Chapter 3
The Front Line: EMS, Law Enforcement, and Probation and Parole

> Mental health continues to be a topic people would rather ignore, especially management.—Survey Respondent, National Association of Emergency Medical Technicians (2017)

First responders—which typically include emergency medical services (EMS), "line" (or patrol) law enforcement officers, and firemen—are workers who are dispatched to crime scenes, accidents, and emergencies. Aside from bystanders and witnesses, they are often the first to encounter people in crisis and even more likely to be the first to engage with these individuals. These professionals routinely encounter the turmoil, panic, and pain in its rawest form and thus are often dealing with difficult and serious situations—perhaps even daily. In regard to confronting mental illness, the primary concern lies in the lack of relevant training for the vast majority of these professions. For example, EMS personnel commonly have *some* level of training to enhance their ability to work with individuals experiencing mental health crises and/or who have a mental illness (diagnosed or undiagnosed); on the other hand, law enforcement officers commonly have *little to no required training* in mental health-related topics. This training deficiency is beginning to be addressed as some departments are moving to require officers, or a subset of law enforcement agencies' patrol units, to be trained to serve on Crisis Intervention Teams (CIT), but this is not yet universal. Therefore, it is imperative to carefully consider the unintended consequences of having citizens routinely encountering professionals who are not properly trained to work with individuals experiencing mental health crises when emergency services are dispatched. While many urban and suburban areas have created a mobile crisis unit that provides immediate services in the event of a mental health crisis, these units are often underfunded or work in isolation. Ideally, these mobile crisis units work together with local law enforcement when emergency services are called. This chapter discusses the current picture of first responders' work with individuals with mental illness and citizens

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experiencing mental health crises. It further identifies probation and parole officers as part of the first responder definition as these professionals confront the very same issues as do their colleagues in patrol law enforcement and EMS.

3.1 Know the Role

Dealing with people who are ill day in and day out can be difficult for almost anyone. Much like any other illness (in particular, chronic illness), those with mental illness also may seek treatment repeatedly with varying levels of success (and failure and/or setbacks). Also, many illnesses can progressively worsen over time particularly with lack of treatment, including undertreatment. Seeing the same person over and over as a first responder or treatment provider—often colloquially called frequent flyers—can take its toll. Imagine, if you perceive that whatever you do on your job, that very little of it seems to be helping or that you feel like you are simply "doing the motions" without anything to show for it.

"Helping professionals" often get into the business directly due to a passion or desire to want to help people. For example, on a top police news and blogging site—PoliceOne.com—a recent post entitled "7 reasons I'm still a police officer" explained that the unnamed author cherished "protecting those who cannot protect themselves," and "getting help to someone who needs it" as his or her main reasons for continuing to serve while the recent political climate seems to have given rise to a downturn in confidence in American law enforcement officers (PoliceOne, 2016). With a broken continuum of care and a consistent lack of systematic resources, protecting vulnerable citizens and proving help to those who need it can be a very difficult and often frustrating task. If you factor in the bureaucracy of local, state, and federal government, one can begin to envision a series of roadblocks that can often demotivate American first responders, leading to further unintentional consequences. For example, these barriers commonly lead to burnout, and this burnout leads to mental health concerns for these helping professionals and first responders.

Unfortunately, these concerns have become self-evident in the amount of suicides within these professions. In a recent study by the Centers of Disease Control and Prevention, "protective service" professionals including law enforcement and firefighters were found to have the sixth-highest suicide rate and will over double the national average suicide rate of that year (30.5 per 100,000 versus 12.6 per 100,000 average for American Adults, both in 2012; McIntosh, Spies, Stone, Lokey, Trudeau, & Bartholow, 2016). Even more stark, female protective service professionals experienced the highest suicide rate relative to other adult females in any other occupation (14.1 per 100,000).

It is far from clear what level of impact deinstitutionalization has had on the mental health of these professionals themselves; however, it is clear that deinstitutionalization has starkly increased the interaction of helper professions with individuals with mental illness and/or individuals at high risk to experience mental

health crises. On its website, the National Alliance on Mental Illness strongly suggests that "law enforcement agencies have increasingly become the de facto first responders to people experiencing mental health crisis" while citing indirect evidence to support this claim. From the evidence presented in the last chapter, this bold claim appears to have a lot of truth to it in the absence of direct study; either way, it is certain that these interactions are common, frequent, and have an impact on both responders and respondees in ways we are yet to completely understand.

Probation and parole officers also struggle with these very issues yet have been largely forgotten in the growing research in this area. Further, probation and parole officers often have to contend with increased caseloads and decreased resources due to the nature of recent justice reforms and policies set in place to decrease prison overcrowding/populations. As revealed in the previous chapter, the vast majority of individuals in need of services are not receiving them in jail or prison settings. At this point, the vast majority of treatment resources continue to remain in the communities probationers and parolees return to; however, connecting these individuals with services often remains challenging. Research is direly needed in this area as probation and parole officers often have caseloads that include individuals with varying degrees of mental illness and co-occurring disorders who may require routine care.

For supervisees with serious mental illness, community corrections agencies have often adapted a special agent role or "unit" to address "extreme" cases and thus focuses training resources on agents with the most challenging caseload (Lurigio, 2001). Yet, the job also demands that *all* agents confront individuals when they are having mental health crises. Relative to patrol police officers, it appears that many in community corrections have broader experiences with individuals with mental illness and/or at risk of experiencing mental health crises. A litany of research questions arise from these interactions and are yet to be explored.

For example, probation and parole officers aid in the success of individuals in lieu of incarceration or post-incarceration. The transition of leaving jail, prison, or court-ordered treatment can be the most difficult period for person; in fact, a wide array of literature focuses on this transitional period as a particular moment of high risk of problems (most likely, relapse, recidivism, rearrest, and/or re-incarceration; Begun, Early, & Hodge, 2016; Jacob & Poletick, 2008; Stewart & George-Paschal, 2017). Consider that the mission of community corrections agencies often highlights and prioritizes the assurance of accountability among their supervisees to promote successful outside of jail and prison facilities and to ensure public safety. One must rhetorically consider, then, the level of accountability to be placed on individuals with mental illness and co-occurring disorders. Perhaps the following question should be carefully considered: how should probation and parole officers respond to supervisees who are in violation with their conditions of supervision or release directly due to mental illness and/or substance abuse?

The front lines of first responders are people who truly get to be pillars of support in times of crisis. They often help those in need when the worst has happened, quickly becoming the worst moments in people's lives and memories. The level of empathy and concern for others is truly a remarkable feat that often gets overlooked when assessing the problems of tending to individuals with mental illnesses.

