the hinges to see if it opens outward or inward. If the door opens outwards (toward you), step back and stand on the hinge side of the door, well back, so it is not slammed into you.
   - If it opens inwards (away from you), step back and stand on the handle side so that if they intend to yank open the door and strike at you, you will not immediately be in line of the blow.
   - If the landing or porch is narrow and there is not room for that, stand well back from the door, after you knock.
   - If you must stand at the top of some stairs, hold onto something with one hand so that, were you suddenly pushed, you would have a chance of protecting yourself from a dangerous fall.
   - Stop screen doors with a foot to keep dogs from lunging out at you.
2. Do not approach the scene with your arms full. We have a tendency to carry too much medical equipment to these types of calls. Most of the equipment is not necessary, and you must be in a position to defend yourself. At least one arm should be free.
3. When you enter the scene, be aware of doors that can lock behind you essentially trapping you with your aggressor. You can use a wedge or other blocking devices, or duct tape over the door latch to keep the door open for a safe exit from the room or home.
4. Do not lose focus on your patient and be distracted by other individuals in the room. You can perform a quick survey from the doorway to see potential threats, including other angry individuals, weapons or even dogs. (This includes even the smallest dog—they may not be able to reach higher than your ankle, but they can still leave a nasty laceration, sometimes followed by an even more nasty infection).
5. As described above in the section on assessing the environment, survey the room for anything out of place. Whenever possible, try to also assess other rooms in the house, not only for people or objects that might be dangerous, but in general, an understanding of a patient's living environment can be very telling.

Figure 2.3 Authors' examples of surveying for safety:
I once entered the house of an elderly woman suffering from paranoia and dementia. In a quick survey of the room, I saw two dark items uncharacteristically protruding from a beaded curtain. Upon checking, I realized that she had thrust two large butcher knives in the frame of the window. Her plan was that if some unwanted person entered her home (and here I was!), she would back up to the window, and yanking out the knives, disembowel the invader. Had I not spotted the knives and gotten to them first, I might not be writing these lines now.

In another call, the owner had two Doberman pinschers, which were barking and lunging at us through the door. We asked the owner to put the dogs into a bedroom and close the door. He did what we asked, and we entered the home. Just to be safe, however, we called for police and animal control. After a brief time, the patient got unhappy with us, becoming increasingly agitated. He made a beeline to the bedroom door, intending to set the dogs free. We ran out of the house, leaving our equipment behind, and jumped into the aid car. The dogs proceeded to attack the aid car, and chewed or tore off the mirrors and emergency lighting, then attacked the tires, before being subdued by the police and animal-control officer. We then re-entered the home with a police escort. The patient was arrested for assault on a public safety officer, was transported in the back of our now chewed-up aid car to the hospital, and then transferred to jail after medical treatment.

Lesson #5 – Knowing What's Around You Saves Lives

Field or Situational Awareness

You must be conscious of what a potential aggressor is doing, and what it probably means. Remain conscious of:

- **Where are your escape routes?** Is something blocking your way out?
- Are there any **obstacles**, sharp corners or other hazards that you need to avoid?
- **Are there any weapons** around that can be used against you, or in the worst case, that you can pick up in your own defense?
- **Is the person's aggressiveness escalating?** If so, what is the proximate cause of their escalation, and what mode of aggression are they moving into? (See the latter sections of this book).
- Does their threat display have a secondary purpose? Do they have **allies** who are waiting for you to get off-guard, at which point they will join in the attack?
- What are *your* non-verbal behaviors? **Are you getting mad too?** If so, it is best to disengage; if not, you will merely get very angry together, and the situation could become explosive.
- **Where is your 'team?'** Where are the police? Are other firefighters and EMTs aware of the danger, and what are they doing to help control the scene?

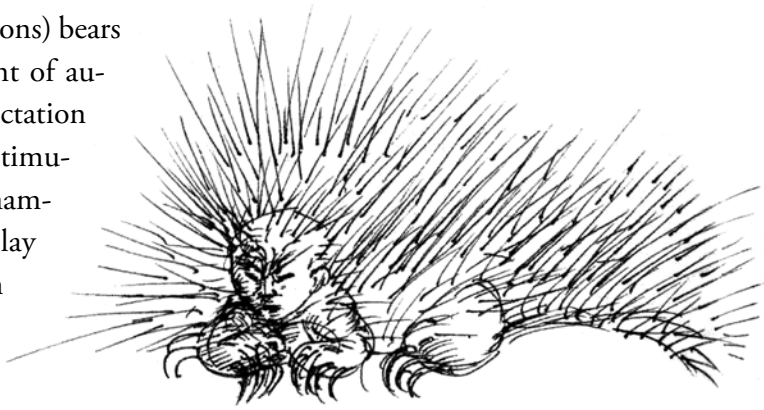
CHAPTER 19

Useful Tactics For Dealing With Symptoms Of Paranoia And Persecution

Figure 19.1 This chapter focuses on paranoia, not psychosis
This chapter focuses on tactics specific to paranoia. Rather than the delusional state, which we will discuss in Chapters 24 & 25, here we are discussing an attitude with the following characteristics: a sense of being persecuted, consistent blame of others rather than oneself, and a hair-trigger sensitivity to being vulnerable.

