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The Joliet Emergency Management Model for Mental Health and Illness (JEMMHI)

Using Collaboration, Existing Resources, and New Perspectives to Combat Mental Illness

John Lukancic

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John Lukancic

Dedication

For my family…

My wife Tracy,

My Children McKenna, Ella, Liam, and Marie.

Only one of you will ever read this book. You know who you are.

Preface

The original concept for this book has been in my head for almost a decade, and my interest in mental health goes back to the early 1990s when I was in college (the first time). I was fascinated not only with the concepts of psychology but with the methods my professors and other professionals used to help those with mental illness.

Having been a child of a police officer and nurse/teacher, I had an inkling that I would wind up somewhere in the helping professions (I was told that I was assumed to become a priest or brain surgeon). Unfortunately, I was not virtuous enough for one or intelligent enough for the other.

Since I can remember, I have been exposed to firefighters and police officers. My police officer father had police officer friends, and my uncle was a firefighter. I have a photo of me playing with a self-contained breathing apparatus (SCBA) mask in my parent's garage when I was about five.

As I grew up, beginning at age 12, I had my own experiences with firefighters and police officers at a local gym run by a world-champion powerlifter (who was also a police officer). I saw first-hand how everyone interacted – they were funny and brash but kind and helpful (and they swore… a lot, which explains my nearly constant use of bad words).

In 1995, firefighters at the gym talked about a new hiring testing process for the fire department and encouraged me to apply, which I did. I wasn't top of the list and figured I wouldn't get hired, so I continued with my life, graduating from college and preparing to do

whatever I decided to do next. As the old saying goes, fate would intervene when I least expected it.

My first day as a firefighter was April 7, 1997. Over the next two years, I completed firefighter, emergency medical technician, and paramedic training. Without having a background in any of it, it was a full-time effort just learning the skills I needed to keep my job.

As a firefighter and paramedic in the 1990s, I was culturalized to believe that expressing emotion, grief, or discomfort regarding stressors of my job was a sign of weakness. I did what everyone did; I went on calls, did my job, and didn't say anything. No problem. Every once in a while, something horrific would happen to someone in the community. Like all firefighters and paramedics, I was part of a crew that would handle the problem and return to the station. Once or twice, I ended up at the local watering hole after shift change at 7 AM (the bars opened early in the town next to mine). Alcohol wasn't my thing, but I found the camaraderie of the firefighters comforting.

I lived my life. I got married and adopted my oldest daughter. My wife Tracy and I built a house and had three more children. I watched my children, friends, and loved ones grow and change. I lost significant people, gained others, got promoted several times, and kept going to work.

Everything was progressing fine (with a few hiccups) until 2014 when a critical incident affected me. I had 17 years and thousands of calls for service under my belt, including countless other "critical incidents." The event involved a child the same age as my youngest daughter at home and put me into a crisis that I didn't recognize at the time. Through the intervention of my family and one of my mentors, the weight subsided, and a new interest in firefighter peer support and mental health was sparked.

By early 2017, I had been trained as a peer supporter by the Illinois Firefighter Peer Support group and began to try to help. In December 2017, I requested permission to create a peer support group in Joliet. I received approval and funding from the International Association of Firefighters (IAFF) Local 2369 to travel to Connecticut to be trained by Union Master Instructors. I was scheduled to attend that class in April 2018.

Fate reared its ugly head again in March 2018 when I was injured at a structure fire. Injuries were not new to me (as those who know me can attest). Having recovered from back surgery, torn ACL surgery, torn pectoral tendon surgery, torn rotator cuff surgery, herniated disks in my neck, and another rotator cuff injury, I was sure that a torn quadriceps tendon would just be another hurdle that I would jump (so to speak). I canceled my trip to Connecticut and got to work.

During my recovery, I continued to learn about mental health. I read, studied, and learned what I could. I returned to work in a light-duty capacity as soon as possible. During that time, I met some important people who would change the course of my life, Br. Ed Arambasich, Sr. Mary Frances Seeley, and Dr. Terry Smith. You will see these names crop up throughout this book.

I approached the local firefighter unions, IAFF Local 44 and 2369, to sponsor another IAFF Master Instructor Course, this time in Joliet. They agreed, and the Joliet Foreign Fire Tax Board funded the course. It was something productive to do while I worked on recovering from my latest surgery and got back to work. Unfortunately, that did not work out, but that's another story for another day.

Our journey begins in Chapter 1…

Acknowledgments

This book and program would not be possible without the help and support of many people and organizations. Thank you for your education, experience, patience, honesty, advice, and time.

James J. Lukancic and Patricia A. Lukancic, *Dad and Mom*

James P. Lukancic, *brother and a better paramedic than I ever was.*

Patty Petersen, the *best sister ever, even though she almost killed me.*

The City of Joliet *lent its name to this endeavor.*

The Men and Women of the Joliet Fire Department, *patient and supportive.*

Chief Jeff Carey, *the rudder*

Battalion Chief Aaron Kozlowski, *the Devil's advocate*

Captain James Boyd, *kindness incarnate*

Apparatus Operator William Pubentz, *reluctant but natural peer supporter*

Edward Arambasich, OFM, *friend to all, chaplain*

Battalion Chief Mike Stromberg, Retired, *mentor and the first JFD peer supporter*

IAFF Local 44 and IAFF Local 2369, *the sponsors of peer support*

The Joliet Foreign Fire Tax Board, *the funders of peer support*

Mary Frances Seeley, OSF, Ph.D., *proof that God is real*

Silver Cross Hospital *provided a home for our program.*

The Men and Women of Thriveworks®, *no such thing as coincidence*

Steve van der Watt, *salesman extraordinaire*

Francis Ruettiger, *legend, mentor, friend*

Nancy Nelson, LCSW, *Aspire Center for Positive Change*

Courtney O'Brien, LCPC, *Aspire Center for Positive Change*

Jan Quillman, *Joliet Councilwoman and program supporter*

Jim Capparelli, *Joliet City Manager and a good sport*

Finally…

Old Man Fire (yeah, I know…), *who ended my career but not my life.*

The Man Upstairs, *who reminded me that I still may have something to offer, even if it's not what I expect.*

Introduction

This text is intended for citizens, students, emergency dispatch centers, fire departments, emergency medical service (EMS) providers, police departments, clinical care providers, physicians, non-profit organizations (NPOs), and those in government seeking alternatives to mental healthcare in their communities.

Its purpose is to generate discussion regarding mental health and illness solutions, to facilitate functional and sustainable options in care, and add to the literature on mental illness and health - not to solve the mental health problem in America.

For citizens, the book offers knowledge of emergency care, practical guidance for self-assessment and triage of mental illness, and suicide prevention information. For students, it may provide a simplified look at potential solutions for some mental health and illness care. For Emergency Medical Dispatchers (EMDs) and other emergency dispatchers, it offers methods to involve public safety answering points (PSAPs) more deeply in the mental health process and techniques to communicate with those in crisis. For Emergency Medical Technicians (EMTs) and paramedics, it offers in-field care guides for the mentally ill and those experiencing traumatic stress.

Police officers who read this text will be exposed to the amount and nature of training that EMS possess in mental health and illness and will be more familiar with what they do on the scene. Clinical care providers and physicians should be well-versed in all aspects of their client and patient care, and the care they receive in the field during a crisis is valuable information for them to possess. NPOs may be exposed to new ways to collaborate with other agencies to

improve community mental health. Finally, those in government (especially funders) may find methods to institute alternative methods of mental health care in their communities.

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Part 1: Primer

Chapter 1: The Early Joliet Community Mental Health Model

This chapter examines the process by which the City of Joliet, Illinois, USA, tried to remedy components of the mental health problem on a local level. A popular emergency management maxim states that “all emergencies begin and end locally.” Who better than local resources to understand the community? Who better than local resources to know high-crime areas, familiar callers, and dangerous situations? Who better to respond than the responders assigned to the same community?

The Beginning: Firefighter/Paramedic Mental Health

Mental health has been a growing issue in the fire service in recent decades. Firefighters have always had the risk of experiencing traumatic stress due to their presence at severe and impactful events and other mental health issues (Carey et al., 2011). Since 9/11, responders' mental health has been addressed in the popular media, and since 2017, fire department members have been considering mental health support for firefighters in Joliet. In 2019, members of the Joliet Fire Department began discussing the topic of firefighter mental health due, in part, to the inclusion of mental health syndromes, such as post-traumatic stress disorder (PTSD), to the list of pensionable disabilities in Illinois law (Article 4. Firefighters Pension Fund, Municipalities 500,000 and under, 1963/2020).

The Joliet Firefighters Labor Unions, International Association of Firefighters (IAFF) Local 44, and IAFF Local 2369 saw the benefit of improving firefighter mental health. They

endorsed the funding of training for a peer support program. A volunteer offered to organize and coordinate the program for firefighters. In mid-2019, with some administrative resistance, a presentation was made to the Joliet Foreign Fire Tax Board, a group elected by the department membership to spend out-of-state insurance tax funds to provide peer support training to selected members of the JFD. The funds were granted, and IAFF Master Instructors were scheduled to instruct a 30-member group in firefighter peer support.

The Joliet Firefighters Peer Support Group (JFPSG)

The JFPSG was formed in August 2019 to help firefighters manage mental health and traumatic stress incidents by providing peer support and rapid clinical care to firefighters and their families. Thirty people were chosen to be peer supporters and participate in the initial training. These trainees included active firefighters of various ranks, retired firefighters, two local clinicians from Aspire Center for Positive Change (in Channahon, IL), two chaplains, a suicidologist, and a sitting City Councilwoman. The training was completed on September 12 and 13, 2019, at a Joliet Fire Department Training Facility.

The leadership of the JFD changed soon after the group was formed by adding a new Deputy Fire Chief, Jeff Carey, to the administration. Chief Carey was open to developing the concept of mental health within the fire department and partnered with the JFPSG to improve issues with firefighters in their families. This eventually resulted in the Joliet Community Mental Health Development Team and Crisis First Aid for Paramedics (CFA-P).

The Joliet Fire Department Community Mental Health Development Team

The Joliet Fire Department Community Mental Health Development Team arose from the JFPSG, starting as an ad hoc group focused on mental health issues in the City of Joliet. The

initial members included John Lukancic (Ed.D. Candidate), Chief Jeff Carey, Battalion Chief Aaron Kozlowski, Dr. Mary Frances Seeley, Br. Ed Arambasich, and Jan Quillman.

John Lukancic MA, CCISM, Paramedic, JFPSG Coordinator

John Lukancic retired from the Joliet Fire Department in 2019 and holds the title of Mental Health Coordinator for the JFD. He is a licensed paramedic and licensed emergency medical services (EMS) Lead Instructor. He is a doctoral candidate at Liberty University focusing on Counseling and traumatology and has attained a master's degree in organizational leadership. He is also the JFPSG Coordinator, a Certified Critical Incident Stress Manager, and a member of the Illinois Critical Incident Stress Management Team and Illinois Peer Support Network.

Jeff Carey, Joliet Fire Chief. Paramedic

Jeff Carey is the Chief of the Joliet, Illinois, Fire Department. He has challenged the accepted limits of local fire department involvement in the community and achieved prominence through managing the administration of over 60,000 COVID-19 vaccines in Will County, Illinois, and reimagining full arrest care and community risk reduction techniques. Previous to this role, as the Deputy Chief, he had the foresight to recognize the mental health issue and wanted to make positive changes for the entire community.

Aaron Kozlowski, Battalion Chief in Charge of Emergency Medical Services (EMS), MS, RN

Aaron Kozlowski is the current Battalion Chief in Charge of Emergency Medical Services (EMS) for the Joliet, Illinois, Fire Department. He is a licensed paramedic, EMS Lead Instructor, and registered nurse (RN) with experience in training techniques and emergency

medicine. He is an Illinois Professional Emergency Manager (IPEM) with a master's in Executive Fire Leadership from Arizona State University and a trained peer supporter. He served as the Battalion Chief in Charge of Training when mental health planning began.

Mary Frances Seeley, OSF, PhD., Suicidologist, Author, Lecturer

Mary Frances Seeley is a Catholic Sister, suicidologist, and hotline expert, having organized, coordinated, and managed multiple crisis hotlines over the last 50 years. She has attained a Ph.D. from Northeastern University (Boston) in law as it pertains to hotlines and is the author of a book in development regarding hotline use. As a suicidologist, she has lectured worldwide, served as the Illinois President of the American Association of Suicidology (AAS), and is a volunteer member of the JFPSG.

Ed Arambasich, OFM, Joliet Fire Department Chaplain

Ed Arambasich is a Catholic Brother and Chaplain for the Joliet Fire Department. He has experience in education, pastoral care, and knowledge of the fire service mission and culture. During his time in ministry, he has served as a Chaplain for the New Orleans, LA Fire Department and Quincy, IL Fire Department. He was present post-9/11 during recovery operations and is a JFD peer supporter.

Jan Quillman, RN, City Councilwoman

Jan Quillman has been a sitting City Councilwoman since 2005 and has served in many other service and leadership capacities in Joliet since the 1990s. She is also a registered nurse and a fire peer supporter.

Other Contributors to the Development Team

Steve van der Watt, Thriveworks® Counseling

Nancy Nelson, LCSW, Aspire Center for Positive Change

John Koch, Battalion Chief in Charge of Community Risk Reduction

Terry Smith, Psy.D., Executive Director, The Upper Room Crisis Hotline

The Unsustainable and Unexpected Bump in the Road: 988

In October 2021, Community Mental Health Development Team members met with a local hospital to discuss local mental health issues. In the meeting, they were told about a proposed program (the 988 system) and the parameters for development: the 988-crisis line, mobile crisis units, and 23-hour facilities (see Chapter 3). Immediately, the team members brought up certain aspects of the program that may cause issues – especially concerning 988 and the mobile crisis teams and asked for more information. The hospital administrators pointed them in the right direction, and it was found that the upcoming plan was even worse than they had thought after hearing about it during the meeting. After investigating the SAMHSA document, the firefighters doubted the plan's efficacy and redoubled their efforts to create a sustainable and practical local program for use with the public.

Getting Over the Bump: Moving Forward

Understanding the challenges the federal plan would encounter, the Community Mental Health Development Team decided to move forward and develop the local crisis program. Several thoughts permeated the meetings of the team. First, the crisis intervention aspect of the program was an excellent place to start, but it was only one component of the issue; there were still missing pieces to the puzzle, including prevention, education, and, most obviously, definitive clinical care.

One of the biggest challenges in the Joliet area was finding timely treatment for those with mental illness. At that time, the typical wait time for a first appointment with a basic clinical care practitioner was 4 – 6 weeks. For psychiatry services, it went to 16 weeks for a first appointment. The group realized that crisis intervention would only provide limited help if clinical care was unavailable.

Clinical Care

The solution for this problem came in late 2021, when a private counseling group, Thriveworks®, approached the Joliet City Manager, Jim Capparelli, and asked to be part of Joliet's employee assistance program (EAP). Thriveworks® is a national counseling organization that employs 3,500 clinical mental healthcare professionals in over 30 states. The program was simple; in exchange for office space in Joliet, Thriveworks® would provide a clinician to the employees of the City of Joliet to provide mental health treatment. Mr. Capparelli knew the fire department was working on mental health solutions and brought Thriveworks® representative Steve van der Watt to the development committee for a discussion. During the meeting, Jeff Carey asked, "if you can provide mental healthcare to the employees of the City of Joliet, can you provide it to our entire community?" It was there that the solution took shape.

Joliet is a community of over 150,000 people (U.S. Census Bureau, 2021). Knowing that one in five people has mental illness nationwide, we can surmise that approximately 30,000 people in Joliet experience some mental illness (Mental Health America [MHA], 2021). The ambulances of the Joliet Fire Department encounter thousands of these patients every year. The question became, "how does the City of Joliet provide care for everyone who needs it at no out-of-pocket cost to them?" This was complicated by the fact that 35% of Joliet residents were insured by Medicaid, which, at the time, did not provide robust coverage for mental illness care

(fortunately, this has since been rectified, and Thriveworks® has become approved Medicaid providers), and 5% – 10% were uninsured.

Mr. Capparelli, Chief Carey, and Mr. van der Watt discussed the possibility of the City of Joliet funding what is not covered by insurance plans and those without insurance from a City-sponsored fund. An annual contribution of $400,000 would cover the entire populace for one year. Later, the City of Joliet City Council unanimously voted to fund the program.

The Development Team approached two local hospitals and asked them to participate in the program. One hospital's leadership indicated they were only concerned with acute mental health care and not long-term problem management.

The other hospital administrator, Ruth Colby, President and Chief Executive Officer of Silver Cross Hospital, located in New Lenox, Illinois, however, expressed interest in helping solve the problem. Silver Cross provided office space in one of their professional buildings (serendipitously located in the geographical center of Joliet) for Thriveworks® to operate.

Other challenges existed, however, that had to be overcome. First, how would they verify that the people using the program are residents of Joliet? Second, how would they provide this service to the homeless population, a group greatly in need of this program? Third, how can the program be expanded to grade school, junior high, high school, and college level students who may not live within the city limits of Joliet?

The first issue involved developing a method to assure that Joliet residents had access to the program, but those outside Joliet did not. As much as they wanted to help everyone, there was only so much funding for the project. A multi-tiered solution was found.

Initially, announcements about the program implementation were sent with resident water bills, advising them of the program and allowing residents to access it using their water bill

account number. Since renters and people experiencing homelessness may not have water bills, a voucher system was created. Vouchers were provided to homeless shelters, community centers, and ambulance crews to distribute as people in need were encountered. Each voucher has a unique, one-time-use code that allows the bearer to register for an appointment to be seen by a clinician.

Each appointment through Thriveworks® costs approximately $100 for counseling care. Those with insurance were asked to provide their information, and the Joliet fund would pay the balance of unpaid benefits. Those without insurance were covered 100% by the Joliet fund.

The next issue was how to ensure children in Joliet were covered. Joliet has two grade school districts, two high school districts, one private high school, two college campuses, and many other educational institutions with students who are residents and non-residents of Joliet. By the end of 2022, all institutions and districts had been contacted and informed of the program and participated at some level. The Joliet Township program will be discussed in Chapter 25.

The grand opening of the Joliet Thriveworks® location occurred in July 2022 and has, by the writing of this text in April 2023, enrolled over 500 residents from Joliet in mental health treatment.

Initial Results

Chief Carey presented the following to the Joliet City Council in December 2022.

> The Joliet Fire Department developed the City of Joliet Community Mental Health Program as a comprehensive and sustainable program to provide residents access to timely crisis and definitive mental health care. In most cases, the mental health program allows all residents to see a crisis interventionist within minutes and a mental health clinician within 24 hours.
>
> In the first 90 days of the program, the fire department paramedics performed Crisis First Aid on over 190 patients suffering from mental health or traumatic stress issues. Almost 120 residents have enrolled in weekly therapy sessions through Thriveworks®. In our program, residents can see the same therapist as often as needed. Eleven residents have

no insurance and can only get the required therapy because of the City's program. The same is true for the over 35 children receiving care. Before the City's program, it was difficult for children under 18 and on Medicaid to find a therapist.

A couple of weeks ago, we received a call from the social worker of a three-year-old foster child with severe behavioral issues. The foster parents could not find anyone to treat the child and were left with the only option being to return the child to the care of the State. Thriveworks® has brought in a specialist from the northern suburbs who drives to the Joliet office weekly to see this child, giving them a chance to succeed with treatment through the City's program. To say these parents are grateful for the City of Joliet's program would be an understatement. This is just one of the many stories we get from parents weekly.

According to the CDC, schools faced unprecedented disruptions during the pandemic and cannot address these complex challenges alone. The pandemic has disrupted many school-based services, increasing the burden on parents, increasing stress on families, and potentially affecting long-term health outcomes for parents and children. Helping schools provide safe and supportive environments—in-person or virtually—is critical to students' well-being. The City of Joliet's mental health program is now available in all of Joliet's schools, including Joliet Junior College and the University of St. Francis. Joliet Township High Schools and Lightways Hospice have started their fund to cover their students and clients who are not Joliet residents.

As the word about the City's program has spread, we continue to receive calls to help other cities, schools, and private businesses start similar programs. We have received calls from as far away as Virginia. Others who have approached us include:

The Silver Cross Emergency Medical Service System (SCEMSS) Paramedic Program approached us to instruct the CFA-P program to their paramedic students, completed in fall 2022.

The City of Rockford, IL, has adopted our program and is coming here to undergo initial Crisis First Aid for Paramedics training.

Two weeks ago, we met with the City of Green Bay, WI., after they discovered our program and wanted to replicate it.

As other local fire departments have heard of our program, we have been asked to present the program at the upcoming Will County Fire Chief's meeting. The Will County Chiefs may want to implement Joliet's mental health program countywide.

All of the cities we talked to have the same issues we have, including availability, behavioral health issues, physical health issues, traumatic stress-inducing events, responder mental health prevention, and lack of timely access to definitive mental health care. Many of these are alleviated by our mental health program of Crisis First Aid for Paramedics (CFA-P) and Thriveworks®.

Crisis First Aid (CFA) was developed at no cost to the City as a collaborative effort with input from the Upper Room Crisis Hotline, Aspire Center for Positive Change (our peer support clinicians), the Joliet Firefighters Peer Support Group, and the Joliet Fire Department. It was developed and revised over one year and implemented in 2022. Over 200 firefighters are educated in field crisis intervention using knowledge, experience, and new communication techniques.

While some entities, such as Will County, Rockford, and Green Bay, already provide mobile crisis teams, they may differ from the Joliet Fire Department crisis response in several ways. First, crisis intervention availability is an issue. While local mobile crisis teams are present in Will County, they do not operate on a 24/7/365 basis. Many only respond during business hours, leaving 2/3 of the day when no care is present. Further, the three mobile units in Will County ostensibly provide care for 700,000 residents, meaning there is one crisis interventionist per 77,000 residents (33% of the time) and no crisis interventionists for 700,000 residents 67% of the time.

The Joliet Fire Department offers crisis intervention 24/7/365, meaning 100% of the 150,000 population is covered daily, every day, at a ratio of one crisis interventionist to 2,200 residents.

Second, mobile teams respond to mental health issues, not traumatic stress events or responders experiencing mental health difficulties. While statistically, 20% of Joliet residents have a mental illness (30,000) and approximately half (15,000) are untreated, many hundreds more Joliet residents experience traumatic stress events annually (such as accidents, motor vehicle crashes, deceased family members, and a host of others). Most communities provide no care for these people until they reach clinical levels of distress or require emergency intervention. In Joliet, by using Crisis First Aid for Paramedics (CFA-P), we work preventatively with those experiencing traumatic stress to ensure they have the support and education required to manage issues in the early stages, thereby potentially preventing clinical problems from developing.

Another difference is the medical aspect of our crisis response. All behavioral patients and severe traumatic stress reactions receive an initial and focused medical assessment from our paramedics. Research has shown that those with severe mental health issues have shortened lifespans, often due to co-occurring physical matters, and that sometimes mental health problems and physical problems may mimic one another. Most MCUs do not medically evaluate the people they respond to and may delay medical treatment for those experiencing medical issues, sometimes to tragic effect.

Responder mental health has also become a widely discussed issue. CFA-P allows firefighters to self-evaluate, monitor their peers for mental health issues, and act before long-term problems develop. In the two years before training our firefighters in CFA, the fire department Peer Support Group had dozens of calls for assistance from our active firefighters in addition to regular critical incident defusings, which are standard procedures. In the six months since our firefighters were trained in CFA, while still

> routinely dispatched for essential defusings of incidents, the Peer Support Group has had no individual calls for assistance from active Joliet Firefighters. This demonstrates how providing resources and education has helped our active firefighters become more resilient.
>
> Finally, mobile teams continually see the same patients because most lack the timely availability of clinical care. The game-changing difference in our program is the ability to refer people to rapidly available definitive care where their issues can be treated.
>
> As the program continues to grow, we have implemented an outreach program through our Community Risk Reduction Division, interacting with the community to reach our most vulnerable citizens.

As the above report shows, the Joliet Fire Department Community Mental Health Program was implemented after the JFD members were trained in Crisis First Aid for Paramedics (CFA-P), and definitive care was funded through the City of Joliet and made available through Thriveworks®. The program has resulted in many positive interactions with the community, crisis intervention, and clinical care.

This being said, there is still much to do. While people with whom the Joliet Fire Department has contact receive crisis and definitive care, there is still a large gap to fill on the front end of a response. Additionally, the prevention aspect of the program is still being built due to budgetary and personnel limitations. More dispatchers are needed, crisis intervention courses must be taught to the Emergency Medical Dispatchers, and policies must be amended to provide the proper care.

Next Steps

The next steps of this program include completing the Joliet response and making the service available county-wide (and perhaps state-wide). In Will County, IL, there are three dispatch centers (DeMar-Lafferty, 2017) and 38 fire departments (Will County Emergency Management, n.d.) which may benefit from Crisis First Aid programs. All the programs are free and available. Individual fire departments may provide educational information to the public

regarding mental health and illness through their community risk reduction and prevention divisions.

Chapter 2: Stepping Back

Mental health and illness have recently garnered more attention in the mainstream media, but it is far from a new issue. Mental illness has been a challenge for all of human history; it is complex and includes social, economic, medical, biological, psychological, and spiritual aspects (Abdul-Hamid & Hughes, 2014; Anfinson & Kathol, 1992). Historically, many methods have been used to attempt to quell mental illness, from exorcisms and prayer to psychoanalysis and medications (American Academy of Orthopaedic Surgeons (AAOS), 2018). Unfortunately, a lasting and sustainable mental health and illness management system has eluded us. This text will certainly not solve the problem of effective management of mental illness, but it may provide some previously unidentified parts of a possible solution.

This text is separated into nine parts. Part 1 briefly explores the background of the Joliet Community Mental Health Program and the current state of mental health in the context of world history and the United States. Part 2 identifies practices put forth by the federal government in recent guides, specifically the Substance Abuse and Mental Health Services Administration (SAMHSA) *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit,* and federal law. Components of the federal program and how they may relate to individual states will be examined using Illinois as an example. The drawbacks of the program are also explored. Knowing how we got to where we are to improve in the future is essential. Through honest and pragmatic examination, the historical repetition, potential flaws, and monumental (and

unnecessary) cost of mental health management can be exposed to create solutions to existing challenges.

Part 3 will move to specific problems and potential solutions by using both existing resources and new ideas and discussing partnerships between agencies to enable synergistic service modalities to be developed and implemented. These solutions may include a paradigm shift and a change in the understanding of resources already in place to help manage crisis intervention and mental health and illness-related care. These ideas may help program creators generate a reasonable and sustainable mental health care system in which those with the existing expertise and those who maybe further trained in mental health can be used to their best possible effect.

Part 4 will discuss public service solutions, including law enforcement, community risk reduction programs, emergency medical service response to behavioral and traumatic stress incidents, and community paramedicine programs.

Part 5 of the text will discuss the components of the *Joliet Emergency Management Model for Mental Health and Illness (JEMMHI)*, including crisis intervention trained citizens, emergency medical dispatchers (EMDs), police, paramedics, and communication with private practitioners and non-profit organizations to provide rapid in-person and telehealth services that may better fulfill the federal mandate. It is hoped that some concepts will help close existing gaps within that program.

Part 6 will discuss some pertinent ideas in mental health today, including public-private partnerships, Thriveworks® Counseling, Silver Cross Hospital, National Alliance on Mental Illness (NAMI), and Joliet Township High Schools. Part 8 will discuss suicide prevention, and Part 9 will provide references, a glossary, and an index.

Please take note of a few things. First, the author is not a clinical care provider for the mentally ill. He is a retired firefighter and paramedic who has experienced patients with many mental health issues in the real world (and in his own life), many of them not cared for as they should be by a failed system. He is in the late phases of completing a doctorate in counseling with a traumatology focus. He has been working with the firefighters of the Joliet Fire Department in Joliet, Illinois, USA. You will see references to scholarly sources to show sound scientific backing, but you will also occasionally see the local field firefighter and paramedic emerge.

The author also realizes that when one has a hammer in hand, every problem may look like a nail, so the solutions in this text may lean heavily toward his specialization. Indeed, the honest answer and the most effective incorporation of the fire service, emergency medical services (EMS), police, private entities, educational facilities, and non-governmental organizations into mental health and illness lies somewhere between what is happening and what is put forth in this book.

Chapter 3: History of the Problem

From the beginning, the historical aspect of mental health and its related assessment and treatment has been closely related to the sociocultural and economic contexts in which it has existed throughout time, and most of the modern ideas regarding mental health have been tempered by economic and political interests as much as altruism and science (Eghigian, 2018).

Several years before writing this work, a renewed focus on mental health began in America. While it may seem as if this focus is new, previous generations have faced the same challenges. They have spent a great deal of time, effort, and money on finding and implementing mental health care solutions that are effective and sustainable. The social and cultural elements that have merged into the current need for service have been building in the U.S. for centuries. Right now, this is where we stand:

1. There are insufficient clinical practitioners to manage the current need for mental illness treatment – a problem that will worsen in the coming years (U.S. Department of Health and Human Services [US HHS], 2016).
2. There are not (nor will there be) enough general health physicians to manage physical or mental ailments (Colwill et al., 2008).
3. Plans for providing mental health care are focused at the federal, state, county, and community levels (Community Emergency Services and Support Act, 2022; SAMHSA, 2020).

4. Crisis intervention is the new catchphrase in mental health management, but traumatic stress response, prevention, recovery, and mitigation are largely ignored.

This chapter will explore the history of mental health management, beginning in the distant past and culminating in present-day America. This historical view is only a thumbnail of mental health and illness, not a concise history. It is designed to put current plans and actions in mental health care into the proper context. The Spanish philosopher George Santayana famously stated in 1905, "those who cannot remember the past are condemned to repeat it" (Santayana, 2009, p. 132). We should take this advice to heart in the field of mental health.