3.1.1 EMS and Trained Firefighters

Emergency Medical Services (EMS) refers to the medically trained professionals (and their agencies) who are dispatched to incidents of medical emergencies to provide acute out-of-hospital care, triage, and transportation services to medical facilities for further assessment and treatment (District of Columbia Department of Health, 2017). They include (1) paramedics—highest level of training and licensure of their class, paramedics are skilled in ambulatory medicine delivery, heart monitoring, intubation, establishing an airway when it is occluded, and other advanced life support procedures (e.g., defibrillation); (2) emergency medical technicians (EMT) of varying levels of training and expertise including EMT-Intermediate (one step lower in training relative to paramedics—to be phased out in upcoming years), Advanced-EMT (limited range of ambulatory medicine delivery, yet fully trained in advanced airway procedures and set to replace the EMT-I level of certification), and EMT-Basic (limited range of emergency care procedures, yet include the most important such as defibrillation, procedures in case of potential spinal injury, and oxygen therapy); and (3) ambulance personnel (who are, at times, cross-trained in a certification listed above). As mentioned earlier, EMS personnel work closely with law enforcement and fire departments when responding to various types of emergencies. In fact, in most major metropolitan areas, when EMS is run as a public venture, it often falls under fire services in organizational charts. Further, EMS has been increasingly privatized as noted in a recent *The New York Times* expose entitled "When you dial 911 and Wall Street answers" (Ivory, Protess, & Bennett, 2016), leading to new challenges yet to be adequately researched and assessed.

As with most medical-related occupations, EMS personnel do receive some training as it relates to mental health, albeit minimal at this time. Most critically, it should be noted that EMS personnel and firefighters have consistently and historically retained a medical orientation to care coming from a *non-law enforcement* perspective. In other words, as first responders to incidents featuring mental illness and/or mental health crises, law enforcement professionals have been criticized for their paramilitary orientation and approach which often is contraindicated for these types of incidents. So, while the level of training may not be substantially different in the certification and licensure process (and re-certification process) for law enforcement and EMS personnel, the orientation should theoretically produce significantly different results on the street.

In Florida, training often consists of lectures relating to excited delirium (e.g., symptoms of bizarre and aggressive behavior, psychomotor excitement (high rate of breathing and feelings of "on edge"), paranoia, panic, and potential violence), combative patients, and the use of restraint and drugs such as ketamine. In all actuality, these topics are covered within broader lectures on interfacing with patents, often lasting a few hours (at best; Strate, 2017). In New Orleans, similar coverage was confirmed with a local training manager and community liaison (Belcher, 2017). As such, the majority of the EMS and firefighter workforce remain critically undertrained in mental health across the nation. Further, there is a dearth of literature on

the impact of privatization of these services on the quality of care given to individuals with mental health concerns. This is a critical issue as privatization has become more prevalent since the economic downturn and recession in the United States in 2008. Anecdotally, it appears that there is a great potential for more problematic interactions between private sector EMS personnel and firefighters; *The New York Times* expose detailed worsening response times, failing and faulty equipment, and poor service that have led to the death of at least two patients (Ivory, Protess, & Bennett, 2016).

3.1.2 Law Enforcement

The vast majority of "line" law enforcement personnel across the country attend standardized training, called Peace Officer Standards and Training (POST). The POST standards are created and maintained by state-level commissions and vary across state. As such, the level of mental health training police cadets receive varies. For example, in California, cadets attending POST-certified police academies across the state will receive at least one module that addresses the following: (1) an introduction to the laws put into place that protect people with mental illness and disabilities, (2) training in recognizing the behaviors that can be a red flag or serve as indicators of mental illness or disability, (3) training in de-escalation skills, (4) training in responses that are appropriate to differing situations that include indirect referrals for the individual and direct referrals to community partners, and (5) educate cadets in mental health and disability stigma to ensure reduction in stigma (California Commission on Peace Officer Standards and Training, 2017). This content was developed in partnership with the National Alliance on Mental Illness, local mental health professionals, and POST subject matter experts to ensure best results; and while the hours of training dedicated to this module may vary, mostly this Regular Basic Course receives a minimum of 664 h of training (yet most academy average over 850 h of overall training, signifying that most academies go above and beyond the minimum to ensure adequate training of new cadets).

In 2017, California leads the United States in the development of this type of embedded training in POST academies. This is directly due to state legislation that was signed into law in October of 2015. California Senate Bill 11 created a statutory mandate directing the Commission on Peace Standards and Training to include "adequate instruction in the handling of persons with developmental disabilities or mental illness, or both…[and] to establish and keep updated a continuing education classroom training course relating to law enforcement interaction with developmentally disabled and mentally ill persons" (2015). As time passes, it will be interesting to see if other states follow suit, take an alternative approach to ensuring better training practices, or remain stagnant. At this time, most law enforcement training mirrors the status quo for EMS personal explained above. This status quo tends to focus on "containment and transportation" (Strate, 2017). Such training can include tactics of restraint, which again, can be contraindicated in some situations. To, at

minimum, make mention of how to approach encounters with individuals with mental illness and/or citizens experiencing a mental health crisis, law enforcement training may include de-escalation skills in the form of "Verbal Judo" or something quite similar. Verbal Judo is training program developed by George Thompson (whose doctorate was in English and was further trained in rhetoric) that focuses on the power of persuasion and verbal communication to redirect behavior. It remains empirically unclear whether these tactics show statistical improvement in outcomes when encountering individuals with mental illness and/or citizens who are experiencing a mental health crisis. Yet, Verbal Judo remains incredibly popular as a training option for developing crisis intervention skills in the United States and abroad.

The most concentrated and promising investment in affecting change among law enforcement, EMS, and trained firefighters has been in building Crisis Intervention Team (CIT) programs and its related training. This in-service training has become robust, evidence-based, and is thought to be the leading solution to the current state of affairs of underserving vulnerable mental health populations and individuals with disabilities. CIT is explained further below.

3.1.3 Probation and Parole

Probation and parole officers face a different challenge working with individuals post-conviction and post-incarceration. The agent's role involves supervising individuals who have been arrested of a crime and are sentenced to a probationary period or individuals who are being released from incarceration. Typically, supervision involves case management, frequent and (often) random drug tests, and regular visits and/or check-ins. Policies can differ across states as well as with the federal approach; however, the basics and routines are essentially very similar (United State Courts, 2017).

In urban areas with adequate resources, special units within community corrections have been created to address the mental health caseload that these agencies may have. For example, in New York City, the New York City Probation offers a forensic mental health unit to "help their clients adjust to probation supervision while also addressing…mental health needs…, [including] working individually with clients and tracking their progress, sometimes through periods of hospitalizations and homelessness" (2017). This is a relatively new unit, with mandates to begin forming in 2008 after a formal review gaps in services performed by New York City. It is difficult to determine the effectiveness of this type of program; yet, it does appear that it and others like it deploy evidence-based practices and services designed to show improvements in outcomes for this target population. Much more research on the effectiveness of these programs are slated to emerge in upcoming years.

One recent study, by Wolff and her colleagues, shows that there is great promise in deploying specialized mental health caseloads (Wolff, Epperson, Shi, Huening, Schumann, & Sullivan, 2014). This study used a mixed-methods approach to first

ensure that trained special agents in New Jersey were staying true to their training and evidence-based approaches while also following up to observe any potential differences in outcomes among probationers with mental illness who are supervised on a specialized caseload versus those who are not. Their findings show that the special caseloads were deployed with rigor and probationers who received these special services had statistically improved criminal justice and mental health outcomes (e.g., fewer violations of probation resulting in arrest and jail days, improved mental health symptoms, better quality of life, etc.) relative to those who were not placed on a special caseload (although they did qualify). This study is robust, yet the researchers urge future researchers to examine special caseloads with a random control treatment design to be able to understand whether other potential confounding factors are interfering with these results.

Probation and parole officers will be as important as first responders in managing mental health in American communities in the upcoming years. In fact, there will likely be more burden directly placed on their shoulders to be on the front lines of this response.

