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# Mental Health-Medical Crisis Team Impact on First Responder Outcomes on Persons with Mental Illness

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MA, Walden University, 2017

BS, Missouri School of Science and Technology, 1986

Dissertation Submitted in Partial Fulfillment

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## Abstract

Persons with mental illness (PMIs) are 16 times more likely to experience harm when interacting with police than individuals without mental illness. This inequity has recently become prominent in American discourse due to the ubiquitous use of cell phones and social media, where videos of incidents between police and PMIs circulate. In this generic qualitative research, members of a collaborative mental health and emergency medical service professionals (EMSPs) team in an urban area were interviewed to assess the team members' perceptions of the impact of the program on frequency of adverse outcomes during interactions with PMIs. The theoretical framework for this study was based on the sequential intercept model (SIM), which identified six key points where PMIs can be redirected from the criminal justice system towards short- and/or long-term social services. Semi structured interviewing was used to capture the attitudes of 11 members of collaborative crisis teams as they cared for PMIs during a traumatic crisis. Thematic analysis was performed to identify six predominant themes including the program serves as an alternative response to traditional emergency response; partnerships are fluid and respectful; safety is a priority on calls; police are all-in; policy makers and community are taking notice; and short and long term linkage is key. The results of this study potentially benefit first responder systems nationwide, highlighting the benefits of emphasizing mental health strategies such as the collaborative mental health professional and EMSP team in caring for PMIs in a crisis as well as gaps in the system particularly as they relate to availability of, and diversion to, short and long term services.

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# Dedication

I would like to dedicate this dissertation to my family. Without your support and encouragement, I could have never made this dream a reality.

# Acknowledgments

I want to thank my family for encouraging and helping me through this adventure. I could never have reached this goal without your love and support. A special thank you to my husband and children for supporting me during my most trying moments when my passion for justice and crusade for dismantling oppression may have been overzealous. Thank you to my siblings, you made me aware that we are not all born the same, mentally and physically, and that systems of oppressions and circumstances in our lives can impact or guide our futures, fairly or not. You are the reason I worked so diligently on this research, and you are the reason, along with the recent exposure and exacerbation of political ideologies that lack an empathic lens, I maintained this level of motivation to positively affect social change. A special thank you to my son, Sam, whose intelligence and editing expertise were invaluable. Thank you to my husband, Nick, for supporting me to achieve my dream. I appreciate and love you all tremendously.

Thank you, Dr. Hickman, for guiding me through this rigorous dissertation process. Your support, along with your passion and wisdom, have made this adventure seamless and I will forever be grateful for your guidance in helping make this research so salient and expansive. Thank you, Dr. Hershberger, for your tireless support particularly in the area of design study. I appreciate the time you took to ensure my study was appropriately defined and relevant. And thank you to the DissFam for just being so supportive, friendly, funny, fun, and encouraging. I am fortunate to have been a part of such a loving, helpful, academic family.

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# Chapter 1: Introduction to the Study

The police in the United States, whom community leaders have ostensibly designated with the responsibility to protect and serve citizens, have had a disproportionately contentious and often complicated relationship with persons with mental illness (PMIs; Friedman, 2021). The police are generally not extensively trained in the best strategies to deal with these individuals (Baker & Pillinger, 2020a). Interactions between the two groups have resulted in higher instances of violent and deadly outcomes than interactions between police and individuals not suffering from mental illness (Friedman, 2021).

In 1989, mental health advocates in Eugene, Oregon, recognized the need for a program to address emergency situations with a behavioral health component (Climer & Gicker, 2021). These mental illnesses have exacerbated the potential risk for adverse or violent outcomes resulting from interactions between PMIs and first responders (Baker & Pillinger, 2020a).

One of the mental health community's priorities is to mitigate consequences of mental illness, but public funds have not been sufficient to adequately address the needs of the mentally ill as a result of deinstitutionalization in the mental health field (Frances & Ruffalo, 2018). The convergence of these deleterious issues has encouraged mental health and public safety professionals to address these issues as they impact the Black community (Williams, 2018). The recent media attention given to instances of deaths of Black individuals at the hands of police has caused many police organizations to reimagine some of their strategies and tactics when interfacing with the constituents they

serve (Lemieux et al., 2020). Chapter 1 covers the background, problem statement, purpose of the study, research question, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and finally, significance.

## Background

Mental health professionals (MHPs) and police departments have attempted to initiate many new treatment programs throughout the years to address police response to individuals experiencing a mental health event. One of these strategies is crisis intervention teams (CITs), which are voluntary programs designed to train police officers in mental health intervention (Khalsa et al., 2018). Law enforcement organizations have initiated CITs in locations including Memphis, Tennessee; Baltimore, Maryland; Colorado; and Florida (Booty et al., 2020; Compton et al., 2017; Ellis, 2014). Another method that law enforcement agencies have installed is the co-responder model, which involves pairing a law enforcement officer with an MHP (Helfgott et al., 2016). Community leaders have attempted this strategy in Boston, Massachusetts; Nova Scotia, Canada; and Seattle, Washington (Bailey et al., 2021; Kisely et al., 2010; Morabito et al., 2018; Stigter-Outshoven, 2019; Swartz, 2020). A third strategy that agencies have attempted is the mobile crisis unit (MCU), which includes multiple MHPs responding to mental health specific crises (Daggenvoorde et al., 2018). Policymakers have introduced this strategy in California; Pennsylvania and Toronto, Canada (Ireland, 2022; Muehsam, 2019; Lord & Bjerregaard, 2014).

In the following sections, I analyze the success of each of these programs, as well as subsequent programs which have utilized successful aspects of the above strategies,

such as Eugene, Oregon's Crisis Assistance Helping Out on the Streets (CAHOOTS) program and the program I studied.

Of these strategies and initiatives, none has been as thorough or successful in implementation as the CAHOOTS program in Eugene, Oregon (Climer & Gicker, 2021). The program concentrates on a smaller, less diverse community; therefore, this research extends the approach by focusing on utilizing a program similarly implemented within a much more densely populated and racially diverse demographic (Goble, 2021). The treatment, coupling MHPs with emergency medical service professionals (EMSPs) in a mobile van, has shown promising results in rendering care to individuals in need of assistance (Climer & Gicker, 2021).

In this chapter, I provide background on public safety as it relates to dealing with individuals with mental health problems. I describe the mental health treatment program's role in improving outcomes between public safety and PMIs. My research centers upon the team of the program I studied that is used to alleviate police from dealing with nonviolent, mental health crimes. MHPs and EMSPs are sent to attend to the individual experiencing a crisis (Carroll, 2021). Munetz and Griffin's (2006) sequential intercept model (SIM) was used as the theoretical framework in this study. The nature of this study includes the methodology, strategy, target population, and relevant definitions in this research. This section is followed by assumptions, the scope and delimitations, limitations, and significance of the study.

## Problem Statement

PMIs experience harmful outcomes when interacting with police at a rate of sixteen times that of individuals not suffering from a mental illness (Myers, 2017). Due to the proliferation of several recorded violent interactions between police officers and PMIs, the concept of discrimination of PMIs has become a major topic of discourse between outraged community members, law enforcement, and policy makers (Lum et al, 2022). Users of social media platforms served to magnify and circulate videos of these tragic deaths, which resulted in the rise of movements such as Black Lives Matter (BLM), which included both Black and White individuals. One of the most publicized goals of the BLM was to defund (or reimagine) the police (Lum et al., 2022). Protestors and demonstrators delivered this message in many cities throughout the United States, and in response, governors, mayors, and city council members began researching potential police reform strategies (Friedman, 2021).

Law enforcement organization officials understood that individuals with untreated mental illness were vastly overrepresented in almost all aspects of the criminal justice system, including arrests and law enforcement (Veeh et al., 2018). These officials felt they had addressed this issue with the CIT program (Bratina et al., 2020). For the last decade, instructors of this voluntary 40-hour CIT program taught de-escalation, crisis, and response techniques, as well as ways to provide support for placement into long-term care programs (Bratina et al., 2020). Although officials considered these methods to be promising, statistics appear to have shown otherwise: members of certain communities

appear to feel that any involvement of PMIs with the police is at significant risk of adverse outcomes (Saleh et al., 2018).

The inability of the CIT programs to prevent or mitigate PMI deaths, when engaged in activity with police, is inextricably tied to the lack of seriousness, vigilance, and faith in the mental health field (Peterson & Densley, 2018). Officers may interpret the fact that the program is voluntary as opposed to mandatory, and only 40 hours if implemented, to be an indication that their superiors do not consider it to be essential to their practices (Peterson & Densley, 2018). Most importantly, the numbers and statistics do not appear to prove program efficacy (Peterson & Densley, 2018).

Although the aforementioned research regarding adverse outcomes involving PMIs and first responders illuminates important findings, I have found no research that has examined approaches to addressing the treatment of PMIs during a crisis event involving first responders. Given such, further research is warranted that could examine treatment approaches of PMIs in an effort to address the documented problem that PMIs are sixteen times more likely to be harmed by police than other individuals (Myers, 2017).

## Purpose of the Study

The purpose of this generic qualitative design is to explore and understand how individuals associated with the collaborative crisis team (i.e., an MHP and EMSP) perceive the treatment's impact on the rate of PMI adverse outcomes when a PMI experiences a mental health crisis.

## Research Question

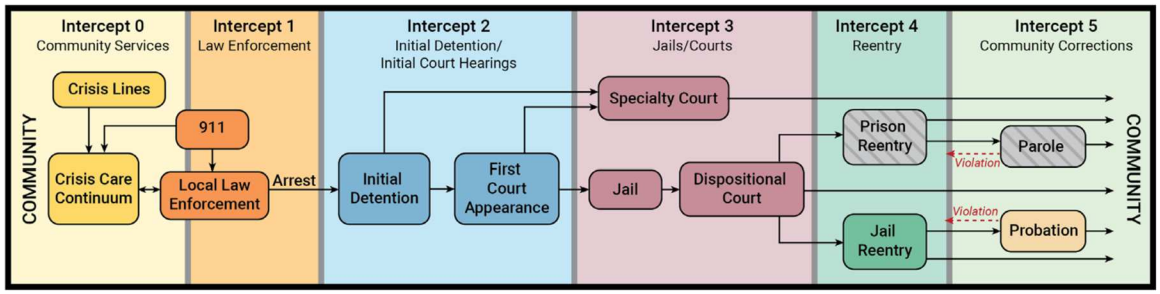
RQ1: What are the attitudes of the collaborative crisis team (MHP and EMSP) on PMI adverse outcomes according to individuals associated with the program?