The *delusional* paranoid patient has this attitude complicated by fixed false beliefs and even hallucinations.

Dealing with a paranoid patient can be surpassingly difficult. The person's motto of life could be summed up in a phrase: "If there is a problem here, it's your fault." The paranoid world is one of dominance and submission: the paranoid tries to dominate the other people in their lives, and is terrified or enraged at being forced to submit.



The paranoid patient (even without delusions) bears a consistent attitude of blame, resentment of authority, fear of vulnerability, and an expectation of being betrayed by people they trust. Stimulant users, notably those addicted to methamphetamine and cocaine, frequently display these behaviors. It is also a very common 'solution' that criminals arrive at to excuse any failure. Paranoid people are, at core level, terrified that they will be made vulnerable, but they're aggressive toward that of which they're afraid. One helpful image of the paranoid person is an angry porcupine: all quills, with a soft underbelly, hunched over, ready to strike in hair-trigger reaction.

- **Paranoid people interpret relaxation as vulnerability.** Friendship means letting your guard down. Therefore, such people can become more paranoid when you begin to establish rapport with them. With paranoid folks with whom you have frequent contact, such as some homeless

mentally ill patients, don't be surprised if they suddenly flare up with suspicion or accusations after an occasion that was friendly or otherwise uneventful.

- **Being mistaken is another form of vulnerability.** Rather than admitting wrongdoing or mistakes, paranoid patients reflexively *project* negative feelings on the other person. If they feel hate, they believe you hate them. If they have any difficulty with a medical intervention, they will claim you deliberately hurt them or subjected them to noxious or dangerous treatment.
- **Paranoid people live like detectives**. They continually search for evidence to prove what they already know is true. They have *ideas of reference*, in which they believe that other people's conversations, glances, or actions are directed at them. They assume that others are conspiring about them, talking about them, or laughing at them. Ironically, their (re)actions, in response to these ideas often cause others to act in exactly the way the paranoid person expects and fears.
- **Paranoid people make others uncomfortable and/or afraid.** Because of their aggressive or standoffish behavior, they can make other people uncomfortable or afraid. If they sense fear in you, however, they will expect you to attack them, and they will then 'attack you back first.' Fear drives their aggression.

Try to Let Them Know What Is Going On

- Because paranoid people are so suspicious, they will often quiz you concerning why you're doing something. It often makes tactical sense to say what you're going to do, so there is no ambiguity.
- At the same time, you shouldn't accept being quizzed incessantly. You aren't required to explain every action. In fact, it might be a tactic to throw you off guard or distract you.

Physical and Psychological Personal Space with the Paranoid Patient

Many paranoid people are preoccupied, even obsessed with fears that they will be invaded or controlled in some fashion. Those in paranoid psychotic states are often afraid that they will be molested or otherwise sexually violated. Some of the following are, of course, relevant when dealing with any patient, but they're doubly important with the paranoid patient.

- **Maintain the angle.** Whether standing or sitting, turn your body at a slight angle, so that physical 'confrontation' is a choice rather than a requirement. If you 'square off' and directly face a paranoid patient, you *force* him or her to turn away if he/she doesn't want to face you.
- **Mindfulness.** Never let down your own guard. You're in an avalanche zone, and anything could set off another slide.
- **Too friendly is as dangerous as a threat.** Try to be aware when things are getting too relaxed. It isn't only about you maintaining awareness. If the paranoid person relaxes, they may suddenly startle, realizing that for a brief moment, they let their guard down. They may respond by exploding to make sure you don't 'take them over.'
- **Cover your triggers.** Paranoid people may try to provoke you. If you lose your temper, they will feel justified in whatever they do to you as well as it keys into their terror-based aggression. A slang expression for this is 'fear biters.' They bark and snarl and when you react, they attack as if you went after them first.

Is There a Specific Paranoid Rage or Violence?

There is no specific 'paranoid rage.' Instead, paranoia is an 'engine' that drives rage in all its various forms. Verbally control the patient using tactics specific to the mode of rage they're exhibiting rather than de-escalating 'paranoia' itself. Paranoid patients can exhibit traits of fear, frustration, intimidation, and manipulation. With their focus, however, they're rarely disorganized (Section IX).

Figure 19.2 Review: paranoia and persecution

The paranoid patient has an attitude that if anything is wrong it is another person's fault. Whether delusional or not, they see others as conspiring against them or persecuting them.

- If they are also delusional and paranoid, use any of the standard tactics for delusional people. (Chapters 24 & 25)
- De-escalate based on the behavior, not the paranoia.
- Let them know what's going on.
- Speak in formal tones. Don't be too friendly.
- They will try to provoke you so they can 'hit you back first.'
- Be aware of both physical and emotional spacing. Maintain a correct distancing, neither too close nor too far.
- Differentiate by not being too friendly, and if they're delusional, clearly separate yourself from their paranoid ideas without getting into an argument with them.
- Maintain your calm—the paranoid patient is usually assaultive when they feel under attack, when they perceive you as controlling them, or when they perceive that you are afraid.
- If you do have to take them to the hospital or intervene medically on scene, let them know what is going on and why. Paranoid patient are most likely to become dangerous when they base their actions on their imagination rather than on reality.