3.2 Common Interactions

The vast majority of interactions between first responders and individuals with mental illness and/or experiencing a mental health crises are often perceived as negative. Textbooks, advocacy groups, and research often use a lens of the perspective of individuals with mental illness, which is compelling and offers great insight into the plight of this target population. This text does make light of this perspective, often heavily, to ensure adequate assurance of busting myths that plague this topic, to improve understanding in the area, and to help make sense of the broken nature of our mental health care systems. Yet, exploring these interactions from this perspective alone will only be able to depict a smaller part of the broader problem. To gain better understanding into and compassion for the issues explored in this text, it will be important to understand both sides of the interaction.

3.2.1 Frequent Flyers: An Example of Typical and Common Interactions (and Frustrations)

In Austin, Texas, Travis County Emergency Medical Services grew curious about a number of repeated calls to 911, often from the same patients time and time again (Plohetski, 2008), a common occurrence experienced by EMS professionals across the country (Belcher, 2017; Strate, 2017). One such example described a man calling emergency dispatchers three times in 1 day, resulting in three separate trips to local hospitals. Further research into this same case uncovered that over the course

of 2 years, paramedics were called to this man's home 290 times (an average nearing three times a week). As a result of such cases, Travis County began to track these data in order to better serve the community and identify a better solution for such patients with extraordinary need. In particular, this study found:

- Ten patients made up more than 1 percent of the system's 130,000 contacts with patients in two years. Their most common complaints were stomach or chest pain, injuries or respiratory problems. Paramedics also responded to calls when the patients exhibited behavioral problems.
- Nearly all of the patients went to a hospital emergency room each time, sometimes crowding into already overflowing facilities.
- The patient who was seen 290 times in the two-year period was evaluated by paramedics twice on 36 days and nine times in a separate seven-day period.

This new tracking system and database has allowed for Travis County EMS to take a better look at their processes and where their time and resources were being spent (and wasted). For example, and at that time (in 2008), Travis County was spending $300 on labor, gasoline, and medical equipment costs for the average call and was putting in more than an hour of time commitment. The cumulative drain repeated and unsuccessful calls for service have on the system had become a critical issue with regard to the *quality* of services for the entire service area. Adding to the emerging crisis, cutbacks were occurring contemporaneously to Austin's mental health centers and hospitals, resulting in increased activity in emergency rooms (and, by default, emergency medical services) in addition to the lack of resources and reduced quality care available in the area at the time.

Common problems arise in situations where these inefficiencies in the system promulgate. In other words, frequent flyers in the system can cause a ripple effect. For example, patients may end up in emergency room beds for too long, possibly even days or weeks without medical history or medication information. The emergency room, particularly at hospitals serving the vulnerable and underserved populations, can also have less capacity to provide thorough treatment or assistance for patients experiencing mental illness. In Travis County's case, local stakeholders were compelled to search for alternatives after this critical introspection into its mental health-care system's inefficiencies in order to overcome these obstacles and have even attempted to resolve things directly with patients in need. They have since explored better triage plans and policies for mental health patients by EMS, adding a nurse to emergency services dispatch to assess patients over the phone, who appear to have mental health concerns, and developing a community health paramedic position. In one instance, Travis County EMS actually met with a patient and her caregiver directly to discuss ways to help and avoid frequent calls/hospital trips. The effort was successful temporarily until the patient was arrested and, upon her release, the cycle of frequent calls began again. Yet, the willingness to explore out-of-the-box options is now on the table for many jurisdictions dealing with the very same issues.

"Frequent flyers" are common jargon among first responders (Belcher, 2017). Interventions with particular focus on the emergency room have been created and tested and show promise (Michelen, Martinez, Lee, & Wheeler, 2006). For example,

a relatively recent study of in New York City showed that an emergency department diversion program featuring health priority specialists and community health workers successfully reduced the return rate to the hospital. It appears that many areas are exploring broader community partnerships to engage on fixing this problem rather than having an approach spearheaded from a sole source (such as EMS like in Travis County or by a hospital, such as in this case in Manhattan).

3.3 Common Problems

The Treatment Advocacy Center is a nonprofit working to safeguard for the "effective treatment of severe mental illness" by removing barriers to services and care; this nonprofit also clearly documents the common problems facing American mental health services today (Treatment Advocacy Center, 2017a, 2017b, 2017c). Relevant to this discussion, the center recently released a study discussing the interactions between law enforcement and individuals with mental illness. The study laid out some alarming statistics initially to drive its focus; for example, "people with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement" (Fuller, Lamb, Biasotti, & Snook, 2015). This particular study, entitled "Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters," explores additional data angles and alternative sources for estimates when data is unavailable to continue its point. Using publicly available data, Fuller, Lamb, Biasotti, and Snook uncover that while only a few individuals shy of 1 in 50 Americans are said to have untreated and severe mental illness, this segment of the population seems to be involved in *at least* a quarter of fatal shootings by law enforcement. In fact, their estimates put this statistic closer to half of these shootings involve this particular segment. When looking deeper, these researchers estimate that roughly one in ten citizen-police encounters also involve this segment. While it may be tempting to also assert that these statistics are being sourced by an advocacy group who may be well served by articulating these problems in the most negative light to get a reaction or to seed change, the report clearly recognizes its close partnership with the National Sheriffs' Association in evaluating these issues facing law enforcement.

Recall our discussion above about frequent flyers as well. Imagine having 10% of your workload (roughly) dedicated to citizens who have untreated severe mental illness, many of whom you (and/or your fellow coworkers) routinely encounter. Also imagine feeling powerless to do anything about it as your training offers you few options, certainly fewer options *that work*. The viewpoint of the center is to develop a strategy to scale down confrontations between individuals with mental illness and law enforcement in order to diminish the number of fatal police shootings; it has worked closely with law enforcement over the years to begin promulgating solutions. Coauthor and Executive Director John Snook makes his point clear—"By dismantling the mental illness treatment system, we have turned from a

Table 3.1 Summary of undercounted: The role of mental illness in fatal law enforcement encounters (Treatment Advocacy Center, 2017c)

Overview: This study reviews law enforcement homicide reporting, examines the role of mental illness in the use of deadly force by American law enforcement, and recommends practical changes in policy to aid in reducing fatal police shootings
Findings
• The risk of being killed while being approached or stopped by law enforcement in the community is 16 times higher for individuals with untreated serious mental illness than for other civilians • By the most conservative estimates, at least one in four fatal law enforcement encounters involves an individual with serious mental illness. When data have been rigorously collected and analyzed, findings indicate as many as half of all law enforcement homicides ends the life of an individual with severe psychiatric disease • The arrest-related death program operated by the Bureau of Justice Statistics within the US Department of Justice is the only federal database that attempts to systematically collect and publish mental health information about law enforcement homicides. The program was suspended in 2015 because the data available to the agency was not credible enough to report
Recommendations to policymakers
• Restore the mental illness treatment system sufficiently that individuals with serious mental illness are not left untreated to the point that their behavior results in law enforcement action • Accurately count and report the number of fatal police encounters in a reliable federal database • Accurately count and report all incidents involving use of all deadly force by law enforcement, not only those incidents that result in death • Systematically identify the role of mental illness in fatal law enforcement encounters
Since the study
• The twenty-first century cures act, passed by congress and signed by President Obama in December 2016, included a mandate for the US attorney general to collect and report data on the role of serious mental illness in fatal law enforcement encounters • The Bureau of Justice Statistics overhauled its system for collecting law enforcement homicide data and, in December 2016, resumed reporting arrest-related death statistics. Using the new methodology approximately doubled the number of arrest-related deaths that were verified and reported by the Department of Justice. The role of mental illness in them has not yet been reported

mental health crisis from a medical issue to a police issue. This is patently unfair, illogical, and is proving harmful to both the individual in desperate need of care and the officer who is forced to respond." To address these concerns, the report recommends (1) a reinvestment and "restoration" of mental health-care services, particularly for individuals with severe mental illness; (2) to establish a centralized (at the federal level) tracking and reporting system of police use of deadly force, even if these incidents do not result in death; and (3) to assure that any data collection has the capacity to identify the role when law enforcement utilizes use of deadly force. See Table 3.1 for a summary of the report.