## Conceptual Framework

The theoretical framework for this study was based upon the SIM. In the early 2000s, the developers of this model originally identified five key intercept points where PMIs can receive short- and/or long-term social services support and relief as they navigate the criminal justice system (Munetz & Griffin, 2006). The model evolved over several years since its origination in 2000 followed by several refinements with the most recent addition of a new paradigm, Intercept 0, by Abreu et al. (2017). By expanding this model to include this prequal intercept, policymakers from both of the mental health and criminal justice fields are able to conceptualize the full scope of actual interactions that PMIs experience with regards to their paths through the criminal justice system (Abreu et al., 2017). Figure 1 displays a depiction of the SIM time continuum.

**Figure 1**

*Sequential Intercept Model Time Continuum*




**Source:** Policy Research Associates, Inc., https://www.prainc.com/sim/.

*Note.* From *The Sequential Intercept Model*, by Policy Research Associates, n.d. (https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf).

Although programs such as the one I studied primarily fall within the initial intercepts, Comartin et al. (2021) reinforced the concept of inserting mental health influences throughout this linearly defined time continuum. Abreu et al. (2017) recognized this need early within the time continuum by identifying Intercept 0, which represents the community services point in which PMIs can be directed to local crisis care services without having to necessarily call 911 or involve the criminal justice system. Intercept 1, pertaining to early law enforcement intervention, involves diversion by law enforcement via a sophisticated and informed 911 process in which dispatchers are educated on behavioral health crises and are supplied a decision tree for redirection guidance. Dispatchers can divert individuals in crisis to either a team such as the program I studied or a CIT certified officer (if resources are limited). Intercept 2 (Initial Detention/Initial Court Hearings), Intercept 3 (Jails/Courts), Intercept 4 (Reentry) and finally Intercept 5 (Community Corrections) are all downstream of the initial entry where the program I studied makes its biggest mark (Pinals & Callahan, 2020). I describe each intercept in further detail in Chapter 2.

Those who designed the program I studied specifically originated the program for most optimal impact within Intercepts 0 and 1, where PMIs can be diverted at their first initial contact with law enforcement (Pinals & Callahan, 2020). The impact of programs such as the one I studied is far-reaching and has effects that ripple through all intercepts due to its goal of advocating for PMIs throughout the law enforcement and legal system (Wasser et al., 2017). The SIM's primary purpose is to provide structure and direction in

the assessment of available resources to identify gaps, needs, and improvements in the areas of social services best suited to assist individuals dealing with mental illness (Comartin et al., 2021). A key factor for SIM to be a successful interceptor is the existence of readily available support programs to divert the individual dealing with mental health issues to the appropriate service rather than to the criminal justice system (Bonfine et al., 2018). These community services are optimal when synergy between stakeholders is present and ongoing (Wasser et al., 2017). Programs supporting substance abuse treatment, housing needs, community corrections, judicial and legal needs, physical health needs, and many other services are successful if communication is ample, open, and connected (Munetz & Griffin, 2006). SIM is a strategic planning tool developed to ensure transition of PMIs enduring trauma (initiated by a 911 emergency call) to an appropriate social service rather than through the traditional criminal justice system (Munetz & Griffin, 2006).

## Nature of the Study

I performed a generic qualitative study to explore the impact of the program I studied on adverse outcomes involving PMI and first responders. This qualitative design provides a lens into each participant's comprehension and worldview (Caelli et al., 2003). Semistructured qualitative interviews are open-ended, allowing the free flow of information such that new ideas and constructs can spontaneously surface. The structured segment of this interview process allows for consistency of general themes to be introduced and investigated based on questions defined and delivered to all participants (Percy et al., 2015). Whereas the open-ended questions allow for stream of conciousness

discourse, the structured segment facilitates the participants' speaking in a thorough and complete manner to explicate feelings, behaviors, and experiences associated with topics presented to all participants (Percy et al., 2015).

I selected the generic qualitative design because of the freedoms to explore the participants' sentiments without restrictions and with the goal of exploring and capturing information that may not have surfaced had I used a more closed-form interviewing processs. I felt my experience as a therapist was integral in this open-form, person-centered process.

The sampling strategy for this generic qualitative study was purposive. Purposive sampling entails recruiting only participants who meet the specific criteria (Cooper & Endacott, 2007). Participants in the generic qualitative study are selected deliberately so as to contribute to a richer understanding of stakeholder's feelings, perceptions, and comprehension from being part of the treatment process (Cooper & Endacott, 2007).

I selected multiple individuals who have worked as part of the program I studied (i.e., MHP, EMSP) for the interview process. The manager of the program I studied, with their knowledge of MHPs and EMSPs throughout the history of the program, provided a list of appropriate individuals fulfilling the criteria. The program manager provided an ample list of potential interview candidates. I interviewed 11 individuals (six MHPs and five EMSPs) for this study. The participants were homogeneous in terms of their education and career goals, which supported the objective of the data reaching a relatively quick saturation point (Hagaman & Wutich, 2017). The interviewees consisted of adult participants who have worked as part of the team of the pogram I studied in some

capacity, currently or at some point in the recent past. The interviews took place via videoconferencing or telephone per the participant's request. The semistructured interview included open-ended questions aimed at understanding perceptions of the treatment's impact of the program I studied on the rate of PMI adverse outcomes when a PMI experiences a mental health crisis.

After the interview phase, I transcribed the recorded interviews using DEDOOSE software (https://www.dedoose.com), which allowed me to become closer to and familiar with the data and provided a head start in identifying commonalities and themes (Andraka-Christou et al., 2021). I used Microsoft Excel to process the data and assign preliminary codes to describe the content; this consequently enabled me to identify emerging patterns and themes from the several interviews and respective data sets. Using the software, I closely examined the data to identify common themes, topics, ideas, and patterns of meaning that came up repeatedly When thematic analysis was originally developed, Clarke and Braun (2018) formulated a six-step process: familiarization, coding, generating themes, reviewing themes, defining and naming themes, and writing up. The method is flexible, though, and with my Microsoft Excel and programming skills I adapted the steps to support my own tailored process and research. I wanted the result to be grounded by a sound, rigorous, and tailored process. Ultimately, names and themes relevant to the study were identified and revealed in a comprehensive report.

## Definitions

*911 call*: Emergency telephone number for use in emergency situations or when a crime is occurring. Assistance may come in the form of police, fire department or ambulance (Baker & Pillinger, 2020a).

*Co-responder models*: Typically involves an individual from law enforcement and the mental health community working together to respond efficiently and effectively to a person experiencing a mental health crisis (Morabito et al., 2018).

*Crisis Assistance Helping Out on The Streets (CAHOOTS):* One of the first mobile crisis intervention programs, established in 1989 in Eugene, Oregon, in which an MHP and emergency medical technician (EMT) collaborate to attend to individuals dealing with a mental illness in public spaces (Climer & Gicker, 2021).

*Crisis intervention team (CIT)*: Mental health community collaborates with law enforcement to educate police officers on effective ways to manage individuals with mental illness during a crisis (Bratina et al., 2020).

*Emergency medical technician (EMT)*: A health professional who provides basic, noninvasive, medical care in an emergency situation. They typically assist in transporting individuals in need via a vehicle, such as an ambulance, to the hospital and are sometimes associated with law enforcement or fire departments (Thielmann et al., 2022).

*Emergency medical system professional (EMSP):* An emergency medical services first responder who performs emergency medical treatments, such as EMTs and paramedics.

*Mental health crisis*: A situation in which an individual's reasoning, reactions, and behaviors may become irrational, illogical, or harmful due to mental illness. The individual experiencing the crisis may be at risk of harming themselves or others and/or be incapable of caring for themselves in terms of accessing food, clothing, and shelter (Bailey et al., 2021).

*Mobile crisis intervention team (MCIT)*: Operates with a team of two specially trained individuals in the fields of mental health and emergency medicine. The team generally takes 911 calls that are deemed nonviolent and contain a behavioral health component (Carroll, 2021).

*Mobile crisis unit (MCU)*: An alternative to calling 911, this rapid response team supplies mental health services to individuals in distress or crises (Lord & Bjerregaard, 2014).

*Paramedic:* Emergency health professional trained to provide emergency medical care outside of hospitals and medical offices to people who are injured or ill (Thielmann et al., 2022).

*Persons with mental illness (PMI or PwMI)*: Refers to persons with a wide range of mental health disorders in which the individual's mood, thinking, and behavior may be negatively impacted so as to impede daily functioning. Some of the more common disorders include depression, anxiety, paranoia, schizophrenia, eating disorders, and addiction (Abdullah & Brown, 2020).

*Program I studied*: A city, state community program in which specific mental-health-related 911 calls are redirected to a Mental Health Center in which a social worker

and EMSP assists individuals in need of assistance during a crisis. This alleviates police from dealing with nonviolent crimes (Carroll, 2021).

## Assumptions

I assumed the stakeholders would be able to accurately recall their experiences with the program and respond to questions as truthfully as possible. I assumed that participants would compare treatment experiences that have contributed to reducing PMI arrests when dealing with the police, particularly when a mental health issue is the reason for interaction. I assumed the MHP/EMSP collaborative program would be implemented in accordance with the steps prescribed by the preeminent, successful CAHOOTS program, while tailoring for the urban setting. I assumed that stakeholders could comprehend the correlation construct and use it to explain their perceptions of arrest frequencies and adverse outcomes of PMIs. These assumptions were key in ensuring integrity with the research process in terms of controlling for bias.