Mental health problems and solutions must be viewed through the lens of science, culture, history, and religion of their time to achieve a proper framework for the issue. Different cultures throughout different timeframes have had their responses to mental illness, and each generation builds upon the one that precedes it. Looking through these responses through our current 21st-century lens may not portray these subjects properly; they must be viewed through the lens of normal behavior and treatment of the time.

Pre-History and Mental Illness

Beginning around 10,000 BCE (give or take a few millennia), the earliest accepted middle eastern civilizations of Mesopotamia, Asian civilization of the Indus Valley, ancient Egyptians, Mesoamerican groups of the American Southwest, Europeans of the northern Mediterranean, and others began to practice agrarian and herding lifestyles rather than the nomadic ways of their ancestors (Baker & Goucher, 2015). These stationary settlements allowed more extensive groups of people to gather in city-states. Here, evidence of mental illness treatment begins to appear (Weiss, 2018). The mental illness of the time in these areas was

usually attributed to demons, gods, and other phenomena such as magic (American Academy of Orthopaedic Surgeons (AAOS), 2018; Weiss, 2018).

It wasn't until Hippocrates (600 BCE) that mental disorders started to be, in some circles, seen as treatable illnesses similar to physical sickness (Kleisiaris et al., 2014). Mania, melancholy, insanity, disobedience, paranoia, panic, epilepsy, and hysteria were all discussed by Hippocrates during his life time, marking a significant step forward in mental illness identification (Kleisiaris et al., 2014).

The Renaissance Era: The First Institutions

While Hippocrates was ahead of his time regarding mental illness identification and management, some of the old ideas previously mentioned were alive and well through the dark ages to the renaissance. During the 14th and 15th centuries, however, events would occur that would resonate throughout the world and affect mental health for the next five hundred years – the creation of the first mental health institutions. While there is debate on the first mental health institution, the origin can most likely be traced to Spain in the late 1300s or early 1400s (Pérez et al., 2012). The understanding of mental illness was still in its infancy, however.

The 17th Century: Descartes and Dualism

Modern dualism refers to the idea that the body and mind are separate entities. While Plato discussed a type of dualism (using the spirit instead of the mind), the more modern version was introduced by Renee Descartes in the 17th Century (DK, 2017; Zalta, 2020). While common-place and accepted today, the idea that the mind and the body were separate (mind-body dualism) represented a new mode of thinking during the time. It would shape future generations' perception of the connection between mind and body and mental and physical illness.

The 19th and 20th Century Expansion

With dualism firmly entrenched in the philosophical environment, mental illness identification and treatment would experience rapid development in the 19th century with notable leaders in the field, such as Sigmund Freud. Freud's description of the unconscious effects of past events and psychodynamic theory was groundbreaking, is still in limited use today, and is known as psychotherapy's first force (Seligman & Reichenberg, 2014). Development continued into the 20th century with pioneers such as B. F. Skinner (behavioral and cognitive theory, the second force of psychotherapy) and Carl Rogers (humanistic psychotherapy, the third force of psychotherapy) (Seligman & Reichenberg, 2014).

Even with the advancements in treatment for the mentally ill, the asylum system grew across Europe throughout the mid-19th century (D'Antonio, n.d.; Le Bonhomme & Le Bras, 2022). The initial intent of the asylum was to provide a place of healing for the mentally ill, but the concept was abandoned in favor of the new idea of the "psychiatric hospital." (Le Bonhomme & Le Bras, 2022, section 3).

Mental Health in America

Getting where we are in American mental health has been a long and sometimes painful journey. As we will see, mental health concerns are not new in the U.S. In fact, in recent years, we seem to be treading into the familiar (and frightening) waters of the 1940s.

During an August 1986 press conference, Ronald Reagan told his audience, "the nine most terrifying words in the English language are: I'm from the Government, and I'm here to help" (Ronald Reagan Presidential Foundation and Institute, n.d., section 2). While the statement was a humorous allusion, it was meant to illustrate a feeling some Americans had long understood. When the federal government gets involved in the day-to-day lives of Americans,

they often do so less-than-efficiently. They may sometimes worsen situations (Ronald Reagan Presidential Foundation and Institute, n.d.).

This concept is no truer than in America's history of mental health care. This journey can be traced to the beginnings of this country (Grob, 2019; Torrey, 2013). This history can be broken down into four time periods, including the colonial period through the first industrial revolution (1790 - 1840), the second industrial revolution through the end of World War II (1840 – 1945), the end of World War II through 1980 (1945 - 1980), and the end of the cold war era to the present time (1980 - Present). During these times, we have seen mental health care go from community care to institutional care and back to community care. We have also gone from local and state care to federal involvement, back to local and state care, and again to federal involvement.

Colonial Period through the First Industrial Revolution (1790 - 1840): Local Care

As the United States was founded during the colonial period, most responsibilities for the seriously mentally ill were borne locally "by the family and community" (Grob, 2019, p. 3). Those with mental illness were cared for by those closest to them in their local areas. As the 1800s began, however, some mentally ill were starting to find their way to "jails, poorhouses, and asylums" (American Academy of Orthopaedic Surgeons (AAOS), 2018, Chapter 16), which started the trend toward institutionalization (American Academy of Orthopaedic Surgeons (AAOS), 2018).

Second Industrial Revolution through World War II (1840 – 1945): Institutional Care

With development, growth, and a more wide-spread society, however, a shift in responsibility toward institutionalization gradually took place (Grob, 2019). After the Civil War, Dr. J.B. Gray envisioned a community-based mental health system that would act "through

education, social culture, religion and involvement in national life" (Mandell, 1995, para. 1). By the beginning of the following century, "mental hygiene" was born (Bertolote, 2008). Mental health hospitals largely replaced asylums (American Academy of Orthopaedic Surgeons (AAOS), 2018). This shift would shape the world of mental health for the next 100 years. While institutions were initially structured to create smaller, intimate treatment facilities to provide quality service, allowing patients to recover and leave the institution, it was realized that patient conditions were not improving (Grob, 2019). Additionally, while there were public and private institutions in every state, the patient populations of the institutions were growing larger and exceeding levels conducive to improvement and release (Grob, 2019). The overcrowding and warehousing of patients suffering from mental health issues resulted in a severe decrease in acceptable levels of care and, often, deplorable conditions inside the institutions.

In his book *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (2013), author E. Fuller Torrey describes the process by which the U.S. Government dismantled the mental healthcare system in 1940s America leaving some of those with mental illness to rely on improper resources and many to fend for themselves.

After institutionalization began and before 1945, mental healthcare was essentially the sole domain of state and local governments, with little federal government involvement (Torrey, 2013). That changed in 1945 when a national mental healthcare plan was introduced, which would begin the process of de-institutionalization in America, focusing on community mental healthcare (American Academy of Orthopaedic Surgeons (AAOS), 2018; Torrey, 2013).

Post-World War II through the Cold War (1945 – 1980): De-Institutionalization

After World War II, the issue of mental health reached the national stage when Roger Felix advocated for federal management of mental health affairs, including community mental

health centers for the prevention of mental illness and social change to improve conditions in the country (Torrey, 2013). As Torrey (2013) explains, "(i)n ordinary times, Felix's radical mental health plan would have quietly circulated in Washington among a few interested people, then died a natural death. But the postwar years were not ordinary times" (Torrey, 2013, p. 22). During the war, it was found that mental health issues were far more common than previously thought and affected many in the U.S. (Torrey, 2013), and the National Mental Health Act was signed in 1946 (Grob, 2005). Funding for community mental health centers (CMHCs) was provided in 1963 (Mental Retardation Facilities Construction Act, 1963).

The move to federalize mental health included closing state mental hospitals and transferring patient responsibility to community mental health centers (CMHCs), which the federal government funded. This action, coupled with a new class of drugs, antipsychotics, was seen as a viable remedy for mental health care (American Academy of Orthopaedic Surgeons (AAOS), 2018; Torrey, 2013). By the 1970s, there existed many different types of mental illness treatment facilities, including "short-term mental hospitals, state and federal long-term institutions, nursing homes, residential care facilities, CMHCs, outpatient departments of general hospitals, community care programs, community residential institutions for the mentally ill with different designations in different states, and client-run and self-help services, among others" (Grob, 2005, p. 428). Unfortunately, as patients were discharged from the state hospitals, they were not finding their way to the CMHCs for continued care, not taking their medications for various reasons, and CMHC fund misuse was common (Torrey, 2013).

By the late 1970s, under President Jimmy Carter, plans were underway to restructure the national mental health system, but the 1980 presidential election changed that. When President Ronald Reagan was elected, funding for the CMHC program ended (Grob, 2005). Unfortunately,

the state hospitals which previously treated the mentally ill within their states had closed because the CMHCs replaced them before funding cuts. Ultimately, the increased discharges from state hospitals and lack of follow-up care led to increased homelessness and exploding prison populations. It is now estimated that 25% to 35% of people experiencing homelessness and over 40% of the prison population suffer from mental illness (Padgett, 2020; Prison Policy Initiative, n.d.). The practices of the past may not be wholly responsible for the statistics, but the policy decisions that resulted in those practices have played a role.

Cold War to Present (1980 – Present)

When CMHC funding was cut, and into the 1990s, in addition to homelessness, it became evident that seriously mentally ill and violent individuals were being released into the public and were sometimes being housed in inappropriate facilities, such as nursing homes, putting other people in those facilities at risk (Torrey, 2013). Additionally, police interaction with the mentally ill increased, leading to the tragic loss of life in some circumstances and increased arrests and incarceration of the mentally ill (Torrey, 2013).

Our Current Predicament

We find ourselves in familiar territory, although in a new way. Instead of massive mental health care institutionalization of the early 1900s with no actual treatment, we have enormous prisoner populations in the 2020s with similar results. According to the Prison Policy Initiative (n.d.), 43% of prison inmates have a mental illness. The number in local jails is similar at 44%. Of the 43% mentioned above, 66% of prisoners in federal prisons report receiving no mental health treatment while incarcerated – the number is raised to 74% in state prisons (Prison Policy Initiative, n.d.). This data reminds us of the warehousing of those with mental health in hospitals

– where they received little effective treatment- to the warehousing of the mentally ill in prisons – where they receive little effective treatment.

Unfortunately, we find ourselves in familiar territory with the solutions as well. As Roger Felix put forth the idea of national mental healthcare in 1945 and Jimmy Carter's attempted reform of the late 1970s, the federal government has dipped its collective toe back into the mental health waters starting with Public Act 116-172 and the Substance Abuse and Mental Health Services Administration (SAMHSA) *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit.* George Santayana's words will resonate as we explore the plan.

Part 2: Solution and Problems with the Solution

Chapter 4: The "New" Proposed Solution: 988 & Related Programs

As we saw in Chapter 3, the federal government's involvement in the mental health milieu is nothing new. This chapter addresses the existence of the federally mandated 988 phone number and its related components as documented in the Substance Abuse and Mental Health Services Administration (SAMHSA) *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit,* as well as Federal Public Act 116-172 (passed in 2020), and current pending legislation as of the printing of this work.

Additionally, to provide an example of how this plan has been implemented at the state level, we briefly address the content of Illinois Public Act 102- 0580, also known as the Community Emergency Services and Support Act (CESSA), which sets requirements specific to Illinois based on the SAMHSA document.

National System

The contents of Federal Public Law 116-172 represent the federal government's re-entry into the mental health fray by establishing the 988-telephone system through the Federal Communications Commission (FCC), describing the line as it relates to suicide and its creation in coordination with the National Suicide Prevention Lifeline (NSPL). The 988-phone system is

one of the core elements of the newly proposed community crisis response system outlined in the SAMHSA document. It includes regional or statewide call centers coordinating in real-time; centrally deployed, 24/7 mobile crisis response; 23-hour crisis receiving and stabilization programs; and essential crises care principles and practices (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). We will explore each of these in this chapter.

Regional and Statewide Call Centers Coordinating in Real-Time

The call center concept includes a clinically staffed crisis line available 24/7. The SAMHSA document details that the crisis line must meet the National Suicide Prevention Lifeline Standards (NSPL); to include a brief suicide assessment, an imminent risk policy, and appropriate follow-up (SAMHSA, 2020; National Suicide Prevention Lifeline [NSPL], n.d.). The plan included rebranding the National Suicide Prevention Lifeline as the 988-Suicide Prevention and Crisis Response Hotline, which occurred in July 2022.

Centrally Deployed 24/7 Mobile Crisis Teams/Units

The SAMHSA document also describes the mobile crisis teams (MCT or MCUs) as being able to reach any person in the service area at their home, workplace, or any other community-based location in a timely manner (SAMHSA, 2020). The term *timely* is not defined. These mobile crisis teams include a licensed or credentialed clinician who will respond to the person's location, perform crisis intervention, and link them to care (SAMHSA, 2020). According to the SAMHSA document, best practices for the MCUs include incorporating trained peers (those with lived experience), responding without law enforcement presence (unless exceptional circumstances warrant), real-time GPS and geolocation technology in partnership with the region's crisis call center, and the ability to schedule outpatient follow-up appointments

(SAMHSA, 2020).

23-hour Crisis Receiving and Stabilization Programs

The SAMHSA document describes the crisis receiving and stabilization services as local under 24-hour facilities that provide a home-like, non-hospital environment (SAMHSA, 2020). These facilities are conceptually reminiscent of the CMHCs discussed in Chapter 3.

Essential Crises Care Principles and Practices

Essential crises care principles and practices are a critical component of the SAMHSA document but are not explained significantly. This lack of information becomes important when determining which agencies may perform crisis care in the field.

Many formulae exist for crisis management. Jacobs (Community Psychological First Aid), Slaikeu (Comprehensive Model for Crisis Intervention), Flannery, Mitchell, and Everly (RAPID-PFA Model, SAFER-R Model), Aguilera, James and Gilliand, Greenstone and Leviton, and Kanel (ABC Model), and Cavaiola and Clifford (LAPC Model) are all available methods of crisis intervention techniques (Everly, 2017; Jacobs, 2016; James & Gilliland, 2017; Roberts & Ottens, 2005). While all are branded differently, many contain similar components.

Robert's Seven-Stage Crisis Intervention Model is arguably one of the best-known crisis intervention models. It describes the needs of those experiencing crisis (Roberts & Ottens, 2005). The seven stages include:

1. Crisis Assessment: Stressors, coping skills, available resources.
2. Establish Rapport: Supportive relationship.
3. Identify issues: Gain information about the cause of the crisis.
4. Deal with feelings: Active, supportive listening.

5. Explore alternatives: Previous, new coping.
6. Create a plan: This may include many components, from referrals to hospitals.
7. Follow-up: Check-in for status (Roberts & Ottens, 2005).

A New Proposed Bill

In 2021, the Federal Government proposed *H.R.7666 - Restoring Hope for Mental Health and Well-Being Act of 2022*. This bill has not been voted on by the Senate or signed into law as of this writing but is indicative of the ineffectiveness of the 988 proposed plan. The bill has redeeming value, however, including finally including emergency medical services (EMS) into the conversation regarding mental health, grant funding for mental health education, and substance use programs – provided the funds are appropriately spent (not a hallmark of the federal government).

The 988 highlight of this bill includes a $101,621,000.00 annual appropriation between 2023 and 2027 ($508,105,000.00 total) to "improve" the 988 system, 80% of which will go to call centers (that's over $406,000,000.00 for 200 call centers over five years). Each call center will add over $2 million to their organizations over that period.

Illinois Public Act 102 – 0580: One State's Response

Illinois Public act 102 -0580 was slated to go into effect on January 1, 2022 (and then postponed until July 2023). The Community Emergency Services and Support Act (CESSA) was a new law designed to aid in implementing the 988 system (and its components) and increase the availability of mental health services to the public (Community Emergency Services and Support Act, 2022). It is heavily based on the SAMHSA document described earlier. We will discuss the drawbacks of the program in the next chapter.

Chapter 5: The Problems with the Solution

Each of the three components of the program has significant drawbacks. We will address each element in this chapter, but the most egregious shortcoming is that people must wait until they are experiencing a "crisis" to find help. The entire program is predicated on the fact that a crisis is happening rather than preventing a crisis from occurring by effectively identifying and managing a mental illness. The focus instead should be educating the public on seeking help for mental illness issues before the crisis occurs, preventing it if possible. We will discuss these topics more in Chapter 7 and Chapter 11.

Regional and Statewide Call Centers Coordinating in Real-Time

First and foremost, the definition of crisis must be clarified when describing 988. In first-response parlance, a crisis is an emergency that must be handled immediately to avoid serious consequences – it does not seem as if this is how 988 defines a crisis. An imminently suicidal or homicidal person or one with an altered level of consciousness are examples of emergencies. It cannot be stressed more strongly that the aforementioned suicidal, homicidal, those with altered mentation and their families should not call 988; they should call 911! If the caller's dog dies and they are depressed and not suicidal, 988 may be available to speak to someone briefly. In emergency conditions, the emergency number was, is, and will always be 911. The mixed

messages that are being sent could be deadly.

988 has no reliable method for alerting local emergency dispatch centers should an emergency response be necessary. The developers are aware of this drawback (Saunders, 2021). The 988 system will spend millions (maybe billions) of dollars to eventually be parallel to the 911 system, which has proven itself over decades of use and is already managing 240 million calls in the U.S. annually (National Emergency Number Association [NENA], n.d.). This parallel nature will cause (and already has caused) delays in service and confusion. It may negatively impact patients during emergencies, where time is of the essence (Sanders, 2011).

Also, the clinical staffing for call centers mentioned in the SAMHSA document seems unlikely due to current and future shortages of mental health clinical practitioners nationwide (US HHS, 2016). Chapter 9 discusses the shortage of clinical care in more detail.

The SAMSHA document holds that "if the person describes a serious medical condition or indicates that they pose an imminent threat of harm, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve the situation" (p.20). Unfortunately, the call-takers used in the crisis line are ostensibly not trained to assess a patient medically, as most clinicians are not. This lack of training may delay recognition of potentially serious medical issues and increase the response time of emergency medical services (EMS), potentially resulting in severe consequences. This concept will be covered in more depth in Chapter 6.

Additionally, it implies that mobile crisis personnel have a method to communicate with emergency responders (which they do not) and have some governance role in the response (which they do not). Further, it calls into question existing standing medical orders from EMS physician medical directors – a licensed paramedic on the scene of a medical call does not need

the advice, permission, or coordination of a mobile crisis unit member to render medical (or psychological) aid at this level of care.

Mobile Crisis Teams/Units (MCTs/MCUs)

The challenges with MCUs are many, and some may be life-threateningly dangerous to both the public and responders. First, as discussed earlier, the severe national shortage of clinical care professionals for mental health issues is a significant obstacle in staffing these units. Second, the areas and populations to be covered can be large, and response times may be very high. An example of this can be found in Will County, Illinois. According to census documents, Will County, Illinois's land area exceeds 800 mi.², and the population is just under 700,000 (US Census Bureau, 2020). As a point of comparison, the entire state of Rhode Island is just over 1000 mi.², and the population of the State of Wyoming is under 600,000 (U.S. Census Bureau, 2020; U.S. Census Bureau, 2023). As of this writing, and after six months of trying, there exist only three MCUs in Will County, none of them 24/7 to service 700,000 people (that's one team for every 233,334 people, some of the time).

Relatedly, the definition of *timely* is essential, primarily when the potential exists for the patient to be experiencing a physical and possibly life-threatening illness such as stroke, heart attack, or a myriad of other issues (see Chapter 6). Substantial delays in response may occur. As of the writing of this text, there are only 66 MCUs in Illinois, a state of 12 million people.

Importantly, this largely unavailable credentialed team will ostensibly respond to the scene (person's home, work, etc.) and perform crisis intervention. Crisis intervention is not therapy. Also, it seems clear in the SAMHSA document that the person they are performing crisis intervention with will not become a long-term client of the responder. This proposed process poses several challenges, including the safety of the responders. It makes certain

assumptions about the location and environment of the person being conducive to clinicians performing crisis intervention (e.g., in the field as opposed to in the office).

Those who work in the field understand what has been described by one firefighter as "the barking dog dilemma." This dilemma refers to the complex and often distracting conditions on the scene when responding to a person's home (as opposed to them coming to an office). These challenging environments include barking dogs (of course), children, spouses and partners, televisions, music, arguing, and countless other distractions that may impede crisis intervention. Often, these environments may not be warm, safe, well-lit, calm, quiet, focused, and comfortable as in clinical settings.

One issue has presented itself as MCUs are being built. Essentially, any organization with adequately trained personnel can offer an MCU service. Unfortunately, most of the services in the author's response area are only available on a "day-shift" basis, meaning the units are staffed during business hours but not before or after. Anyone in emergency response knows that a crisis is not relegated to business hours only. Crises occur at all times of the day and night.

This situation is further complicated by the desire to remove police presence from the response and is a recipe for disaster. Many crisis response units will be unfamiliar with the various areas to which they respond. These areas include high-crime areas and other potentially dangerous environments with which police, fire, and ambulance crews are familiar. The SAMHSA document discusses the coordination with emergency responders as necessary; however, this is much easier said than done in the real world. Many first responder agencies have unique communication methods that do not transfer over the municipal, county, or town boundaries, leaving the mental health units unable to convey their needs rapidly, especially in an emergency.

23-hour Crisis Receiving and Stabilization Programs

Recall Chapter 3 for the Community Mental Health Center challenges of the 1970s. While the concept of the 23-hour facility seems to be good on the surface, the fact remains that many areas do not have these resources available in their communities. Current and future facilities, too, will have challenges concerning the current and future shortages of clinical personnel and will likely be very costly to build, staff, and maintain. As we saw in the 1980s, funding for these services is not guaranteed, meaning the programs, if funded federally, may not be sustainable.

More Problems: The State of Illinois Example

The Community Emergency Services and Support Act (CESSA) was implemented (for the first time) in January 2022. Ostensibly, when it was realized that the law could not be executed as planned, the state moved the implementation to July 2023. The creation of a public act that directs dispatch center resources and police resources and largely ignores fire and EMS resources was written and implemented without the robust involvement of these parties. The original 988 stakeholders list demonstrates this drawback (Illinois Department of Human Services [IDHS], 2021).

First, there was only one dispatch representative [from an agency that does not use 911 service, the Illinois State Police (ISP)] and one police representative on the stakeholder list (also from ISP, an organization that primarily manages traffic on the interstate) (Illinois Department of Human Services [IDHS], 2021).

Dispatch centers already effectively manage thousands of calls for service daily in Illinois (almost 30,000, in fact) (911.org, n.d.), assigning appropriate resources to respond to all sorts of issues. Police are invaluable because they provide much-needed safety on scenes – a concept not

adequately addressed in state law. The law is so focused on keeping the police away from behavioral health scenes that they aren't considering the safety of all responders that they provide. Chapter 10 discusses this in more detail.

Disturbingly, there were no representatives from the fire service on the original Illinois stakeholder list to implement this process (Illinois Department of Human Services [IDHS], 2021). This lack is concerning, considering that fire departments all over Illinois (numbering 1,100) routinely staff emergency medical technicians at basic, intermediate, and paramedic levels (all of whom may be trained quite readily for crisis responses to which the aforementioned mobile crisis units will be dispatched) (Illinois Department of Public Health [IDPH], 2017; *National Fire Department Registry Summary*, 2022). This absence issue has since been rectified, but not in time for any meaningful change. In addition, fire and police are tasked with providing service if the mobile crisis units are unavailable, making it "ok sometimes" but not others. This inconsistency sends a mixed message to the public that if paramedics respond, substandard care is being provided. Nothing could be further from the truth (see Chapter 12).

The Law notes that a paramedic or emergency medical technician (EMT) defined in the Emergency Medical Services Act does not constitute a "responder" unless the responding agency has agreed to provide a specialized service in conjunction with the Division of Mental Health. Neither the process for this nor the specific requirements necessary are defined. We will see later that emergency responders, especially paramedics, can manage crises in the field with minimal additional training. Lawmakers may not haveunderstood the training and capabilities of the 15,000 paramedics in their state (IDPH, 2017).

Also, it is noted in the act that each 911 public safety answering point (PSAP) and providers of emergency services dispatched through a 911 system must coordinate with the

mobile mental and behavioral health services established by the Division of Mental Health. As mentioned in the federal standard above and Chapter 4, this coordination is far easier said than done.

The Division of Mental Health is directed to provide guidance regarding how dispatch and response entities should coordinate with mobile mental and behavioral health services when responding to individuals who appear to be in a mental or behavioral health emergency. This interference may severely hamper and delay emergency response.

The state goals for mobile mental and behavioral health services are listed in Section 25, Part A of the Act. Major components of the section include linking the behavioral health patient to clinical or other appropriate community services, transportation to proper facilities, and de-escalation and communication techniques (Stephon Edward Watts Act, 2022). We will see later that public servants in the community already perform (or can perform) all of these tasks.

Case-In-Point: Nashville, TN: March 2023

Unfortunately, the issues with crisis lines being used in emergencies have already manifested themselves with tragic results. In March 2023, a school shooting occurred in Nashville TN. According to reports, an acquaintance of the shooter saw suicidal language on a social media post that was published shortly before the attack at 9:57 AM. (Stephenson, 2023) In the intervening 13 to 14 minutes, the acquaintance called the shooter's father, sent him screenshots of the posts, and was directed by him to call the suicide prevention line, which she did at 10:08 AM. She was told by the operator to call the local police. At 10:11 AM, the shooter entered a Nashville school, killing six (Stephenson, 2023; Raby, 2023).

One of the primary theses of this book is to notify 911 during mental health crises. In this case, the outcome may not have changed but the reported 13 or 14 minutes lost deciding who to

call may have been used in more productive ways. Again, the suicide prevention lifeline should be used subordinately to 911 after a 911 operator determines the severity and risk involved with the call. The mixed messages being sent that crisis and suicide lines are adequate during emergencies is misplaced and dangerous.

Part 3: Conundrums

Chapter 6: The Medical Aspects of Mental Health, Medical Mimics

The content of this text has already alluded to the need for mental and physical assessment to rule out a physical cause for symptoms. As much as mental health professionals may want to represent mental health symptomologies as entirely within their realm, a substantial number of mental health presentations may be caused by physical conditions (Schildkrout, 2014). These conditions are sometimes called medical mimics and represent a significant problem within medical and psychological sciences (McKee & Brahm, 2016). As early as the 1930s and more apparent since the 1970s, the medical community has struggled with how medical conditions may present as psychiatric ones (Koranyi, 1979; Martin, 1983; McKee & Brahm, 2016; Phillips, 1937). In two early studies by Phillips (1937) and Marshall (1949), the importance of identifying physical disorders which may present with mental symptomologies is discussed. Marshall saw 22% of psychiatric unit patients suffered from a physical condition that potentially influenced psychological illness. He astutely viewed "relief of mental symptoms by the treatment of an underlying physical disorder as of great significance and worthy of investigation in relation to mental disorder" (Marshall, 1949, p. 364).

A lesser but still substantial rate was found by Hall et al. (1978), as reported by Martin (1983). It was found that over 9% of psychological symptoms in the available sample were due to medical disorders, not psychological illnesses (Hall et al., 1978). These results have been repeated in other studies, with some reaching up to 20% (Hall et al., 1981; Koranyi, 1979). This issue is well explained by Schildkraut (2014), who reports, "(c)linicians may miss a diagnosis because they do not know enough about a particular disease and its manifestations" (p. xii).

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Status of Medical Mimics in the Current System

Physical concerns have been largely ignored during the current discussion regarding mental health responses. It seems to be assumed that mental health symptoms are caused by mental health disorders, dismissing the potential for physical illness causes (McKee & Brahm, 2016). As a result of this assumption, those suffering from mental health symptomologies may be deprived of a proper physical assessment, which may exacerbate existing problems and allow for the development of new ones (Hall et al., 1981). According to McKee and Brahm (2016), this is especially true in "the elderly, patients with a history of substance abuse disorder(s), patients without prior history of psychiatric illness, patients with preexisting medical illness, and patients from low socioeconomic strata" (Carlson et al., 1981; McKee & Brahm, 2016, p. 290)

Since the discussion began, numerous physical disorders have been identified as displaying psychiatric symptoms, many of which have been known for decades. Schildkraut (2014) and Testa et al. (2013) have created wide-ranging listings of these disorders. Schildkraut (2014) has identified 70 disease processes, and Testa et al. (2013) have identified four main categories of illness, including endocrine, metabolic, and deficiency states; internal diseases; and neurologic disorders (p. 86), which may present with psychological manifestations of symptoms.

Specific endocrine and metabolic conditions such as hypothalamic diseases, hyperprolactinemia (high prolactin levels), Hashimoto's thyroiditis, pheochromocytoma, Addison's disease, Cushing's syndrome, gender-related hormonal disorders, Grave's disease, parathyroid diseases, hypoglycemia (low blood glucose), pancreatic cancer, and Lyme disease, may all cause psychiatric symptoms (Schildkrout, 2014; Testa et al., 2013).

Further, electrolyte deficits from dehydration, hyponatremia (low sodium), and hypomagnesemia (low magnesium) may be suspected as well (Testa et al., 2013). Nutritional deficiency may account for issues as well. Vitamin D, Niacin, B12, and Thiamine have listed deficiencies resulting in mental health symptoms (Schildkrout, 2014; Testa et al., 2013).

Internal medical issues such as pulmonary edema or pulmonary embolism, cardiac issues, certain blood disorders, anemia, polycythemia (high red blood cell count), Sickle-cell disease, celiac disease, irritable bowel syndrome, infection, hypoxia, and many others may also present with mental illness symptoms (Schildkrout, 2014; Testa et al., 2013).

Finally, Schildkraut (2014) and Testa et al. (2013) identify neurological disorders such as head trauma, cerebrovascular accident (stroke), Alzheimer's disease, dementia, epilepsy, migraines, brain tumors, Parkinson’s disease, and Tourette’s syndrome as having psychological symptomologies. The following chart contains some physical illnesses with mental symptomologies. This list is not exhaustive but was built to illustrate the wide breadth of mental symptoms for physical illness. It is important to note that many of the listed disorders may also have physical presentations, which may be recognized by a person trained in assessment.