While death is the most extreme result of problematic encounters between law enforcement and an individual with mental illness, this remains a very rare event and relatively uncommon. It could be said that these events are becoming increasingly common; however, it is the goal of this section to emphasize routine results from these often problematic encounters. This is explored further below.

3.3.1 Police-Citizen with Mental Illness Encounters

Unfortunately, with the prevalence of mental health and dwindling treatment options, come the prevalence of conflicts, as made clear with the Treatment Advocacy Center report. These issues have since clearly spilled over into the public consciousness as partially evidenced by recent incidents in the news involving law enforcement and those suffering from mental illness—particularly when these encounters turned deadly. For example, there was the incident in July 2016 with social worker of an autistic man being shot by police in Miami that reverberated in news cycles around the country, with shares on social media with links to Internet sources rehashing the incident (Rabin, 2016). Perhaps the level of attention this story received sparked some conversations about the real issue: fear and misunderstanding as it relates to mental illness. Was this a case of fear and misunderstanding? With all of the officer-involved shootings and social unrest as of late, has the fear of violence led to more aggressive response by police? Would understanding autism have helped to ensure everyone's safety in this situation?

In this Miami incident, police were dispatched to a scene with the information that a man was on a city street threatening to commit suicide with a gun. This turns out to be not the case. After the chaos settled, police learned that a 23-year-old man with autism was holding a toy truck. When the officers reached the scene, they rightly identified the man who created the disturbance that prompted the call to 911; yet, this man was not responding to their orders. A caretaker from a nearby mental health facility attempted to intervene and explain the nonthreatening situation. Somehow the situation escalated to the point that the officers on the scene fired upon the autistic man and his caretaker and both were injured. Bystander's cell phone video was delivered quickly to the local media, which depicted the caretaker laying prone, hands clearly in the air, next to the man creating the disturbance who was sitting Indian style with an object in his hand. The caretaker's attempts to intervene were obviously unsuccessful. This bystander-shot video is one of the many recently shared on the Internet that have been a potent tool of critique of law enforcement tactics. These videos can also be a useful training tool and conversation starter on common problems that have been long simmering beneath the surface of public scrutiny.

Law enforcement officers hold difficult jobs for many reasons, as it is the nature of the position and the need for quick, split-second thinking that can have considerable consequences. Further, complicating police use of force decisions described above is an instance colloquially called "death by cop" or "suicide by police." In this scenario, an individual provokes and intends to be shot and killed by a police officer. This is not only disturbing for the individual involved but also by law enforcement. For example, in the suburban and rural areas just north of New Orleans—an hour's drive away from the city—two citizens recently confronted law enforcement with the intent of having officers end their lives by forced execution (within 2 days of each other; Rodrigue, 2017). In one case, officers attempted to engage in a traffic stop for a simple violation; the man in the car began to speed away and led officers on a high-speed chase. This resulted in a crash, with the man

leaving the car with a machete and subsequently yelling at officers to "shoot me, just shoot me." In the second case, a woman in a rural area armed with a gun was engaging in similar behaviors when police were called to her house. In both cases, police were successful in de-escalating the situation and able to connect these "suspects" with mental health services in lieu of arrest. These starkly different outcomes from Miami story versus the one out of the New Orleans area are striking. The case where no deadly weapon was found to be in play turned out to be potentially fatal for two citizens, while the cases where deadly weapons were clearly identified resulted in no one being harmed. Actually, the latter resulted in real help for the two individuals that needed it.

Maybe further investing in SWAT (or Special Weapons and Tactics team) training can help in these situations. According to the National Tactical Officers Association (NTOA, 2008), "A Special Weapons and Tactics (SWAT) team is a designated law enforcement team, whose members are recruited, selected, trained, equipped and assigned to resolve critical incidents involving a threat to public safety which would otherwise exceed the capabilities of traditional law enforcement first responders and/or investigative units." These teams are often used on missions including "hostage rescues, barricades, snipers, high-risk warrant service and high-risk apprehensions, dignitary protection, terrorism responses, special assignments, and other incidents which exceed the capability and/or capacity of an agency's first responders and/or investigative units." Here, both law enforcement and emergency personnel train and work together to complete the missions of the specialized team. Also, as one would assume with the term "high risk," these missions can involve some potentially life-threatening or violent scenarios. For instance, take high-risk warrant service and apprehensions. Often these involve a person who is wanted for murder or a violent crime. The SWAT team would be engaged and briefed on the mission to serve the warrant and apprehend the wanted individual prior to going out in the field. Then, the team would travel to the location and attempt and ideally successfully apprehend the individual. Obviously, much of this process involves potentially risky engagement. It is possible that the wanted individual is armed and willing to "put up a fight" if needed. Additionally, there may be a group of individuals armed with weapons at the location of interest. Also, if the individual does resist arrest in any way, the SWAT team may use force, including deadly force. All of these potential scenarios put the law enforcement, medical personnel, wanted individual(s), and even bystanders/witnesses at risk of injury or death.

Yet, the often-aggressive tactics and appearance of SWAT are almost certainly contraindicated in most cases discussed here. A simple Internet search of SWAT and mental health uncovers some signs of trouble regarding the use of SWAT for individuals with mental illness. For example, an expose of the Chicago Police Department's use of SWAT for mental health-related events revealed at least 38 clear cases that met these criteria, some with tragic outcomes (Lazare & Southorn, 2017). In fact, it appears that Chicago Police Department's use of SWAT in these situations is increasing. A Boston Globe reported recently featured a heartbreaking interview with a father in Hingham, Massachusetts, who lost his son in a mental health-related SWAT raid. On July 8, 2017, Austin Reeves locked himself in his

bedroom with his dog and a gun and told his family he needed some time alone. Leading up to this situation, Austin, age 26, was speaking with his ex-girlfriend on the phone. He was reeling from their recent breakup and he was clearly distraught—to the point she hung up with Austin and quickly called the police to check on his welfare. As a result, the police had called the Reeves' house phone and got a hold of Russell Reeves, Austin's father. Learning about what was going on, Russell checked the guns in his house and found that they were all locked, as always. Austin arrived at the family house shortly thereafter and was met by his father explaining the situation and asking if he was okay. Austin grew upset when he learned the police had called the house, which he fled to his bedroom to be alone as a result. Russell, feeling out of options, called the police back asking for help. This escalated over a period of 10 h from the moment two uniformed police arrived to a full SWAT response and standoff with the police. How did a routine call about a family in distress turn into SWAT response? His father pleaded with police just to leave the family alone at that point, yet the police did not stand down. Eventually, the SWAT team infiltrated his bedroom and shot Austin, resulting in his death. To further intensify the pain of the Reeves family, the Hingham Police Department left a message on the family answering machine sometime after the standoff that was intended for the neighbors also impacted by this event: "Hello, this is a message from the Hingham Police Department. The Hingham Police Department would like to thank you for your cooperation this morning and notify you that the incident on Edgar Walker Court has been resolved. Thank you" (Russell, 2017).