## Scope and Delimitations

The scope of my study concentrated on the efficacy of the program as it has been heavily publicized, leverages key facets of the highly touted CAHOOTS program in Eugene, Oregon, and has an urban setting with the diverse demographics necessary for the purpose of this study (Carroll, 2021). As part of the qualitative component of the research, I interviewed stakeholders who were aware of and impacted by the treatment program. I then analyzed the interview transcripts of this generic qualitative study to assess emerging themes.

The delimitations of this study included using a single police department in a specific urban area due to time constraints and accessibility issues. Second, due to police-department-specific confidentiality rules, departments did not give me permission to interview police officers or recipients for research. Despite this, I was able to establish enough key stakeholder information within the public safety realm to provide a "proxy" understanding of their perceptions of the intervention. As with most human services studies, ethics is of highest importance; thus, transparency and open communication was integral in this work. I offered each interviewee the option of reviewing the final assessment to ensure alignment and agreement in terms of their input to the research.

Also, I performed this study in an urban setting during a pandemic. The conclusions made by this study may not be generalizable nor transferable towards more suburban or rural settings. Demographics are quite different between urban versus other settings, likely hampering generalizability because of different perspectives and lifespan events.

## Limitations

Two major limitations for the qualitative segment of the study include the potential for the researcher to bias the participant's explanations and descriptions simply by virtue of their presence, as well as the fact that not all stakeholders can articulate their perspective in equivalent fashion. My goal was to eliminate as much bias and uncertainty as possible (McSweeney, 2021).

Likely barriers were perpetual skeptics who are pessimistic of the prospects that any program could be effective, particularly those individuals who have been adversely

affected by police violence (Baker & Pillinger, 2020b). Challenges included generalizing results. In other words, it could be difficult to obtain buy-in from society if the study yielded results that could improve the public safety system via this re-imagined form of policing. There are many stakeholders who would need coaxing in terms of implementing and diverting funds for such a drastic change in the existing programs. If the results are socialized appropriately and expediently, potentially acting as a catalyst for future pilot programs in other jurisdictions with other characteristics, then researchers could address these limitations.

## Significance

This study is significant in that much of the existing body of research regarding mitigating police violence towards PMIs focuses on CIT training in which mental health constructs and de-escalation techniques are taught in a 40-hour course (Helfgott et al., 2016). However, Peterson and Densley (2018) exhaustively reviewed over 25 empirical research articles spanning over a 30-year period pertaining to the efficacy of the CIT program and concluded, based on their definition of successful outcomes, that little could be inferred about the program's impact. Concurrent to the establishment and implementation of CIT, a promising program emphasizing the infusion of MHPs and EMSPs for the response of any traumatic police events with a behavioral health component was tested and eventually implemented and integrated in the public safety system (Waters, 2021). In other words, evidence suggests that when specialists handle a traumatic police event with a behavioral component, negative outcomes among the respondents could be curtailed (Climer & Gicker, 2021). This study afforded the

opportunity to ascertain whether interventionalists perceive the treatment entailing the collaboration of an MHP and EMSP in responding to traumatic police events with a behavioral health component as reducing the rate of adverse outcomes among PMIs.

## Summary

In this chapter, I explain my vision regarding police interaction with PMIs. The public safety system exists to serve and protect the citizenry (Gordijn et al., 2017). Part of achieving that goal requires individuals in positions of authority understanding the plight of the populations they serve and responding compassionately (Bearfield et al., 2021). PMIs experience harm at 16 times the rate of individuals not suffering from mental illness, implying that they continue to be targeted at a higher rate than other populations (Myers, 2017). The resulting stigma and oppression of PMIs experience perpetuate negative stereotypes and support unhealthy mental states of mind (Jacobs & Quinn, 2022).

Because of these statistics, I have exhaustively searched the literature to find viable public safety options that would prevent adverse outcomes for PMIs when involved with first responders. City leaders in Eugene, Oregon (with a population of 200,000) regard one such program, CAHOOTS, as successful and a potential solution for other townships. Throughout the years, though, multiple researchers have tested programs with varying degrees of success to address the mental illness issue in public safety (Peterson & Densley, 2018). These programs can consist of any combination of police officer, MHP, and/or EMSPs. In this chapter, I state the problem of PMI deaths at the hands of the police and the associated research question: What are the attitudes of the

collaborative crisis team (MHP/EMSP) on PMI adverse outcomes according to individuals associated with the program? A generic qualitative research study supports the approach to answering this question.

In Chapter 2, I review the literature concerning the history of PMIs as it relates to their current states of mental health and how the police interact with them during a traumatic mental health event. As PMIs experience harm at 16 times the rate of individuals not suffering from mental illness (Myers, 2017), I am motivated to study ways to reduce or improve those interactions. I review the many different programs the public safety system has created to remediate these interactions that result in death, beginning with the CIT training program, to co-responder, then mobile crisis intervention team (MCIT).

# Chapter 2: Literature Review

## Introduction

The following literature review expounds upon the devolution of mental health institutions, as well as public safety officials' response, resulting in adverse incidents involving first responders and PMIs (Frances, 2019). This paper focuses on the public safety sector's response to these incidents involving PMIs when involved in a traumatic mental health event.

## Brief History of the Mental Health Care System

Americans have experienced a major change in the mental health field during the 20th century (Frances, 2019). Over 500,000 individuals resided in psychiatric hospitals in 1955 (French, 1987). Researchers in the mental health field learned that individuals with mental illness could receive treatment with psychiatric drugs and psychotherapy rather than the harsher techniques utilized in the decades before (Frances & Ruffalo, 2018). Through education and widespread communication, society accepted that individuals with mental illness could receive treatment and assimilate (French, 1987). The government funded programs such as Medicaid and Medicare and directed funding towards community mental health centers (Dyck, 2018). Although this may have been effective for treating individuals with less severe illnesses, a subset of the population, considered severely mentally ill, did not receive any psychiatric care at all (French, 1987). Individuals suffering from schizophrenia, major depression, or bipolar disorder often experience homelessness (Dyck, 2018).

**Impact of the Mental Health Care System and PMIs of Color**

Black individuals experience depression, anxiety, posttraumatic stress disorder (PTSD), substance abuse, and suicidal thoughts as manifestations of centuries of racism and perpetuated negative stereotypes (Abdullah & Brown, 2020). As a result, Black individuals are overrepresented in homeless, incarcerated, unemployed, and impoverished populations, and ergo the PMI population (Edwards et al., 2018).

The experiences of people of color with treatment of mental health have left them with skepticism and trust issues (Abdullah & Brown, 2020). Historically, professionals have misdiagnosed people of color at higher rates than their White peers, and the medical community, with affirmation from the government, has exploited communities of color to promote medical advancement (Edwards et al., 2018). Clients who are misdiagnosed (and who often face inept cultural-specific care) experience poorer mental health treatment outcomes (Akinyemi et al., 2018). People of color are more likely to experience forced involuntary treatment (either inpatient or outpatient) contributing to the stigma, hostility, and lack of willingness to seek voluntary care, which adds to disparities in mental health treatment outcomes (Oduola et al., 2019). As a result, people of color use their own approaches to attend to their mental health care such as emergency room services, church outlets, and utilizing uncredentialed extended family for treatment (Campbell & Winchester, 2020). When these options fail, individuals of color may resort to self-medication which can lead to experiencing homelessness (Bonfine et al., 2018). These shortcomings in mental health treatment options support the conclusion that the mental health field causes substantial harm to people of color (Monk, 2020).

**Public Safety and PMIs**

When an individual is suffering from a serious mental disorder, they may appear confused, disoriented, agitated, hallucinatory, or disconnected from rational thoughts and feelings (Pachankis et al., 2018). In many cases, individuals witnessing or confronted by this behavior feel threatened and call the police (Baker & Pillinger, 2020b). Due to deinstitutionalization and thus a lack of dedicated resources to support social service programs commensurate with the numbers of individuals released from custody, the police have become the frontline for dealing with the mentally ill (Baker & Pillinger, 2020b). Campbell (2019) recognized that the transition from institutions to public spaces has led to "the criminalization of Americans with severe psychiatric illnesses." Police have become de facto first responders for mental health issues, and prisons serve as surrogate psychiatric hospitals for individuals with the severest mental disorders (Edwards et al., 2018).

**Public Safety and People of Color With Mental Illness**

According to recent studies, police altercations with people of color result in fatality at a disproportionate rate compared to others (Lemieux et al., 2020). While PMIs account for less than 19% of the U.S. population, they are shot and killed by police at a rate sixteen times as high as individuals not suffering from a mental illness (Myers, 2017). Analysts collected 5 years of public safety data reflecting demographics and circumstances in which an engagement between police and an individual ended in the individual's death. Edwards et al. (2018) revealed that death rates remained steady throughout the data collection period. Barring any dramatic happenings such as major

societal changes, controllable (i.e., police reform, gun control) or uncontrollable (i.e., pandemic), rare events, such as death by police force, occurring in a large population typically remain stable (Edwards et al., 2019).

Law enforcement agencies and police unions often fail to hold officers accountable for misconduct; as a result, officers can repeat acts of misconduct and behave unethically towards the individuals they are tasked to serve (Lemieux et al., 2020). Even with recorded acts of misconduct, a police officer can typically avoid dismissal or relocate to other municipalities (Trivedi & Van Cleve, 2020). Lemieux et al. (2020) further hypothesize that officers that have committed unwarranted acts of aggression without reprisal are likely to repeat the offense.

**Lack of Accountability in Law Enforcement**

Lack of accountability could also contribute to law enforcement officers' lack of vigilance in collecting details and explanatory data relating to incidents (Hodge & Ortiz, 2020). The Federal Bureau of Investigation (FBI) established the Uniform Crime Report in 1930 to record crimes. Municipalities report information on a voluntary basis (Evans, 2019). Although the FBI's database is the most comprehensive of its kind, the FBI reveals it is not exhaustive (i.e., not all types of crimes reported, demographics of perpetrators not collected, etc.), lacks timeliness, and has quality control issues (Evans, 2019). On-duty law enforcement officers report justifiable homicides, but researchers estimate underreporting to be near 50%; the reports often fail to provide information about the officers or circumstances surrounding shootings (Atherton, 2022).