Medical Issue	Psychological Signs/Symptoms	Physical Signs/Symptoms

Addison's disease	Weakness, fatigue, malaise	Hypotension, hyperpigmentation
Arsenic poisoning	Personality changes, apathy, confusion, delirium	Drowsiness, headache, confusion
Brain tumors	Irritability, affective disturbances (depression or euphoria/mania), delirium, change in personality, disturbances in cognitive functioning, dementia, psychosis, hallucinations, delusions, catatonia, mutism	Headaches, vision problems, hearing problems, seizures
Carbon monoxide poisoning	Difficulty concentrating, apathy, fatigue, lethargy, irritability, restlessness, agitation, confusion, disorientation, coma	Headache, nausea, vomiting
Cushing's syndrome	Depression, anxiety, insomnia, psychosis	Increased body/facial hair, hump on the back of neck, diabetes
HIV/AIDS	Mania, anxiety, psychosis	Fever, fatigue, pneumonia
Hypoglycemia	Nervousness, apathy, irritability	Headache, irregular heartbeat, dizziness
Hypothyroidism	Depression, weakness, poor concentration	Slow heart rate, thinning hair, puffy face

Hypoxia	Fatigue, poor judgment, anxiety	Low oxygen saturation, elevated pulse, respirations
Multiple sclerosis	Depression, agitation, anxiety	Slurred speech, numbness, tingling, vision impairment
Pancreatic Cancer	Depression, Anxiety, Panic, feeling of impending doom, danger, or death. Also possible: agitation, restlessness, fatigue, insomnia	Abdominal pain, jaundice, new-onset diabetes
Parkinson's Disease	Mood (e.g., depression and anxiety) and cognitive changes (slowed reaction times and hallucinations)	Tremor, stiffness, altered coordination
Partial Seizures	Depression, anxiety, anger, fatigue, and confusion	Tingling, twitching, strange tastes and smells
Niacin deficiency	Apathy, nervousness, depression (early stages) and delirium, acute psychosis (later stages)	Headache, fatigue
Pheochromocytoma (tumor producing norepinephrine and epinephrine)	Anxiety, fear, panic	High blood pressure, headache, rapid heartbeat

Head injury (post-concussion syndrome)	Confusion, memory loss. Depression, anxiety, apathy	Headaches, dizziness, ear ringing
Dysmorphic disorder and pre-menstrual syndrome	Anxiety, depression, delusions, hallucinations	Bloating, backache
Thiamine deficiency	Lethargy, drowsiness, memory loss	Abdominal discomfort, nausea
Tourette's syndrome	Difficulty with concentration, depression, anxiety disorders, social withdrawal	Simple and complex tics
Traumatic brain injury	Many symptoms, including cognitive deficit, amnesia, and personality changes	Loss of consciousness, headache, vomiting, seizures
Uremia (kidney disfunction)	Early stages, irritability, insomnia Later stages, psychosis, suicidal ideation	Shortness of breath, fatigue, muscle cramps
Vitamin B12 deficiency	Fatigue, mood changes, psychosis	Breathlessness, feeling faint, headache

A partial list of physical disorders with mental symptomologies. Adapted from Schildkraut (2014), Testa (2013), Hall (1978), Sanders (2011), mayoclinic.org, nhs.uk, nih.gov, harvard.edu, clevelandclinic.org, hopkinsmedicine.org, sciencedirect.com

An important issue within mental health is some providers' assumption that a physical complaint is due to a previously diagnosed mental health condition. A lack of medical history "does not protect against unrecognized physical illness (Hall et al., 1981, p. 632). Happell et al.

(2016) discuss the need for all healthcare providers to avoid this "diagnostic overshadowing" when assessing patients' physical complaints.

Additionally, for decades, studies have demonstrated that those experiencing mental health disorders suffer from a higher number of physical disorders than the public and that the best practice for new-onset psychological symptoms is to eliminate physical causes before searching for psychological ones (Carlson et al., 1981; Chandler & Gerndt, 1988; Phillips, 1937). This idea suggests that any patient with mental illness, particularly new-onset mental illness, should be medically evaluated.

The question becomes, “should all people suffering from mental health issues be medically evaluated?” The answer from our perspective is “yes.” It is well known that not only can medical issues cause psychiatric symptoms, physical illness and mental illness can and do co-occur. It stands to reason that someone with a panic disorder, which may cause difficulty breathing, may also suffer from a cardiac or pulmonary issue with similar symptoms. In short, mental illness may not be wholly responsible for the physical symptoms the person is experiencing. Thus, a medical evaluation consisting of an initial and focused assessment is always prudent for these patients. While these assessments are sensible, it may not be necessary to transport all patients to the emergency department (ED).

In a 2004 study, Jones et al. (2004) discussed the high rate of co-occurring physical disorders in the mentally ill population. The study, citing various sources, noted obesity, cardiovascular disorders, gastrointestinal disorders, diabetes, HIV, and chronic and acute pulmonary disease as issues present in a significant number of the mentally ill (p. 1250). These findings suggest a reasonable index of suspicion that a medical condition may be co-occurring with a psychological one, meaning a physical assessment should be completed. Unfortunately,

research has also shown that those with serious mental illness have significantly shorter lifespans than the general population due to poorer health (De Hert et al., 2011).

Researchers have discussed some medical tests needed to rule out certain conditions. These tests include pulse oximetry, chemistry panel (including electrolytes, blood glucose, liver function tests, blood urea nitrogen, creatinine), assessment of therapeutic drug levels as appropriate, urine drug screen for substance use, blood alcohol level, complete blood count, urinalysis, thyroid function testing, erythrocyte sedimentation rate or C-reactive protein, rapid plasma reagin screening for syphilis, acquired immune deficiency syndrome/human immunodeficiency virus (AIDS/HIV) screening, with additional follow-up testing if positive (McKee & Brahm, 2016). Hall et al. (1981) also discuss the need for in-depth testing, stating that "careful physical, psychiatric, and neurological examination, SMA-34 blood chemistry, including CBC, routine urinalysis, and ECG and EEG after sleep deprivation" (p. 632) would identify the physical issue causing mental illness symptoms in 90% of cases (Hall et al., 1981). Some of these tests are expensive and time-consuming and may not be practical in all cases (N. Anderson, personal communication, January 22, 2023). However, performing as many as possible may identify a physical issue. In Chapter 13, we will discuss the potential for some of these diagnostic tests to be done in the field.

Medical Mimics and the Current System

Unfortunately, the 988 system and its components do not consider medical mimics, assuming those who call suffer from psychological issues. The operators at 988 call centers are ostensibly not trained to assess the person medically over the phone and do not have easy access to emergency responders should a medical problem present itself.

Also, the responders in the mobile crisis units do not have the training or equipment to assess for, treat, or transport those experiencing medical issues in the field. Their only option during a medical emergency is to dial 911, a dangerous waste of precious time, especially in an emergency.

Finally, there is no indication that the 23-hour facilities will include a medical assessment component, meaning that none of the features of the SAMHSA plan have any apparent medical assessment or testing whatsoever.

Chapter 7: Crisis Care

As we have alluded to in Chapter 5, one of the significant drawbacks of the current proposed plan by the federal government is the focus on crisis care as a mode of finding treatment for mental illness. While it certainly is easier to wait for a disaster to occur in someone's life to identify a mental illness, it isn't altogether the most humane or efficient way to manage it.

Let's use a car as a way to illustrate the point. Imagine seeing a small fluid spot on your garage floor as you pull out one day. You don't know what the fluid is, but you know it's not normal for the car to leak. You have a few options – you could investigate the nature of the fluid yourself, talk to someone who knows about cars and describe the fluid to them, take the car to a mechanic to have a look at the car, ignore the problem, hoping it will go away, or some combination of these.

You decide the leak is not that bad and decide to worry about it later – after all, the car seems to be running fine, and you have to get to work. Over the next week, the stain on the floor grows, but it's still not big enough for you to panic, so you don't prioritize the issue. You'll have it looked into next week.

Next week comes and goes. The car is still getting you where you need to go without any problem except for the growing pool of fluid on the garage floor. The following Monday, you leave for work, and the check engine light is illuminated. You start to think you should get the vehicle checked out, but you still put it off – after all, repairs may be expensive, you don't have the money to fix what's probably wrong, and the car is still running ok.

You put a piece of cardboard under the vehicle to protect the garage floor and forget about the problem for another month. Meanwhile, you notice in passing that the temperature gauge on the dashboard is reading higher than you remember; it used to be about halfway between cool and hot, but now it's creeping up toward hot. The car still runs fine. Maybe you didn't notice the temperature all along.

By Friday, you are on the interstate driving to work. The car starts to smoke from the engine compartment and stalls as you drive. The car will not restart. You call a tow truck to get the car to a mechanic. The driver asks where you want the car to go; you have no idea who fixes cars in your area and ask the driver if they know a place. They recommend Mitch's Auto Repair. You don't have a choice but to have the car towed there.

Mitch looks under the hood and gives you some bad news; you have a blown head gasket. It will cost $1,600 to repair it. He says that usually, one would notice fluid leaks and overheating, and the check engine light usually comes on before this happens. You change the subject and quietly kick yourself for ignoring the problem.

While perhaps overly simplistic, this concept may apply to mental health (and all health). The small fluid leak is reminiscent of a minor mental health issue, perhaps mild depression. When people feel mild depression, they have several options, just like the car owner. The person may research the problem for themselves, discuss it with their support system, decide to have the

issue assessed by a professional, such as their physician, or try to ignore it and hope the condition improves.

Unfortunately, too many people ignore the problem and watch it worsen until it spirals out of control. Only then does the problem become a crisis, just like when the car breaks down on the freeway.

In the car example, a little preventative maintenance may prevent the leak altogether. Perhaps the car owner educates themselves on common car problems, such as leaking fluids, and learns to check them periodically. This education may make the car owner better recognize the problem and perhaps find the correct fix before it breaks down. See Chapters 15 and 18, Prevention and Mitigation.

The initial problem was a leaking coolant hose, which could have been easily fixed. When the leak was found, some early proactive measures could have been taken to handle the issue. The person could have made an appointment to get the car checked out by a mechanic they already know and trust who may manage the problem while it was small and easy to repair instead of in an emergency with someone new. See Chapter 15, Secondary Prevention.

Since the problem was allowed to continue to the crisis phase, the vehicle must be towed and repaired. Hopefully, the car owner will learn from the experience and work on solutions by focusing more on prevention in the future. See Chapters 16, 17, and 18, Response, Recovery, and Mitigation.

Chapter 14 will discuss the Joliet Emergency Management Model for Mental Health and Illness (JEMMHI). Its concepts of prevention, response, recovery, and mitigation may be used to reduce the impact of the problem or prevent a crisis altogether. The person may enact

preventative concepts for mental health issues. Also, they may educate themselves in recognizing potential mental illness symptoms to identify them in themselves and others.

In a mental illness setting, a current primary care physician or mental health clinician would be comparable to the mechanic you know and trust. When problems are recognized and addressed early, common sense dictates that they may be handled more efficiently when the person is in a milder state of distress.

Unfortunately, waiting too long may have serious consequences; the tow truck may be an ambulance responding to a mental health crisis, and the unknown emergency mechanic may be a local hospital emergency department (ED) physician.

Finally, it is possible to blow a head gasket without warning. Still, the possibility may be reduced if the car is appropriately serviced and issues are managed after they are noticed. Similarly, mental illness may occur suddenly and without warning and must be addressed. The point of this analogy is that the general population needs to be educated with essential information regarding mental health and mental illness. They may be better prepared if the opportunity presents itself to keep minor issues from becoming significant.

Crisis intervention, while important, may be in the late stages of a mental health journey that potentially could have been managed earlier. Perhaps prevention of the problem should be the priority. Close the barn door before the horse gets out, not after.

Chapter 8: Silos

What are They?

Any book about mental health must address the issue of silos. A silo may be defined as reduced communication, sharing, and cooperation between entities and may be present for various reasons. While silos are often identified within organizations, they may also exist between organizations (or disciplines). Silos may exist among non-profit, non-government mental health agencies and within the government. Efficiency may be reduced when silos exist within an organization and may be non-existent between organizations. Communication breakdown and the non-use of common systems may create inter-organizational silos, and the loss of efficiency may be unintentional. Between agencies may be worse, especially when agencies "do their own thing" to build their importance and maintain their funding levels.

When individual agencies work apart (within their silos) for the same goals, problems may develop. Often, groups may not know that other groups are working on the issue. Sometimes, however, these organizations realize they are duplicating work but continue anyway to maintain funding levels, memberships, or political clout. This is the danger of the silo, especially in mental health.

An example may be found in the area of crisis intervention. There are many different systems of crisis intervention from various organizations. All are useful, but many cover the same topic in the same way. The author knows this because he used and cited these resources to create more efficient hybrid versions of the Crisis First Aid Family of Courses, which are much shorter in duration and will be presented in Chapter 16.

Another problem lies with the MCU concept in Chapter 4. The mental health and political silos could not see that paramedics are well placed and well suited to perform crisis intervention in the field. No one wanted to go outside their silo for a possible solution, and organizations have been competing with other organizations instead of collaborating with them.

Within governments, a multi-service institution such as a county or municipality may fund different agencies with different goals and objectives, (e.g., fire, EMS, police, public health, etc.), different budgetary "pieces of the pie," different programs, and different standing in the community. It is sometimes difficult (or impossible) to get the groups to share information, funding, or resources to solve problems efficiently. Further, smaller and larger governmental bodies (e.g., cities and counties) often have duplication of political bodies, agencies, and effort, making effective problem-solving difficult. The groups must have shared objectives in areas where overlap occurs, and the left hand must know what the right hand is doing (and vice versa) to solve problems proficiently. Like many things in this book, that is much easier said than done.

Silos may also exist between apparently unrelated groups who may share common goals and objectives of which the other is unaware. There are several examples of silos to be discussed, including the potential common goal between mental health and illness education and emergency medical service responders and fire departments, as well as the common goals and objectives between primary care providers and clinical mental healthcare.

Various organizations exist within communities to educate and provide service to those with mental illness, and, as we will explore in Chapter 11, fire departments respond to events and promote community risk reduction as part of their overall missions. These groups should work together to reach more people to provide education and potential solutions.

One of the most critical mental health and illness silos is between mental health clinical care practitioners and physicians. As discussed in Chapter 6, those with mental illness often have co-morbid conditions that a medical doctor must address, and physicians often treat mental health issues requiring pharmacological intervention. Fortunately, integrated care is becoming more common between clinical care and physicians (Cohen et al., 2015).

Coordination of activities is critical to the success of the overarching goals of all these agencies – and this coordinator should not be the federal government but the local government or other agreed-upon agency that understands the challenges their communities face.

Please note that the author is aware of the perception of his silo, that of the fire service and paramedicine. The difference is that he does not profess that either of these disciplines has all the answers regarding mental health and illness. The goal is to introduce the fire service to the mental health and illness continuum of care to help other fields do what they do best. This being said, there are some things that the fire service does well.

Lessons from the Fire Service: Unity of Command and Accountability

Some organizations may take lessons from the fire service. Unity of command, span of control, and accountability are all critical concepts to ensure tasks are completed efficiently. Unity of command is a common theme within the incident command system (ICS). It includes the precept that each unit reports to a single leader (officer, coordinator) (Smith, 2008). This reporting ensures the activities on the scene are done efficiently, without duplication. The span of

control refers to how many people one person may effectively manage. This number in the fire service is usually 2-7, depending on the risk involved (Smith, 2008). Finally, the group leader manages and monitors each group member to further the overall mission. This results in individual accountability, group leader accountability, and IC accountability.

This is a problem with the silos mentioned above; each group has a different goal. There is no organizational structural way to ensure objectives or tasks are not duplicated and that all groups are working to solve the larger problem. In short, there is no IC, the results of which anyone in the fire service knows will be ineffective at best and tragic at worst.

A basic example of the unity of command and span of control would be a structure fire scene at which 15 firefighters operate. First, the coordinator (IC) breaks the 15 into smaller groups. These groups are separated into manageable spans of control for one supervisor to manage (usually 2-7). The IC decides that three groups of five are appropriate for completing the tasks. One person is in charge of each group (usually a fire officer). Now the span of control is 4:1 for the groups (each group leader manages four firefighters) and 3:1 for the IC (the IC manages three group leaders). The IC may briefly discuss objectives and assignments with the group leaders and send them to their work. The objectives focus on three standard priorities, life safety, incident stabilization, and property conservation (Smith, 2008).

The firefighter groups may include a search and rescue group (find occupants and remove them), a fire attack group (extinguish the fire), a ventilation group (make the fire area more tenable for both victims and firefighters), or another group deemed necessary by the IC (e.g., fire confinement, ventilation, or salvage). Each group has different objectives, but the effect, on the whole, is synergistic and oriented to achieving the objectives that will produce the desired goal.

This process permeates the fire service and may be helpful when coordinating outside mental health services. If it is not done, there is no synchronization of effort or coherent strategy to solve the larger problem – any progress made will be due to chance, not planning. This is the state of the relationship between many local mental health non-profit and non-governmental organizations.

For example, suppose three non-profit, non-governmental local agencies are present in the community. Each maintains a website, offers online information about mental illness, and has in-person course development teams. Each has a crisis line that operates during regular business hours.

The coordinator discusses general objectives with the outside agency leaders. They agree that a 24-hour local helpline is essential, a centralized location for information should be developed, and coordinated course offerings should be made. The coordinator assigned the leaders of the respective helplines to meet, select a group manager and plan a 24-hour multi-group helpline to eliminate service duplication. Another group is formed from the three consisting of the internet designers of each. The same process occurs; a leader is selected and manages the group to create a new, comprehensive website. The same happens with the in-person course teams.

In a perfect world, this would occur and be effective. But everyone knows it is unrealistic until the individual groups bridge their silos and work with one another transparently and synergistically. This must happen for the process to be effective at addressing agreed-upon issues.

Bridging Silos

The solution to silos is not to break them down but to bridge them. While it is evident to most that the way to bridge silos is through collaboration, the problem becomes how to make collaboration an attractive alternative to what groups are already doing. Many within their silos see collaboration as a threat and the opposite of competition – why share with a group seen as a competitor? To address this, Newlands (2003) warns against viewing competition and cooperation as opposite ends of a spectrum. They may coexist in a mutually beneficial manner for everyone involved and be likened to opposite sides of the same coin.

According to Katz et al. (2021), individuals and groups must decide between competition and cooperation by assessing which is more beneficial within the realm in which they operate. For mental health (as with all human services), the focus should be on managing the more significant problem. Again, easier said than done.

Change is not a Four-Letter Word

As we saw in the previous section, models for bridging silos within the business world involve finding mutually beneficial aspects of collaboration. Unfortunately, this may be only part of the solution. One of the other parts may be difficult - organizational cultural change.

According to Schein (2010), an organization's culture (in fact, any culture) may be studied at three levels, including artifacts, espoused values, and underlying assumptions (Schein, 2010). Artifacts refer to aspects such as language, clothing, and art. Since, according to Schein (2010), it is difficult to establish a deeper understanding of culture from artifacts alone, we will focus on the remaining two espoused values and underlying assumptions.

Espoused values play an essential role in the mental health setting and may sometimes be contradictory. An example in mental health may include organizations that commit to reducing

stigma and enhancing care for the mentally ill but refuse to work with other groups with similar goals to achieve it.

Finally, underlying assumptions within a culture often help explain contradictions in the espoused values mentioned above (Schein, 2010). This may be most evident in the desire to maintain employment and income within an organization. Working collaboratively may be seen as a threat to one's livelihood – "if we solve the problem, we are all out of a job." "If we share our money with them, we have less for ourselves, and some of us might be out of a job." This reduces the feeling of safety and security of the organization's members. Is it any wonder why the problems don't get solved?

Further Opportunities for Growth. A Fire Service Perspective

A possible solution to the silo problem and related cultural change is to see eliminating the current problem not as a negative but as a positive that allows for new and creative growth. Examples of this may be found in Fire Service history in *America Burning* and the addition of emergency medical services (EMS) to the fire service.

In the 1970s, fire was a severe problem in the United States. According *to America Burning* (1973), at the time of printing, 6,200 people died in fires annually in America. Additionally, 100,000 people were injured due to fires during the same time. These statistics prompted the creation of the National Commission on Fire Prevention and Control, a group tasked with developing solutions to the fire problem. The Commission evaluated the fire issue from different perspectives and made recommendations that are still practiced today. In addition to fire departments, they involved engineers, designers, and manufacturers by providing information regarding fire protection (National Commission on Fire Prevention and Control (U.S.), 1973).

This document resulted in the creation of fire prevention programs throughout the country, the parent of modern Community Risk Reduction (CRR) programs today (see Chapter 11). By developing prevention programs (which 77% of U.S. fire departments maintain), fire departments found another valuable activity besides fire suppression (National Fire Protection Association [NFPA], 2021). It helped fire departments remain relevant and needed in the community. If those on the Committee were concerned with keeping the status quo and their jobs, this issue might have never seen the light of day. Most importantly, the method put forth in the document worked, and the total number of fires and fire fatalities began to decline steadily over the next 40 years. The total number of fires since 1980 has dropped from 2.9 million to 1.3 million in 2021, and the total number of fire fatalities in the U.S. in 2021 was 3,800, down from 6,505 in 1980 (National Fire Protection Association [NFPA], 2022).

A related trend began nearly a decade before. In 1966, a white paper entitled *Accidental Death and Disability: The Neglected Disease of Modern Society* was the first to discuss the need for pre-hospital care in the form of emergency medical services. The result of this paper was the development of the first Emergency Medical Technician (EMT) standards in 1969 and a greater focus on first aid and trauma care in the lay population (Bucher & Zaidi, n.d.; National Academy of Sciences (US) and National Research Council (US) Committee on Trauma et al., 1966). This was followed by the EMS Systems Act in 1973, resulting in growth in fire service EMS (Bucher & Zaidi, n.d.). EMS service has become a standard part of the fire service in the intervening years. Today, 59% of the 27,000 registered (and 29,000 total) fire departments nationwide offer basic life support (BLS) care, 39% offer non-transport EMS services, and 21% provide advanced life support (ALS) care (*National Fire Department Registry Summary*, 2022; National Fire Protection Association [NFPA] et al., 2021).

The key takeaway message is that the fire service has found ways to keep itself relevant in the community, keep staffing levels up, and perform public service while significantly reducing the fire problem in the U.S., proving that creative and innovative people will always keep forward-thinking organizations growing, changing, and evolving. The same can be true with mental health organizations.

Chapter 9: Clinical Care

While clinical mental healthcare has proven to be a significant obstacle in managing mental illness, that is only part of the problem. There are also shortages in other areas of care that are important to discuss. Many classifications of professionals may act as clinical treatment providers for mental health, and physicians have become more involved.

Today's Mental Healthcare, The Psychologist vs. the Psychiatrist: The Players

Sometimes it is difficult to keep track of the players on the mental health and illness scorecard. Primary care physicians, psychiatrists, psychologists, counselors, and social workers are all different jobs with some overlap in responsibilities. Additionally, many within these categories have different specializations, such as marriage and family counseling, addictions counseling, school counseling, child psychology, trauma, etc.

General Practitioner/Primary Care Physician

The General Practitioner (GP) or Primary Care Physician (PCP) is often called the family or personal physician. They are medical doctors (MDs). In recent decades, the PCP has made a large footprint in mental healthcare. These physicians may perform general mental health assessments and prescribe medications for specific issues such as depression, anxiety, etc. In

more complex cases, they may refer their patients to a psychiatrist or counselor for further therapy and collaborate for better overall care (Cohen et al., 2015). While PCPs are an excellent resource for the mentally ill in our communities, it has been reported there are not enough (and will not be enough) general health physicians to manage patients in need (Colwill et al., 2008). It should also be noted that a significant portion of mental illness symptoms is physical in origin (see Chapter 6). Further, the mentally ill have a high level of co-occurring physical illnesses (McKee & Brahm, 2016), meaning that regular physical assessments by a physician are critical to those experiencing mental illness.

Psychiatrist

The psychiatrist is a trained and licensed medical doctor (MD) specializing in mental health and mental illness. Like cardiologists or neurologists, they complete medical school and focus on their specialty (a bit simplistic, but you get the idea). They often perform counseling duties similar to other mental healthcare practitioners, but under their medical training and licensure, they can prescribe medications to help manage symptoms of mental illness. Unfortunately, there is a severe shortage of psychiatrists in the U.S. (numbering up to 30,000 by 2024), and 96% of counties lack psychiatric medication prescribers, forcing PCPs to help manage mental health issues requiring medication (Pheister et al., 2021).

Psychologist, Counselor

In many jurisdictions, the titles psychologist and counselor are used interchangeably. These professionals often have master's degrees or higher education (e.g., Ph.D., Psy.D., or Ed.D.) and are licensed in the state where they practice. Different states may have differing requirements for the licensure of these professionals. Psychologists and counselors are not medical doctors and cannot prescribe medications - using other treatment methods. They may

partner with a psychiatrist or a person's PCP to create more effective treatment plans that include medications (Cohen et al., 2015). Shortages of these professionals exist and will worsen in the coming years.

Social Worker

Social workers and counselors may seem similar on the surface, and in some ways, they are. The Social Worker usually possesses a master's degree or higher (Ph.D. or DSW) and may perform psychologist or counselor treatment modalities on individuals. They also often have the added benefit of connecting people to needed resources outside their practice area (U.S. Bureau of Labor Statistics [BLS], n.d.).

The Emergency Department (ED)

The much-used (sometimes misused) hospital emergency department (ED) is often left out of the conversation. As described earlier in this chapter, the lack of available clinical and medical treatment offerings has forced many to use the ED for mental health issues and medication refills that they cannot attain anywhere else. As one would expect, those using the ED are often people experiencing poverty, under-served, and under-represented community members.

State and County Health Departments

Various types of state and county governmental agencies also offer healthcare of multiple types. These agencies may provide many programs to the local community but are not immune to the staffing issues affecting the mental health professions.

Shortages

Under the best of conditions, U.S. Department of Health and Human Services projections indicate 2025 shortages of 16,940 mental health and substance abuse social workers; 13,740

school counselors; 8,220 clinical, counseling, and school psychologists; 6,080 psychiatrists; and 2,440 marriage and family therapists (U.S. Department of Health and Human Services [US HHS], 2016). This shortage totals over 47,000 clinicians of different specialties. Remember, these were best-case scenario numbers published in 2016, long before COVID-19 and our communities' increased mental health awareness. Refer to Chapter 2 for worse news on the psychiatrist shortage.

These shortages underscore the importance of getting the right help to the right people. In Chapter 15, we will discuss the prevention and use of the Self-Triage Tool. In Chapter 24, we will discuss suicide and the Columbia Suicide Severity Rating Scale (C-SSRS), which may be used to gauge the seriousness of mental health issues and point people in the right direction in seeking treatment.

Collaborative Care

Fortunately, a new and effective practice of collaborative care is emerging. In collaborative care models, the patient may visit their PCP. The PCP may send them to a counselor for therapy and follow up with the counselor to prescribe medications if required (Cohen et al., 2015). Chapter 8 discussed the silos in these areas. Unfortunately, many people do not have a PCP to visit, especially in under-served areas, a severe problem that must be managed.

As we discussed earlier, a system must be established that provides proper care to the people who need it in the community, a task which may be aided by some outside the traditional mental health groups. In Part 4, we will explore the fire service role in managing this task.

Part 4: Public Service Solutions

Chapter 10: Safety & Law Enforcement

Fire and EMS regularly respond with police to all sorts of incidents, including structure fires, medical calls, motor vehicle crashes, and, yes, mental health and illness calls. Police add a needed level of security for responders and citizens on the scene. Additionally, police may encounter mentally ill people as part of their daily calls for service without EMS present. One cannot discuss responses to mental health without including the police in the discussion.

As discussed in Chapter 4, the change in the mental health landscape in the 1980s and 1990s caused an increased interaction between police officers and the mentally ill in their communities. Some of these interactions ended negatively. Police realize they have a responsibility to the public regarding mental health. They have taken steps to educate police officers to better communicate with those with mental illness. The industry standard to this end is crisis intervention training (CIT) for law enforcement officers, a good program, but far more than a law enforcement officer needs to manage a scene until EMS arrival (see Chapter 16 in Part 5).

SAMHSA, CESSA, and Police

The SAMSHA document and Illinois CESSA Act described in Chapter 4 and Chapter 5 take a hardline stance on police officers (and EMS) and their response to behavioral

emergencies, arguing that their response to those events is minimal and should be left to the MCU to determine the need for them. Emergency responders understand the value of police on these scenes and the safety they provide.

Role of the Police on Mental Health Scenes: Security and Safety

Police and Fire/EMS work well together in the field because each knows their role, and each (usually) stays in their lane. Police who are first on the scene of a structure fire will often attempt to extinguish the fire or perform life safety actions until the fire department arrives, at which time they let the fire department "do their thing." Similarly, police will provide first aid or CPR until an EMT arrives, again allowing the EMT "do their thing." Fortunately, for fire and EMS, police remain on the scene to provide safety and security for responders and citizens.

On the other side of the coin, fire departments/EMS will stage away from an unsafe event (e.g., shooting, battery) until the police manage the scene safety and "do their thing" before they enter the scene and are trained to avoid disturbing evidence to better enable police to perform investigations. This relationship has developed over many years and works very well in practicality.

The lines may be blurred, however, at a call for a person in mental distress because there is often not an apparent physical injury that must be tended to or a building on fire. The response may be to a combative individual (with or without mental illness) – a call to which police successfully respond every day.