Can some of the SWAT training can be applicable to or hinder decision-making when officers are serving on their regular duties? Many SWAT training materials cover crisis response, but it is unclear exactly how much (if at all) mental health is referenced in SWAT training receive across the country. Much more research is direly needed in this area to address these emerging and potentially more common interactions, particularly as these trends are perceived to be on an upward trend.

3.3.1.1 Baltimore, Maryland: A Model Story for Systemic Failure on the Front Line

The Baltimore Police Department (BPD) has been in the news a number of times, unfortunately most have been for extremely negative circumstances and events relating to mental illness (Young, 2016). According to the US Department of Justice's (DOJ) Civil Rights Division report on the BPD:

- BPD's use of force against individuals with mental health disabilities or experiencing crisis violates the Americans with Disabilities Act.
- BPD's officers routinely use unreasonable force against individuals with mental health disabilities or those experiencing a crisis in violation of the Fourth Amendment. Additionally, by routinely using unreasonable force against individuals with mental health disabilities, BPD officers repeatedly fail to make reasonable modifications to void discrimination in violation of Title II of the American Disabilities Act of 1990.

- Since 2004, BPD has provided some specialized training to its new officers on how to interact with individuals with disabilities and those in crisis. But this training has not been provided to all officers (United States Department of Justice, 2016).

In many investigated situations, officers have assaulted vulnerable citizens, many of which have not committed a crime. Some of these assaults escalated into the use of unnecessary nonlethal force (e.g., deploying a Taser device) and lethal force resulting in at least one death. According to a recent Baltimore Sun article, "ACLU-Maryland reports that of the 109 people who died in police interactions from 2004-2014, 38 percent (41 people) were likely individuals with mental health and/or substance abuse issues" (Young, 2016). Again, these conflicting statistics underscore the need of monitoring such practices as indicated in the Treatment Advocacy Center report highlighted earlier in this chapter.

The BPD is only one department with clear and substantiated evidence of "engag[ing] in systemic disability-based discrimination" despite the many investigated across the nation done by DOJ. This is extremely disheartening for many reasons since these issues include both concerns with regard to individuals with disabilities as well as race concerns. The article discusses further that the police being the first responders to mental health calls is part of the overarching problem in not only Baltimore but the criminal justice system as a whole. Community responses have begun to offer suggestions to overcome the struggles of those with mental illness in the area. Those responses begin with the idea of addressing this issue as a "health-care matter" rather than a criminal justice/law enforcement issue. As stated over and over in this book and research surrounding this topic, the outlook by both the community and the DOJ is to gear toward more community care to those with mental illness. The goal here is not only to reduce individuals re-entering the criminal justice system but also to avoid entry to begin with in the first place. Baltimore is in dire need of a crisis response team to help with the increasing problem of caring for those with mental illness. This would not only take the burden from the police department but also ensure those who need would receive proper care.

3.3.1.2 Not All Is Lost: Positive Law Enforcement Interactions

A little training can, in fact, go a long way. Consider an expose featured on Vox, entitled, "How America's criminal justice system became the country's mental health system," which details the story of Kevin Earley of Fairfax County, Virginia. At the time the article was published in 2016, Kevin was 37, and the interviews of himself and of his father shed light on the struggles he has had with his own mental health and how this has subsequently intersected with law enforcement. Both Kevin and his father, Pete, share multiple experiences with police in Kevin's time of crisis with his mental illness. In one instance, Kevin explains his experience with a police officer during an encounter that resulted in his arrest and further paranoid, while in his last serious encounter is much more positive:

> One encounter began shortly after a psychotic episode that briefly landed him in an emergency room in 2002. Within 48 hours, Kevin wrapped tinfoil around his head, claiming that

> the CIA was reading his thoughts. He slipped out of the house and broke into a stranger's home to take a bubble bath, and eventually several officers and a police dog arrested him and took him into custody.
>
> [Yet, in] Kevin's last serious encounter with police in 2006, he was staying at a safe house, where people with mental health problems could relax for a night. There, he took off his clothes — thinking it made him invisible — and walked outside. A police officer, with training for mental health crises, approached Kevin. Kevin was scared, remembering the last time police approached him (and tased him). But this officer talked softly, reasoned with him, and, finally, convinced him to get into the car – no violence necessary. The cop didn't take Kevin to jail – he took him to a hospital. There, Kevin got a case manager. She fended off criminal charges, got Kevin into a "housing first" program for aid, and helped him sign up into a jobs program where he learned to become a peer-to-peer support specialist. (Lopez, 2016)

This last encounter with police in Fairfax County significantly changed Kevin's life situation. For the past 10 years, he has not had any negative police contact and has been under proper medication and care for his illness. Just a change in the approach taken by first responders can have lifelong positive outcomes. Kevin's story is a success story. He and his father believe that his final encounter resulted in transformative change as he was treated as a mental health patient and not a criminal. He was approached in a different manner by professionals who understood his illness and were focused on providing help in his time of need. While the systemic changes needed for agencies such as the Baltimore Police Department will take time, the good news is that there are plenty of documented stories of success to keep the faith that, in time, things can improve with dedicated positive momentum.

3.3.2 Interfacing with the Homeless or Near-Homeless Population

One interrelated issue worth mention here is the lack of trust vulnerable populations have with police and emergency medical services, largely due to years of misunderstanding, miscues, and problematic encounters. This trust may be further eroding giving the unresolved issues described above, exacerbating the crisis on the street. In 2004, Zakrison, Hamel, and Hwang published a study focusing on the trust homeless people in Toronto who have with local police and paramedics and potential health-related outcomes. Perhaps their findings are not so surprising; among their sample of 160 homeless Canadians staying at a local shelter when surveyed, there was a wide margin of difference in willingness to call the police in times of emergency relative to emergency medical services (69% of the sample compared to 92%, in the same order as listed). This was surely related to the differences in the level of trust these homeless individuals had in these professionals (a median of 3 out of 5 for police versus a 5 out of 5 for emergency medical services personnel, with 1 representing the lowest trust and 5 representing the highest trust). Additional responses from this sample are quite compelling: about one in ten self-reported an assault by a police officer in the last year, while none reported such an action by emergency medical services personnel.

What if there is no assurance on who would arrive on a scene of an emergency if emergency dispatch was called? What if, since 2004, these levels of trust have further eroded, especially in the United States that does not feature universal healthcare coverage as its neighbor to the north? Answers to such questions still allude us, as is common theme for this text.