Due to the lack of specificity in the FBI database in 2015, news organizations such as *The Washington Post* and *The Guardian* began to collect supplementary information in 2015 (Sofer, 2021). These entities leveraged the Freedom of Information Act, which enabled them to subsidize existing information and collect additional information from law-enforcement agencies and other informed sources (Miller et al., 2017). Jackman (2020) fortified data with information from local news reports, independent databases, and their own reporting. These new databases include locations of occurrences, municipalities that were involved, and demographic information about individuals involved (i.e., race, age, sex, and weapon used; Miller et al., 2017). However, these organizations had limitations in terms of obtaining information about officers involved, making it difficult to draw inferences regarding demographics relating to officers and civilians (Miller et al., 2017). Regardless, the prevailing analysis revealed that police disproportionately kill minorities and Black Americans even when those minorities and Black Americans are unarmed (Edwards et al., 2019).

Health professionals are integral in the data collection process as they are at the frontlines of this public health emergency (Agee et al, 2019). Individuals involved in these aggressive acts present at emergency rooms, which leads to emergency workers treating victims and consoling families (Bailey et al., 2018). Bailey et al. (2018) recognized that because health care workers are trained in physical and mental health care in that environment, they can obtain salient information for research. Racial inequities in police violence towards consumers have motivated researchers to find solutions by assessing mental health interventions and communicating analytical and

data-driven results to the police, public and policymakers (Lemieux et al., 2020). Ultimately, Ray et al.'s (2017) findings indicated that systemic changes are needed and that body cameras and independent investigations at the local level have not been effective enough. Successes need to be implemented at the state and national level and codified into law (Bailey et al., 2018).

**Body Cameras, Cell Phones, Social Media, and Accountability**

Individuals started using cell phones for the purpose of taking pictures around the year 2000, and recording video a decade later, as companies adapted phones for smart capabilities (Ramirez, 2018). Although the origins of social media can be traced to the late 1990s, users became more fervent posters and sharers of information, thoughts, views, pictures, and videos around 2005 (Ramirez, 2018). Bystanders witnessing an event frequently record the activities by cell phone and disseminate them via social media (Ramirez, 2018). Ramirez (2018) stated that the merging of smartphones and social media applications acts as a vehicle for accountability.

As technology advanced in the civilian realm, the public safety sector was also becoming more transparent to its constituents (Hodge & Ortiz, 2020). In 2014, police officers started using the first modernized body cameras to foster positive relationships and interactions between officers and the public (Gaub et al., 2022). Stoughton (2018) suggested that when an incident occurs in which a citizen is killed by an officer, the officer's body camera can record the interaction and be used as evidence of the justifiability of the officer's actions.

While initial research showed positive outcomes regarding reduction in violent incidents between police and the public due to the use of body cameras, researchers are finding recent studies to be inconclusive (Stoughton, 2018). Because of occurrences of recorded and posted incidents in which police officers appear to interact with civilians in ways some consider to be unjustifiable, according to Stoughton (2018), much of the public has lost confidence and respect for police officers. Many of the individuals killed are people of color, a fact which has acted as a catalyst for engagement of movements such as BLM (Bearfield et al., 2021). The lack of confidence towards public officials, combined with the incident rates involving Black people, has resulted in a loss of trust among members of many communities in versions of events given by police (Ramirez, 2018).

Citizens and legislators have demanded that all police wear these bodycams with the hopes that the technology will make police accountable, mitigate police abuse, and promote police reform (Hodge & Ortiz, 2020). Although the evidence has been mixed, Hodge and Ortiz (2020) did find some positive outcomes. In their preliminary study, Hodge and Ortiz (2020) concluded that body cameras had a noticeable effect on police work and criminal justice. Researchers observed marked reduction in complaints against police, as individuals' behaviors while under the impression they are being observed are more accommodating (Stoughton, 2018). At the same time Stoughton (2018) noted police use of force fell by 50% according to the study.

With this increase in accountability, observers have had the ability to scrutinize police behaviors more closely (Stoughton, 2018). It is problematic when police, forced to

respond to frontline mental health incidents, must solve situations for which they are neither qualified nor have the dedicated resources (Carroll, 2021).

Police receive training to deal with situations that require them to be on high alert and prepared for worst-case scenarios that may entail violence and danger, requiring force and split-second decision making (Engel et al, 2022). Engel et al. (2022) stated that police often respond to situations in which individuals are experiencing serious, traumatic mental health events such as addiction, bipolarism, schizophrenia, among others. Baker and Pillinger (2020a) stated that police are not necessarily suited or trained for mental health traumatic events. Baker and Pillinger (2020a) also stated that PMIs are two to three times more likely to be shot and killed by police than individuals without mental health issues. Police officers' skills are more relevant in other situations that require combating more violent situations (Wood et al., 2021).

As a result, many police departments across the United States believe collaboration between MHPs and EMSP could be the optimal solution (Jacobs et al., 2021). In the subsequent sections, I discuss literature search strategy and theoretical foundation followed by a description of the evolution of police programs implemented to combat acts of aggression by police against PMIs.

## Literature Search Strategy

I conducted my research via electronic measures, leveraging contents of such databases as ProQuest, SocIndex, Google Scholar, EBSCOhost, EBSCO, ProQuest Central ERIC, PsychINFO, Taylor and Francis Online, and SAGE Premier. My search technique entailed pursuing peer-reviewed and timely material, articles published within

the last 3–5 years, in order to present the most current and salient material pertaining to my research topic. The keywords I used to search for relevant articles on my topic centered upon the following terms and themes: *deinstitutionalization, police killings, Persons with Mental Illness and police, Crisis Intervention Team, Mobile Crisis Intervention Team, Mobile Crisis Unit, co-response model, 911 calls, mental health stigma against and amongst certain cultures, police brutality, mental illness, racism, law enforcement, criminal justice, social inequality, behavioral crisis, mental health street triage, mental health and police collaboration, deaths after police contact, police use of force, police reform, reimagining the police, defund the police, police diversion programs, police body cameras, police transparency, FBI database, implementation evaluation, Sequential Intercept Model,* and *generic qualitative research.*

Although this search concentrated on published articles within the last 5 years, some items date further back in time as they relate to the origin of research theories and frameworks, as well as the history of mental health and public safety systems. In all, the search resulted in hundreds of articles, with rich, relevant content to support information which guided my literature review in which questions are addressed such as "What are the attitudes of the collaborative crisis team (MHP/EMSP) on PMI adverse outcomes according to individuals associated with the program?" These questions support and guide the research problem and design.

## Theoretical Foundation

The SIM was the foundation for this research. Users of this framework have embraced its goal of diverting PMIs from a path towards criminal behavior (Bonfine &

Nadler, 2019). The SIM identifies six points of interception along a time continuum in which the PMI is at risk of entering or moving further into the criminal justice system (Comartin et al., 2021). The developers of the model identified key issues at each point and have recommended specific interventions and social services designed to remediate the PMIs' problem (Comartin et al., 2021).

Intercept 0, the most recent addition and inserted retroactively to the time continuum, was introduced by Abreu et al. (2017), who recognized a clear need for community services to be at the initial stage of the continuum. Their vision included social and community services intercepting individuals in crisis before merging with the justice system, thus diverting the individuals towards a more appropriate and relevant social services treatment. Griffin and Abreu (2015) argued that community and social services should act as the underpinnings of the entire continuum. Intercept 0 is designed to intercept the PMI at the immediate onset of any issue that could be perceived as threatening or crisis related (Abreu et al., 2017). If crisis response is necessary, the designers of the model identified crisis response models (such as support team assisted response [STAR] programs, community behavioral health clinics, and crisis response centers) to be most efficacious in diverting the PMI from criminality (Wasser et al. 2017). Police strategies and interventions are equally important in assisting disadvantaged and vulnerable populations by leveraging their CIT training, homeless outreach teams, sober programs, and so forth (Griffin & Abreu, 2015).

Intercept 1, or the Law Enforcement intercept, encompasses the 911 dispatcher training, specialized police responses, and super-user reduction (Bonfine & Nadler,

2019). The dispatcher is trained to identify a behavioral health component to a call (using a decision tree that assists them in diversion) and sending the appropriate CIT (Comartin et al., 2021). Local law enforcement receives training to interact with PMIs working to build a better rapport and understanding of their plight, perspectives, and behaviors (Marotta, 2015). The officers also receive training at identifying and working with reducing super-utilizers of the 911 system by establishing bonds, providing specialized services, and continual and consistent check-ins (Griffin & Abreu, 2015).

Intercept 2 involves non-clinical staff screening for mental illness and/or substance abuse disorders at settings such as jail booking, holding cells, court lock ups, and other steps prior to the first court appearance (Griffin & Abreu, 2015). Behavioral health providers may utilize data from jails, and jail and court staffs can use pretrial supervision and diversion services to prevent episodes of incarceration if defendants are deemed low risk to exhibit criminal behavior or fail to appear in court (Bonfine & Nadler, 2019).

Intercept 3 utilizes treatment courts or specialized dockets for charges related to behavior of PMIs, such as adult drug courts, Veterans' treatment courts (as well as collaboration with Veterans' Justice Outreach specialist from the Veteran's Health Administration), and mental health courts. Health care providers at jails may provide access to medication-assisted treatment (MAT) for PMIs with substance abuse disorders. (Wasser et al., 2017)

Intercept 4 focuses on PMI exit from jail or prison. Jail employees or in-reach providers can utilize transition planning, which improves reentry outcomes using services

relevant to an individual's needs before release. Inmates may receive a minimum of 30 days' worth of medication upon release as well as prescriptions for these medications (including MAT medications for substance abuse disorders). Case managers may transport individuals from corrections providers directly to services, which increases positive outcomes (Bonfine et al., 2018).

Intercept 5 involves specialized community supervision of PMIs and people with substance abuse disorders via specific caseloads. MAT may be useful for people with substance abuse disorders, as it can reduce relapses and overdoses among PMIs returning from detention. PMIs may receive access to recovery supports, housing, benefits, and employment opportunities. Criminal-justice specific barriers to access to these services are very important (Wasser et al., 2017).