The key to such interactions is for police to "do their thing" until EMS arrives and then allow them to manage the call, helping as needed and providing safety as they do on medical calls for service. To successfully manage communication with a person in crisis, the police only

need to use Crisis First Aid for Law Enforcement (CFA-LE) (a free 20-minute course), not CIT (a 40-hour course) that costs taxpayers millions per year (see Chapter 8, Silos).

The Joliet Medical Model for Law Enforcement (LE) Response to Behavioral Events

A far more practical use of LE in behavioral incidents is to use the Joliet Medical Model for Behavioral Events and Traumatic Stress. This model is predicated on the fact that LE will render aid on first arrival if needed and then defer to paramedics on a medical call for service. They then remain on the scene for security and support. A behavioral event should be no different. Just as a LE officer provides first aid and CPR (basic life support and minor medical care) to a person in the early stages of a medical incident before EMS arrival, they may provide basic behavioral care on the scene until EMS arrives in the form of CFA-LE. As we will demonstrate, EMS, particularly paramedics, are well suited to perform crisis intervention at a more advanced level than LE.

Why Fire/EMS and not Police?

We will discuss the value of fire/EMS in mental health and crisis intervention in detail later. For now, we want to clarify how the response to a behavioral patient should progress in the field. Some realities must be addressed. One of these is public opinion. An honest approach to the standing of fire/EMS and police with the public is necessary when looking at who should be the lead on a mental health call for service.

Gallup polls have been done for years on the public perception of ethics and honesty among various professions. Since 1977 (38 separate surveys), 52% of respondents rated the ethics and honesty of police offers as high or very high, 35% as average, and 11% as low, very low, or no opinion. Firefighters were added to the survey only once in 2001 on the scale, rating

90% high or very high and 10% average. EMTs were not counted, and the events of 9/11 may have skewed the results of the firefighter category (Gallup, n.d.).

Another poll done by Iops (2021) of 1,000 Americans found that 49% of police officers were seen as trustworthy and 21% untrustworthy. Compare this to firefighters at 80% trustworthy and 7% untrustworthy, and paramedics and EMTs at 76% trustworthy and 8% untrustworthy (Ipos, 2021).

None of this data is being presented to imply that police should not be on the scene of behavioral health emergencies. They are invaluable in a safety and security role, but it may not be necessary to directly participate with the person unless required, allowing paramedics to manage the patient. Chapter 16 will further detail the CFA-LE program.

Chapter 11: Fire Service Community Risk Reduction & Mental Health

There are over 1.15 million firefighters in the U.S. today and 29,000 fire departments (*National Fire Department Registry Summary*, 2022). These take the form of career (approximately 30%) and volunteer or combination departments (approximately 70%) (National Fire Protection Association [NFPA] et al., 2021). Many fire departments have investigated and implemented Community Risk Reduction (CRR) programs. According to the National Fire Protection Association (NFPA), "CRR is a process to identify and prioritize local risks, followed by the integrated and strategic investment of resources to reduce their occurrence and impact" (National Fire Protection Association [NFPA], n.d., para. 1). A community risk is defined as any potential event that may harm the community (National Fire Protection Association [NFPA], 2020).

CRR has seven main characteristics. It is proactive, integrated, community-based, data-driven, partner-oriented, effective, and efficient (Vision 20/20, 2023). While the above attributes of CRR are essential, the two most critical for mental health are that programs are specifically community-based and data-driven. Each area has individual mental health issues that can be

described by proper data interpretation – the local focus on mental health is stressed numerous times in this text. Positive results, in turn, may be shown through the same data-driven methods.

There are also five pillars to reducing the risk associated with CRR. These include emergency response, education, engineering, enforcement, and economic incentive (U.S. Fire Administration [USFA], n.d.). Again, two of these stand out for mental health, emergency response, and education. When emergency responders are sent to a mental health call for service, they can de-escalate the event and make things better for the patient by providing crisis intervention and resources. More important, however, is the education of the public in mental health concepts and management.

Community Risk Assessment (CRA)

According to *NFPA 1300: Standard on Community Risk Assessment and Community Risk Reduction Plan Development* (2020), the community risk assessment (CRA) is done to identify risks in the community. These risks may be broad in scope and are focused on the individual community in which they are based. Mental illness is, at some level, a risk in most communities and may be included.

Community Risk Reduction Plan (CRR Plan)

The CRA (discussed above) categorizes and prioritizes the risks identified to build the CRR plan. When these risks are identified, there are several ways to manage them. The methods discussed are avoid, mitigate, accept, and transfer (National Fire Protection Association [NFPA], 2020). Avoid refers to removing the threat, mitigate refers to reducing the impact of the threat, accept refers to taking no action against the threat, and transfer refers to conveying the threat to someone else (National Fire Protection Association [NFPA], 2020). Admittedly some of the

methods that the NFPA espouses are interesting (to say the least), such as the accept and transfer methods, but the first two, avoid and mitigate, hold merit for mental health.

Mental Health and CRR

CRR programs give local leaders, through their fire department professionals, the ability to assess their communities for risks and design and proactively implement programs to manage, mitigate, and prevent those risks. As we have seen in Chapter 3, since the time of Hippocrates, mental health has been recognized as being on par with physical health regarding recognition, management, and treatment. Although most CRR programs focus on fire and medical-related issues, such as smoke detectors, fall prevention, drowning prevention, choking prevention, and home fire safety, an argument for more progressive CRR can be made for mental health (J. Carey, personal communication, November 30, 2022). The fire department CRR programs may partner with other local agencies to help manage, organize, and integrate resources and education. These partners include police, county health departments, and non-profit and non-governmental organizations (NPO/NGO). The Joliet Emergency Management Model for Mental Health and Illness (JEMMHI) will be discussed in Chapter 14 and may be implemented into the CRR plan.

As of the writing of this text, CRR has a nebulous definition. In short, it is whatever the local fire department says it is based on the CRA done for the jurisdiction. Regardless of the local definition, one of the critical components of the CRR plan is evaluation. The plan must be evaluated within defined timeframes, and its effectiveness must be determined using gathered data. This evaluation is essential to the program's evolution because the plan may eliminate specific hazards in the community, and new threats may present themselves.

Chapter 12: Medical & Mental Management, the Case for Emergency Medical Services (EMS)

The SAMHSA document discussed in Chapter 4 states, "the mobile crisis staff must decide if other first responders, such as police or emergency medical services, should be involved while understanding that this is not the preferred approach and one that should only be used when alternative behavioral health responders are not available, or the nature of the crisis indicates that EMS or police are most appropriate" (p. 20). Recall the problem of timely response in Chapter 4 and medical mimics in Chapter 6. Response time for the MCU may be very high, and the 988-call center and MCU responders may be able to assess mental health issues but do not have the training or equipment to manage or evaluate for medical problems.

There are, however, those in the community who can do both – those in the emergency medical services (EMS) system. As we saw in Chapter 6, it is vital that physical or mental symptoms not be routinely attributed to a diagnosed (or new) mental disorder. The person must be able to call a person who can think critically, ask pertinent questions, and quickly send

appropriate resources. Additionally, those sent resources must be 24/7/365 and able to manage medical and mental health crises in the field.

Levels of Medical Training: EMD, EMR, EMT, AEMT, Paramedic

Dispatchers, emergency medical responders, emergency medical technicians, and paramedics are all integral components of the pre-hospital emergency medical system. Each has its role and training requirements.

Emergency Medical Dispatchers (EMD)

Public Safety Dispatchers take emergency calls for service at a public safety answering point (PSAP), usually connected to 911. The 911 system has proven itself over decades, managing 240 million calls in the U.S. annually (National Emergency Number Association [NENA], n.d.).

The Emergency Medical Dispatcher (EMD) is a public safety dispatcher with additional medical and policy training, with a role of vital importance as a member of the healthcare provider team in the identification and management of both physical and mental complaints (Clawson et al., 2015). According to The National Highway Traffic Safety Administration (NHTSA) (1996), the roles of the EMD are several-fold, including receiving and processing calls, determining the nature and severity of calls, and coordinating response assistance.

EMDs are trained to elicit information calmly and compassionately from callers, communicate nonjudgmentally, and de-escalate hostile and anxious callers – all while determining the potential condition of the patient (Clawson et al., 2015; NHTSA, 1996). This determination is possible through training the EMD receives in medical terminology, sign and symptom recognition of various disorders (e.g., levels of consciousness and shock), and education regarding the structure and function of the seven body systems (i.e., nervous system,

circulatory system, respiratory system, musculoskeletal system, genitourinary system, digestive system, and skin) (Clawson et al., 2015; NHTSA, 1996). Additionally, the EMD may be required to complete continuing education to maintain licensure, and the overall program is overseen by a medical director physician (Clawson et al., 2015).

Like others in the medical profession, the EMD performs an initial assessment with the caller to gather information. This information includes the who, what, when, why, where, and how of the problem. This task is challenging, but EMDs have the ability and training to manage many types of callers, including non-English speaking callers, callers who are deaf and hard of hearing or people with other disabilities that may affect communication, and child callers.

The role of the EMD in the mental health evaluation process primarily stems from their education in body systems and illness, experience managing troubled callers, ability to elicit valuable information, ability to follow established standard operating procedures, and proximity to contacting in-person care.

According to 911,gov (n.d.), most states already offer EMD service as part of their primary or secondary dispatch centers, with some data unavailable. Perhaps a better use of funding would be to enhance 911 dispatcher staffing and training to EMD levels rather than creating a whole new system, but we will discuss that later.

The EMD Related to 988

The 988 program documents recognize the need for each 911 PSAP and provider of emergency services dispatched through a 911 system to coordinate with mobile mental and behavioral health services; however, this coordination is complex. The connection of potentially national resources (depending on which 988 call center takes the call) with local emergency responders is difficult and requires an infrastructure that does not exist. In addition, due to

differing local communication systems, Mobile Crisis Unit (MCU) personnel may not have contact with many local emergency response agencies. The ultimate goals, according to SAMHSA, is to allow all MCUs to have contact with local emergency dispatch centers and provide call centers with the geolocation ability to locate callers in crisis (SAMHSA, 2020). These goals are very tall orders, indeed.

For example, a call from someone to 988 will be routed by the area code from which the call was placed to the nearest appropriate call center (Saunders, 2022). If someone is not available to take the call, the call may be transferred to another call center, where, it is hoped, an operator will be available. As the calls are transferred, it is possible that a call placed from Joliet, Illinois, may be answered in Washington State, Indiana, or further away. These call centers cannot rapidly contact emergency resources in Joliet, Illinois, if the person is experiencing a medical problem, is imminently suicidal, or is experiencing another issue that requires in-person assessment and care. In reality, the call center may not be able to determine that the person is experiencing a medical problem because they are not trained to do so. The ideas of geolocation and other far-off technologies are also nice, but these are abilities that emergency 911 dispatchers do not possess yet, let alone crisis lines. According to 988, 2% of their callers require emergency care; it is unknown how emergency response agencies are being contacted for this response (National Public Radio [NPR], 2022). Interestingly, in a local study in Joliet, Illinois, 88% of behavioral callers required transport to the emergency department. This is a very large gap that needs to be explained.

A similar problem exists with texting. Texting, while a preferred method of communication today (even in crisis communications), is, at best, a mediocre transmission technique, especially where assessment and emotion are concerned. A two-part 2022 study

demonstrated that the receivers in texting interactions could ascertain the other person's emotion in just 20% of cases. Unfortunately, 85% of the message senders thought their emotion was transmitted correctly to the receiver (Holtgraves, 2022). There is a significant variance between the perceived conveyance of emotion and the actual conveyance of emotion. In crisis communications, this is unacceptable and potentially dangerous. Also, empathizing with someone via text is difficult because the context and perception of the other person's knowledge are missing when two people who do not know each other communicate via text (Holtgraves, 2022). So, while 988 has received many texts since its inception (almost eight times the number of calls), it is unknown if the sender and receiver are communicating correctly and if the intended messages are being sent or received (Seitz, 2023).

A far more reasonable solution is the local 911 system. Already existing local resources possess the technology to locate those in distress. Further, those in crisis already know that 911 is a resource for them and may (rightly) call before trying 988. Also, while texting 911 is an option, the goal is to dispatch emergency personnel to the scene for in-person care, not to handle the call's content via text. Finally, many dispatchers are trained EMDs and can critically evaluate a person over the phone to determine the most appropriate resources to send, including medical resources.

It is clear that the EMD already possesses the training and ability to communicate with callers in both mental and physical distress, with the added benefit of access to the rapid response by EMS agencies and police, if needed. This fact is in stark contrast to 988 in several ways.

First, as of 2023, there are 200 crisis call centers in the nation in the NSPL (now 988) network – staffing in the individual centers is unknown (988 National Suicide and Crisis Hotline,

n.d.). The NSPL indicates that the line received over one million calls in 2021, which has increased to around 300,000 per month since July 2022, two million in the first six months of use, and approximately four million per year (Seitz, 2023).

Compare the 200 nationally recognized 988 call centers potentially answering four million calls in 2023 with over 5,000 primary and secondary PSAPs (nationwide) effectively answering 240 million calls for service with almost 100,000 dispatchers (911.gov, n.d.; Kitch, 2022; NENA, n.d.). The current 911 system could absorb a 1.6% increase in call volume, especially with supplemental funding now provided to 988. A properly functioning system already exists to manage phone crisis intervention, and a new system is a terrible waste of time and resources.

To illustrate this point further, Illinois has six 988 crisis call centers that handled just over 84,000 calls in 2021 and are on pace to total 144,000 in 2023 (988 National Suicide and Crisis Hotline, n.d.). Compare this to the almost 200 911 PSAPs in Illinois, receiving 8.7 million calls for service in 2020 (911.gov, n.d.). This equates to 33 times the number of call centers and 60 times the call volume of the 988 system already being managed effectively by 911. Adding 144,000 to this, even with current staffing, equates to fewer than two additional calls per day per center. Additionally, over 85% of dispatch centers in Illinois already provide EMDs (911.gov, n.d.).

The National Emergency Number Association (NENA), which represents PSAPs on a national level, published a report in 2022 discussing challenges to the interoperability of communications (the incompatibility of the multitude of communications systems nationwide) – a problem that has plagued PSAPs and emergency response agencies for decades (that 988 thinks it can solve). This interoperability, funding, and oversight were primary obstacles to improving

the 911 system. Perhaps the millions (or billions) of dollars and complex organizations put into 988 would be better spent to enhance the 911 system to include crisis intervention, more EMD coverage, and geolocation service development.

This text has already demonstrated a severe gap in the physical assessment capability of the 988 call takers and their ability to contact 911 dispatch centers if emergency response is required. The clinical responders in the 988 crisis line are presumably not trained to assess a patient medically or send immediate resources to render aid. This lack of training may delay recognition of potentially serious medical issues and increase the response time of emergency medical services (EMS) to several types of emergency patients, potentially resulting in tragic consequences.

According to the Journal of Emergency Medical Services, only 20 states have funded their 988 systems long-term (Seitz, 2023). This is a good thing. Hopefully, those in government who hold the purse strings will realize that 988 is attempting to re-create an existing system and will choose to fund 911 at a higher level instead.

Also, answer methods, rates, and times are issues with 988. First, the auto-answer feature of 988 (a machine picks up the call) is a problem. According to Suicidologist and hotline pioneer Mary Frances Seeley, Ph.D., the best practice is for a real person to answer a crisis line. Callers often terminate the call or refuse to leave a number for a return call when they hear a recorded message (M. Seeley, personal communication, April 24, 2021). When 911 is called, a real person answers the call and begins to speak with the caller within the national standard of 15 to 20 seconds (with some local exceptions in understaffed areas). When we tested 988, we had to wait between 60 and 90 seconds to speak to someone, four times longer than 911.

Further, according to 988, only 88% of calls are answered (988 National Suicide and Crisis Hotline, n.d.). Additionally, no data indicate that the 12% of abandoned calls to 988 (480,000 calls in 2023) receive follow-up. If a 911 hang-up occurs, most PSAP policies require a callback or a responder be sent to check on the caller's status. What happens to the 12% who don't stay on the line with 988?

Importantly, we are unaware of any study that 988 prevents suicide because little follow-up information indicates anyone checks on the caller to gather data. One rare study offered that only 45% of web chat and text contacts in 2021 were less suicidal than when they contacted the line (Gould et al., 2021). What happens to the rest of the people who call? We would know the result if 911 were used and responders were sent. Follow-up is critical in these instances.

Levels of EMS Care

According to the National EMS Scope of Practice Model, there exist four general licensure levels of emergency medical service training in the United States, Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic (National Highway Traffic Safety Administration [NHTSA], 2019). These more or less correspond with Illinois EMS levels of Responder, Basic Emergency Medical Technician (EMT-B), Intermediate Emergency Medical Technician (EMT-I), and Paramedic Emergency Medical Technician (EMT-P). Each group of medical responders has specific goals, objectives, and competencies that the provider must master to become licensed. While we will briefly describe all levels, this work will focus on the paramedic-level provider.

Emergency Medical Responder (EMR)

The Emergency Medical Responder (EMR) is the most basic of the professional field care providers (NHTSA, 2019). They often include those who arrive on the scene first to initiate assessment and life-saving measures (with medical oversight) while recognizing the need to provide access to higher levels of care (NHTSA, 2019). Education for EMR certification may be administered by various accredited EMR education provider groups, including the American Red Cross (ARC) and the American Safety and Health Institute (ASHI) (NHTSA, 2019; 2021).

Emergency Medical Technician (EMT)

The Emergency Medical Technician (EMT) builds upon the EMR standard of care and provides more in-depth (but still basic) training as well as transportation to medical facilities (NHTSA, 2019). In more isolated areas, the EMT may routinely provide community health care (NHTSA, 2019). Education for EMT licensure may be administered by accredited EMT education provider groups (NHTSA, 2019; 2021).

Advanced Emergency Medical Technician (AEMT)

The AEMT provides controlled advanced care and transportation to medical facilities. Under medical supervision, they may perform more advanced care than the EMT in a limited capacity. (NHTSA, 2019; 2021).

Paramedic

The paramedic uses complex education and training to perform advanced skills under medical direction, transportation to medical facilities, and referrals to higher levels of care. The paramedic also educates the public regarding health and psychological conditions (NHTSA, 2019). Education at the paramedic level includes training to a state, national, or associate degree level for licensure (NHTSA, 2019; 2021).

Medical Care in the Field

While EMS paramedic crews cannot diagnose or perform many diagnostic tests mentioned in Chapter 6 and are certainly not a replacement for physician assessment and treatment, they perform primary and secondary assessments and focused physical examinations on patients to differentially diagnose during their daily calls for service. Differential diagnosis includes determining the probability of certain disorders based on the patient's chief complaint, signs, and symptoms (Sanders, 2011). This assessment is often of great value as one study demonstrates that paramedics make an accurate physician-verified diagnosis in 67% of patients, with some of the remaining diagnoses missed potentially due to a lack of available diagnostic testing in the field (Koivulahti et al., 2020). These results have been consistent across national boundaries. While a dearth of information exists for paramedics in the U.S., American paramedic studies reveal a high recognition rate of several disorders.

Training Requirements

The training requirements for EMS practitioners are contained within a five-factor educational program, including the *National EMS Core Content, National EMS Scope of Practice Model, National EMS Education Standards, National EMS Certification, and National EMS Education Program Accreditation.* The following training standards are taken from those documents.

Training for the Paramedic: Preparatory

The preparatory training for paramedics describes the knowledge the paramedic requires to provide advanced care. The paramedic is comprehensively educated in EMS systems, roles, responsibilities and professionalism, quality improvement, the role of medical oversight, and the culture of safety.

Additionally, the paramedic is educated in workforce safety and wellness concepts, including wellness principles and responder mental health, research impact, data collection, evidence-based decision-making, research principles, documentation of patient findings, report writing, and supporting medical necessity.

Training progresses with emergency medical services communications and communication with other health care professionals to establish cohesive team care, communications dynamics, telemetric monitoring devices, and transmission of clinical data.

Importantly, therapeutic communication is stressed, including healthcare literacy, interviewing techniques, verbal diffusing strategies, managing communication challenges, family-centered care, adjusting communication strategies for age, stage of development, and patients with special needs, and nondiscriminatory communication that addresses inherent or unconscious bias and culturally aware attitudes.

Medical, legal, and ethical aspects of paramedic care, including consent, confidentiality, advanced directives, statutory responsibilities, mandatory reporting, ethical principles, and patient rights, are all essential concepts taught to the paramedic student. This education continues with training, principles of anatomy and physiology, medical terminology, pathophysiology, and lifespan development.

Training for the Paramedic: Public Health

In public health, covered topics are EMS roles, governmental and non-governmental roles and resources, impacts of social, geographic, economic, and demographic determinants of health, special populations such as geriatric and pediatric patient populations, and patient and community education.

Training for the Paramedic: Pharmacology

Basic and advanced pharmacological principles are addressed, including medication safety, medication legislation, naming and classifications of medications, storage and security, medication interactions, adverse drug reactions, pharmacokinetics, pharmacodynamics, and medication schedules. Additionally, medication administration, routes of administration, and resources for the safe administration of weight-based dosing are covered.

Acute and chronic or maintenance medications are addressed. Names, facts, indications, contraindications, side effects, routes of administration, dosages, actions, complications, and interactions are discussed. In addition, drug class names, side effects, and polypharmacy are covered as well.

Training for the Paramedic: Airway Management, Respiration, and Ventilation

Advanced airway management training includes anatomy, assessment, patency techniques, physiology and pathophysiology, assessment of adequate and inadequate respiration management, and oxygen therapy.

Training for the Paramedic: Assessment

The paramedic is well trained in assessment and reassessment concepts, including scene safety and situational awareness, scene management, the impact of the environment on patient care, assessing hazards, violence, the need for additional resources, standard precautions, and multiple patient situations. Additionally, primary assessment and lifesaving interventions and practices are taught and mastered.

Also, in the assessment realm, history taking, including investigation of the chief complaint, mechanism of injury, associated signs and symptoms, past medical history, pertinent negatives, interviewing techniques, and therapeutic communications and adaptive interview techniques, are practiced and mastered.

Secondary assessment, including vital signs, assessment of pain, and techniques of physical examination, including the respiratory, cardiovascular, neurological, musculoskeletal, and major anatomical regions, are learned.

Training in the use of monitoring devices such as pulse oximetry, noninvasive blood pressure, cardiac monitoring including twelve lead ECG acquisition and transmission, blood glucose determination, and title CO_2 monitoring and interpretation of waveform capnography, venous blood sampling, 12 lead ECG interpretation, and blood chemistry analysis is also done.

Training for the Paramedic: Medical Issues

Medical concepts resulting from pathophysiology, assessment, and management of a medical complaint of all body systems are taught. Covered issues: Abdominal disorders such as acute and chronic gastrointestinal hemorrhage, bowel obstructions, liver, and biliary tract disorders, pancreatitis, peritonitis, and other gastrointestinal disorders.

Cardiovascular disorders: Acute coronary syndrome, hypertensive emergencies, aortic aneurysm and dissection, thromboembolism, heart failure, nontraumatic cardiac tamponade, cardiogenic shock, vascular disorders, cardiac rhythms, conditions that predispose patients to cardiac rhythm disturbances, infectious disease of the heart, congenital heart disease, and cardiomyopathy.

Endocrine disorders: Diabetic emergencies, chronic diabetes, adrenal disease, pituitary disorders, and thyroid disorders.

Genitourinary disorders: Complications of dialysis, sexual assault, acute and chronic renal failure, acid-base balance disturbances, fluids and electrolytes, and infection.

Hematology disorders: Sickle cell disease, coagulopathies, hemostatic disorders, red blood cell disorders, and white blood cell disorders.

Immunology: Allergic and anaphylactic reactions, systemic inflammatory response syndrome, hypersensitivity, and immunodeficiency syndromes.

Infectious disease: Assessment and management of a patient who may have an infectious disease, decontamination, sepsis, and septic shock, HIV-related disease, hepatitis, meningitis, vaccine-preventable diseases, viral diseases, sexually transmitted diseases, tetanus, vector-borne diseases, and emerging infectious disease.

Neurology: The decreased level of responsiveness, seizure, stroke, dementia, delirium, Alzheimer's disease, headache, brief resolved and unexplained event, Parkinson's disease, and hydrocephalus.

Nontraumatic musculoskeletal disorders: nontraumatic fractures, spine disorders, joint abnormalities, muscle abnormalities, overuse syndromes, and rhabdomyolysis.

Psychiatric or behavioral emergencies: Basic principles of the mental health system, patterns of violence, abuse and neglect, suicidal ideation, excited delirium, anxiety, depression, medical fear, substance use disorder, PTSD, acute psychosis, cognitive disorders, thought disorders, mood disorders, neurotic disorders, somatoform disorders, and personality disorders,

Respiratory: Respiratory distress, failure, or arrest, upper airway diseases (e.g., foreign body, croup, and epiglottitis), lower airway diseases (e.g., asthma, bronchitis, pneumonia, COPD), spontaneous pneumothorax, and pulmonary edema.

Shock: Essential components of normal perfusion, physiologic response, types of shock, treatment of shock, complications of shock, and circulatory assist devices.

Resuscitation from cardiac arrest: Ethical issues, CPR physiology, system components, special arrest situations, post-resuscitation support, termination of resuscitation, and premorbid conditions.

Trauma: Trauma scoring, transport issues, abdominal trauma, bleeding, chest trauma, environmental, head, neck, spine trauma, orthopedic trauma, and soft tissue trauma.

Obstetrics, gynecology, and prenatal care.

Pediatrics and geriatrics.

Patients with special challenges: recognizing and reporting abuse and neglect, abuse and intimate partner violence, neglect, homelessness, poverty, bariatrics, technology-dependent patients, Hospice and terminally ill, home care, sensory defect or loss, developmental disability, and autism spectrum disorder.

Rescue operations, hazardous materials operations, mass casualty incidents, and incident management (National Highway Traffic Safety Administration [NHTSA], 2021).

Depending upon the program, paramedic students are also required to complete many hours of precepted ambulance care (ride time), precepted emergency department rotations (clinicals), and specialty rotations (e.g., behavioral, obstetrics/gynecology), giving them a well-rounded and holistic view of the patient and the system in which they work. When applied to the medical mimics in Chapter 6 and the communication section to come, it is clear that the paramedic is well-suited to manage the mental illness patient and may be able to distinguish between medical and mental illness in some cases.

PARAMEDIC SCOPE, TRAINING, AND EDUCATION

According to the National Highway Traffic Safety Administration (NHTSA) (2019), the paramedic scope of practice is described below.

> (T)he Paramedic's scope of practice includes basic and advanced skills focused on the acute management and transportation of the broad range of patients who access the emergency medical system. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

> In some communities, Paramedics provide a large portion of the out-of-hospital care and represent the highest level of out-of-hospital care. In communities that use emergency medical dispatch systems, Paramedics may be part of a tiered response system. In all cases, Paramedics work alongside other EMS and health care professionals as an integral part of the emergency care team. The Paramedic's scope of practice includes invasive and pharmacological interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on an advanced assessment and the formulation of a field impression. The Paramedic provides care designed to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an appropriate health care facility.
>
> The Paramedic has knowledge, skills, and abilities developed by appropriate formal education and training. The Paramedic has the knowledge associated with, and is expected to be competent in, all of the skills of the EMR, EMT, and AEMT. The major difference between the Paramedic and the Advanced Emergency Medical Technician is the ability to perform a broader range of advanced skills. These skills carry a greater risk for the patient if improperly or inappropriately performed, are more difficult to attain and maintain competency in, and require significant background knowledge in basic and applied sciences.
>
> The Paramedic is the minimum licensure level for patients requiring the full range of advanced out-of-hospital care. The scope of practice is limited to advanced skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight.
>
> The Paramedic transports all emergency patients to an appropriate medical facility. The Paramedic serves as part of an EMS response system, ensuring a progressive increase in the level of assessment and care. The Paramedic may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility. In addition to emergency response, Paramedics often perform medical transport services for patients requiring care within their scope of practice (NHTSA, 2019).

The Paramedic Related to 988

The MCUs are poorly equipped to identify or manage physical issues with mental symptomologies or those experiencing altered levels of consciousness in the field. Paramedics, however, are. There are over 170,000 paramedics in the U.S. and over 15,000 in Illinois alone, and these numbers are growing (IDPH, 2017; Zippia: The Career Expert, n.d.-b; U.S. Bureau of

Labor Statistics [BLS], n.d). Looking at the statistics earlier in this chapter, if one of 170,000 paramedics were sent to all of the four million calls to 988 that may occur in 2023, each paramedic would respond to just 24 more calls per year (4,000,000/170,000 = 24/365, 0.6 calls per day). In Illinois, if one paramedic were sent to all 144,000 calls to 988, the paramedic would respond to an additional 9.6 calls per year (144,000/15,000 = 9.6/365, 0.2 calls per day). Resources already exist for paramedics to respond and, like EMDs, could be better funded to enhance care.

Cultural Considerations

One often missed idea is that of cultural competency. It is well known that different cultures have varying responses to mental health issues, and cultural consciousness is a critical care component (Cash & Weiner, 2006). Another reason for paramedic inclusion in the process is their knowledge of the cultures within the communities they serve. Paramedics work with people in the community daily and are more likely to comprehend specific challenges that those in the community experience. The strategic position of fire stations servicing communities allows paramedics to interact with those in their response areas frequently. In short, the paramedics from the individual stations are more available and may understand their smaller response areas better than an MCU that may be responsible for a much larger population.

Chapter 13: Community Paramedicine & Mental Health

Community paramedics essentially perform house calls. The house call was once a mainstay of the medical profession, once accounting for most patient contact by physicians in the U.S. (Kao et al., 2009). The rationale for the house call is simple – observe the conditions in which the patient lives, their support systems, and their home quality of life. It was well known that observing the patient's home (e.g., cleanliness, medications, alcohol use, and potential neglect) was imperative to evaluate their overall health (Kao et al., 2009). As time progressed, technology and transportation improved, cities grew in size, and insurance and Medicare became prominent, the house call went by the wayside in favor of facility-based care (Kao et al., 2009).