3.4 Evidence-Based Solutions

Great strides have been made in the development of evidenced-based services and programs to address the ongoing mental health crisis in the United States. For law enforcement, the Bureau of Justice Assistance (2017) and its partners have produced the Police-Mental Health Collaboration Toolkit that can educate key stakeholders and community partners on the most progressive and research-informed practices available today. The dedicated website for the toolkit features an easy-to-follow, step-by-step guide to the ten essential elements of police and mental health collaborations that have been proven to be successful in the jurisdictions that have implemented it: (1) collaborative planning and implementation; (2) program design, (3) specialized training; (4) call-taker and dispatcher protocol assessment and revision; (5) stabilization, observation, and disposition; (6) transportation and custodial transfer; (7) information exchange and confidentiality; (8) treatment, supports, and services; (9) organizational support; and (10) program evaluation and sustainability.

Currently, the website includes the learning experiences and successes of the Houston, Los Angeles, Madison (Wisconsin), Portland, Salt Lake City, and University of Florida Police Departments in customizing programming to meet their needs as well as their communities' needs. The common features of each are explored below.

3.4.1 Crisis Intervention Teams: The *Preferred Solution*

Crisis Intervention Team (CIT) programs "[are] community partnership[s] of law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorders, their families and other advocates" (Crisis Intervention Team International, 2017). First developed in Memphis, and sometimes known as the "Memphis Model," CIT programming offers police-based training from an inventive first-responder model. The *team* aspect of CIT primarily involves law enforcement and local mental health providers and other related service providers. The overarching goal of the partnership is to aid in working with a person in crisis and route these individuals to medical treatment in lieu of criminal justice processing that has become so common, creating a seamless flow for individuals with mental health concerns to receive services in the community. This

often starts with dispatch flagging calls for service, relaying relevant information over to officers who receive dedicated CIT training and linking up with professionals in the community who are plugged into the CIT partnership to address potential clients' needs. Each CIT is customized to the local community and, as such, is nimble to adapt to changes in the community. The model prioritizes and promotes the best welfare for people in crisis as well as concretely connecting them with the best option for success and recovery. Additionally, CIT provides for a safer interaction for law enforcement in the event of a crisis situation.

The National Alliance on Mental Illness and their local affiliates have been key in promulgating CIT training across the country. These trainings have become standardized and feature 40 h of training on the following topics:

- **Learning from mental health professionals and experienced officers in your community**. One of the reasons CIT is successful is that it connects officers with a team of clinicians and fellow officers who can advise, problem solve, and support them when a challenging situation occurs.
- **Personal interaction with people who have experienced and recovered from mental health crisis and with family members who have cared for loved ones with mental illness**. NAMI members present at the training, providing officers a first-hand opportunity to hear stories of recovery, ask questions and learn what helps (and harms) when a person is in a crisis.
- **Verbal de-escalation skills**. CIT teaches a new set of skills for ensuring officer safety – the words, approach, and body language that convince a person to get help or defuse a potentially violent encounter.
- **Scenario-based training on responding to crises**. With the help of volunteers or actors, officers practice their skills in common crisis situations and get immediate feedback from instructors and classmates. (National Alliance on Mental Illness, 2017)

The standardized curriculum was developed through a partnership of the National Alliance on Mental Illness, the University of Memphis Crisis Intervention Team Center, CIT International, and the International Association of Chiefs of Police. Since implementation, research has shown the difference coordinated training can make: in Memphis, dispatch calls for "mental disturbances" fell substantially, by 80%; CIT-trained officers surveyed by researchers reveal that they feel they spend less time on such calls and feel more effective on meeting the needs of people with mental illness in their community; and CIT makes a clear difference in connecting citizens to the services that they need (e.g., counseling, medication, and other forms of treatment) relative to individuals being processed by the criminal justice system (Deane, Steadman,Borum, Veysey & Morrissey, 1998; Compton, Demir Neubert, Broussard, McGriff, Morgan, & Oliva, 2011; Dupont, Cochran, & Bush, 1999; National Alliance on Mental Illness, 2017; Massaro, 2004; Tully & Smith, 2015).

With such enthusiasm and empirical support, many cities are moving toward positive and proactive measure to help educate local law enforcement and better help the citizens they serve. One way this is happening is to have officers trained in mental health practices. For example, New Orleans Police Department (NOPD) now trains officers regularly in CIT with the hopes to continue with more and more both new and veteran officers trained. This is a new concept and will hopefully prove to be effective for the city of New Orleans when dealing with individuals in

crisis. On the downside, the state of Louisiana continues to have budget cuts that directly affect the amount of treatment, specifically inpatient hospitals, in order to treat those with mental illness properly.

Having law enforcement trained in handling individuals with mental illness and those in crisis is essential because they are often the first to arrive on the scene when emergency services are called. Also, keeping in mind that not all information provided by the caller is accurate when a phone call is made for emergency assistance. For example, a bystander may call 911 if a person is wandering through a public setting yelling at strangers. The bystander may have little to no information about the person or the situation but observes an individual in an irate situation. A police officer is then dispatched to the scene with no information regarding the mental status of the irate person. It is important that the officer approach the scene with caution for many reasons.

3.4.2 Mental Health First Aid

Originating in Australia, the Mental Health First Aid curriculum was developed in 2001 by a nurse with a background in health education, named Betty Kitchener, and a professor of mental health literacy, named Tony Jorm. It has become known to be a rigorous yet "light" course that is delivered in 8 h. Mental Health First Aid has been likened to the mental health equivalent of CPR for non-clinicians when attending to a heart attack, with the goal of being able to appropriately and effectively intervene until "the real help arrives"—the trained professionals (Mental Health First Aid USA, 2017). The curriculum features ways to understand stigma, basic mental health knowledge, and related topics; however, the main focus of the course is to be competent in a five-step action plan in cases of a panic attack, suicidality, or an overdose situation. As such, it gives a practical and evidence-based approach to tending to these situations when they occur. Further, Mental Health First Aid appears on SAMHSA's National Registry of Evidence-Based Programs and Practices as a promising strategy in improving knowledge, attitudes, and beliefs about mental illness as well as non-specific mental health disorders and symptoms (SAMHSA, 2017).

For first responders, Mental Health First Aid appends their knowledge, skillset, and tools to effectively attend to mental health crises. Anecdotally, this evidence-based practice is proving effective in these professions. For example, in a recent article from the Department of Homeland Security First Responder division (formerly under the website firstresponder.gov), a fire and rescue captain expressed his observations of the Mental Health First Aid Curriculum:

> Law enforcement is beginning to recognize that some of the situations they have found themselves in recently have been misjudgments of people with mental health issues…and if they had been able to recognize certain symptoms, they may not have taken the, you know, forcible action that they took….[If first responders] don't have a baseline training for these guys,… they can only draw on their own experience. And if they don't have any experience [dealing with mental illness], then they're going to come up with their own idea of whether it's right or wrong. We'd rather make a decision than not make a decision. (Department of Homeland Security, 2015)

The article expresses other first responder leadership's impression of the training in a positive light while explicitly suggesting others consider joint investment in both CIT and Mental Health First Aid. Notably, Mental Health First Aid is much cheaper and quicker to deploy while also allowing for easily local sustainability through the form of "train-the-trainer" curriculum. That is, Mental Health First Aid offers standardized courses for individuals interested in becoming certified instructors. Thus, if a local jurisdiction wishes to make Mental Health First Aid available to a wide array of consumers, including first responders, they may simply invest in an initial round of training while also selecting a subset of trainees to receive instructor certification. These local instructors would then continue training until the local goal is met. This is the approach a regional National Alliance on Mental Health affiliate of Louisiana took in late 2015, continuing on through the current day. As of this writing, this NAMI office has trained several 100 trainees, including local judges, law enforcement, probation and parole, emergency medical services personnel, jail correctional officers and staff, and so on. While the impact of this initiative is unknown, the perception of the trainees has been positive (Richard, 2017).