The SIM has proven effective and even essential for community strategic planning purposes in terms of assessing available resources, capacities, gaps, needs, and redundancies at each specific intercept point. Stakeholders from differing social service disciplines can cross-over to multiple systems/intercepts in addressing mental health, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, people with lived experiences, family members and others (Bonfine & Nadler, 2019). The earlier the interception occurs, the higher the likelihood of reducing arrests, court and jail-time and, finally, recidivism (Griffin & Abreu, 2015).

## The Birth of the CIT

In 1987, a troubled individual dealing with psychosis died at the hands of a Memphis police officer (Dupont & Cochran, 2000). The public outcry led to the evolution of the CIT training program (Bratina et al., 2020). Due to the increasing number of situations in which police interact with PMI, the Memphis Police Department, along with local universities and mental health facilities in collaboration with the National Alliance on Mental Illness (NAMI), established a first responder-based crisis model (Peterson & Densley, 2018). The creators of CIT built the program as a voluntary 40-hour training course, emphasizing basic mental health constructs (Boazak et al., 2020). Their aim was to increase police understanding of and empathy towards PMIs as well as how to approach, communicate, and treat them in a non-threatening manner, with the goal of reaching an appropriate disposition (Watson et al., 2021).

The originators of CIT promoted four tenets to which the program strives (White et al., 2019). One tenet of the program was to improve dispatching (i.e., comprehending, coordinating, and directing CIT officers to calls with a behavioral health component) (Boazak et al., 2020). Another was increased training (i.e., teaching safety, de-escalation, de-stigmatization, and active listening and communication skills and awareness) (Ellis, 2014) Yet another goal was the utilization of coordinated site responses (i.e., working in concert with multiple support-oriented disciplines at the scene, such as ambulance workers and firepersons) (Ellis, 2014). Lastly, the designers of CIT worked to implement inclusive collaboration (i.e., working with local community services for short- and long-term solutions) (Peterson & Densley, 2018).

## CIT Programs

### Baltimore, Maryland CIT Pilot Program

Many researchers have written about the CIT program and its progress in the last 30 years. The District of Baltimore, Maryland, surveyed officers' perceived confidence in their ability to handle mental health calls in terms of service, behaviors, attitudes, and beliefs pre- and post-CIT pilot intervention (Booty et al., 2020). Booty et al. (2020) found 34% of the Central District treatment group felt threatened by PMIs, a sharp decrease from their 60% pre-pilot response, and the control group's Eastern District of 61.3%.

### Colorado Statewide CIT Program

Similarly, Colorado tested its three-decade long state-wide engagement of the CIT program by assessing 6,353 mental health incidents to ascertain efficacy in disposition rates of Special Weapons and Tactics (SWAT) use, arrests, use of force, and injuries (Khalsa et al., 2018). While Khalsa et al. (2018) tested for relationships between original complaint, psychiatric illness, substance abuse, violence risk, and disposition of crisis calls, ultimately concluding officer knowledge increases diversion to treatment centers, the limited scope of the officer population (17%) was concluded to limit generalizability.

### Southern Florida CIT Program

Bratina et al. (2020) performed a CIT study in a four-county area in southern Florida. They collected CIT-directed call documentation of 405 encounters from 2007 to 2011. Of those, Bratina et al (2020) reveal 85% were diverted from the criminal justice system (i.e., criminalization). While data points to positive dispositions resulting from the CIT program, statistical significance is difficult to attain due to multiple factors. The

police officers' determination as to whether the individual in question had a diagnosed mental health issue, Franz and Borum (2011) noted, was largely subjective or difficult to determine. Superiors typically request that officers voluntarily fill out paperwork (specifically relating to CIT constructs) regarding incidents, which can be extensive and time-consuming, thus potentially biasing results (Franz & Borum, 2011). While results were inconclusive, researchers felt the results can inform the field by providing insight regarding facilitation and operating procedures (Bratina et al., 2020).

**Urban Settings and CIT Programs**

Peterson and Densley (2018) assessed 25 empirical studies performed in Southern and Mid-Western states around the country in larger urban areas; it was established that CIT-trained officers perceive their pre-booking jail diversion process improved due to increased use of verbal negotiation. Compton et al. (2017) found high-quality studies lacking in sufficient rigor, which undermined the salience of outcome results, information from intervention versus control groups, and monitoring. The few outcome-focused studies concentrated upon police encounter dispositions such as arrest or emergency room transport (Watson et al., 2021). Peterson and Densley (2018) concluded that results of the 25 studies were neither mixed nor generalizable because emphasis was primarily on urban environments.

**Rural Settings and CIT Programs**

In terms of rural settings, researchers acknowledge unique challenges to adapting the CIT model (Skubby et al., 2013). Skubby et al. (2013) engaged nine focus groups in Ohio between 2006 and 2009 to study the perceptions and dynamics between

stakeholders within rural communities using the CIT model with the primary purpose of jail diversion. Skubby et al. (2013) used thematic analysis from the focus group dialog which revealed the members' beliefs is a chasm between the mental health profession and jail diversion. They found that focus group members perceived the mental health profession to be driven by compassion, empathy, and calmness (traits which translate well to de-escalation), while they considered jail diversion and the pragmatic public safety mindset to be oriented more towards punishment. Rogers et al. (2019) concur that to facilitate a successful implementation of CIT in small communities, the perceived authoritarian police officer demeanor needs to soften and mental health collaborators must work in harmony towards an end goal of helping and diverting individuals towards some form of social services.

**Modified Crisis Intervention Training: The 'R-Model'**

Peterson et al. (2020) realized not only the need for updated mental health constructs within the 30-year-old CIT program, but also drew comparisons to their newly created and condensed 8-hour program, R-Model (Research-Respond-Refer), which concentrates on current and updated knowledge of mental illness, crisis, and trauma, responsive to the current policing climate in America. Peterson et al. (2020) found that the R-Model training had a significant impact on decreasing stigma and increasing officer knowledge of mental health resources based on pre- and post-training scores. Peterson et al. (2020), support the model's concordance with CIT, recognizing that it takes 1/5 of an officer's time away from the streets but resonates just as firmly as the 40-hour CIT program. Perception by officers is positive, and administrators favor this approach as it

allows for optimal use of resources on the streets and in the classroom (Peterson et al., 2020).

**Summary and Conclusions for CIT Program**

Rogers et al. (2019) reviewed 198 studies from a period of 20 years and found much heterogeneity regarding characteristics of police departments. These departments varied significantly, as policies, practices, and officer training programs within organizations, many of which had no universal standards for structure, size, or governance. Carroll (2021) found that this heterogeneity inherently caused inconsistencies relating to training and implementation of the CIT program. Seo et al. (2021) noted that respective department emphasis placed on varying goals made it difficult to come to a consensus on efficacy. As well, Seo et al. (2021) found mixed results pertaining to CIT's guidelines of diversion to a short or long-term community support system rather than arrests, repeat offenses, use of force, officer injury, citizen injury, or diversion to an emergency room. Outcomes relating to officer satisfaction and self-perception (via self-report data) towards the program, though, were positive (Rogers et al., 2019). In other words, when Boazak et al. (2020) assessed outcomes relating to officers' perceptions after CIT training, (such as comfortability, feeling of preparedness, knowledge of mental illness, implementations of de-escalation skills, self-efficacy, ability to feel empathy, patient needs assessment, and social distance) officers scored well.

The model architects' goals were to improve the safety of all individuals involved: police officers, consumers, family members, and the community, with the aim to channel PMIs to an appropriate human and social services organization (Carroll,

2021). Skubby et al. (2013) have continued to promote the success of the program due to the multi-disciplined experts associated with the creation of the model and its wide acceptance and use throughout the country. Although Bosco et al. (2020) question whether adoption of CIT reduces the risk of death or serious injury amongst PMIs when interacting with police during a traumatic event.

Due to the controversy surrounding Black PMI deaths while interacting with police which is enforced by videos and ongoing conversation on social media, the public perceives the program as inadequate and ineffective (Baker & Pillinger, 2020a). Cities and counties across the country are increasingly adopting the promising co-responder model to improve how they engage with people experiencing behavioral health crises (Stigter-Outshoven, 2019). Co-responder models consist of various disciplines, combining the services of MHPs, medically trained individuals, and/or CIT-trained police officers (Bailey et al., 2018).

## Co-Responder Team Models: An Enhancement to CIT

Not long after the CIT model came into prominence, the two-person co-responder team model was developed concurrently in Vancouver, BC and Los Angeles, CA (Morabito et al., 2018; Puntis et al., 2018). Specialized teams composed of a trained police officer and an MHP responded to calls or situations with a behavioral health component (Lord & Bjerregaard, 2014). Bailey et al. (2018) notes that with members of both disciplines present, individuals under duress can be accommodated immediately and effectively. This indicates that the MHPs are able to use their skills to de-escalate the situation while the police officer can perform any necessary actions (particularly if

situations turn violent or if coordination of emergency services are necessary) (Stigter-Outshoven, 2019).

Morabito et al. (2018) state that this model allows law enforcement responses to evolve in real-time with the flexibility and nimbleness needed for on-scene traumas and mental health emergencies. Not only can they provide immediate solutions, but the team is equipped and trained to link individuals with appropriate long-term human and social service-related programs (Sofer, 2021). Team members implement this model in various ways, with the most common pairing being an officer and mental health crisis worker in a vehicle during an entire shift (Seo et al., 2021). Other implementations involve dispatchers directing the officer and mental health worker separately to the location of the scene (Puntis et al., 2018). Depending on personnel and equipment resource availability, the teams can support an entire region or focus on concentrated areas where mental health incidents repeatedly occur (Morabito et al., 2018).