While Mobile Integrated Healthcare (MIH) and Community Paramedicine (CP) are often used together (i.e., MIH-CP), the two are different. As the name implies, MIH is heavily integrated with all aspects of patient care, including primary physicians, physical therapists, dentists, and other providers (including community paramedics). This means the system is complex by necessity. CP may be a component of MIH by offering certain services such as

medical assessments, medication checks, home safety responsibilities, immunizations, and follow-ups, but the scope of CP programs is smaller.

CP was first put into practice from 1995 until 2000 in the Red River project. This project was instituted in New Mexico due to a shortage of primary healthcare in the area (American Academy of Orthopaedic Surgeons (AAOS), 2018). The program ended when sufficient primary care services arrived, but the concept was successfully adapted for use in other places, culminating in special CP licensure in Minnesota (American Academy of Orthopaedic Surgeons (AAOS), 2018) and board certification through the International Board of Specialty Certification (IBSC).

CP programs are malleable to the jurisdiction, meaning they can perform functions most needed in the community after a detailed needs assessment by local health departments (American Academy of Orthopaedic Surgeons (AAOS), 2018). Additionally, CP programs are beginning to draw and perform diagnostic tests of varying natures in the field using mobile point of care (PoC) equipment. This testing allows some of the tests mentioned in Chapter 6 to be done in the patient's home. Some of the other services provided by community paramedics include:

- Cultural competency-based care
- Community needs assessment
- Individual needs assessment
- Blood work and test evaluation
- Plans of care
- Chronic disease management
- Mental health management (American Academy of Orthopaedic Surgeons (AAOS), 2018)

Community Paramedicine and Mental Health

The community paramedic has a definite role to play in the mental health management of those in the community. As we discussed in the previous section, the current model of most healthcare is still focused on an office visit. While telehealth services are becoming more common, office visits are still the norm. CP programs may institute mental health medication compliance checks, co-occurring condition assessments, and monitoring between physician or clinician appointments to ensure the person maintains progress.

Part 5: JEMMHI

Chapter 14: A Different Way

The Joliet Emergency Management Model for Mental Health and Illness (JEMMHI)

Real Talk… Sorry

I'll apologize to the reader in advance for the editorialization. Here is the part of the book where the street firefighter rears his head. It is the opinion of this author that the real problems and solutions are as follows:

1. 988 may find it challenging to handle real emergencies and should be secondary to 911. It was designed too quickly without elected officials understanding the capabilities of professionals in their communities and the resources already in place to manage mental health and illness.
2. All callers in any distress should call 911. Crisis and emergency are synonyms, and 988 cannot manage emergencies. The 911 centers should be adequately staffed and

equipped to handle the call volume; this includes training new emergency medical dispatchers (EMD) personnel.

3. We already trust 911 dispatchers with our lives every day and 240 million times a year in this country; they can handle this with some support and funding. The money spent to create a parallel system to 911 in 988 should be applied to make 911 more robust to handle the increase in calls and upgrade emergency services. The call should go to 911, evaluated by a professional EMD, and proper resources should be provided to the caller (in-person or transferred to 988).
4. Since 988 is here (at least for now, before it stops being funded – see Chapter 3 and Chapter 5), the 911 EMDs should direct non-emergency calls to 988 for support over the phone. The EMD (over 2,800 in Illinois alone) can transfer the person to 988 if no emergency exists.
5. Dispatchers should send actual emergency responders (paramedics and police) to emergency calls for service or people they feel require in-person intervention. And yes, I said police. The police are invaluable resources to have at an emergency scene. I respect them greatly because they have protected me countless times in the field. Keeping police away from responses is a bad idea. You don't need a police officer until you do; then, it's too late to get them there. This may get responders killed. Instead of funding ideas that will not work long-term, let's staff departments appropriately and teach everyone already in the field how to properly perform crisis intervention (paramedics, police, and fire) and communicate effectively.
6. Mobile crisis teams are dangerous, and the practice should be rethought. The program has been live for six months as of this writing, and so far, only 66 MCUs have been

staffed in Illinois (none of which are 24/7. That's 132 team members in Illinois for 12 million people, sometimes. That's one team for every 181,000 people - maybe.

7. All paramedics should be trained in crisis intervention and respond instead of mobile crisis teams. There are over 170,000 paramedics in the U.S. and over 15,000 in Illinois alone (Illinois Department of Public Health [IDPH], 2017; Zippia: The Career Expert, n.d.-b).

Back to the Book

In keeping with the lessons learned from managing mental illness in America's past in Chapter 2, and the car example in Chapter 7, the best and most realistic practice for mental illness management seems to be at the local level. As we discussed earlier, communities are best aware of their issues and resources and should be tasked with solving them using a sensible and sustainable plan. The plan must have several components, including prevention, response, recovery, and mitigation,

As has been discussed in previous chapters, the need for substantive and practical mental health and illness programs is sorely needed. One potential model that includes the requirements stated throughout this text is the *Joliet Firefighters Peer Support Group (JFPSG) Emergency Management Model for Firefighter Mental Health.* The author developed this model over several years to help firefighters manage their mental health. It contains components of prevention, response, recovery, and mitigation related to traumatic stress and mental illness. The original intent of the model was to help firefighters manage traumatic stress reactions, but it has been further modified and applied to mental illness for the general public, not just firefighters. Now

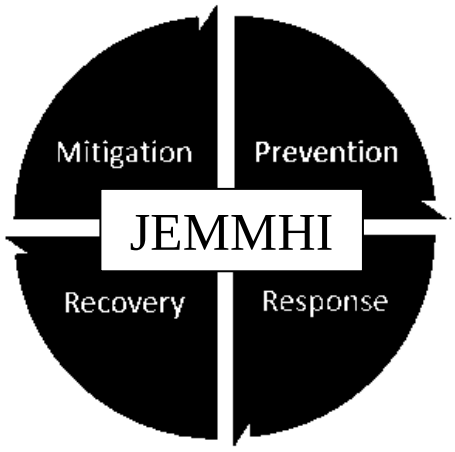
called *The Joliet Emergency Management Model for Mental Health and Illness(JEMMHI)(gem-he)*, the idea has been further applied so anyone, including responders, may use it.

The Joliet Emergency Management Model for Mental Health and Illness (JEMMHI)

Emergency Management is a rapidly expanding discipline that recognizes the need for robust planning and response to achieve recovery and, as a concept, has been in existence from time immemorial (Philips, 2012). Throughout history, people worldwide have assessed risks, planned for them, used the plan in times of need, and then updated it. The same idea can be proposed for mental health and illness.

Several Emergency Management phase models exist within the field. In most cases, they are four or five-phase models that recognize the consistent and cyclical nature of adverse events and the need to prepare for them. The most accepted model is offered by the Federal Emergency Management Agency (FEMA) and is described in terms of mission areas to include prevention, response, recovery, and mitigation (Federal Emergency Management Agency [FEMA], n.d.).

The Joliet Emergency Management Model for Mental Health and Illness (JEMMHI)



Chapter 15: Prevention

Prevention is based on the best-case scenario ability to halt a crisis event from occurring, thus avoiding adverse effects altogether – in essence, preventing the crisis and making the other steps to JEMMHI moot (FEMA, n.d.). Of course, this is the preferred method of managing any negative issue because there will be no harmful consequences related to an event if that event does not occur. However, within the confines of the mental health and illness field, prevention is not a feasible strategy in all cases. It is unrealistic to believe that severe mental illness or crisis can be wholly prevented. (WebMD Editorial Contributors, 2022).

There are generally three levels of prevention, primary, secondary, and tertiary (Institute for Work & Health, 2015). Primary prevention refers to preventing an illness or injury from occurring altogether, secondary prevention refers to reducing the impact of an illness after it happens, usually by early detection and treatment, and tertiary prevention includes managing long--term consequence of illness (Institute for Work & Health, 2015).

Unfortunately, some mental illnesses are not preventable for various reasons, including biological and some environmental causes, meaning that primary prevention may not be possible. Examples include genetic disease, brain structure abnormality, and toxin exposure

(Mayo Clinic, 2022; WebMD, 2022). What can be done, however, is adequately educating the community regarding mental health management, modifiable risk factors, signs and symptoms, and when and where to seek help – all to prevent a crisis.

While primary prevention may not be possible, secondary and tertiary prevention may be in many cases. Recall that secondary prevention includes early detection and treatment for an issue once a symptom is found, and tertiary prevention reduces the impact of an identified illness. While the primary prevention for the illness may not be feasible, early detection and treatment may be done if people are educated on potential signs and symptoms of mental illness and given the proper advice on who to call for help (e.g., physician, clinician). Tertiary prevention may be affected by regular physician or clinician visits after the illness is diagnosed and by adherence to treatment and medication plans. Remember that JEMMHI is predicated on preventing, responding to, recovering from, and mitigating crises. A crisis may never occur if proper primary, secondary, and tertiary prevention methods are used. It is possible to remain in the prevention phase long-term.

The goal of education is to expose the public to the issue of mental illness, reduce stigma, and educate them to recognize mental illness in themselves or their loved ones. When the public has adequate information, they may be better prepared to seek help in appropriate places when an issue is encountered.

Another critical aspect of education is teaching the public how to manage stress, cope, and build robust social support systems. The more robust the availability of coping strategies and support (e.g., family, friends, neighbors), the better the odds of managing a challenging situation. If mental illness presents itself, the informed person (or those around them) must be educated on

where and how to seek appropriate help in their community. Again, the rest of this model is unnecessary if the crisis is prevented.

Resiliency and Support

The prevention addressed in this model is a continuation of the mitigation phase, to be discussed later. In general, the person must have a robust resiliency and support system. A primary way this may be accomplished is to facilitate the creation of a positive relationship between a person, their support system, and their physician or clinician before a crisis event occurs. First, a social support system must be in place for the person to seek immediate help if needed. This may include family, friends, coworkers, neighbors, church groups, or other supporters. This provides a trusted structure for the person to use during illness or traumatic stress.

Next, a basis for a positive therapeutic relationship and physical health must be cultivated with the person’s physician. This will enable the physician to build the trust necessary to instruct people on developing their resiliency and wellness strategies and referral to a mental health specialist if needed. Additionally, the physician may monitor the patient's physical well-being, reducing the potential for a condition to be missed. These preparatory steps may benefit the person should mental illness present itself.

Some primary prevention strategies may help reduce the incidence of other disorders, including brain injury, substance abuse, prenatal damage, traumatic event exposure, and child abuse and neglect. These strategies may not have anything to do with the sufferer’s actions but with the sufferer's caregivers (such as child abuse and neglect) but may prevent a later issue with proper education and treatment.

Brain Injury

The Centers for Disease Control and Prevention (CDC) (2021) discusses several prevention strategies for traumatic brain injury, including wearing seatbelts, not drinking and driving, wearing helmets during certain activities, fall prevention for those at risk, ensuring safe play areas for children, and violence prevention programs.

Fire department CRR programs and community paramedics may address all of these by providing proper education and information to the public in the form of online and in-person classes, community outreach, website, and social media messages, school interactions, nursing, and extended care facility visits, and religious institution visits.

Substance Abuse

Tobacco and opioid use positively correlate to mental illness (Dragioti et al., 2022). SAMHSA recommends several substance abuse programs primarily aimed at reducing underage substance use (particularly alcohol) in children and adolescents (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.). Adults may also prevent issues related to alcohol use by monitoring their drinking habits and evaluating why they drink, which may require a physician or clinical care (Murray, 2019). Education and the availability of prevention programs in schools and cessation programs for adults should also be made available or advertised.

Another substance use issue includes opioid abuse, which may, under some circumstances, be prevented by discussing non-narcotic medications with a physician, properly using the medications that are prescribed, avoiding alcohol use with opiates, and seeking help if misuse of the drugs becomes an issue (Centers for Disease Control and Prevention [CDC], 2022).

Again, fire department CRR programs and community paramedics may address these with proper public education through online and in-person classes, community outreach (especially to local physicians), website and social media messages, and school interactions.

Prenatal Damage

The internet is packed with advice for expectant parents. The most important aspect of prevention for the prenatal period, however, is for expectant mothers to seek regular prenatal care and follow the advice of their physician. CRR programs may also partner with local physicians to produce social media and written handouts to expectant parents with recommendations for healthy prenatal activities.

Traumatic Event Exposure

The response to a traumatic event depends largely on the individual's resilience and coping strategies (Cash & Weiner, 2006). While experiencing a traumatic event may not be preventable in some cases, people may seek help in the aftermath of such events to help manage mental health problems. Discussing the traumatic event with a clinical professional or physician may be a sound idea if issues exist.

Fire departments and EMS providers have a unique opportunity to help manage traumatic stress in those who suffer exposure to traumatic events. EMS is usually called to the scene to provide patient care and may have the opportunity to help those on the scene who were exposed to the event. The Crisis First Aid for Paramedics section discusses this in more detail.

Child Abuse and Neglect

There are several evidence-based practices available to prevent child abuse and neglect. Some programs are education-focused, and others are interactive with parents and children

(Child Welfare Information Gateway, n.d.). Fire departments may partner with local shelters, churches, and domestic violence agencies to provide information for those affected.

Advice

To reiterate a point made earlier in this chapter, advice for preventing and detecting many issues is to find a regular primary care physician and see them for a checkup. This may be a challenge in underserved areas. Routine medical care may identify illness early and help prevent minor issues from becoming larger (Mayo Clinic, 2022).

The Mental Illness Self-Triage Tool (www.jfdpeersupport.com)

This author has developed a Self-Triage Tool for people to use for mental health and illness direction. While the tool includes many levels of disorder and symptomology, including crisis care, its primary goal is to prevent a crisis from occurring by seeking help within less acute stages of illness.

The concept of triage is simple and has been used within the medical field for centuries. While there are different notions of where the idea originated, it is commonly thought that separating groups of injured and ill into categories came into widespread use in 1700s France; hence a French word is used to describe the process. Physical triage, first used on the battlefield, involves performing a rapid assessment of a patient to ascertain the seriousness of a wound and separating them into three groups. When this is completed, those with the most severe injuries are immediately treated; those with less serious wounds are next, and finally, the least serious are treated (Sanders, 2011).

The purpose of triage is to get the people who need help to the appropriate help provider – a person who is lonely and non-suicidal and wants to talk to someone certainly does not belong in the emergency department, though they may need in-person evaluation and care if the EMD

deems it necessary and may require further care from their physician or a clinician.

The author has developed a similar tool for people to use for mental health. It is simple enough to be understood by most and includes three categories of distress from mental symptoms.

Category 1

Category 1 is reserved for those in a true crisis. A crisis is an emergency requiring a rapid in-person response to be managed effectively. Category 1 includes suicidal, homicidal, and people with altered levels of consciousness – including confusion, those who are not making sense, those who are out of control, or hearing voices. The appropriate action to take with people in this category is to call 911. Other resources may be used in less severe instances, which will be discussed later, but 911 is the preferred choice for a crisis. See Figure 15.1.

Category 2

Category 2 is reserved for those with moderate mental health issues. These may include moderate mental health symptoms such as non-suicidal depression, anxiety, grief, those who have experienced a traumatic event, or those who suspect they may have a mental illness. This list is not all-inclusive, so any moderate, non-life-threatening problem may fall into this category, and moderate is a subjective term. People in this category still need care but may not need an emergency response. While calling 911 is always acceptable, another appropriate response may be to contact their physician or clinician to make an appointment to be seen as soon as possible and use social support and coping techniques until the appointment. Of course, if the person begins to enter crisis - feel suicidal, homicidal, or has altered mentation, 911 should be called immediately. See Figure 15.1.

If a person calls 911 in this group, they will be interviewed by the EMD and sent an in-

person response if the EMD deems necessary. If an in-person response is not required, the person may be transferred to a crisis line, such as 988. Please note that if a person calls 911, they will most likely receive in-person aid. This is so the paramedic may perform an assessment on the patient and provide resources to use in the future (see Chapter 16).

Category 3

Category 3 is reserved for those with mild issues. This may include needing to talk to someone, loneliness, isolation, worry, and transient sadness or nervousness. In this category, the person may call 911 but may also use social support (e.g., family, friends, coworkers, church) and coping strategies and may use helplines such as 988, the crisis text line, or any other available resources to talk to someone. It is also appropriate for the person to call their physician or clinician to make an appointment. See Figure 15.1.

Note

It must be understood that if, at any time, the person displays thoughts or actions that put them in Category 1, then 911 must be called immediately. Also, if the person or family member is unsure, an appropriate response would be to call 911.

Summary

The main goal of the prevention phase of JEMMHI is to prevent a crisis by using primary, secondary, and tertiary practices. This may eliminate the crisis, provide quick recognition and treatment of issues, and provide long-term care for existing problems. The next three chapters will examine the process that follows a crisis - beginning with the response.

Mental Health Self-Triage Tool

Category 1 1 **Emergent, Imminent Danger**	Call 911 Always **CRISIS**	You or someone you know... • Is suicidal (attempts, threats, plans, warning signs) See CFA I section • Is homicidal or violent • Has altered level of consciousness (confused, not making sense, out of control) **RESPONSE, RECOVERY, MITIGATION PHASES**
Category 2 2 **Intermediate/ Moderate**	You May Call 911 or Make appointment with your physician or counselor ASAP Use Category 3 until appointment	You or someone you know... • Moderately Depressed (Significant but bearable) • Moderately Anxious (Significant but bearable) • Moderately Stressed (Significant but bearable • Moderately Grieving (Significant but bearable) • Experienced a traumatic event and are having difficulty. • Suspect a potential mental illness but aren't sure. PREVENTION PHASE
Category 3 3 **Minor/Mild**	You may call 911 or Use crisis lines like 988 and the Crisis Text Line Social Support/Coping, Church, Family, Friends	You or someone you know... • Just want to talk to someone • Lonely • Isolated • Worried • Transient sadness • Transient Nervousness PREVENTION PHASE

The mental health self-triage tool is designed for the public to help them decide what service they may need. The purpose of the tool is to ensure those who need mental healthcare get the care they need in an appropriate timeframe. Anyone may call 911 at any time for help. Remember, though, not everyone needs professional clinical care or transport to the hospital, many issues may be managed with adequate coping and social support.

If you are unsure of your level, call 911.

Figure 15.1

Chapter 16: Response

Crisis Intervention & Management

We discussed the concept of prevention in detail in Chapter 15. For this text, the response phase is the phase at which either prevention techniques have failed or were insufficient, or a sudden occurrence of an unforeseen or severe event occurs. As we have discussed, some issues within mental health are not predictable or preventable, and sometimes prevention plans are inadequate to manage the existing problem.

Also, as we have discussed with the local response to emergencies, the response phase begins with those closest to the person in distress: family, friends, coworkers, neighbors, and ultimately, themselves. An essential part of the process is to help those in the public assess themselves and their family members and to instruct them in proper communication with those who experience mental health issues. Adequate communication techniques may help prevent a

crisis event from escalating. Crisis management may include coping strategies, established social support (e.g., church, friends, family, etc.), crisis hotlines (e.g., 988), or other local resources.

Inevitably, people will experience crises from existing or new mental illnesses or exposure to traumatic stress. In these instances, a robust crisis management system must be in place to help those in distress. Most communities already possess emergency response in the form of dispatch centers, fire and EMS response, and police assistance for dangerous or suicidal patients. This chapter recognizes and makes use of those resources.

The response phase of the program focuses on what happens when the prevention phase is ineffective and the person continues deteriorating to the crisis stage. Our definition of a true crisis is that it is an emergency and is reserved for people who are suicidal (in thought or action), homicidal, have altered mentation (e.g., confused, not making sense, or out of control, talking to people who are not there), have physical complaints, or a person who an emergency medical dispatcher (EMD) deems in need of in-person care. It must be reiterated that if a person is in a true crisis, this is an emergency, and 911 should be called for an in-person response. Crisis lines like 988 may not be adequate in coordinating emergency response to people and, thus, in our opinion, should not be called.

16.1: JFD Crisis First Aid Family of Courses

Over the last several years, this author has developed courses in cooperation with the Joliet Fire Department to aid different groups in crisis management. Some of these courses are mentioned in this text. They include Introductory Crisis First Aid (CFA-I), Crisis First Aid for Emergency Medical Dispatchers (CFA-EMD), Crisis First Aid for Law Enforcement (CFA-LE), and Crisis First Aid for Paramedics (CFA-P). Except for CFA-I, the programs are quite similar and have a group of core elements that allow them to overlap in the field.

The first of the courses to be developed was the CFA-P course. It was adopted by the Joliet Fire Department and found helpful when managing behavioral patients and those experiencing traumatic stress reactions. CFA-P led to the introductory course and the LE and EMD courses.

This text introduces the CFA Family of courses for illustrative purposes. The complete courses are free of charge by contacting the Joliet Fire Department at (815) 724-3500 or emailing jcarey@joliet.gov.

16.2: Introductory Crisis First Aid (CFA-I)

Since most psychological first aid courses are time-consuming for the learner, the author saw a need for a brief course that could be taught in approximately ten minutes to just about anyone. The course relies heavily on using 911 in many circumstances (e.g., suicidal, homicidal. and altered level of consciousness) for the course to be taught in ten minutes.

The course is summarized in a one-page guide, and this guide is the only material needed for the ten-minute course. The program's primary use is to identify suicidal talk, mood, and behavior and to summon help by calling 911 to get professional care routed to them. The second section of the course includes a very brief outline regarding communicating with non-suicidal, non-homicidal, and non-altered levels of consciousness individuals should a person desire to help.

To provide an easily remembered pneumonic, the helper must only remember the word SALES. This stands for safety, approach, listen, encourage, and support (see Figure 16.1). Safety refers to the helper making sure they are safe. In the case of suicidal people, violent people, or

people with altered mental status, the helper must protect themselves first, which may include leaving the person and moving to a safe area to call 911.

If the person is not dangerous, and the helper desires to assist, the next step advises them to approach the person genuinely, indicating the desire to offer support. If the person asks them to leave, the best course of action is to go and call for help (i.e., 911) if the helper believes it is warranted.

The next component is to listen to the person after asking them what the problem is. Sometimes the person may openly discuss the issue with someone who genuinely wants to help. It is crucial during this phase that the helper refrains from giving advice. Just listen to the person in a caring, non-judgmental, and helpful way.

Most reactions to stressful events are on a continuum of normal behavior, and often symptoms experienced by those with mental illness may be normal for them. The helper should remind the person that they are there for them, and the person can talk if they are comfortable doing so. If the person is experiencing something abnormal for them or is having a violent or self-harming reaction, the helper should leave the area and call 911.

The helper should make sure that the person is reminded of support systems and other resources that are available to them. This may include family, friends, religious groups, clinicians, or physicians. There are also crisis lines the person can call, such as 988.

If it is possible and appropriate to do so (e.g., the helper knows the person), checking in with them after the crisis is encouraged. Remember, in all cases, the helper always has the option to call 911 for help.

SUICIDE

Something to look out for when concerned that a person may be suicidal is a change in behavior or the presence of entirely new behaviors. This is of most concern if the new or changed behavior is related to a painful event, loss, or change. Most people who take their lives exhibit one or more warning signs.

WARNING TALK

If a person talks about:

- Killing themselves
- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

WARNING BEHAVIOR

- Increased use of alcohol/drugs
- Looking for a way to end their lives/online searches
- Withdrawing from activities
- Isolating from family/friends
- Sleeping too much or too little
- Calling people to say goodbye
- Giving away valued possessions
- Aggression/recklessness
- Fatigue/Acting anxious or agitated

WARNING MOOD

- Depression
- Anxiety
- Loss of interest
- Irritability
- Humiliation/Shame
- Agitation/Anger
- Relief/Sudden Improvement
- Extreme mood swings

Remember, no matter how much you want to help there are issues that are outside your capability to handle. Someone who is suicidal or is harming themselves (cutting, burning) needs PROFESSIONAL HELP!
Call 911.

If the person is suicidal (wants to kill themselves), homicidal (wants to kill someone else), has an altered level of consciousness (confused, not making sense), is out of control, or you are not sure...

S
SAFETY

Your own safety comes first. Leave the area!
Call 911 as soon as you can for their safety!

A
APPROACH

If the person is not in any of the conditions above, be genuine in your approach and your desire to help.

IF YOU ARE IN DOUBT OR IF PERSO

Figure 16.1

16.3: Core Elements of CFA-EMD, LE, P

The remaining CFA courses employ core elements to help manage individuals in crisis and maintain the personal mental health of the responder. These core elements include the support partnership, specific issues related to empathy, including countertransference, compassion fatigue, burnout, vicarious traumatization, self-care, communicating with people with special needs, communicating with older adults, building rapport, reflective listening, and reassurance.

CFA is a method of crisis management. Many formulae exist in this field. Slaikeu (Comprehensive Model for Crisis Intervention), Mitchell, Flannery, and Everly (SAFER-R Model), Aguilera, James and Gilliand, Greenstone and Leviton, and Kanel (ABC Model), and Cavaiola and Clifford (LAPC Model) have all been part of the crisis intervention milieu (Roberts & Ottens, 2005; James & Gilliland, 2017; Jacobs, 2016).

Robert's Seven-Stage Crisis Intervention Model is arguably one of the best-known techniques that describe the needs of those experiencing crisis. The seven stages include:

1. Crisis Assessment: Stressors, coping skills, available resources.
2. Establish Rapport: Supportive relationship.
3. Identify issues: Gain information about the cause of the crisis.
4. Deal with feelings: Active, supportive listening.
5. Explore alternatives: Previous, new coping.
6. Create a plan: This may include many components, from referrals to hospitals.
7. Follow-up: Check-in for status (Roberts & Ottens, 2005).

The history of trauma and crisis intervention goes back to ancient times, and many of the interventions seem to be common sense (Montagner Regoli et al., 2019). People have always used coping skills to improve their condition after stressful events. Helpers have always understood that relationships are important, asked appropriate questions and listened to the answers, discussed potential measures to solve the problem, and checked in occasionally after the event. Only recently have programs of best practices been developed to help manage those in crisis. The detailed programs focus on people with specific roles in the crisis intervention process (e.g., dispatchers, law enforcement personnel, and paramedics). An attempt has been made to sift through much of the unnecessary information and get to the heart of crisis intervention to provide a more rapid way to train responders in intervention techniques.

One of the primary themes of these programs is that none of the responders are clinicians, and they should not act as such. For this reason, a significant amount of background information on mental disorders and other clinical aspects of care is unnecessary. What is necessary, however, are helpful communication and de-escalation methods and referral to rapidly available

clinical care or hospitals.

The Support Partnership Overview

The responder must establish themselves as part of a trusted team with the person requiring intervention to provide effective CFA. Both team members (i.e., the responder and the person) must have a similar goal. Since we cannot expect one in crisis to have a well-articulated endpoint, the responder must help the person understand their discomfort and provide them with needed support.

Congruence, Unconditional Positive Regard, and Empathy

The support partnership is based on the therapeutic alliance in professional counseling espoused by mental health practitioners Carl Rogers and Miller and Rollnick (Seligman & Reichenberg, 2014; Miller & Rollnick, 2012). This relationship refers to the need for the responder to demonstrate three critical elements while interacting with the person. The name was changed to ensure responders do not assume they are performing "therapy."

The three elements are congruence, unconditional positive regard, and empathy. *Congruence* refers to the genuineness with which the responder approaches the situation - focusing on the person's well-being(Seligman & Reichenberg, 2014).

Unconditional positive regard refers to the understanding that the person is an individual with thoughts, ideas, and feelings doing their best to manage their situations. In short, the responder must accept them as individuals, considering they do not have to agree with what the person says (Seligman & Reichenberg, 2014).

Empathy is possibly the most essential concept of CFA. When responders practice empathy, they put themselves into the person's situation (Seligman & Reichenberg, 2014). This differs from sympathy, in which the responder "feels sorry" for the person. Empathy allows the

responder to listen to the person and better reflect their feelings attentively (Miller & Rollnick, 2012). Quickly accomplishing these tasks will enable the responder to build the trust necessary to discuss the traumatic event.

Countertransference, Compassion Fatigue, Burnout, and Vicarious Traumatization

The danger of countertransference, compassion fatigue, burnout, and vicarious traumatization, are ever-present to the responder. The responder must be vigilant against these issues due to the type of work in which they engage. Still, there are added dangers in attempting to build a support partnership. When a support partnership is formed, the responder may have some residual effects after contact with the person. Countertransference refers to the responder's influence on the patient and the patient's influence on the responder. This process is normal during human interaction (Levers, 2012).

Compassion fatigue, or secondary traumatic stress, is a natural event when responders interact with people under stress (Levers, 2012). Occasionally, the responder may be traumatized by the event that traumatized the person seeking help (Schupp, 2015).

Burnout is another severe problem. While there is no accepted consensus on the true definition of burnout, experts agree that it is characterized by exhaustion and loss of interest in the job (Everly, 2018; Levers, 2012). The responder's mental health must be monitored, and self-care must be performed (Levers, 2012). Finally, vicarious traumatization is present when those who work in human services express empathy. This empathy may cause changes in the responder’s mindset and personality.

Self-Care

Responders are known for their desire to help others during difficult times. Unfortunately, just as in the other helping professions, responders often neglect their mental

health when providing that care. For this reason, the responder must practice effective self-care and have robust coping strategies (Jacobs, 2016; Levers, 2012). One important key is the social support of coworkers, friends, and family (James & Gilliland, 2017; Jacobs, 2016; Levers, 2012; NCTSN, 2006). Periodically, the responder should physically, emotionally, and spiritually assess themselves to ensure they remain well in all these areas (Levers, 2012). The responder may utilize many of the techniques presented later to help them manage their mental health

Age, Disability, & Traumatic Stress Overview

As discussed previously, traumatic stress reactions may encompass various behaviors. In addition to the responses described in the previous section, responders must address special populations and potential atypical reactions.