3.4.3 Alternative Destination Pilot Project: North Carolina

North Carolina developed a novel approach to for emergency medical services working with patients with mental illness—called the Alternative Destination program. Rather than transporting the patients to the emergency room and waiting for a psychiatric evaluation, EMS enabled their personnel to transport them directly to a psychiatric facility. This was piloted initially in 2009 and has been expanded upon in recent years. The wait times in North Carolina emergency rooms were looming, medical professionals were overwhelmed, and resources were strapped. The Alternative Destination pilot project in Wake County, North Carolina, set out to alleviate these problems in a smarter way.

The Alternative Destination protocol was strictly defined to focus resources on those who need it the most yet who are not in exigent need of *emergency* medical services: (1) primarily, patients must not be experiencing a mental health crisis to a point that may require sedation or show an acute change in mental health status, (2) a patient's pulse is no more than 120 (e.g., signifying potential agitation or excited delirium), (3) a patient cannot present with other acute medical symptomatologies, (4) an extremely liberal blood alcohol content level must be met (up to 0.40, or anything less than five times the legal limit; note: if this condition is met with a high BAC while the other conditions presented here are met, this is an indicator of high alcohol tolerance), (5) each patient must be able to perform the activities of daily living (ADLs, or self-feeding, bathing, personal hygiene, dressing, using the bathroom and toilet hygiene, and walking and/or mobility), and (6) a patient must have a blood glucose level of less than 300 mg/dL. If all of these qualifiers are met, EMS can redirect the patient to other medical facilities qualified to handle these patients with available space. To implement this protocol and its strict guidelines, "advanced practice paramedics" were trained using a 240 h course, including topics such as

available mental health resources within their own community as well as patient evaluation and assessment. By 2015, 20 trained advanced practice paramedics were active in Wake County, with over 30 others trained and ready to activate. Initial internal evaluations have been compelling: Miller (2015) reports that the pilot project has reduced emergency department transports by 20% from 2013 through 2015 by directing 764 patients to other facilities out of 3831 total mental health and/or substance abuse evaluations by advanced practice paramedics.

Over the length of a year, it was estimated that the program saved $500,000 in Medicaid costs. Unfortunately, as often in the case with innovative programming, the pilot has led to some stumbling blocks. For instance, despite the decrease in costs to Medicaid, the local EMS budget was strained due to reduced reimbursements as premiums are placed on transports to the emergency departments. This becomes a difficult paradox in that transportation directly to the psychiatric facility for treatment is best for the patient in need yet does not allow for reimbursement most of the related activities (including the increased work of the newly trained advanced practice paramedics), although, in the grand scheme of things, this pilot program is better for the emergency medical care system as well—and the system as a whole has been committed to seeing the program work.

The Alternative Destination pilot program appears to be a beneficial option for individuals who experience mental illness symptoms regularly but are not actively in the midst of a crisis. Those that may need a medication adjustment have not been harmed in any way and have or were always not in a panic attack or related moment. On a positive note, programs like the Alternative Destination pilot program are beginning to catch the attention of governments and other areas across the nation. The North Carolina State Government has recognized the program which has helped to spread information. Similarly, over 260 programs throughout the United States have begun to implement similar protocols.

3.4.4 Community Paramedic Program: Grady EMS (Atlanta)

Meanwhile, in Atlanta, the Grady County EMS (GEMS) Vice President of Operations, Michael Colman, began a search for a better option for the mental health calls in the area. Colman was able to identify that about 6%, or 6410, of the 911 calls to GEMS were determined to be psychiatric or suicide related. He reviewed the call volume data and was able to further determine that those that called EMS at least five a month were often made from individuals that had a mental illness. “A financial analysis using a sample of 156 patients from this group determined that it cost Grady EMS over $100 more than they received in reimbursement for each of these transports. In addition, the emergency department spent over $400 more on each patient than they received in reimbursement” (Stanaway, 2016). Consider here this amount is *in addition to* what is already being reimbursed by Medicaid, insurance, etc.

In response to this information, Grady EMS implemented a community paramedic project. According to the California Emergency Medical Services Authority, which offers fine details about this model:

- Community paramedicine (CP) is an innovative and evolving model of community-based health care designed to provide more effective and efficient services at a lower cost. Community paramedicine allows paramedics to function outside their traditional emergency response and transport roles to help facilitate more appropriate use of emergency care resources while enhancing access to primary care for medically underserved populations.
- Community paramedics are licensed paramedics who have received specialized training in addition to general paramedicine training and work within a designated community paramedicine program under local medical control as part of a community-based team of health and social services providers. Paramedics are uniquely positioned for expanded roles as they are geographically dispersed in nearly all communities, inner city, and rural, always available, work in home- and community-based settings, are trusted and accepted by the public, are trained to make health status assessments, recognize and manage life-threatening conditions outside of the hospital, and operate under medical control as part of an organized system approach to care (California Emergency Medical Services Authority, 2017).

Grady EMS looked to find a solution to help patients experiencing a mental health crisis other than the typical means. Those in crisis "were routinely subjected to unplanned physical restraint, chemical restraint, police restraint and even arrest" (Stanaway, 2016). This is to say that a person experiencing a mental health crisis were often not able to be de-escalated without the use of physical force and/or medication. These are also extra costs as well as safety concerns for all involved.

This pilot program was developed in 2012 and put into operations in early 2013. Grady EMS created a crisis response team which includes a paramedic, a Grady Health System licensed counselor, a Behavioral Health Link clinical social worker, and even, at times, a third-year psychiatry resident. This crisis team responded with the regular EMS staff during the pilot phase of the project. Additionally, the crisis team could be dispatched at the request of those on scene but did not respond alone and was only available on weekdays. Their part in the on-scene process was to provide an assessment and a medical evaluation for the patient in need.

Later, after completion of the pilot phase, the program began implementing the full program. In the full program, the crisis intervention team was then able to respond as an independent unit without regular EMS accompaniment. Further, rather than just the original 40 h per week availability, the program was expanded to 80 h to allow for additional services to be provided. GEMS personnel used the Georgia Crisis Action Line (GCAL) in the field when the team was not available:

> GCAL is the 24/7 hotline for accessing mental health services in Georgia. The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to people with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. (Georgia National Alliance on Mental Illness, 2017)