**Boston, Massachusetts Co-Responder Program**

American urban areas are particularly encumbered with individuals afflicted by behavioral health issues; these areas tend to be more populated by people of color, particularly the Black population (Schroeder, & Peterson, 2018). In 2011, the Boston Police Department (BPD) implemented a co-responder program encompassing a police officer and MHP tasked with responding to situations which involve a behavioral health component (Morabito, 2018). Morabito (2018) recognized that while co-responder models have been implemented in several municipalities, researchers have yet performed little analysis that compares results to the now ubiquitous CIT programs. These co-

responder programs date back to the early 1990's, originating in California, yet Shapiro et al. (2015) found just a handful of studies to date. This model leverages the unique skills of the police officer and the MHP to de-escalate traumatic situations and reduce traffic through the public safety system (Crilly et al., 2020). In this model, subjects can be diverted to more appropriate service-oriented mental and physical health accommodations (Morabito et al., 2018).

Crilly et al. (2020) note that the models vary in certain dimensions of the model treatments, such as having plain-clothed or uniformed officers, concentrating on hot-spot areas versus focusing broadly across the city, clinician co-responding types, and available community services. There could be several and varying mediator variables or factors as well; Morabito et al. (2018), whose study involved the BPD program that utilized the hot-spot approach, stated the co-responders would traverse the area on foot and engage with the citizens. This mediating factor could increase the probability of a successful outcome, which must be recognized (Morabito, 2018). Other documented factors, Morabito (2018) notes, thwart progress in this model including gaining trust with the police, not having a dedicated car, data collection not clearly defined, and roles not well established.

**Nova Scotia Short-Term Crisis Team**

Kisely et al. (2010) instituted a quasi-experimental design and used pre-and post-intervention (an integrated short-term crisis team comprised of mental health services, municipal 'plain-clothes' police, and EMSPs) with quantitative data points to measure co-responder intervention data. These data included number of calls to the 24-hour hotline, number of mental health calls to police, number of crisis visits, and the call-to-

door time; the research concluded that these partnerships improved efficiencies in treatment of PMIs (Kisely et al., 2010).

The crisis team's services increased use by people in crisis, families, and service partners while reducing on-scene time and call-to-door time (Kisely et al., 2010). After controlling for confounders, Kisely et al. (2010) noted that consumers engaged with the integrated team and showed greater synergy than control members as measured by outpatient contacts. Kisely et al. (2010) noted that the qualitative results validated the results of focus groups and interviews: public safety and mental health collaborations can improve efficiency as well as the treatment of PMIs.

**Seattle Police Department Pilot Co-Responder Program**

Seattle's Police Department (SPD) initially expanded their well-established CIT program to include two full-time officers and a sergeant assigned to follow up on cases and work with PMIs to establish a link to social service agencies while serving as a liaison between family members and the local Mental Health Court (Helfgott et al., 2016). SPD renamed the program Crisis Response Team (CRT) and enhanced it by including a full-time MHP to assist in situations with a behavioral health component (such as severe mental illness or drug/alcohol dependence) while circumventing the traditional jail and ER dispositions in favor of social service systems (Todd & Chauhan, 2021). Program directors designed the 'call filter' triage system to use a rigorous decision-making process to identify mental health incidents and direct the CRT appropriately which minimizes officers' efforts and enables more focus on law enforcement scenarios (Helfgott et al., 2016). Yang et al. (2018) recognized the positive

impacts of the CRT process, observing that over one-third of cases (some repeat offenders) qualifying as crisis events were referred to either non-law enforcement agencies, local community services, and/or administrative clearance, relieving much of the burden ordinarily placed on the public safety or emergency health systems. Todd and Chauhan (2021), in their study of the mental health issues in Seattle, recognized that the CRU officers and the full- and part-time MHPs assigned to the CRT pilot are not able to respond to every call involving mentally ill individuals due to budget and time constraints. Todd and Chauhan (2021) found that diversion strategies are also not timely enough (and are thus suboptimal), yet evidence showed that the program played a role in improving police and citizen relations.

**UK Street Triage Co-Responder Team**

Horspool et al. (2016) explored a form of the multi-discipline response team, Street Triage (ST), used in the United Kingdom since 2013 to ascertain whether its purported strengths (less stigma and trauma to the PMI than the traditional police response) are realized. Horspool et al. (2016) found that the program originated with the purpose of navigating the emerging mental health crisis of which police officers felt ill-informed and underprepared. Horspool et al. (2016) used qualitative thematic analysis to identify a framework of key elements and issues associated with the goals of the study as well as culled inductive indicators from transcripts. The aim of the study was to identify the optimal service team configuration while also understanding their impacts on stakeholders (Keown et al., 2016).

Kirst et al. (2015) chose not to include the perspectives of service users who have received the service, or their family and careers, thus there were limitations to generalizability and perceptions beyond the small group invested in the program (Kirst et al., 2015). While quantitative data was not used, the perception by the stakeholders was that the program did reduce the amount of time to case resolution, reduced the number of repeat contacts, and changed the nature of the incident disposition such that most individuals with mental illness were diverted to social services (Keown et al., 2016).

Keown et al. (2016) recognized that limitations with the triage related to an inability to optimize resources, relationships between police officers and MHP were not necessarily supportive of one another, and the police officer's default position in terms of taking the most risk averse approach (even if it disadvantaged the consumer) because it is the path of least resistance. This perception by police officers of PMIs is potentially tied to fatal outcomes or directly to understaffed/underfunded social programs (Horspool et al., 2016).

**International Co-Response Team**

Researchers have strongly indicated in their literature that as the population of PMIs increases, the public safety sector faces unique challenges as tensions rise between police and PMI due to their potentially unexpected and disturbing behaviors (Agee et al., 2019). While governments have attempted to improve this situation, many policing agencies have adopted successful models across the world (Seo et al., 2021).

While Seo et al. (2021) note that the ubiquitous CIT program reigns in the United States, it also exists in Europe, Canada, and Australia. CIT's ubiquity may appear

encouraging regarding its impact, yet Peterson and Densley's (2018) meta-analysis of several CIT related studies (including outside the United States) concluded that there were no significant defining results. Furthermore, Boazak et al. (2020) noted a general lack of research assessing quantitative, objective outcomes (i.e., arrests, use of force, diversion to emergency department) using official non-U.S. country statistics.

Despite Boazak et al. (2020) observing a lack of measured impact, these countries recognized the necessity for the inclusion of MHPs within the process. Canada, Australia, the United Kingdom, and other European countries enhanced their models to include a clinician to exercise their skills in efforts to diffuse, de-escalate, and improve a difficult situation with a PMI (Peterson & Densley, 2018).

Additionally, program directors recognized the need for a medical component to assist in any traumatic physical (i.e., overdose, confusion, anxiety, skin/bone breakage, etc.) situations (Wood, 2020). Canada's Crisis Outreach and Support Team (COAST), Australia's Mental Health Intervention Team (MHIT) and Police and Clinical Early Response (PACER) models, the UK's ST, and the many variations of Mobile Response Teams in America such as the MCU, Mobile Crisis Assistance Team (MCAT), MCIT, CRT, and ST, among others, are all examples of strategies designed to assist PMIs (Bailey et al., 2021; Heffernan et al., 2021; Herrington & Pope, 2014; Keown et al., 2016; Landeen et al., 2004). The implementers of these programs strive to assist PMIs by reducing arrests, injury, or death, and diverting them to some kind of social services program (Seo et al., 2021).

Seo et al. (2021) communicate the results of their meta-analysis in terms of efficacy of the three program types (CIT, co-response, and multi-disciplined response teams) as well as by setting (American versus non-American). Stigter-Outshoven (2019) propose that American public safety systems could benefit from the strategies inherent in the multi-discipline response teams, such as guiding these multi-discipline teams directly to the scene of a PMI in a traumatic situation and relieving some of the burden from police officers whose primary emphasis can be better directed elsewhere.

**Summary and Conclusions for Co-Responder Models**

Co-response programs offer great promise in improving police response to individuals experiencing mental health crises, but more research is needed before it can be established as an evidence-based practice (Morabito et al., 2018). Morabito et al. (2018) state that some of the criticisms of the co-responder program primarily concern the relationship between the police officer and MHP participating in the intervention. If the relationship is respectful and complementary, then researchers reveal outcomes tend to be positive (Stigter-Outshoven, 2019). Researchers sometimes find high turnover or conflict between the two due to power struggles, lack of role definition, and respectfulness issues (Kirst et al., 2015). Therefore, some experts demonstrate that a complete division between the health professionals (mental or medical) and the police officers (aside from assignment of diverted 911 calls) tends to work best, thus the evolution of the mobile crisis intervention team (Sofer, 2021).

## MCITs

### MCITs in Large Urban Areas (North Carolina and Toronto)

Lord and Bjerregaard (2014) recognized the need to research MCUs in large urban jurisdictions (i.e., North Carolina, Toronto) as PMIs share many qualities and histories relating to mental health disorders including paranoia, hallucinations, anger problems, and/or addiction. These morbidities manifest in higher rates of homelessness, violence, repeated arrests, as well as associated physical disorders (Muehsam, 2019). Interveners often find it difficult to coordinate and facilitate treatment as the PMI is unaware or too incapacitated to meet their own physical and mental needs (Kahan et al., 2020). Lord and Bjerregaard (2014) analyzed the use of the MCU, which consists of a licensed MHP and either a nurse or psychiatrist, and their ability to recognize and handle suicidal gestures, psychosis, and substance abuse on the spot. Services are real-time and the team can meet the PMI using the least restrictive effective response wherever the interaction occurs (Lord & Bjerregaard, 2014).

Muehsam (2019) stated that MCUs are particularly suited for large, urban jurisdictions, as unique and broad-based strategies are required to service areas typically widespread and including diverse populations. But, as Lord and Bjerregaard (2014) point out, MCU professionals are also acutely aware of the need for law-enforcement back-up when emergent risks outweigh benefits and interventions are not conducive towards a safe resolution.