Children

Children observe adults and may take on their coping strategies (Liga, 2019). We must also be aware that coping strategies will most likely vary depending upon the stage of development in which the child experiences traumatic stress. There are four generally recognized stages of child development, each with its benchmarks. These include birth to 2 years; age 3-6; age 7-11; and age 12-18 (Jacobs, 2016). The birth to 2 years group generally remains unaware of the trauma but may respond later to physical sensations such as sight and sound. They usually present as irritable and want to be close to caregivers (Jacobs, 2016).

The 3-6 age range will most probably be unable to cope with the event without the direct aid of the caregiver. They may experience regressive symptoms such as bed-wetting and thumb-sucking (Jacobs, 2016). At ages 7-11, children are beginning to arrive at the stage where they

seek to understand the event in more detail. They may experience irritability and regressive behaviors as well (Jacobs 2016).

The 12-18 age group may manage traumatic stress at times like an adult and at times like a child. It is common for people in this age group to withdraw from friends and family (Jacobs, 2016). Most responders have already been trained to communicate with children effectively.

Older Adults

Older adults may have cumulative life experience that exacerbates the effect of traumatic events. This may manifest itself in many ways. Common ways include memory issues and physical discomfort (Jacobs, 2016).

People with Disabilities

Additionally, care must be taken when communicating with those with special needs. This may include everything from physical to developmental disabilities. Some tips below may be used for communication.

- Use parents/caregivers as a resource
- Use "person-first" communication (e.g., the person living with a disorder)
- Needs and abilities vary, be patient
- Avoid assumptions
- Introduce yourself
- Communicate clearly
- Use appropriate eye contact

- Speak directly to the person, not the companion
- Do not touch or distract service animals (Thornton & Lukancic, 2021; NCTSN, 2006).

Building Rapport, Reflective Listening, Reassurance

Rapport refers to the ability to put the Support Partnership into effect by establishing congruence, unconditional positive regard, and empathy. While techniques to establish rapport may vary from program to program, it must be developed with every help-seeker. See the individual CFA sections that follow for more specific information.

Reflect (Reflective Listening)

Through their training, responders already have excellent listening skills. The following are some mental health-related best practices to help the responder communicate better with someone in crisis or with a mental health disorder.

Reflection refers to reflective listening used when communicating with a person in crisis. It is a technique updated by Miller and Rollnick and is a critical part of a well-known communication method known as Motivational Interviewing (MI) (Miller & Rollnick, 2012).

When reflecting, the responder asks open-ended questions and nonjudgmentally listens to the other person's response (Miller & Rollnick, 2012). They are not directing, advising, or expressing meaningless platitudes when reflectively listening. They attempt to understand the person's feelings and formulate a plan to support them during a difficult time.

Open-Ended Questions

When seeking understanding, an open-ended question is one of the best methods of enquiring. An open-ended question aims to have the person expand on their thoughts, using more than one word or short phrase to provide an answer. Predictably, the opposite of the open-ended question is the closed-ended question and is usually best demonstrated by a yes or no response. Responders are well acquainted with these types of questions.

An example of a closed-ended question: "Are you sad?"

An example of an open-ended question: "You seem sad…can you tell me what's bothering you?"

You can see that the answer to the first question may be answered by a single word, yes or no. The second question asks more of the person and is potentially much more revealing about their mental state.

Non-Judgmental Active Listening

Another critical element of listening reflectively is to be non-judgmental. Responders are not there to pass moral judgment on others. This does not mean they must agree with what the person says or their lifestyle choices; it simply means that they must realize that everyone has different life paths that bring them to the current moment (Seligman & Reichenberg, 2014). Responders must accept this and focus on the task of listening and reflecting. A key component is maintaining unconditional positive regard (see Support Partnership section).

Reflection

We should note that many responders do this regularly with patients and bystanders. When the responders mirror the person's thoughts back to them within the context of their cultural norms (if known), enabling them to both say and hear their perception of their feelings, they may give them a better understanding or different perspective (Miller & Rollnick, 2012). This facilitates a positive relationship with the person, showing that someone cares.

An example of a statement: Person: "I feel like there is a weight on my shoulders; I am so sad."

An example of associated reflection: "…so you are saying you are depressed; can you tell me more?"

When this reflection is done, the person can correct the responder if they are not reflecting accurate information. This facilitates a true understanding of the problem (Miller & Rollnick, 2012). While reflection is effective, the responder must be sure not to engage in "parroting." Parroting means repeating the person's words back to them verbatim and may give the impression that the responder does not understand or care.

Summarize

When the person is finished talking, the responder should summarize the general message the person was trying to convey. This puts the responder on the path to knowing the primary problem and enables them to help most effectively.

Reassure

The process of reassurance focuses on the feelings that the person is experiencing. Components of the reassurance process include normalizing, affirming, and encouraging.

Normalize

A key concept in the reassurance process is to communicate to the person how they feel is natural and provide support. The act of "normalizing" is of great value in crisis communications (Everly, 2017, Jacobs, 2016). People may exhibit many different reactions after traumatic events. This may range from anger to depression and anything in between. Normalizing lets the person know that they may feel any way they wish when an event occurs, and it is an expected response. However, one area of caution to remember is not to normalize unusual behavior, such as violence or self-harm (Everly, 2017; Jacobs, 2016).

Affirm

Affirming is recognizing the strengths in the person as you find them. An example of this may be found by observing how the person responds to the event. If someone shows emotion, the responder may note the person's courage to be open. Conversely, the responder may note their

strength if the person shows no emotion. The key is to find what the person may be doing right and positively reply (Miller & Rollnick, 2012)

Encourage

The key to this activity is to provide hope for the future and ensure the person understands they are not alone (Jacobs, 2016; Mental Health First Aid, 2015). The responder must be cautious not to dismiss the person's feelings while encouraging and reminding them that help and support are available.

16.4: Dispatchers and CFA-EMD

A crisis phone line is a vital component of this program, but a critical misstep occurred in the development of 988. The concept of 988 is sound, but 988 should be notified *after* the caller is evaluated by an Emergency Medical Dispatcher (EMD) and potentially assessed by a paramedic to ensure a physical problem requiring medical intervention or other life-threatening condition does not exist. In short, 911 should be called *first,* and the call may then be *transferred* to 988 if no emergency response is required or may be recommended after assessment for those not needing transport to the emergency department.

We recommend that the 988 number be integrated into the current 911 communication system, which has successfully dispatched emergency personnel to events for decades. When dispatchers are trained in basic methods of crisis first aid, using the Crisis First Aid for Paramedics algorithm adapted for the EMD, they can provide phone crisis intervention while resources are dispatched to the person requiring assistance. If no emergency exists, the call may be transferred to 988.

The history of the 911 system is a long one. The first line was created in the 1960s and has taken over 50 years to become a standard for emergency response – it is currently part of the

fabric of America. This system presently manages 240 million calls annually nationwide and is known to and used by the general public (NENA, n.d.). Currently, 96% of the land area of the United States is covered by trained 911 dispatchers and many by Enhanced 911 systems, many of which include location determination in certain circumstances (NENA, n.d.).

In Illinois, 50 ILCS 750, the Emergency Telephone System Act, states that 911 will be established as the "primary emergency telephone number" (Emergency telephone system act, 2017, Chapter 134 Para. 5) to allow quick response to those seeking police, fire, medical, rescue, and other emergency services (Emergency telephone system act, 2017). One could argue that crisis intervention falls into the "other emergency services" category and should be serviced by 911. The law already provides safety, redundancies, and other reliability assurances to ensure the system maintains dependable service and keeps pace with emerging technologies. The State of Illinois has a post-consolidation total of 200 active dispatch centers for emergency response and six crisis call centers for 988 (911.gov, n.d.; 988lifeline.org, n.d.).

Finally, many behavioral health patients, their families, and bystanders call 911 when behavioral issues occur. People in most areas are familiar with the 911 system, which may be their default resource during behavioral events, even though alternatives such as 988 exist. It makes sense to have people continue to call 911, have EMDs evaluate the caller, and either send in-person care or transfer calls to 988 if required.

Since 988 does not have adequate communication with PSAPs, emergency calls may not reach those centers to summon emergency personnel to scenes promptly. The MCUs (described earlier) also have no contact with PSAPs short of calling 911.

This is not true moving the other way, however. 911 dispatch centers may transfer calls to the 988 centers in non-emergency situations. If all callers dial 911, the EMD may direct the caller to the appropriate resource after a comprehensive assessment.

Recall from Chapter 4 that neither 988 call centers nor the MCU responders seem to have adequate medical training or equipment to assess the caller, meaning delays (some life-threatening) will be ever-present within the system. This is an important but often ignored aspect of mental health care. Since the 1970s, mental health researchers have discussed psychological and physical illness overlap of symptomologies and how mental health symptoms may mimic physical illness symptoms and vice versa (Martin, 1983; Testa et al., 2013). See Chapter 6, Medical Mimics.

Fortunately, many still call 911 instead of 988 when in crisis. Since many PSAP operators are trained as Emergency Medical Dispatchers (EMDs) and have a direct link with emergency medical service (EMS), they can ask pertinent questions and gather data to reduce the possibility of a medical issue being missed and perform CFA until crews arrive on the scene to render in-person aid.

How are 988 and 911 Different? Examples:

988

Caller: "I'm feeling so anxious, and I can't sit still; I have this tightness in my chest, and my hands are tingling. Must be another panic attack; it's been years since I had one."

988 Operator: "Tell me what's going on in your life to make you anxious."

Caller: "I don't know. This just came on all of a sudden."

988 Operator: "Take a few slow, deep breaths and try to ground yourself."

Caller: "I'll try."

The 988 Operator continues for the next 20 minutes to discover the cause of the anxiety until the caller stops responding. The operator does not know the caller's location and cannot send help.

Let's look at the same caller with an EMD:

Caller: "I'm feeling so anxious, and I can't sit still; I have this tightness in my chest, and my hands are tingling. Must be another panic attack; it's been years since I had one."

EMD: "You are experiencing chest tightness and tingling; this may be a panic attack but may be a medical issue also; I am dispatching an ambulance to your location to check you out. Please stay on the line with me. Tell me more about how you are feeling."

Caller: "This came on suddenly while I was on the treadmill at home."

EMD: "Does it feel better since you stopped running?"

Caller: "A little bit."

EMD: "Is the tightness only in your chest, or is there discomfort elsewhere?'

Caller: "I have some throbbing in my left arm, too."

EMD (Siren being heard): "Ok. I'll let the ambulance crew know what you told me. It sounds like they are there."

Based on information from the EMD, the ambulance crew entered the caller's home with appropriate medical supplies, including their ECG monitor, assessment equipment, oxygen therapy equipment, and front-line drugs.

The caller in the example was suffering from a cardiac event, a myocardial infarction (MI), or a heart attack. In this case, the paramedics who responded arrived less than 10 minutes after the call was placed. They met with the patient and saw she was cyanotic (blue) in color, having obvious difficulty breathing, and was anxious. While preparing to administer oxygen, they measured oxygen saturation of 89% on room air (too low); they applied the oxygen,

checked the person's vital signs, and followed up with a 12-lead ECG. They interpreted the ECG and determined there was ST elevation in multiple leads. They started an IV and administered the person nitroglycerine and baby aspirin per the local protocol and called the hospital, preparing for transport. When the patient arrived at the hospital, she was taken to the cardiac catheterization lab, where she received a stent to open a blocked coronary artery and was admitted. The 988 Operator, in this case, focused on the potential for mental health issues, not physical ones. This could easily have been a fatal mistake if the patient had called 988 instead of 911.

Crisis First Aid for Emergency Medical Dispatchers (CFA-EMD)

This section discusses the Joliet Fire Department Crisis First Aid for Emergency Medical Dispatchers (CFA-EMD) educational model. This synopsis is not a replacement for the entire course but underscores some of the more critical concepts for the EMD to successfully communicate with someone in crisis before EMS or police arrival.

The program is not intended to provide definitive treatment for any mental health issue or to manage or diagnose any behavioral or physical health disorder; these are for the medical and clinical realm and require highly educated, trained, experienced, and licensed professionals. It is, however, designed to provide a quick understanding of crisis communications for dispatchers with limited training time and funding, with other pressing responsibilities. The program is free of charge by contacting the Joliet Fire Department at (815) 724-3500 or emailing jcarey@joliet.gov.

The realm of mental health communication has been rapidly expanding for the last several decades, but there is still much to learn. Many textbooks and training classes exist to teach a provider how to intervene during mental illness challenges and traumatic stress responses

– sometimes to the point of over-complication. Thousands of pages of text and hours of instruction have been developed to teach basic crisis intervention to responder-level personnel. While the dispatcher is not often considered a responder, they are an all-important first link in a successful chain of patient care (Clawson, 2015).

This is where Crisis First Aid is somewhat different. The original version of CFA was designed for licensed paramedics operating in the field with behavioral patients and traumatic stress sufferers. As it was developed, tested, taught, and used, something became evident - the "what" and "why" of mental illness management were not as important as the "who" and the "how."

This enabled the developers to focus on a person-centered program that uses the same steps regardless of the issue the person is experiencing. After physical illness is ruled out, it is not necessary to understand the complexities of the behavioral issue or traumatic stress reaction; it is only required to see the person as a person in need and to understand the near-universal steps to help them navigate the issue before EMS arrival if it is needed.

CFA is a form of initial and transient crisis care that may be likened to physical first aid. Physical first aid seeks to perform minor to potentially life-saving interventions for a person in distress to stabilize them until they can receive definitive care, if necessary. CFA-EMD uses a similar model to stabilize a person in an emotional or psychological crisis until EMS arrival or until the call is transferred to an appropriate resource.

Course Rationale

EMDs are already trained to communicate with all types of callers in crisis. With a small amount of additional training, they may be instructed on additional communication techniques

that may benefit the caller in crisis while sending in-person aid or transferring them to another resource.

In severe circumstances such as suicidal, homicidal, and altered level of consciousness calls, the EMD is simply attempting to stabilize the person until help arrives (e.g., EMS, police). Other non-emergency calls for help may be referred to crisis lines such as 988 after medical, suicidal, homicidal, and altered level of consciousness issues are ruled out. At such a time, if 988 becomes unsustainable and ceases operation, EMDs will be well-equipped to fill the role with little additional training.

Course Fundamentals

The primary uses for CFA-EMD will include helping to manage callers who call 911 and are experiencing a medical or mental health crisis until first responders arrive on the scene or managing non-emergent callers until they may be transferred to a crisis line. Examples include but are not limited to:

- Suicidal callers
- Homicidal callers
- Altered level of consciousness callers (out of control, not speaking sensibly, etc.)
- Medical issues
- Any other caller the EMD decides through assessment would benefit from in-person care.
- Other dispatch personnel (even those not meeting the criteria above)

If appropriate, non-emergency or non-medical callers who contact 911 may be assessed by the EMD and routed to another provider, such as 988. This limits the amount of intervention that the EMD is required to provide to response times for EMS and police.

EMDs should send an in-person response to most callers due to the complex nature of in-person assessment. An example where this may not be necessary would be a non-suicidal person who called because his dog had just died, and he needed to talk to someone. A person with new-onset depression with no precipitating factor, however, would warrant an in-person assessment by a paramedic (see Chapter 6 for Medical Mimics).

Course Goal

The goal of the CFA-EMD program is as follows:

- To teach the EMD techniques to interact with a person in psychological distress or crisis.

Course Objectives

The specific objectives of the CFA-EMD program are:

- Upon completing the course, the student will accurately define the concepts of support partnership, congruence, unconditional positive regard, and empathy.
- Upon completion, the student will describe the purpose and components of the 3 Ps and the 3 Rs.
- To continue to the practical portion of the course, the student will complete a written examination.
- The student will successfully participate in a supervised role-play and use all aspects of the program with 100% success using identified critical criteria.

Course Components

While there are many components to general psychological first aid (PFA) programs, the CFA-EMD has been simplified based on a realistic view of EMD intervention and available training time. Many PFA programs are complex and time-consuming, making them difficult to complete.

There are only two main instructional and two practical components to this program. The instructional components include a written guide and a brief online course describing the support partnership and the 3 Ps and 3 Rs (see the next section). The practical component consists of a short written test and a proctored scenario to verify that the material has been learned and properly applied. The proctored scenario is designed to be instructional.

The 3 Ps and 3 Rs of CFA-EMD

The two main components of the CFA-EMD program are the 3 Ps and the 3 Rs, which represent a comprehensive and easy-to-recall method to help the person in crisis. When EMDs follow this method, they can be confident that the person's most important needs have been addressed. As always, follow your local policies.

The 3 Ps are:

1. PARTNERSHIP
2. PROTECT
3. PERFORM CFA-EMD

The 3 Rs are:

1. RAPPORT
2. REFLECT
3. REASSURE

EMDs already perform many of these skills with every person they encounter; however, the process of CFA may add some new perspectives to those skills. The purpose of mentioning them here is to put them into their proper context within the CFA-EMD communication process and remind the EMD that they must be addressed.

The three Ps are Partnership, Protect, and Perform. The 3 Ps represent a mnemonic to help the EMD to begin the interaction with the support partnership in mind and to look for important information during the initial stages. The steps are detailed in the following sections.

Partnership

First and foremost, to provide effective CFA, the EMD must establish themselves as part of a trusted team with the person requiring intervention. Both team members (i.e., the EMD and the person) must have a similar goal. Since we cannot expect one in crisis to have a well-articulated endpoint, the EMD must help the person understand their discomfort and provide them with needed support. This is the Support Partnership and should be done by the EMD on every call.

Protect

When the EMD interacts with the person, they must ascertain if that person is suicidal, homicidal, has an altered level of consciousness, or has a medical complaint. If the answer to any of these questions is "yes," then the EMD should dispatch the appropriate responder to the scene (e.g., EMS, fire, police). If the answer is "no" and the person suffers from moderate or mild non-suicidal mental health and illness issues, the EMD may refer them to the appropriate resource contained in policy. (e.g., 988, Crisis Text Line, local crisis line) or may send paramedics to perform an in-person assessment. As mentioned in the previous section, most callers should receive a physical evaluation.

Perform CFA-EMD

The final P puts the EMD on the path to performing CFA-EMD. The EMD will begin with the 3 Rs of CFA-EMD. The rapport-building principles in each program are similar, but some differences exist.

Rapport

The three primary components of rapport-building are safety, explaining the CFA-EMD role to the person, and understanding the limits of confidentiality.

Safety. The EMD should ensure the basic need of safety is being met for the person. If the person is in a dangerous area, instruct them to move to a safer one.

If the person is suicidal, attempt to keep communications open by asking open-ended questions while emergency units respond. The idea is to delay the suicidal person with the hope of emergency responders arriving or "buying time" to increase the time between suicidal thoughts and actions (See Chapter 24). Questions to ask include:

- "Are you considering suicide?" "Do you want to kill yourself?" Ask the question outright. Do not use euphemisms or non-specific language.
- Do you have a plan? The more detailed the plan, the bigger the risk.
- Do you have access to lethal means? Available lethal means (guns, drugs), higher risk.
- Are you alone? If they are alone, the risk is higher.
- How does the caller sound? If the caller is hysterical or monotone, they may be more likely to act (Seeley, 2018).
- What are you hoping to accomplish? You may challenge the person by discussing how their plan will fail and discussing the pain they will cause (Everly, 2017). Be aware that the caused pain may reinforce the suicidal behavior under certain circumstances (e.g., a child angry at their parents) (M. Seeley, personal communication, April 24, 2021).

The EMD may spend the entire call on the safety aspect of the person. This is entirely acceptable; completing all aspects of the program with every caller is not required.

Role. Explain that your role is to aid until other resources arrive.

Confidentiality and Mandated Reporting. Confidentiality and privacy are critical components of CFA-EMD. The responsibility of mandated reporting always takes precedence over the help-seekers confidentiality. The EMD must remember that if circumstances warrant communication to other authorities as a mandated reporter, they must adhere to the law and established policy.

Summary

The EMD will provide a positive experience with the person that will continue during the next step of care with EMS. The EMD will most likely interact briefly with the person experiencing a mental issue. The time spent with the caller will largely depend upon response times for EMS or police or the transfer process to a crisis line. The EMD may not use all the components of the CFA program with every caller. This is to be expected.

16.5: Law Enforcement and CFA-LE

This section discusses the Joliet Fire Department Crisis First Aid for Law Enforcement (CFA-LE) educational model. This synopsis does not replace the entire course but underscores some more critical concepts for the LE officer to communicate with someone in crisis before EMS arrival.

The program is not intended to provide definitive treatment for any mental health issue or to manage or diagnose any behavioral or physical health disorder; these are for the medical and clinical realm and require highly educated, trained, experienced, and licensed professionals. It is, however, designed to provide a quick understanding of crisis communications for LE with limited training time and funding, with other pressing responsibilities. The program is free of charge by contacting the Joliet Fire Department at (815) 724-3500 or emailing jcarey@joliet.gov.

CFA is a form of initial and transient crisis care that may be likened to physical first aid. Physical first aid seeks to perform minor to potentially life-saving interventions for a person in distress to stabilize them until they can receive definitive care, if necessary. CFA-LE uses a similar model to stabilize a person in an emotional or psychological crisis until EMS arrival.

Like physical first aid, it is not important for the LE officer to understand why the person is acting as they are. It is important, however, to communicate with them in a caring and compassionate manner. For instance, someone trained in CPR does not need to know the complexities of the pulmonary and circulatory systems to administer it. They need basic guidelines to perform the task. The same is true of crisis first aid. Many programs are unnecessarily complex and teach the helper things they do not need to know. A LE officer does not require a 40-hour class to explain CPR, and they do not need a 40-hour course (like CIT) to learn effective communication with someone experiencing a behavioral issue. As of 2021, there were 650,000 full-time police officers in the U.S., and instructing them all in CIT is not feasible.

Course Rationale

Despite what SAMHSA and CESSA would have everyone believe, LE officers will still consistently respond to behavioral calls for service. LE and mental health are often too closely related to assume that police may be eliminated from the discussion; it is unrealistic. As we will see later, the key for LE is not to handle the issue but to help stabilize the person until EMS arrival. This means that basic communication techniques for crisis communication should be taught to all LE, not CIT to a select few.

The fundamental differences between CFA-LE and CIT are that CFA-P essentials may be taught in 20 minutes to a LE Officer, is free of charge, and may be conducted remotely. In contrast, CIT is a 40-hour course that costs millions of dollars to administer nationwide (see Chapter 8: Silos). CFA-LE can be learned very quickly and implemented immediately.

Course Fundamentals

CFA-LE relies on the medical model mentioned in the previous section. Police and EMS respond to many of the same calls for service, so EMS will already be en route to many calls

where crisis intervention is required. If a LE officer responds without EMS, they may call them to respond if the person is suffering a behavioral event. This program is particularly useful with suicidal or dangerous people while EMS is staged before entry. Some examples of use include but are not limited to:

- Suicidal
- Homicidal
- Altered level of consciousness callers (until EMS)
- Medical issues (until EMS)
- Other LE personnel (even those not meeting the criteria above)

Course Goal

The goal of the CFA-LE program is as follows:

- Teach LE officers techniques to interact with people in psychological distress or crisis.

Course Objectives

The specific objectives of the CFA-LE program are:

- Upon completing the course, the student will accurately define the concepts of support partnership, congruence, unconditional positive regard, and empathy.
- Upon completion, the student will describe the purpose and components of the 3 Rs and their role in de-escalation.
- To continue to the practical portion of the course, the student will complete a written examination (if practical is completed).
- The student will successfully participate in a supervised role-play and use all aspects of the program with 100% success using identified critical criteria (not required, but recommended).

Course Components

While there are many components to general psychological first aid (PFA) programs, CFA-LE has been simplified based on a realistic view of LE officer intervention and available training time. Many PFA programs are complex and time-consuming, making them difficult and expensive.

There are only three main instructional and two practical components to this program. The instructional components include a written guide and a brief online course describing the support partnership and the 3 Rs. The optional practical component consists of a short written test and a proctored scenario to verify that the material has been learned and properly applied. The proctored scenario is designed to be instructional.

The 3 Rs of CFA-LE

The two main components of the CFA-LE program are the 3 Rs, which represent a comprehensive and easy-to-recall method to help a person in crisis. When LE officers follow this method, they can be confident that the person's most important needs have been addressed and that the situation is on the way to being de-escalated. Remember to follow all local protocols. The 3 Rs are:

1. RAPPORT
2. REFLECT
3. REASSURE

LE officers already perform many of these skills with every person they contact; however, the process of CFA may add some new perspectives to those skills. The purpose of mentioning them here is to put them into their proper context within the CFA-LE communication process and remind the LE that they must be addressed.

The 3 Rs and De-escalation

One of the fundamental concepts of CFA-LE is to use the 3 Rs to de-escalate a situation when a person with a behavioral issue is encountered who is in crisis. De-escalation is defined as

a disruption in the escalation phase of an interaction to reduce the potential for violence and increase collaboration in problem-solving (Biondi et al., 2021). While there are many separate techniques in the clinical realm for de-escalation, the LE officer who establishes the support partnership through congruence, unconditional positive regard, and empathy, builds rapport, listens nonjudgmentally, and reassures the person is well on the way to calming the situation before EMS arrival (see the Joliet Medical Model above).

Rapport

Rapport is the ability to put the Support Partnership into effect by establishing congruence, unconditional positive regard, and empathy. The three primary components of rapport-building are safety, explaining the CFA-LE role to the person, and understanding the limits of confidentiality.

Safety. First and foremost, the LE officer must provide for their safety, the safety of the person requiring aid, and the safety of others on the scene. The LE officer should follow department policies regarding all aspects of their well-being.

The person requiring aid must also be protected against self-harm. The person may be attempting self-harm, may be suicidal, or may be experiencing a medical condition. LE officers are exposed to people in these circumstances regularly and already know to provide for the person's physical safety. Questions to ask include:

- “Are you considering suicide?” “Do you want to kill yourself?” Ask the question outright. Do not use euphemisms or non-specific language.
- Do you have a plan? The more detailed the plan, the bigger the risk.
- Do you have access to lethal means? Available lethal means (guns, drugs), higher risk.

- Are you alone? If they are alone, the risk is higher.
- How does the caller sound? If the caller is hysterical or monotone, they may be more likely to act (Seeley, 2018).
- What are you hoping to accomplish? You may challenge the person by discussing how their plan will fail and discussing the pain they will cause (Everly, 2017). Be aware that the caused pain may reinforce the suicidal behavior under certain circumstances (e.g., a child angry at their parents) (M. Seeley, personal communication, April 24, 2021).

Finally, bystanders on the scene may need to be protected as well.

The LE may spend the entire call on the safety aspect of the person. This is entirely acceptable; completing all aspects of the program with every caller is not required.

Summary

The LE officer will provide a positive experience with the person that will continue during the next step of care with EMS. The LE will most likely interact briefly with the person experiencing a mental issue. The time spent with the caller will largely depend upon response times for EMS or police or the transfer process to a crisis line. The LE officer may not use all the components of the CFA program with every caller. This is to be expected.

16.6: Paramedics and Crisis First Aid for Paramedics (CFA-P)

It is commonplace for paramedics to be dispatched to behavioral, physical, and traumatic stress-inducing events and for people to require in-person care for one reason or another. These individuals and groups may need basic assessment, basic crisis first aid, and resource guides to ensure they have appropriate treatment for issues related to their experience.

The CFA-P program builds upon the CFA-EMD and CFA-LE programs and has similar, albeit more complex, components.

In previous chapters, we discussed the serious issues with mobile crisis units (MCUs) regarding response, training, danger, and availability. MCU personnel may not be familiar with the areas they visit; they may not have the training required to handle medical issues; they may be entering dangerous areas without police support, and they may not be available on a 24/7 basis.

These problems are managed by Crisis First Aid for Paramedics (CFA-P). Paramedics are well suited to help manage crisis intervention in the field after a brief training in CFA-P. Paramedics have a direct line to the PSAP to request police help or further response, are available 24/7 in strategically positioned fire stations, allow for quick response times, have significant medical training, and can perform advanced medical interventions in the field. Perhaps most importantly, they have 24/7 availability of a physician in the form of local EMS medical control (see Chapter 12).

As we saw in Chapter 4, some may argue that paramedics are not well-suited to performing crisis intervention in the field. Chapter 12 discusses that paramedics are trained well in mental health disorders, manage people in crisis regularly, and are present in many scenes where traumatic stress is possible. Numerous training programs in various forms of psychological first aid are available to the public, including Mental Health First Aid®, Psychological First Aid from the National Child Traumatic Stress Network, Psychological First Aid from Johns Hopkins University, and Individual Crisis Intervention from the International Critical Incident Stress Foundation (ICISF) –to name a few. These programs are excellent (this author has taken them all), but they can be long in duration (some over eight hours).

While the courses are valuable for the layperson, much of the subject matter provides training that the licensed paramedic already possesses (see Chapter 12). This, coupled with the busy training schedule of paramedics in various disciplines such as cardiology, endocrinology, neurology, and many other fields, puts a premium on training time. The CFA-P program may be delivered quickly and is available digitally for paramedics.

While paramedics do not possess the training, skills, or licensure to operate at the clinical level, it is possible for these paramedics, with appropriate training, to manage the initial care of a patient who has been party to a traumatic stress-inducing event or is experiencing a behavioral issue.

Current Level of Care (Behavioral and Traumatic Stress)

The typical care method for behavioral patients within many areas includes initial care, assessment, and transport to the hospital. With only some variations, paramedics do not generally discuss their behavioral issues with the patient. This avoidance may not be due to a lack of education but a combination of factors such as culture, the perception that they cannot effectively care for those with behavioral issues, and challenges in communication. In short, paramedics may have been culturized to believe they cannot help and may not be trained to ask the correct questions to help their patients best. This course improves both.