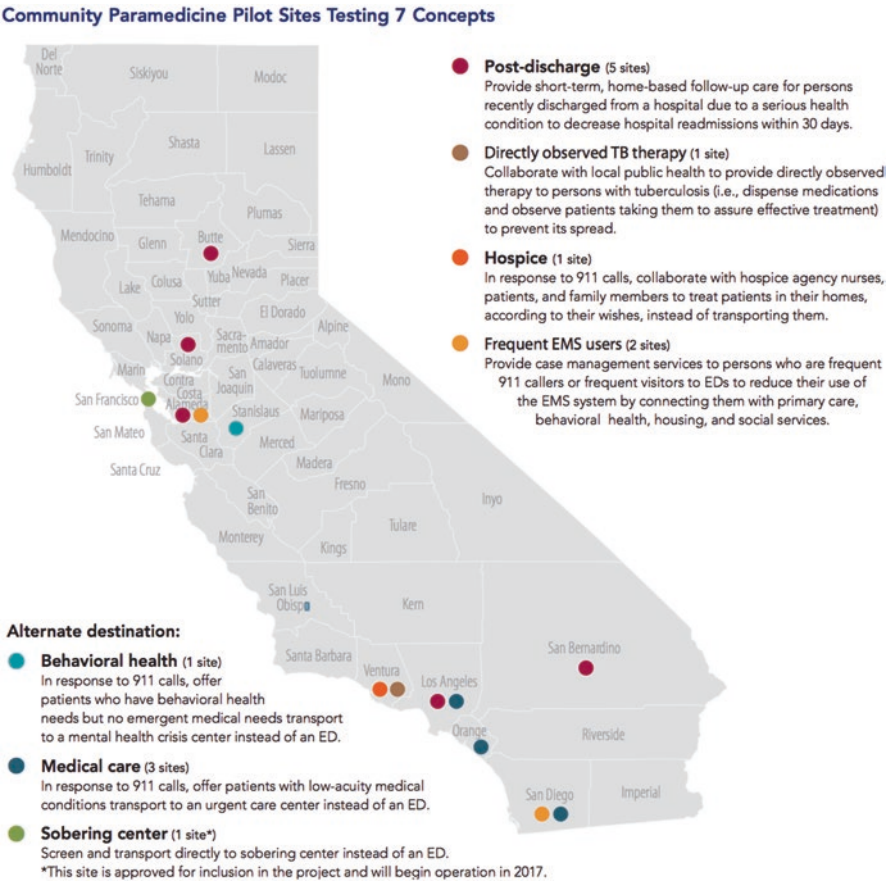

Fig. 3.1 Latest community paramedicine projects offered by the Emergency Medical Services Authority of California, a leader in community paramedicine innovation

Calling GCAL involves a mental health professional who has the ability to evaluate a patient via phone contact. This evaluation can take place in a matter of minutes and results in a number of options with the best interest of the patient upheld. If necessary, the mental health professional could have the paramedics on scene transport the patient directory to a psychiatric facility. Further aiding in the success of the program, Grady EMS created a process that allows 911 dispatchers to transfer some calls directly to the GCAL, if certain criteria are met. GCAL can also call Grady EMS back if an ambulance is in fact needed to respond (Fig. 3.1).

Coordinated programs like this one have allowed patients who would otherwise have been arrested or possibly restrained in a most disruptive situation to receive care in a better manner while also saving money and resources. This can be shown by the data, "In 2013, Grady EMS dispatch transferred 175 calls directly to Behavioral Health Line saving Grady EMS about $13,000. The Grady EMS

Upstream Crisis Intervention Group responded to 20 percent of EMD category 25 calls totaling 1,250 responses. The team obtained 275 refusals/no transports. Many of those patients were provided with safety plans and outpatient appointments, which prevented unnecessary emergency department visits totaling about 1,925 bed hours" (Stanaway, 2016). Michael Colman described the financial aspect of the changes within the program and has estimated it to be over $140,000 and adding in the referrals that did not require transports savings of $248,000 for 2013. Additionally, "In 2014 the psych unit responded to 1778 calls, potentially saving EMS over $100,000. In 2015, Grady EMS received 7668 calls that were psychiatric in nature. Of those, the psych unit handled over 20%, again saving EMS over $100,000" (Stanaway, 2016).

Another added benefit of the program is also the job satisfaction increase for Grady EMS. As discussed in another chapter, burnout and compassion fatigue are common occurrences of jobs as first responders often responding to crisis on a regular basis. According to the program director Tina Wright, staff reported a "higher-than-normal" job satisfaction as the program kicked into high gear. Wright discussed that many staff members feel as though they are really making a positive change in their community which has led to a personal sense of satisfaction.

3.4.5 A Survey of Other Approaches Across the Country

There are many more instances of successful and budding programs being sown across the United States. Indeed, there does appear to be progress in the disarray of the current state of the mental health system of care. For example, the state of California is engaging in 13 community paramedicine projects, adopting this model to localized needs (California Emergency Medical Services Authority, 2017). Madison, Wisconsin, is one of the six law enforcement-mental health learning sites and serves as a model for other sister jurisdictions (City of Madison, 2015). Statewide efforts have been made in Colorado, Connecticut, Florida, Georgia, Illinois, Maine, Ohio, and Utah to provide specialized training in police responses in cases of mental illness and mental health crises (Bureau of Justice Assistance, 2017). In Alabama, the Birmingham Police Department has a number of programs within their Community Services Division that help to improve the overall relations between the public and law enforcement. These improvements are sought to be done through a variety of community services initiatives. One program specifically works to improve the process of police call outs dealing with individuals with mental illness. The program involved specially trained officers called Community Services Officers (CSOs) that "provide crisis intervention social services through direct service, referral and consultation. Their objective is to stabilize a crisis, attempt to prevent further crises, and enhance their client's well-being. They network and maintain professional relationships with relative community resources and strive to provide exemplary crisis intervention services" (Birmingham Police Department, 2017).

Much more innovation is occurring in recent years, many of which are smaller pilots that have promise for broader adoption. One thing is for certain, much of the innovation is occurring on the local level, as guided by national resources and broader research trends. While this section does not offer a comprehensive review of the innovations occurring across the country, it is important to note that there has been an explosion of activity of collaborative projects in recent years. This is likely to continue for some years to come. Perhaps in the near future, there will be a clearinghouse of projects similar to other resource databases that have grown popular in recent years.

3.5 Conclusion

A persistent issue presented in this chapter is the lack of awareness and training of mental illness among those who currently need it the most, American first responders. This often leads to problematic, and sometimes deadly, police-citizen encounters. While the American public often only learns of the most troublesome of these encounters through the media, bystander accounts and video, and so on, there has been a great deal of innovation to ameliorate the volatility of these encounters through training, partnerships, policy changes, and strategic alterations of systemic responses to potential mental health calls for service. With so much focus placed on law enforcement, it is important to take a step back and take full stock of the collaborative nature among medicine, paramedicine, and law enforcement and understand each role for each of their potential to intervene in mental health crisis events.

These collaborative relationships are critical in one of the most comprehensive and promising models to address the consistent problems regarding mental illness today—the persistent contact of individuals with mental illness has with the police and the criminal justice system often without addressing any of the underlying mental health concerns. This model, the Crisis Intervention Team, is increasingly a part of the solution for many communities looking to address the persistent issues discussed in this book. Further, this model tends not to be deployed in absence of other evidence-based solutions to address the underlying problems. Programs such as Mental Health First Aid and community paramedicine projects are gaining popularity to add additional layers of awareness and system processes to intercept potential criminal justice concerns with community-based services that typically cost taxpayers much less while offering better outcomes.

Finally, it is important to clearly define the role of probation and parole officers (e.g., community corrections) in regard to serving individuals with mental health concerns. These professionals are often overlooked, just when their role appears to be increasing given the pressures to move away from overutilization of American prisons and to alleviate overcrowding in these facilities. At the time of this writing, community corrections have received far less attention in regard to serving Americans with mental illnesses relative to their first responder counterparts. One exception is the utility of specialized caseloads or units, which seem to offer promising advantages over mixed caseloads for probationers and parolees with mental illness.

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