**Indianapolis Mobile Crisis Assist Team**

Bailey et al. (2018) performed a qualitative study on the successes and limitations of the Mobile Crisis Assistance Team (MCAT) in which an Indianapolis Metropolitan Police Department (IMPD) officer partners with a mental health clinician, behavioral health clinicians, and an Indianapolis Emergency Medical Services (IEMS) EMSP to service emergency calls with a PMI. Bailey et al. (2018) revealed through interviews that policymakers successfully implemented the strategy (utilizing the team's 320 hours of training on mental health and services collaboration and coordination, the use of a non-intimidating team van and plain- or specially clothed responders) in a district with a high social disorder index and rate of mental health and medical emergency calls. Bailey et al. (2018) recognized that in the early stages of implementation of this 24 hour a day, seven days a week program, the stakeholders dealt with some limitations and barriers, yet noticeable benefits were an outgrowth of the knowledge gained. Improvements made as a result of the pilot program included flexible and formal policies and procedures to help guide program implementation, streamlined communication protocols for all parties, access to ample and cultivated community relationships and services to refer clients to, cultural and systematic barriers addressed, roles clearly defined and respected, and finally triangulation of client data for quick and tailored response (Kahan et al., 2020).

**CAHOOTS MCIT**

In 1989, researchers in Eugene, Oregon, established the CAHOOTS program with the aim of handling non-violent mental health calls typically handled by the police (Climer & Gicker, 2021). These researchers designed a hybrid, integrated health care

service capable of handling noncriminal, non- emergency police and medical calls by combining and leveraging the abilities of clinicians, MHPs, and EMTs and/or nurses (Goble, 2021).

CAHOOTS operates with teams of two workers: a mental health specialist skilled in counseling and de-escalation techniques, and a medic or nurse with emergency medical skills. The program has received positive feedback due to its success rate in reducing the criminalization of individuals dealing with mental health issues (Jacobs et al., 2021). Program operators established a dedicated van which operates at all hours. Because the public has been so impressed and supportive with the program, funding has steadily increased such that a second van was procured and is able to be deployed providing an overlap of assistance (Goble, 2021). Proponents of the program have stated that nearly 20% of 911 calls are directed to the CAHOOTS van, saving police officers time that can be redirected towards more violent or criminal activities (Glauser, 2020). In fact, Glauser (2020) states that in 2019, CAHOOTS responded to over 24,000 calls of which only 311 required police backup. Proponents have stated that not only does CAHOOTS have the backing from the public the police understand and appreciate their value which allows for comradery, engagement, and optimism (Climer & Gicker, 2021). Because of its popularity, and due to the criticism towards public safety regarding PMIs (particularly amongst Black individuals), many states and cities are launching their own pilot programs based on the CAHOOTS model (Klingner, 2020). Alternatively, though, some experts state the program has not been proven in large, urban areas and is not evidence-based (Bailey et al., 2018). The program I studied is one of those pilot programs

that is attempting to widen that scope to extend the program to that larger population (Klukoff et al., 2021). This program is the focus of this research.

### Summary and Conclusions for Mobile Crisis Intervention Unit Models

According to the most recent study findings, researchers are recognizing promising outcomes from the Mobile Crisis Intervention Unit Models (Swartz, 2020). Participants tend to work in harmony towards the same goals and have similar experience levels in mental health intervention that are specifically relevant to crisis moments where persons with severe mental illness are most in need (Klingner, 2020). While promoting this program as the answer to dealing with PMIs involved in a crisis in the streets may be premature, researchers state the outcomes appear promising (Swartz, 2020).

## Evaluation of Current Systems

### Advantages

Watson et al. (2021) stated that each of the models (CIT, Co-responder and MCIT) has advantages, particularly in the realm of advocating mental health awareness and education amongst the public safety sectors. While the proponents of the CIT programs would like to promote the program as successful, there are very few if any evidence-based studies in which researchers demonstrate positive results, particularly regarding objective outcomes (such as arrests, officer injury, citizen injury, use of force, or diversion strategies). One observed benefit of the program, however, is that Watson et al. (2021) reported that officer perception of their own knowledge of mental and behavioral health after the training is rewarding and positive.

Co-responder program developers put MHPs and/or EMSPs within the police response, many times pairing the two together to respond to a call with a behavioral health component (Wood et al., 2021). Proponents contend that this pairing allows the members to leverage their unique skills and knowledge to attend to a person in mental distress (Morabito, 2018). While the MHP can use their skills to minimize stressors for individuals involved in or reacting to a traumatic incident (potentially redirect the individual towards a mental health care solution), the medical personnel can tend to any physical health issues that have surfaced (Morabito et al., 2018). The officer can serve as backup if the interaction requires more relevant skills (Wood et al., 2021).

Researchers believe MCITs may be the optimal approach in handling PMIs during a traumatic incident as they are programmed to be flexible and incorporate formal policies and procedures to help guide program implementation (Muehsam, 2019). The programs are also streamlined in terms of communication protocols for all parties and provide access to ample (and culturally-adept) community relationships and services to refer clients (Rached-d'Astous et al., 2021). The program can address cultural and systemic barriers, ensure that roles are clearly defined and promote respectfulness, and facilitate the triangulation of client data for quick and tailored responses (Seo et al., 2021).

**Limitations and/or Barriers**

Rogers et al. (2019) note that much of the research centers upon CIT and co-response models, and evidence-based results for these programs can be lacking. While officers believe their knowledge and actions improve based on the 40-hour CIT training,

measures of objective outcomes such as arrests, injuries, and diversions would provide more insight into efficacy and gain the confidence of potential users (Peterson & Densley, 2018). Several issues that commonly surface in these programs include role confusion (i.e., police officers can be overbearing or may not want to cede authority), lack of funding for sustainable long-term resources, stigma amongst police officers towards PMIs, and lack of buy-in by either member of the team (Skubby et al., 2013).

While no program will solve all problems in the public safety realm when dealing with a PMI, the MCITs seem to be optimal (Kirst et al., 2015). Klingner (2020) notes that programs can be strengthened or weakened by the short and long-term services that support it, but the multi-discipline and talented teams appear to be providing the best resources. Qualitative, quantitative, and mixed-methods researchers are studying pilot programs to ascertain if this hypothesis is in fact true (Klingner, 2020).

Smith Lee and Robinson (2019) facilitated a study leveraging the unique strict coding strategy of modified grounded theory approach to analyze in-depth, life history interviews with Black men in a large urban area. Outcomes of the study revealed exposure by witnesses towards police violence in early childhood through adulthood had negative mental and physical health consequences.

Daggenvoorde et al (2018) reinforced through a hermeneutic-phenomenological study that while MCITs are a healthy alternative to CIT programs there can be hiccups to the process in terms of relationships between the MHP, EMT and/or PO. These researchers state that if positive evidence-based outcomes are socialized appropriately to

the team members, friction will be at a minimum and harmony will result in a healthy result for the participants in trauma.

## Denver Support Team Assistance Response Program

The genesis of the MCIT was an outgrowth of the weaknesses and limitations of the co-responder model (Balfour et al., 2017). Originators of the program I studied realized the benefit of approaching subjects with mental health issues with tactics and skills common in the counseling and therapeutic process, while ensuring EMSPs can attend to any immediate urgent medical needs (Samuelsohn, 2021). Law enforcement leaders decide which individuals should receive the service of the MCIT (Horspool et al., 2016). Goble (2021) views the long-term goal of consumers interacting with MHPs and EMTs as diverting them from criminalization and/or emergency services and directing them towards social service programs to find long term solutions in efforts to reduce repeat arrests, violence, addiction, and injury.

## Summary and Transition to Chapter 3

Much of the literature to date has encapsulated ways in which to battle potential abuses of public safety by implementing various interventions that focus on mental health such as CITs, R-model, Co-responder teams and MCITs. While extensive studies analyzed the efficacy of these programs, informative outcomes are limited. Focus on the collaborative EMSP/MHP crisis team has become more serious in recent decades, and shown much promise, but much more could be done to prove efficacy and socializing the results.

The purpose of this generic qualitative study is to examine the attitudes of the collaborative crisis team (MHP/EMSP) on PMI adverse outcomes according to individuals associated with the program. The program I studied is a pilot collaborative MCIT program recently implemented in a large city (Klukoff et al., 2021). In this generic qualitative study, I analyzed attitudes of the collaborative crisis team (MHP/EMSP) on PMI adverse outcomes according to individuals associated with the program. I interviewed members of the program team to gain an understanding of their experience and perspective of the treatment as it related to frequency of arrests and, ultimately, deaths.

# Chapter 3: Research Method

In this chapter, I discuss the research methods used to collect and analyze data to evaluate the efficacy of the team program in reducing PMI adverse outcomes during mental health events involving first responders. The city's police department has documented and tracked the dispositions of mental health calls within their public database. The agency's data collection and retention protocols allow for access to historical and current data relating to and supporting the research method, questions, and hypotheses. To describe the study, I first discuss the setting then research design and approach, followed by the role of the researcher, methodology, participant selection, trustworthiness and finally, ethics. The Walden Institutional Review Board (IRB) approval number is 03-25-22-0351196.

## Setting

The setting for this study is relevant as a majority of adverse outcomes involving PMIs occur in urban areas (Edwards et al., 2019). The local police department is located in the city's metropolitan area. The police department has 1,517 sworn police officers and 307 civilian personnel serving 706,000 residents. The police department responds to approximately 600,000 calls to 911 for service each year with 2.8% (or around 16,800) identified as having a behavioral health component. By 2020, the police department revealed that calls with a behavioral health component were up 17% over the 3-year average (Denvergov, 2022). For the pilot program I studied, the police department concentrated upon the entirety of one specific district, with a few exceptions relating to overflow from a nearby shelter. Prior to the pilot program, the police department 911 call

response system directed police officers handling individuals with health and safety issues towards two paths, through the criminal justice system or a health and hospital system. The program relieved some of the police department's workload by redirecting (i.e., from costly, time-consuming emergency room services and/or possibility of jail) individuals under mental and/or physical duress towards more appropriate support providers. The police department's initial pilot program was administered between June 1, 2020, and November 30, 2020. The program's team, consisting of an EMSP and MHP, deployed via a dedicated van to assist individuals dealing with a mental health crisis by providing immediate care and/or connecting them to potential longer term social services. The team program was in operation between 10:00 a.m. and 6:00 p.m., Monday through Friday, a timeframe established by policymakers using historical empirical data to best fit the needs of the program (Denvergov, 2022).