All fire and EMS service members understand that responses that may cause traumatic stress reactions are quite common. The method of care for traumatic stress reactions has historically been an area of even more weakness for paramedics. The current care method for affected people is largely nonexistent, and if any care is provided, it is highly variable. Training in CFA-P will become part of the standard of care for many different responses, not simply mental and emotional. This program helps the paramedic better prepare to comfort those

experiencing traumatic stress. Paramedics respond daily to calls for service that include death, injury, natural disaster, and other traumatic events that occur in the lives of those in the community. CFA-P can be effective not only at managing those types of events but also incidents within the paramedic's work environment and family.

It is accepted that the elements that compose CFA-P are evidence-based interventions that may be considered best practices. The core skills necessary for effective CFA-P may be taught quickly to previously trained paramedics. This education will enable more paramedics to learn the basic skills to aid those in emotional and psychological distress. Paramedics need a program that considers knowledge already gained through training, experience, and education coupled with new information and skills that will make them more effective at recognizing and managing patients with mental disorders and those who suffer traumatic stress in the field. This program is designed to be incorporated into the existing emergency response structure.

The CFA-P program was developed using Psychological First Aid (PFA) precepts from various sources coupled with real-world experience in EMS. It is a form of initial and transient crisis care that may be likened to physical first aid. Physical first aid seeks to perform minor to potentially life-saving interventions for a person in distress to stabilize them until they can receive definitive care, if necessary. CFA-P uses a similar model to stabilize a person in an emotional or psychological crisis. This program is intended to be used with Introductory Crisis First Aid (CFA-I), Crisis First Aid for Emergency Medical Dispatchers (CFA-EMD), and Crisis First Aid for Law Enforcement (CFA-LE), which were discussed earlier in this chapter.

During an emergency response, the paramedic may come in contact with people who may require CFA-P for various reasons. These include behavioral patients and witnesses, bystanders,

and victims of traumatic stress-inducing events. These people may not necessarily need transport to the ED but may require assistance and education to help stabilize them on the scene.

Course Rationale

Fire departments exist to protect citizens and visitors from the effects of adverse occurrences. These effects may result from both physical and mental events and illness. Paramedics are representatives of the helping professions and are stewards of their departmental missions. In short, CFA-P is consistent with this stated mission and the missions of most fire and paramedic agencies.

Course Fundamentals

CFA-P is a multi-stage, comprehensive program based on existing information coupled with the author's individual experience gathered during thousands of responses for fire, emergency medical services (EMS), hazardous materials response, fire/arson investigation, and time spent working on a comprehensive crisis line. It considers the training and skills that a person acting in these capacities already possesses and adds to their knowledge base to make them more effective at recognizing and managing behavioral issues in the field.

The program is designed to be used by paramedics in many different situations and can be integrated into the paramedic’s regular assessment and treatment process. It benefits loved ones and bystanders at responses, certain patients, prisoners, and other paramedics. The program may be used for major mental illness requiring emergency department (ED) transport, minor psychological challenges not requiring transport to the ED, family, loved ones, and others present who may/may not be patients, and anyone else in crisis, including responders. Examples include but are not limited to:

- Bystanders/family of those in full cardiac arrest or another critical incident such as

disaster,

- Bystanders/family at responses involving children
- Bystanders/family at responses involving domestic violence
- Those suffering from behavioral, medical, or emotional crises
- Suicidal, homicidal, or psychotic patient responses (coupled with ED transport)
- Victims of crime

The program components may also be used with first responders such as paramedics, firefighters, and police officers.

Course Goals

The goals of the CFA-P Program are as follows:

1. To explain to paramedics the basic techniques to interact with a person in psychological distress or crisis using already possessed skills and newly taught techniques.
2. To integrate CFA-P into the routine of paramedics to provide seamless care.
3. To better manage individual crises in a kind and compassionate manner.
4. To perform proper CFA-P techniques in a group or individual scenario setting.

Course Objectives

The specific objectives of the CFA-P Program are:

1. Upon completing the course, the student will accurately define the concepts of support partnership, congruence, unconditional positive regard, and empathy.
2. Upon completion, the student will describe the purpose and components of the 7 Rs.
3. To continue to the practical portion of the course, the student will achieve a score of 80% on a written examination.

4. The student will successfully participate in a supervised and graded role-play and use all aspects of the program.

Course Components

While there are many components to general PFA programs, CFA-P has been simplified due to paramedics' previous education and experience (see Chapter 12). There are only four main instructional and two practical components to the program. The instructional components include a brief description of traumatic stress and other common mental health disorders, the Support Partnership, and the 7 Rs. The practical portion consists of a short written test and a proctored scenario to verify that the material has been learned and properly applied.

Mental Illness and Traumatic Stress Overview

CFA-P may be effective in a host of situations to promote emotional stability in a person. The principles are most applicable for those experiencing non-psychotic mental challenges and those experiencing a traumatic stress response but may be used with practically anyone. Examples of potential diagnosed disorders include anxiety, depression, eating disorders, schizophrenia, posttraumatic stress disorder (PTSD), or other mental health issues. Most patients, even those who do not appear to be in crisis, can benefit from the techniques presented in this program.

Mental Illness and CFA-P

Some forms of PFA require an in-depth educational component discussing various mental health disorders to achieve course completion. For the paramedic, initial paramedic training and continuing education have provided sufficient information on mental health disorders (see Chapter 12). The basic structure of the curriculum, namely the support partnership and the 7 Rs, is a constant in the program. That is, they will be used with all people who receive

CFA-P. The critical aspect of CFA-P is how the paramedic ascertains the problem, develops a relationship with the person, and helps them navigate their thoughts and emotions.

Diagnosed mental illness is a significant problem in the United States. Substantial portions of the populace are diagnosed with mental illness annually. The most common mental illnesses include depression, substance use disorder, and anxiety. It is essential to understand that over 100 diagnosable mental disorders are in the accepted literature (APA, 2013). As always, paramedics do not diagnose; they provide support and resources.

Traumatic Stress and CFA-P

Stress, trauma, and traumatic stress have evolving definitions and may cause some of the population's diagnosed mental health issues. The term stress was not commonly used until the latter half of the 20th century. Generally, stress is the body's mechanism to maintain homeostasis through physical response (Lehrer & Woolfolk, 2021; Cash & Weiner, 2006). Trauma may be defined simply as an event that is painful or distressing and may include physical and emotional components. Traumatic stress may be defined as stress caused by an event that is so severe that it overwhelms the coping ability of those who experience or witness it – or, put another way, a crisis (Friedman, 2015; National Suicide Prevention Lifeline, n.d.).

Depending on the definition one uses, it is estimated that between 50% and 90% of people experience some traumatic event in their lifetime (Briere & Scott, 2015; Friedman, 2015). Additionally, only about 8% develop the debilitating condition of Post-Traumatic Stress Disorder (PTSD) (Briere & Scott, 2015; Friedman, 2015; Schupp, 2015). This begs the question, why do such a small percentage of people who experience traumatic stress develop extreme stress-related disorders such as PTSD? A component of the answer may lie with some CFA concepts.

CFA-P is not a magic bullet for behavioral health; in fact, PFA programs have not been proven to be effective empirically, but it is a first step in a continuum of care (including follow-up and professional counseling care) which may make recovery more likely (Jacobs, 2016; NCTSN, 2006).

There is a profound difference between the stress we feel daily and traumatic stress. Most people manage daily stress using established coping and protection mechanisms (Everly, 2018; Jacobs, 2016). Traumatic stress, however, is a complex subject and may have many effects on the person (APA, 2013; Friedman, 2015; Wilson & Keane, 2004). Further, it is recognized that traumatic stress exposure may lead to certain behavioral disorders such as depression, substance use disorders (SUD), and Post Traumatic Stress Disorder (PTSD) (Friedman, 2015; Wilson & Keane, 2004).

Expected Effects of Traumatic Stress

The effects of traumatic stress may influence many aspects of the whole person. These effects may involve emotional, physical, behavioral, and cognitive areas and are highly individualized (Everly, 2018; Everly, 2017; Jacobs, 2016; Wilson & Keane, 2004). However, as we saw in Chapter 6, paramedics must remember that some of the expected responses to traumatic stress listed below can be similar to several severe physical disorders (Hall, 1978; Martin, 1983; Testa et al., 2013; Happell, 2016). Paramedics must continually evaluate physical complaints to rule out potentially life-threatening conditions and trust their instincts during the assessment.

Additionally, it is understood that field intervention immediately after a traumatic event may be somewhat ineffective due to the nature of shock responses and emotional overload. The most effective components of the CFA-P program are the structured beginning of traumatic

stress care as well as the follow-up 48 – 72 hours after the event, when the person may be more affected by the provided care (Cash & Weiner, 2006).

Emotional Responses (Feeling)

- Feelings of being disconnected
- Anxiety
- Irritability
- Sadness
- Depression
- Anger
- Grief
- Disbelief (Everly, 2017; Jacobs, 2016; NCTSN, 2006).

Physical Responses (Discomfort)

- Nausea, stomach upset, vomiting
- Hyperventilation
- Tachycardia
- Lightheadedness (Everly, 2017; Jacobs, 2016; NCTSN, 2006).

Behavioral Responses (Acting)

- Alcohol/drug use
- Excessive eating
- Withdrawal
- 1000-yard stare (dissociation) (Everly, 2017; Jacobs, 2016; NCTSN, 2006).

Cognitive Responses (Thinking)

- Sensory distortion (auditory exclusion, tunnel vision)

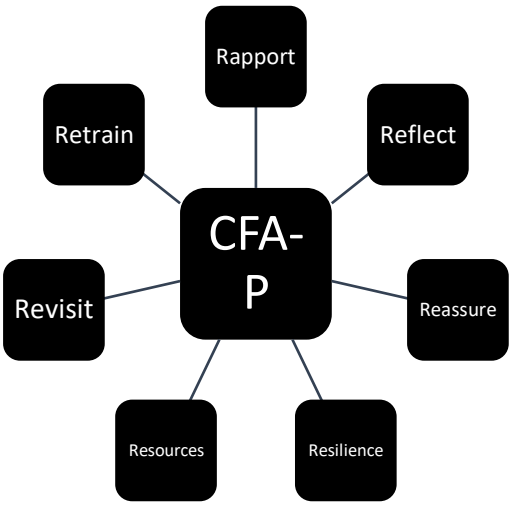
- Guilt
- Confusion
- Concentration difficulties (Everly, 2017; Jacobs, 2016; NCTSN, 2006).

The 7 Rs of CFA-P

Overview

The basis of the CFA-P Program is the 7 Rs. The 7 Rs represent a comprehensive and easy-to-recall method to help people manage traumatic stress reactions and stabilize those with mental health issues in crisis. When paramedics follow this method, they can be confident that the person's most important needs have been addressed.

The 7 Rs are:



1. RAPPORT
2. REFLECT
3. REASSURE
4. RESILIENCE
5. RESOURCES
6. REVISIT
7. RETRAIN

It is important to note that generally, only the first 5 Rs will be used in the field. Others will use the remaining two at a later time. See the Revisit and Retrain Sections for more information.

*********REMINDER*********

In all cases, the paramedic must follow their standard operating procedures (SOP) and standing medical orders (SMO).

Please remember that paramedics already perform many of these skills with every patient they contact; however, the process of CFA may add some new perspectives to those skills. The purpose of mentioning them here is to put them into their proper context within the CFA-P communication process and remind the paramedic that they are items that need to be addressed.

Rapport

Rapport refers to the ability to put the Support Partnership into effect by establishing congruence, unconditional positive regard, and empathy. The four primary components of rapport-building are the introduction, ensuring basic needs are met, explaining your CFA role to the person, and understanding the limits of confidentiality.

Introduce

While considering the components of the support partnership, it is essential that the paramedic calmly and confidently introduce themselves to the person by name, department, and rank. During a crisis event, multiple responders from various agencies may be present. The person may be overwhelmed and disoriented. A proper introduction may help reorient them to the current place and events.

Basic Needs

After the paramedic introduces themselves to the person, they should move them to an area as comfortable as possible, away from stressful stimuli. Consider the conditions at the scene, such as time of day and weather, reminders of the event, such as blood or remains, and bystander presence.

During this time, ensure basic needs are being met. For instance, providing a warm and dry environment may help establish the support partnership quickly. More significant incidents such as disasters may include food, water, shelter issues, or other fundamental need concerns.

A common way to express the needs of the individual is through Maslow's Hierarchy of Needs. The needs of the lower portions of the triangle must be met before moving to the next level. For example, if a person is out in the elements and tending to physiological needs (rain, cold, etc.), they cannot focus on establishing a partnership with the paramedic.

Role: Traumatic Stress

In the event of traumatic stress, after the introduction and after basic needs are met, the paramedic must discuss the role of the CFA provider with the person. At this time, the paramedic separates the role of the CFA provider from that of the paramedic. For example, if a paramedic is acting in the CFA role, they should not simultaneously perform other tasks (such as patient care). Doing this may confuse the person and diminish the Rapport process. The person must feel that the paramedic is focused on them and their problem. The traumatic stress sufferer will not be considered a paramedic patient unless a severe reaction occurs.

Role: Behavioral & Medical Patients

In the case of a behavioral or medical patient, the paramedic will act in their typical role of patient-caregiver throughout the response. They may provide CFA during the response between interventions (e.g. after care is provided and transport is taking place).

Confidentiality and Mandated Reporting

Confidentiality and privacy are critical components of CFA-P. Paramedics are already well-versed in these concepts due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations and mandated reporting laws. The paramedic must remember that if circumstances warrant communication to other authorities (such as police and children and family services) as a mandated reporter, they must adhere to the law. The responsibility of mandated reporting always takes precedence over the help-seekers confidentiality.

Resilience

There are many ways to manage stress, and many complex clinical definitions for resilience exist. In this program, resilience refers to the ability of a person to "bounce back" from a traumatic event and return to baseline functioning. The paramedic will discuss coping and social support as stress management strategies with the affected person.

Coping

When we discuss coping, we discuss how people manage stress. This may include a wide array of activities. Examples of effective coping mechanisms are as varied as those who use them and may be classified as productive and nonproductive (Frydenberg, 2017). Examples of productive coping include improving relationships, compartmentalizing the problem, humor, focusing on positive aspects of the problem, and healthy distraction (Frydenberg, 2017).

Examples of nonproductive coping include dwelling on the negative, self-blame, worry, and substance misuse (Frydenberg, 2017). As you probably recognize, productive methods are more conducive to health, and nonproductive can be damaging (Frydenberg, 2017).

One of the most effective ways to discuss this concept is to ask the person what they have done to manage stress reactions in the past successfully. When this is done, the person may have a list of possible strategies from which to draw. This is especially effective with diagnosed behavioral disorders.

Social Support (Relationships)

Social support is a critical aspect of the CFA-P process. It is known that interpersonal support is one of the most effective mechanisms by which people manage traumatic stress reactions (Everly, 2017, Jacobs, 2016). Sources of social support include friends, family, coworkers, neighbors, and church/religious groups. A good practice in which the paramedic may engage is to ask the person if they would like a call placed to a support person. This is particularly useful in traumatic stress events.

Resources

There is only so much that a CFA practitioner can accomplish, especially in a reduced time frame. In addition, some emotional and psychological issues are outside of the ability and training of the paramedic. For these reasons, the paramedic must have access to resources they may present to the person to help with continued improvement or severe reactions. Some commonly recommended resources for those in crisis are clinical care, crisis lines, support groups, and information on general extended health and the new normal. Resources will be listed in a Resource Guide and distributed to those in need after the event.

Resource Guide

Each area has resources available to help manage traumatic stress and behavioral issues in the long term. This includes locally available clinical care, appropriate crisis lines, and various support groups dedicated to mental and emotional problems. The Resource Guide should contain information related to accessing these services. Also, simple things (e.g., how to get to the local hospital, phone numbers, what to bring with them) are all things the help-seeker needs to know. If the patient is a hospice patient or has a do-not-resuscitate order (DNR), the help-seeker may require assistance contacting resources. Other resources that may provide support, such as faith-based institutions and county health departments, should be listed in the Resource Guide. The guide may be distributed in any form deemed appropriate by each department.

Crisis Lines

Crisis telephone and texting lines can be categorized as a single issue or comprehensive (Seeley, 2021). Single-issue lines address one issue and may include help for traumatic stress, suicide, gambling, sex addiction, grief, alcohol abuse, and other issues (Seeley, 2021). Comprehensive lines address any issue the caller wishes to discuss (Seeley, 2021). The logic

behind the crisis line is that a compassionate and knowledgeable person is available when required. The Resource Guide should list these numbers.

Support Groups

Similar to the rationale of crisis lines, support groups help people manage all sorts of issues. These groups meet in person and sometimes online to support those in need. The Resource Guide should contain information related to accessing these services.

Extended Health & New Normal

Sometimes, people who experience issues may not seek to maintain or improve their health post-incident. For this reason, the Resource Guide should contain information reminding the person to manage their health appropriately. Issues such as sleep, diet, establishing and maintaining a routine, exercise, and the dangers of self-medication and substance abuse are addressed (Jacobs, 2016). While it may be true that the person may never be "normal" again, the event will likely develop into a "new normal" from which the person may move forward.

Emergency Department (ED) and Clinical Care

An essential facet of all CFA is establishing whether the person may effectively continue with daily life functions (Everly, 2017). As the paramedic interacts with the person, they will have a general feel for the severity of the reaction. In certain circumstances, the paramedic may feel that the response that the person is experiencing is severe. In these cases, the paramedic should refer the person to the clinical section of the Resource Guide or, if unsure, transport them to the ED. In the event the person indicates they are suicidal, homicidal, or acts uncontrollably, the paramedic will follow the standard medical orders that are in place for that issue. If the paramedic is unsure or not comfortable leaving the patient, they always have the option to discuss transport to the emergency department or contact medical control, the available directing physician.

Revisit (Follow-Up)

At least one follow-up must be completed with the person post-event from the agency that provided care. This follow-up should be completed no later than 48-72 hours post-event. The person who will perform the contact will be dependent on department policy. During this process, this policy-defined person must contact the help-seeker to check their status and review their steps for coping. They will discuss relationships and resources within the context of the problem and may aid the help seeker in establishing contact with clinical resources or other sources of care. They will review the 7 Rs and finish with retraining, if appropriate.

Retrain (Psychoeducation) Overview

Behavioral

In the case of diagnosable behavioral health disorders such as anxiety, depression, PTSD, and others, the bulk of retraining and psychoeducation should be performed by qualified and licensed professionals. This may include both primary healthcare providers and clinical mental health specialists. The assembled Resource Guide may be used to help locate clinical personnel.

Traumatic Stress

Retraining for those who have experienced traumatic stress primarily involves discussing the signs of traumatic stress and reviewing protective (in the form of self-care) and coping strategies. It may be prudent to seek professional clinical care sometimes, especially for those experiencing strong reactions.

Training Program

The training time of paramedics is valuable. For this reason, the program has been designed to be as short as possible and adaptable to the paramedic's busy training schedule

Components:

1. Pre-test
2. Written materials (Student Manual, Workbook, Resources, Callback)
3. Virtual Course: 1 – 1.5 hours

    Overview and Rationale

    Mental Disorders

    Traumatic Stress

    The Support Partnership

    The 7 Rs

    Procedures

    Simulations
4. In-Person Training: Approximately 20 minutes per student

    Question & answer, review (10 minutes):

    The question-and-answer session is designed to address any student questions before the written exam.
5. Written Exam: The student must score 80% to continue to the practical evaluation (10 minutes). Remediation may be allowed.
6. Practical scenario (10 minutes): Individual participation

The recommended progression through the material is as follows. After completing the pretest, the paramedic will read this CFA-P manual to establish a base of knowledge. Next, the paramedic will complete the virtual training module. A workbook is available to help with information retention. Finally, the paramedic will participate in a practical session role-play exercise before which they must pass a written exam.

This course represents an abbreviated training method requiring the paramedic to devote time to adult self-learning, reducing in-person training time and time away from other duties.

Clinical and Prolonged Care

In some circumstances, the person should be referred to clinical care. This has proven to be difficult in some areas due to shortages of clinical personnel (see Chapter 5). Individual jurisdictions must plan to increase clinical care availability, which may require creativity (see Chapter 19).

Summary

CFA-I, CFA-EMD, CFA-LE, and CFA-P are all response programs intended to identify and manage a person in crisis until they can be connected with appropriate care. This expands the ability for mental illness to be recognized and managed in the field.

Chapter 17: Recovery

It should be noted that the recovery and mitigation phases are only used after a crisis and are usually more in the purview of the clinical counselor and physician than fire and EMS services, although they may play a role. The primary reason they are mentioned here is to illustrate the cyclical nature of the program and to recognize the other professionals necessary to make mental health programs work. Successful prevention, response, recovery, and mitigation

are part of a team approach involving many community aspects working synergistically to affect individual mental health.

The recovery phase may involve the transition from the response phase to the normal or "new" normal condition (Philips, 2012). It is the point in the cycle where rebuilding begins and may last for an extended period. However, within the literature, recovery has different definitions, and emergency management circles may be composed of phases, including short-term and long-term (Phillips, 2012). Short-term recovery generally refers to restoring basic function to continue with needed tasks, and long-term recovery refers to returning to normalcy (Phillips, 2012). These definitions may also be considered consistent with mental illness; however, more complex models exist.

Recovery and Definitive Care

As we discussed earlier, it is clear that recovery is not a simple process and requires a team approach (i.e., physician, clinician, support system, community paramedics, etc.) to be successful. Fortunately, the JEMMHI model is cyclical and includes these resources, and if correctly applied, beginning with prevention, recovery may be made less complex.

While specific treatment modalities are outside the scope of this book, after a crisis, the person must maintain contact with their clinician and physician and ensure they follow the treatment plans set forth for them. This includes keeping scheduled appointments and maintaining medication regimens if used. Substantial planning may be required to manage these areas.

While clinical care is critical in the recovery phase, local community paramedics and community risk reduction programs may aid recovery in various ways. They may provide information as well as in-home needs assessment and medication evaluation. Additionally, they

may provide for physical health-related needs, understanding that physical and mental issues may go hand-in-hand. Finally, they may offer regular visits to the person to ensure they follow the treatment plan between physician or clinician visits.

Recovery Components

Over the last few decades, the mental health community has struggled to define this sometimes-nebulous concept, and much literature has been generated. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies 13 components to recovery, stating that a recovery program must be individualized, provide empowerment, offer hope, allow for self-direction, be non-linear, be strength-based, focus on respect and responsibility, including peer support, be holistic, address trauma, and understand and utilize culture. Further, SAMSHA offers four dimensions of recovery: health, home, purpose, and community (Ellison et al., 2016).

While this remains a popular template for recovery, Ellison et al. (2016) systematically reviewed recovery literature and discovered specific themes that run consistently in multiple scholarly sources. Of the many potential components, the most common was that a recovery program must be individualized and focused on empowerment, purpose, and hope (Ellison, 2016). Empowerment refers to the fact that the person must feel they can affect change. Individualization recognizes each person is unique in their condition and requires different resources and treatments. The person and their team of supporters must tailor the recovery to the person.

Purpose recognizes that a person must have meaningful activities in which to engage, such as work and school, and feel as if they participate in society. Hope means a person must believe they can overcome the illness.

Regular primary care provider or clinician visits will help the person recover. Additional visits by community paramedics may help the process even more and help the person adhere to an individualized care plan.

Chapter 18: Mitigation

Long-Term Management & Reducing Impact

Mitigation uses lessons learned from the first three phases to reduce the likelihood and impact of a crisis event, leading back into the prevention phase (Phillips, 2012). Like with recovery, mitigation is highly individualized. This includes the person, their physician, their

clinician, and their supporters. A plan must be developed between all involved parties to reduce the risk of another event.

After a crisis event occurs, the situation should be evaluated to ensure improvements can be made to the prevention plan. An honest look at the event between the person, their support system, their physician, and their clinician is critical. To fix the problem, the person and their team must understand where the prevention aspect failed and take steps to correct it to reduce the possibility of another event or reduce the impact of the next event that occurs.

For example, a patient who has schizophrenia is feeling good while on their medications, and things are going well at home and work (secondary and tertiary prevention strategies are effective). Things are going so well that the person does not feel the need to take their medications as prescribed. This leads to an adverse event that requires emergency care. When the crisis is managed, and recovery is underway, the mitigation phase should identify the medication issue and be highlighted in the following prevention phase plan.

The Self-Triage Tool mentioned in Chapter 15 may be used again in the mitigation phase. The public should be taught methods to reduce the impacts of mental illness and a technique to self-triage before calling for help. This enables them to determine what action they should take to get the help they need. Many people may not know the appropriate response when experiencing mental difficulty. The Self-Triage Tool may help them make a more informed decision.

One of the tool's key components is for the person to have a primary care provider or a personal or family physician. Many people do not know that their primary care provider (PCP) can help with some mental illness issues, and if it is past their expertise level, the PCP may provide resources and referrals for their patients. For those without a PCP, research may be done to find a physician. County Health Departments and online searches may be effective.

Finally, the mitigation phase will dovetail back into the prevention phase. The mitigation phase is an essential aspect of the JEMMHI model because it encourages the continuous improvement of the entire platform. Over time, the resiliency built from this model will be substantial.

In the case of mental health, mitigation may include the development of new and more robust social support structures, coping strategies, and continued support from professional resources such as physicians and clinicians. This will prepare the person for the next potential crisis and will, with hope, reduce the likelihood of another event.

Summary

The main concern with this model is to recognize the cyclical and lasting nature of the process. This model must be followed consistently, preferably permanently, to work. This will enable the baseline contacts and a positive therapeutic alliance to be created before a crisis, hopefully preventing the crisis from occurring. The key to success in the management of the program is to ensure the repetitive nature of the program remains intact and that the program is constantly moving forward with developing relationships and knowledge.

Part 6: Collaboration

Chapter 1 details how the Joliet Community Mental Health Program began – with firefighter peer support. As the program evolved into a community concern, new problems were discovered, and solutions were sought. It was clear from the start that the fire department could not accomplish what it wanted to achieve without help. Attempts were made to collaborate with

hospitals, health departments, non-profit organizations, and other agencies, often unsuccessfully. Some groups seemed to view the program as threatening their status quo or jobs, which was never the case. Suffice it to say silos were tall and strong.

One of the primary messages of this book has been the need to identify and bridge those silos (see Chapter 8). We discussed silos between fire departments and clinicians, clinicians and physicians, non-profit organizations, private groups, and public agencies. We saw them in their glory while attempting to create a program that would serve all equally.

Fortunately, some groups saw the big picture of what was being attempted and wanted to participate. Part 6 recognizes the people and groups who made the Joliet Community Mental Health Program possible.

As the program developed, crisis care, clinical care, facilities, adjunct care, and education were all considered priorities. The development team managed the crisis care and mobile crisis team problem by producing Crisis First Aid for Paramedics (see Chapter 16). The clinical care aspect was solved by collaborating with the Joliet Fire Department, Thriveworks® (Chapter 19), and Silver Cross Hospital (Chapter 20). The adjunct care and education were addressed by partnering with the local National Alliance on Mental Health chapter (NAMI: Will-Grundy County) and partnering with Joliet Township High Schools (see Chapters 22 and 23).

Chapter 19: Thriveworks®: Clinical Care

What is Thriveworks®

Thriveworks® is a nationwide counseling organization with a network of over 4,000 mental health clinicians in over 30 states who can usually see a person (in-person or telehealth)

the same day or the next day. They offer all sorts of mental health and illness care, including psychiatry. Their clinicians specialize in many areas, enabling them to help a diverse population.

Clinical Care in Joliet

Securing fast and professional clinical care in Joliet was a significant obstacle. As discussed in Chapters 15 and 16, treatment for mental illness should be sought as soon as symptoms present as part of secondary and tertiary prevention. It is a poor health practice to wait for a crisis to occur. In that respect, paramedic crisis intervention is only so effective, and sometimes the help-seeker needs clinical care. In Joliet, in 2021, the average wait time for a first appointment with a psychologist or counselor was 4-6 weeks (as of the writing of this work, it is 7-11 weeks). Psychiatry care wait times were even longer.

The solution for this problem came in late 2021, when Steve van der Watt from a private consulting group, Thriveworks®, approached the City of Joliet City Manager, Jim Capparelli, and asked to be part of Joliet's employee assistance program (EAP). This would allow employees to have additional no-cost mental health and illness care through Joliet's medical insurance provider. EAPs offer services to employees and their families, and mental health needs for firefighters and police are becoming well known.

Mr. Capparelli knew the fire department was working on a mental health program and brought Mr. Van der Watt to the development team. During the meeting, the team had many questions about the program and the company. These questions culminated with Jeff Carey asking, "if you can provide mental healthcare to the employees of the City of Joliet, can you provide it to our entire community?" It was there that the solution took shape.

Joliet is a community of over 150,000 people (U.S. Census Bureau, 2021). Knowing that one in five people has mental illness nationwide, we could surmise that approximately 30,000

people in Joliet experience some variety of mental illnesses (Mental Health America [MHA], 2021). The ambulances of the Joliet Fire Department encounter thousands of these patients every year. The question became, "how does the City of Joliet provide care for everyone who needs it at no out-of-pocket cost to them?" This was complicated by the fact that 35% of Joliet residents are insured by Medicaid, which, at the time, did not provide robust coverage for mental illness care (fortunately, this has since been rectified), and 5% – 10% were uninsured (J. Carey, personal communication, November 30, 2022).

Jim Capparelli, Jeff Carey, and Steve van der Watt discussed the possibility of the City of Joliet funding what is not covered by insurance plans and those without insurance from a City-sponsored fund. An estimated annual contribution of $400,000 (before Medicaid reform) would protect the entire populace for one year. Later, the City of Joliet City Council unanimously voted to fund the program.

How Thriveworks® fits into the Joliet Model

Accessibility was one of the Joliet plan's missing components, which is what Thriveworks® provided. To access the network, a Thriveworks® membership fee is usually required. The office space provided for the City of Joliet's mental health program by Silver Cross Hospital (see Chapter 20) has enabled Thriveworks® to waive the membership fee for all Joliet and Will County residents.

Thriveworks® provides treatment to all age groups and accepts most insurances, including Medicaid. Since Joliet has 35% of the population receiving Medicaid, Thriveworks® needed to be able to take this form of insurance.

Additionally, Thriveworks® was well suited to approach local schools, hospice programs, and other municipalities in and around Joliet, receiving positive responses.

A New Direction

Before Thriveworks® began its affiliation with the Joliet Fire Department, it focused on EAP supplementation for public service and industry. The Joliet Model represented this paradigm's first application to an entire city.

Services Thriveworks® Offers

Thriveworks® offers in-person and telehealth appointments, usually within 48 hours. They help people with the following:

- Relationship issues
- Mental Illness
    - Anxiety disorders
    - Depressive disorders
    - Relationship and marriage issues
    - Trauma disorders
    - Eating disorders
- Stress
- Grief & Loss
- Psychiatry services
- Family challenges

TherapyLand

Thriveworks® also offers TherapyLand in some locations (including Joliet) for children and adolescents. TherapyLand providers specialize in helping children, specifically through play therapy, and come equipped with years of training plus additional certifications that enable them to provide children with quality mental health care.

TherapyLand provides children the tools to explore and express their thoughts and feelings. Several play therapy tools at TherapyLand include home/kitchen play, dollhouses, Bobo dolls and puppets, dress-up, arts and crafts, basketball, blocks, and nurturing toys. TherapyLand is a safe space for children to confront, understand, and work through the problems they encounter throughout childhood. They work with children with:

- Developmental disabilities
- Autism spectrum disorders
- Language development
- Learning disabilities
- ADHD
- Parental divorce
- Bullying
- Behavior problems
- Emotional regulation
- Trauma
- Grief
- Other issues

Results

So far, the public-private partnership between the Joliet Fire Department and Thriveworks® has succeeded. People in need in Joliet receive high-quality in-field crisis care when needed and clinical mental health and illness care from licensed and vetted professionals (see Chapter 25 for more).

Chapter 20: Silver Cross Hospital: The Place to Go

Silver Cross Hospital opened on Thanksgiving Day in 1895, built by the Will County Union of King's Daughters and Sons as a 33-bed facility. Over its 125-year history, Silver Cross became a leader in healthcare in the region and grew significantly, eventually moving to a new

facility in New Lenox, IL, in 2012. They were first recognized as one of the nation's 100 Top Hospitals in 2004, an accomplishment they have repeated ten times—most recently in 2022.

Silver Cross has maintained a close relationship with the Joliet Fire Department and local helping organizations. The Silver Cross Emergency Medical Services System (SCEMSS) has trained hundreds of Joliet Firefighters as paramedics over the last 30 years and is the resource hospital for the Joliet Fire Department.

Sr. Mary Frances Seeley (see Chapter 1) approached Ruth Colby, the CEO and President of Silver Cross Hospital, regarding a partnership with the Joliet Fire Department in the Community Mental Health Program. Due to the value put on exceptional care that Silver Cross has always maintained, they agreed to partner with the JFD and Thriveworks®.

Ms. Colby and Silver Cross went a step beyond this, however. They offered prime office space to Thriveworks® in a professional building in the heart of Joliet, a perfect location for equal access to physical services. They did this for no cost as well. The Joliet Community Mental Health Program owes Ms. Colby and Silver Cross Hospital a debt of gratitude.

Chapter 21: The Joliet Mayor and City Council: The Funders

The Joliet City Manager, Jim Capparelli, was instrumental in developing and approving the Joliet Community Mental Health Program. Additionally, the Development Team met with

the mayor and several council members over numerous weeks in 2022 to explain the program. They were all supportive.

The Joliet City Council voted unanimously to fund the Mental Health Program in 2022 and again in 2023 ($400,000 annually). These leaders understand the need for local mental health services and have served the community well. We thank them for their support.

Mayor Bob O'Dekirk

Councilman Larry Hug

Councilwoman Sherri Reardon

Councilman Pat Mudron

Councilwoman Bettye Gavin

Councilman Terry Morris

Councilman Cesar Guerrero

Councilwoman Jan Quillman (see Chapter 1)

Councilman Joe Clement

Chapter 22: National Alliance on Mental Health (NAMI): Support & Education

The National Alliance on Mental Illness is a nationwide group with local chapters in all fifty states. In 2023, the Joliet Community Mental Health Program Development Team discussed the utility of the NAMI organization and met to partner with the NAMI: Will-Grundy Chapter.

NAMI: Will-Grundy offers support groups, individual and group education, and online training for those with mental illness and their friends and family members. Courses they offer include NAMI Connection. NAMI Family Support Group, NAMI Family-to-Family, and NAMI Basics Online.

NAMI Connection is a support group for adults living with mental illness. It allows for mutual support through social interaction. NAMI Family Support Group holds meetings for those living with someone with mental illness to offer support and education. NAMI Family-to-Family is an eight-week course for family and friends of those living with mental illness, focusing on crisis, coping, and stress management.

Additionally, the Will-Grundy Chapter has been searching for office space and an area to provide a Living Room for those with mental illness. The Living Room will allow a walk-in facility staffed with peers to support those with mental challenges. They have agreed with Silver Cross Hospital and Thriveworks® to provide services within the Thriveworks® office space to accomplish this. This collaboration will ensure that those who use the NAMI Living Room space have access to clinical care, and those who receive clinical care will have access to NAMI programs—another example of positive collaboration in action.

Chapter 23: Joliet Township High Schools: Critical School Component

Joliet Township High School, District 204 (JTHS), has two campuses with over 6,800 students and is a progressive school district with the best interest of its students in mind. The administration is focused on a belief that education and mental health affect the entire community's quality of life – current students become future leaders. They have been open to discussing mental health with the Joliet Fire Department since the beginning of our efforts.

In November 2021, the Joliet Fire Department hosted a meeting with area high schools to discuss high school-aged victims of suicide in several school districts in the area. During the 2021-2022 school year, 12 children who attended area schools completed suicide. During the initial meeting, school representatives discussed plans, programs, and services available to provide mental health to students. While all the schools in attendance provided counseling, crisis care, and other services, JTHS addressed the possibility of adding components of the Joliet Community Mental Health Program to its existing mental health structure.

JTHS already has a robust mental health program that includes local partners, and they added the Joliet Fire Department and Thriveworks® to the list. While students already residing in the City of Joliet are already covered by the Joliet Program, the JTHS District reported that approximately 15% of their students do not live within the City and are not covered by the Joliet program.

To provide for these children, JTHS leaders supplied funds to ensure all students have the necessary clinical mental health care. As of this writing, all students in JTHS schools have access to free rapid, definitive mental health care from professional providers.

Part 7: Suicide

Chapter 24: Suicide Prevention: The Fire Service Role

Note: Reducing suicide is a whole-community effort that requires organized support from many sources (see Chapter 8 regarding silos). This chapter aims to describe the problem of suicide, discuss known risk factors and warning signs, and describe how local fire departments may implement programs to help manage the issue within their communities. Suicide is an extraordinarily complex issue with many moving parts, which may seem oversimplified in this chapter. As we have stated several times throughout this book, the purpose of this work is not to solve America's suicide and mental health and illness problems. The goal is to give practical and realistic guidance, especially to fire departments and paramedics, describing what they may do to help reduce the problem in their communities.

The CDC (2017) tells us that suicide is a problem that is not restricted to any one age group. In 2021, more than 47,000 Americans died by suicide, making it the 10th leading cause of death (CDC, 2021). Moreover, it must be noted that suicide is the leading cause of death for children aged 10-14, the second leading cause of death aged 15-34, the 4th leading cause in adults 35-44, the 5th from age 45-54, and 8th in aged 55-64. In addition, the suicide rate has increased by almost 30% since 1975 and costs billions of dollars annually (CDC, 2017; Skaine, 2015). This makes suicide a critical issue in mental health care.

Suicide is associated with numerous risk and protective factors. There is no single cause of suicide; combinations of elements play a role, which makes prediction difficult, if not nearly impossible (Gold & Frierson, 2020). Risk factors are present at many levels, including individual (e.g., history and genetics), relationship (e.g., violent relationships and isolation), community (e.g., barriers to care), and societal (e.g., media portrayal and stigma of help-seeking). Protective factors also defend against the risk of suicide, including effective coping, supportive

relationships, available physical and mental healthcare, and reduced access to lethal means (CDC, 2017; Gold & Frierson, 2020).

Suicidal people belong in clinical care to manage their issues. This chapter is not a replacement for clinical care; it recognizes the need to call for help if a person is suicidal to secure clinical care.

Suicide: Risk Factors and Warning Signs

As we begin the discussion of risk factors and warning signs for suicide, please note again that no one risk factor or warning sign indicates with certainty that a person is suicidal (Gold & Frierson, 2020). Suicidality is a complex diagnosis. Clinical assessment may determine the combination of factors that make a person suicidal, both from the person and those with which they have contact. This underscores the importance of professional clinical treatment for those with risk factors or displaying warning signs (Gold & Frierson, 2020). If a person shows any risk factors or warning signs in isolation or combination, the best action may be to direct them to clinical care or their physician or call 911. Never ignore suicidal statements or behaviors.

Suicide: Risk Factors

The term risk factor for suicide refers to a condition "empirically demonstrated to correlate with suicide, regardless of when it first becomes present" (Gold & Frierson, 2020, p. 5). According to the Centers for Disease Control and Prevention (CDC), there are many recognized risk factors for suicide, and they may be separated into four categories, including individual risk factors, relationship risk factors, community risk factors, and societal risk factors (Centers for Disease Control and Prevention [CDC], 2017). Some of the more common risks from the CDC are listed below.

Individual Risk Factors

These individual factors contribute to risk:

- Previous suicide attempt
- History of depression and other mental illnesses
- Serious illness such as chronic pain
- Criminal/legal problems
- Job/financial problems or loss
- Impulsive or aggressive tendencies
- Substance use
- Current or prior history of adverse childhood experiences
- Sense of hopelessness (Centers for Disease Control and Prevention (CDC, n.d., Figure 1)

Relationship Risk Factors

These harmful or hurtful experiences within relationships contribute to risk:

- Bullying
- Family/loved one's history of suicide
- Loss of relationships
- High conflict or violent relationships
- Social isolation (CDC, n.d., Figure 1)

Community Risk Factors

These challenging issues within a person's community contribute to risk:

- Lack of access to healthcare
- Suicide cluster in the community
- Stress of acculturation
- Community violence
- Historical trauma (CDC, n.d., Figure 1)

Societal Risk Factors

These cultural and environmental factors within the larger society contribute to risk:

- Stigma associated with help-seeking and mental illness
- Easy access to lethal means of suicide among people at risk (CDC, n.d., Figure 1)

Suicide: Warning Signs

There are observable signs of suicidal ideation. Like risk factors, they may be placed in specific categories. These include signs related to speech, behavior, and mood. Some of the most common signs are listed below.

Something to look out for when concerned that a person may be suicidal is a change in behavior or the presence of entirely new behaviors. This is of sharpest concern if the new or changed behavior relates to a painful event, loss, or change. Most people who take their lives exhibit one or more warning signs, either through what they say or do.

If someone is at risk for suicide, you can watch for warning signs, including:

- Talking about being a burden
- Being isolated
- Increased anxiety
- Talking about feeling trapped or in unbearable pain
- Increased substance use
- Looking for a way to access lethal means
- Increased anger or rage
- Extreme mood swings
- Expressing hopelessness
- Sleeping too little or too much
- Talking or posting about wanting to die
- Making plans for suicide (CDC, n.d., Figure 3)

Suicide Prevention Plan, CDC

Suicide is a complex issue with no simple solution, and there are many suicide prevention programs in the mental health and illness world. The Centers for Disease Control and Prevention (CDC) plan is one of the most comprehensive. The CDC has created a programmatic approach to suicide prevention. It uses a 7-step strategy for prevention that includes strengthening economic supports, strengthening access and delivery of suicide care, creating protective environments, promoting connectedness, teaching coping and problem-solving skills, identifying and

supporting people at risk, and lessening harm and preventing future risk. (Centers for Disease Control and Prevention [CDC], 2017).

In addition to the general provisions of the program, this chapter has added the role that fire departments may play in support of the program through community risk reduction programs or community paramedicine. Most things added to the fire department responsibility list are simple things that may be effective. Also, we make a case for a point missing in many programs: the need to attack this problem not only at an individual level but also at a family level.

Strengthen Economic Supports

Foundation

The existence of economic stressors may, directly or indirectly, increase suicide rates – especially for people aged 25-64 (CDC, 2017). The increased stress from events such as a job or home loss resulting in financial hardship could factor in suicidal ideation. While more study is needed, research suggests that stabilizing the economic aspects of a person's life may reduce suicide (CDC, 2017).

Methods

The primary way economic causes for suicide may be approached is to strengthen household financial security to reduce the stress associated with financial hardships (CDC, 2017).

While fire department Community Paramedicine (CP) and Community Risk Reduction (CRR) programs are limited in managing this issue, one way they may help strengthen economic support is to work proactively with the homeless and the jobless. Many communities have programs to help those with home and employment needs. While not common yet, it is well within the purview of the CP and CRR programs to maintain and distribute lists of community

resources for home and job placement. The CP and CRR programs must use community partnerships to deliver the resources to those in the public.

Strengthen Access and Delivery of Suicide Care (And All Mental Health Care)

Foundation

Those with current mental health issues are at greater risk for suicide (Mental Health First Aid USA, 2015). For this reason, access to mental health care, not just for those who are suicidal, is necessary to prevent suicide (CDC, 2017).

Methods

Widely available, effective, and efficient mental health care is critical to preventing suicide. Issues such as local availability, the proper number of mental health professionals for the community, and insurance issues are all important considerations (CDC, 2017). Much of this text has focused on the need for groups of experts, caregivers, and supporters to work together to manage community issues.

One of the most productive uses for CP and CRR programs is to help manage community mental health. This text is focused on providing emergency and crisis care to those who need it – including suicidal patients. In most EMS response areas, patients who have suicidal ideation are routinely transported to the emergency department for evaluation. While it does provide a means of care and gets the person to a safe environment, it may not be the most effective way to handle a non-actively suicidal person.

To explain, we can surmise that there are varying levels of suicidality. They are:

- Ideation
- Plans
- Behaviors

Suicidal ideation refers to thoughts of suicide. While suicidal thoughts are a risk factor for suicide, many people have these thoughts, and most do not act on them (Boston Child Study Center [BCSC], n.d.). Importantly, thoughts can range from fleeting ideas to a preoccupation with the subject (BCSC, n.d.). According to Ivey-Stephenson et al. (2022), between 2015 and 2019, approximately 10.5 million adults (8.6% of the population) experienced suicidal thoughts in the U.S.

A higher level of concern after ideation is planning. According to Ivey-Stephenson et al. (2022), between 2015 and 2019, approximately 2.1 million American adults (2.5% of the population) reported making plans for suicide attempts. Plans include a person determining the time, place, or means to complete suicide.

The most severe level is behavior. These include actual attempts and rehearsals for the act of suicide. According to Ivey-Stephenson et al. (2022), between 2015 and 2019, 1.3 million American adults (1.1% of the population) reported suicidal behavior.

Often, when suicidal ideation patients are encountered in the field, they are forced to go to the emergency department for evaluation. Suicidologist Mary Frances Seeley, Ph.D., discusses the problem of forcing those with suicidal ideation into hospitalization. She notes that the results of forcing those with suicidal ideation, with no means or plans, to treatment may result in the opposite of what is intended. By forcing those people to be seen, the system only teaches the person that they will be "locked up" if they admit to suicidal thoughts. This may cause them to keep their feelings to themselves. Additionally, when a person is forced into treatment (whether in schools, hospitals, etc.), they learn how to placate best the person delivering the treatment to be left alone – they close off from the help and focus on extricating themselves from the treatment (M. Seeley, personal communication, April 24, 2021).

Clinical suicide assessment can be complex and depends on a person's desire to seek clinical care. A more sensible option may be to widely distribute a tool that may evaluate those people with suicidal ideation in the home, school, or work environment using the Columbia Suicide Severity Rating Scale (C-SSRS) and using the results to direct treatment.

The C-SSRS is a six-question tool that citizens, first responders, teachers, and hospitals may use to gauge the severity of the condition of a suicidal person to seek the most appropriate care (The Columbia Lighthouse Project, n.d.). It is endorsed by the Food and Drug Administration (FDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC).

The questions use straightforward language to scale the person's suicidal ideation, plans, and attempts and make recommendations based on the results. If the person has thoughts of killing themselves or how they would do this, the scale suggests seeking mental healthcare. If they have done anything, started to do anything, or are prepared to do anything to end their life, the scale indicates the person calls 911, 988, or goes to the emergency room. This may enable a person to evaluate their condition or the condition of loved ones to find the most appropriate care.

The scale is available at no cost at https://cssrs.columbia.edu/.

Create Protective Environments

Foundation

The cultures of homes and organizations are primary hindrances to help-seeking behaviors. Stigma reduction at home and programs, policies, and practices must be implemented

in the workplace that supports the person and encourages them to seek help if needed (CDC, 2017).

Methods

Several methods are used in creating protective environments. These include:

- Reducing access to lethal means
- Safe storage of lethal means (firearms, drugs, other means)
- Alcohol abuse treatment (CDC, 2017)

"Research also indicates that: 1) the interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes, and 2) people tend not to substitute a different method when a highly lethal method is unavailable or difficult to access. Therefore, increasing the time interval between deciding to act and the suicide attempt, for example, by making it more difficult to access lethal means, can be lifesaving" (CDC, 2017, p.25). The key, according to the research, is to make the acquisition of lethal means more challenging, to “buy time” for the person.

Gold and Frierson (2020) state that suicide associated with firearms exceeds suicide from all other causes combined. Safe storage of lethal means allows that critical period between deciding to complete suicide and attempting to be lengthened. This time may be vital for the suicidal person. Ensure that firearms, drugs, and other lethal means are not readily available. Firearms must be securely stored in homes and removed from homes if suicidality is present. Medications should be locked in a container and disposed of when they are no longer used.

Alcohol also plays a significant role in suicide. "Research studies in the United States have found that greater alcohol availability positively correlates with alcohol-involved suicides. These policies are important because acute alcohol use is associated with more than one-third of suicides and approximately 40% of suicide attempts" (CDC, 2017, p.25). Additionally, alcohol

and suicide by firearm are strongly related (Branas et al., 2011). In one study, adolescents who completed suicide using guns were almost five times more likely to have been drinking alcohol than those who used other means (Brent, 1987).

The fire department, CP, and CRR's role in creating protective environments is well known when discussing fire and EMS-related issues, but not as much when discussing creating protective environments for potentially suicidal people. There are several simple things that local fire departments may do to provide community protection:

Education. Fire department education programs regularly address community concerns. Suicide is undoubtedly a community concern, so fire department CP and CRR programs should manage the creation of protective environments by reducing lethal means such as guns and drugs and treating alcohol issues.

Gun Storage and Locks. Providing free firearm locks and training on their use may be a straightforward way to reduce the availability of lethal means and increase the time required to complete suicide. If a person is known to be suicidal, removing guns from home is a positive step in the means of control.

Drug Lock Boxes. Providing lock boxes to the public for medication storage is also a way to reduce the availability of medications that may cause harm.

Drug Drop Off and Disposal Service. Fire departments may also provide drug drop-off containers at fire stations for citizens to dispose of unwanted or expired medications. This removes them from the house and reduces risk.

Alcohol Treatment and Prevention. Since alcohol use contributes to suicide, the fire department should highlight local programs to treat alcoholism. This may include listing local Alcoholics Anonymous (AA) meetings on the fire department website or social media page or

holding workshops for the public to discuss alcohol-related issues. These programs should be advertised to both adolescents and adults.

Promote Connectedness

Foundation

Since the 1800s, the protective connection between positive, supportive human interaction and suicide has been known. Social interaction in all its forms is essential to the reduction of suicide – this includes neighborhood organizations, churches, and work (CDC, 2017; Gold & Frierson, 2020)

Methods

Greater participation in community activities may help prevent suicide - connection with community members has been proven to alleviate depression and reduce stress. Proper social leadership may help establish more open-minded ideas regarding mental illness and local support (CDC, 2017).

Outreach is critical. The fire department must create programs that go into the community and offer help. The fire department and its associated programs may promote connectedness in several ways, including sponsoring community activities, creating school peer support groups, and visiting local churches and schools to talk about suicide.

Teach Coping and Problem-Solving Skills

Foundation

Some suicide experts believe that suicidal behavior may be, at least partially, a learned behavior. When negative thoughts and behaviors are exhibited in an environment, it may teach those in that environment (especially children) that those behaviors are effective ways to manage stress (CDC, 2017).

A constructive solution is to model behaviors that encourage problem-solving and critical thinking (CDC, 2017). When this is done, the skills needed to deal with stress and related issues may be passed from generation to generation. This will be discussed in more detail later.

Methods

Since behavior modeling is a common method for parents to pass knowledge to their children, it makes sense that children will use the stress relief skills of their parents to manage challenges. The issue arises when the parent's strategies are unhealthy or dangerous. Parents must understand that their children are constantly watching and learning from them. They will often imitate their behavior.

For this reason, it is also reasonable to assume that some parents and children may not have learned the proper coping techniques to make them the most successful at managing stress. Many educational resilience development programs exist. The programs may be geared toward children (usually in school) or parents. Topics discussed in both programs include problem-solving skills and communication methods (CDC, 2017).

The fire department, CP, and CRR may create online programs to teach coping strategies to parents and kids or perform seminars at local schools discussing how to cope. The fire department must remember that many local community partners may help with these initiatives.

Identify and Support People at Risk

Foundation

It is critical to identify at-risk individuals (CDC, 2017).

Methods

The CDC (2017) identifies two effective methods for identifying and supporting at-risk people. These methods include both the training of gatekeepers and access to crisis intervention.

Gatekeepers refer to people trained in recognizing suicidal behavior. Once the behavior is identified, crisis intervention may be done.

Earlier in the text, we described several Crisis First Aid Programs, one of which is Introduction to Crisis First Aid (CFA-I). This brief, video-based program may be posted on fire department websites or taught after local CPR classes and includes gatekeeper information on suicide risk.

Lessen Harms and Prevent Future Risk

Foundation

When suicide does occur, it must be understood that many who are left behind will be traumatized. These individuals must also be cared for, and suicide contagion must be avoided. A critical consideration that will make a difference in this respect is how suicide is announced. Care must be taken to avoid exaggerated or rumor-laden descriptions of the event (CDC, 2017).

Methods

Some potential interventions that may be used after suicide include postvention approaches and appropriate messaging techniques (CDC, 2017). "Postvention approaches are implemented after a suicide and may include debriefing sessions, counseling, or bereavement support groups for surviving friends, family members, or other close contacts. These programs have not typically been evaluated for their impact on suicide attempts or ideation, but they may reduce survivors' guilt, feelings of depression, and complicated grief" (CDC, 2017, p.41).

Unfortunately, suicide happens despite the best efforts for prevention. The fire department may provide crisis intervention for affected people if an event occurs and ensure the entity affected has local resources to manage the aftermath. Additionally, the CP and CRR

programs may help schools and other organizations create plans for when a suicide affects a particular community.

Community Suicide Prevention Combined Program

The Joliet Suicide Prevention Model (JSM) is a four-objective model that addresses critical components regarding suicide prevention in the community using mission areas from the Joliet Emergency Management Model for Mental Health and Illness (JEMMHI) mentioned in Chapter 14. The local fire department may implement these as part of CP or CRR programs. The JSM program addresses the seven components of the CDC model (strengthening economic supports, strengthening access and delivery of suicide care, creating protective environments, promoting connectedness, teaching coping and problem-solving skills, identifying and supporting people at risk, and lessening harm and preventing future risk) and fits them into the JEMMHI model and fire department activities.

Objective 1: Specific Suicide Prevention Training

JEMMHI Area: Prevention

CDC Strategy Used

Access and Delivery of Suicide Care

Promote Connectedness

Teach Coping and Problem-Solving Skills

One of the key concepts throughout this text is prevention. In keeping with this theme, citizens must be informed of available care and instructed on proper coping skills, including social support. The CP and CRR programs within the fire department are well-suited to perform this task. They have access to vulnerable populations and may be able to bring suicide education to the at-risk population.

Objective 2: Gatekeeper Training: Introductory Crisis First Aid

JEMMHI Area: Prevention, Recovery

CDC Strategy Used

Identify and Support People at Risk

Creating Protective Environments

Lessening Harms and Preventing Future Risk

The Introductory Crisis First Aid (CFA-I) is a positive step toward identifying at-risk persons. The free course (see Chapter 10) instructs people on identifying risk factors for suicide in the people they have contact with. The course's short duration and free nature will hopefully encourage more people to participate. This may help reduce future risk by providing information and practical guidance on creating protective environments.

Objective 3: Regular General Mental Health Training

JEMMHI Area: Prevention, Response, Recovery, Mitigation

CDC Strategy Used

Promote Connectedness

Lessening Harms and Preventing Future Risk

Fire department CP and CRR programs may include regular public mental health training. This may be done in person or through virtual means. Local partners may bring specialists to discuss communications, risk factors, and warning signs, and how to find treatment.

Objective 4: Regular Outreach

JEMMHI Area: Prevention, Response, Mitigation

CDC Strategy Used

Identify and Support People at Risk

Strengthen Economic Supports

Promote Connectedness

Outreach programs are a critical component of suicide prevention. This is where many programs fail. It is not enough to provide information for the public; there has to be a means to go into the public arena and seek out suicidal people and adequately educate them regarding available health and prevention strategies. Outreach may be done anywhere the risk assessment identifies a problem, including schools, nursing homes, churches, recovery meetings, and homeless shelters.

The Family Problem

One of the potential shortcomings of many suicide prevention programs is that they fail to target one of the most crucial prevention resources for suicide, parents. Many suicide prevention programs are directed at adolescents to affect prevention. Repeatedly, we see heartbreaking stories about adolescents who complete suicide. Suicidologist Mary Frances Seeley, Ph.D., identifies this oversight as one of the most critical in the suicide milieu.

Unfortunately, the problems that have contributed to the suicidality of the adolescent have sometimes already done their damage and may be traced to parents either causing the issue or failing to recognize it. Some mental illness symptoms that adolescents face first manifest themselves between the ages of 7 and 14, meaning they already potentially have a diagnosable mental illness (one of the prime warning signs for suicide) before adolescence begins (Kessler et al., 2007). Additionally, "family discord has been identified as a precursor to adolescent suicide" (Stivers, 1987, p. 135).

For this reason, parents must ensure that they are mentally healthy, educated on mental health issues, and adequately modeling behaviors for their children to teach them how to cope. Additionally, parents must be vigilant and may recognize problems in their children early and seek appropriate treatment. This includes taking part in some of the potential programs listed above.

Summary

Suicide is a severe problem in America and has become so complex that people may not think it is preventable. The JFD Suicide Prevention Model incorporates psychoeducation, peer support, regular training, and physical outreach to provide the most comprehensive suicide prevention possible.

Part 8: Conclusion

Chapter 25: Hopeful Beginning

This book has issued some challenges to accepted and ongoing mental health issues, and its intended audience has changed several times during its writing. As mentioned at the beginning of this book, it is not assumed that the program contained herein will solve mental health issues in America. However, we hope it will illustrate the untapped community resources already available to help with the current problem and develop and maintain a sustainable system. The open gaps in mental health and illness care may be filled with collaboration, not competition.

An attempt has been made to simplify an extraordinarily complex subject for the public, fire departments, paramedics, and other agencies to manage small parts and affect improvement. All emergencies start and end locally. Things will improve systemically if we begin the improvement process at the home and local levels. All parts of the puzzle (i.e., person, supporters, clinician, physician) must be in place and do their part for holistic and effective care. Missing any one of them may cause the entire system to break down.

All the identified parties in this book have their part to play in the mental health and illness system; all are needed to make the solutions work - no one field can handle the entire problem itself. To this end, an organized team approach must be designed and used. Hopefully, the information in this book will contribute some ideas to the solution.

Part 9: Sources & Index

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List of Abbreviations

AEMT: *Advanced Emergency Medical Technician*

CESSA: *Community Emergency Services and Support Act*

CRA: *Community Risk Assessment*

CFA: *Crisis First Aid*

CFA-EMD: *Crisis First Aid for Emergency Medical Dispatchers*

CFA-I: *Introductory Crisis First Aid*

CFA-LE: *Crisis First Aid for Law Enforcement*

CFA-P*:* *Crisis First Aid for Paramedics*

CIT: *Crisis Intervention Training*

CP: *Community Paramedicine/Paramedic*

CRR: *Community Risk Reduction*

CUE: Congruence, Unconditional Positive Regard, and Empathy

ECG: *Electrocardiogram*

ED: *Emergency Department*

EMD: *Emergency Medical Dispatcher*

EMS: *Emergency Medical Services*

EMT: *Emergency Medical Technician*

GP: *General Practitioner*

IC: *Incident Commander*

IAFF*: International Association of Firefighters*

IV: *Intravenous*

JFD: *Joliet Fire Department*

JFSPG: *Joliet Firefighters Peer Support Group*

LE: *Law Enforcement*

MCT/MCU: *Mobile Crisis Team /Mobile Crisis Unit*

NFPA: *National Fire Protection Association*

NIMH: *National Institute of Mental Health*

NSPL: *National Suicide Prevention Lifeline*

NGO: *Non-Governmental Organizations*

NPO: *Non-Profit Organizations*

PCP: *Primary Care Physician*

PTSD: *Post-Traumatic Stress Disorder*

PFA: *Psychological First Aid*

SAMHSA: *Substance Abuse and Mental Health Services Administration*

SCEMSS: *Silver Cross Emergency Medical Services System*

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