## Research Design and Rationale

The purpose of this generic qualitative design is to explore and understand how individuals associated with the collaborative crisis team (MHP/EMSP) perceive the treatment's impact on the rate of PMI adverse outcomes when a PMI experienced a mental health crisis. Chapter 3 covers research design and rationale, role of researcher, methodology, procedures for recruitment, data analysis plan and, finally, issues of trustworthiness.

In this research I investigate the question of "What are the attitudes of the collaborative crisis team (MHP/EMSP) on PMI adverse outcomes according to individuals associated with the program?" The phenomenon of this study pertains to

whether this collaborative process will improve outcomes between public safety and PMIs. This generic qualitative research study entails performing interviews of stakeholders where analysis reveals emerging themes. In this study, my intention is to illuminate the specific phenomena as perceived by the stakeholders that I interview. My goal is to understand the attitudes of the collaborative crisis team (MHP/EMSP) on adverse outcomes for PMIs according to individuals associated with the program. The focus is to describe how the stakeholder sees the situation and actions free from any preconceptions or presuppositions on my part. My study's emphasis is to explore and document the rich experiences of individuals as they comprehend the happenings and events through their own consciousness. The stakeholders I identified for this research are the professionals on the team, the MHP and EMSP who actually tend to the PMIs when in distress or under trauma. My results from this qualitative research will inform the public safety system and policy makers of the benefits and weaknesses of the program.

## Role of the Researcher

The role of the researcher is not only to be passionate about their topic, but also to realize that their zeal could bias how they handle the design of their experiment. Selection and questioning of participants and stakeholders, as well as data analysis are at risk of bias. There were no prior relationship between any participants and me. In this generic qualitative research study, my emphasis was to always remain objective by placing controls, checks, and balances within the data collection and analytical processes to ensure impartiality. These controls included my ensuring that the participants and

stakeholders would receive results of the study that reflect their perspective, thoughts, and views. My knowledge that these individuals would receive a report of the study placed me in a responsible position and motivated me to ensure transparent, reliable, and valid results. Additionally, the feedback loop allowed me the ability to incorporate corrections, changes, and updates resulting from any misconstrued thoughts on my end by the stakeholder.

While I view myself as compassionate and empathic particularly to the oppressed and disadvantaged, I recognize that, for a program to succeed, both positives and negatives must be revealed. Thus, I owed the individuals involved in the study, as well as the generalized population an unbiased, objective report. I also realized I already had positive biases towards the program and had to account for and keep my views in check every step of the way. My empathy towards PMIs also had to be revealed and contained. I ensured that I was aware of my stature as an interviewer and have taken measures to ensure comfortability with the participant such that there was no feeling of a power differential. My goal was to perform and produce an exceptional research study, but not at the expense of participants and/or stakeholders. Instead, the objective was to showcase or improve upon a valuable program or begin to introduce alternatives to inform and educate the public to improve the lives of participants and/or stakeholders.

## Methodology

### Participants Selection Logic

I classified as potential participants individuals who were a part of the program's team of the police department at any time since its inception. I performed purposive

sampling as it enabled me to attain the most amount of information from the expert, informed, and veteran participants. These participants received the program's training and cared for individuals dealing with mental duress if those individuals directly asked for it and met the criteria as specified by the call guide protocol, which is interpreted and implemented by the emergency communication telecommunicator. Otherwise, the unit was dispatched via three mechanisms: (a) 911 call takers flag mental health calls and directly send the program's van, (b) uniformed response independently request the assistance of the program to a scene and, (c) the program self-initiates a response in the field (Denvergov, 2022). These participants were known to meet the inclusion criteria as they are specified in the research study and criteria provided to the program manager who is an expert at determining who would provide the most salient information. The program manager provided a list of eligible members whose participation I then solicited, and they could voluntarily respond.

The program's van is not constructed to attend to calls with any potential for violence, so criminal activity associated with disturbance, weapons, threats, violence, injuries, or serious medical needs are directly relayed to police or ambulance. Instead, the team concentrates on individuals in need of assistance (i.e., welfare check) or are intoxicated, suicidal, indecent, trespassing, or in a passive drugged state which all fall under specific nature codes (Denvergov, 2022).

The city's 911 Communication Center uses the police department's Operations Master Incident Guide to ascertain whether a police response or medical care are needed. If it is determined otherwise, based on the specified nature codes prescribed by the

program's directors, then the team is dispatched to the location of the individual under duress. The Communication Center uses a decision tree to best determine an appropriate response. At the same time, the team is at the disposal of the police, fire, and EMSPs who are trained in understanding the capabilities of the program and are therefore confident when they summon them to remediate the situation of the distressed individual with the most fitting solution (Denvergov, 2022).

In terms of the qualitative interviewing process, six individuals from the mental health field and five from the medical field were represented. The interview questions are listed in Appendix A. I performed the analysis until it reached saturation. If further interviews appeared necessary, I would seek out further participants. Five to six individuals represented each identified population. I sent emails to the participants, and if there was no initial response, I made a follow-up call. This continued until at least five to six people per group represented the two stakeholder groups. The program manager provided a population of individuals from which to select. To reach saturation, I ensured there was enough information to replicate the study. These participants are all a part of the analysis via the thematic coding of the transcribed interviews. I gave these participants' information equal weighting as their work is all viewed to be within the same vein and level of importance.

Due to the issues surrounding the pandemic, I performed the interview process virtually via WEBEX (https://www.webex.com) and/or ZOOM (https://zoom.us). I used an audiotape and observation sheet to record and collect salient information. Both ZOOM and WEBEX are industry-wide used products with assured quality and confidentiality

controls (Upadhyay, & Lipkovich, 2020). For the interview process, I asked multiple questions (see Appendix A) pertaining to the research question: What are the attitudes of the collaborative crisis team (MHP/EMSP) on PMI adverse outcomes according to individuals associated with the program? Each interview took approximately 30 minutes to administer but sometimes up to an hour.

Several communities are of particular importance in this study; two of them (PMIs and the public safety system [i.e., police officers]), are described by unique factors and qualities that invariably converge and diverge at varying times depending on the circumstances and situation at hand (Edwards et al., 2019). They form a complex intersection, indicative of systems theory, of qualities such as beliefs, mores, perspectives, compassion, and class, among other factors (Bronfenbrenner, 2000). The considerable research on PMI populations reveals biases by the public safety system relating to the constructs, socioeconomic status, education level, and employment status reinforcing negative stereotypes and bad legal outcomes (Edwards et al., 2019).

**Treatment**

There are multiple ways to request the services of the program I studied. Individuals in the community can call the program's phone number directly or call 911. The communication center then triages the call to ascertain what course of action to take. The emergency communications telecommunicator uses an Operations Master Incident and reference guide containing decision trees, each based on nature codes to determine an optimal response. With operating hours between 10:00 a.m. and 6:00 p.m., Monday through Friday, the program's van is staffed by a local EMSP and a local MHP (and, at

times, a peer support navigator) and provides person-centered services to calls directed by the emergency communications telecommunicator. The emergency communications telecommunicator team specifically addresses calls to constituents experiencing mental health issues such as depression, poverty, homelessness and/or substance abuse issues. On-site assistance consists of a wide-spectrum of no-cost treatments ranging from providing education with references, crisis intervention, therapy, mobile services, and social services.

While teams place emphasis on individuals dealing with a mental health crisis, the team is also equipped to assess and triage low-risk medical problems. In situations that elevate beyond the capabilities of the team, such as physical violence or an emergency health issue, teams summon police and/or ambulance assistance. The ultimate goal of the program is to address the immediate crisis as it occurs on the street, de-escalate, and mitigate any extenuating circumstances, then direct, refer/connect, and transport the consumer to facilities that provide long-term services towards solutions (Goble, 2021).

The program deviates strongly from the traditional police response in that its employees are not equipped with guns and do not perform any law enforcement duties. The remaining individuals not receiving the program's services typically receive assistance from police officers using the traditional law enforcement approach in which the officers respond to emergency calls requiring a quick response, take custody of individuals, place criminals under arrest if necessary, and conduct any follow-up on investigations. The focus is to improve the likelihood that actual violent criminals receive charges and brought to court (Jacobs et al., 2021).

The police department investigated a well-established program based in Eugene, Oregon known as CAHOOTS, the acronym for "Crisis Assistance Helping Out on the Streets." The program has existed for over 30 years and mobilizes two-person teams (a nurse, paramedic, or EMT) and a crisis worker from the mental health field with training and experience in handling crisis situations. The police department program is modeled after CAHOOTS yet tailored for a more urban area. While funded by Your Caring4City Dollars, the program also accepts donations to help pay for miscellaneous items (e.g., water bottles, fruit) for basic needs (Klingner, 2020).

**Procedures for Recruitment, Participation, and Data Collection**

My interviews were semistructured in form so as to promote free-flowing, stream-of-consciousness ideas and perspectives from the participant. Any attempts of mine to lead the interviewee in any way were dissuaded by virtue of the amount of work that went into the development of these questions. Several outside parties that would be defined as objective and would not benefit in any way reviewed them. I deliberately wrote the questions so as not to lead the responder nor to make the responder feel obligated to answer in a specific way. To ensure internal and external validity, I continually emphasized member-checking in which I offered participants the opportunity to check or approve my interpretations and provide feedback if warranted. Consequently, my member-checking improved credibility and was vital in establishing trustworthiness with participants (McSweeney, 2021). For consistency purposes, I asked all participants the same questions (see Appendix C).

Informed consent is essential and provides the participant knowledge of the study and how their information will be applied in an ethical manner (Norcross et al., 2008). The consent form I provided to participants contained a clear and concise description of the research procedures and allowed each participant the ability to review, inquire of any issues, and sign once satisfied. All participating individuals indicated they understood procedures relating to data collection, privacy, and confidentiality provisions which were on the form. I informed all participants of their rights relating to the study with regards to being voluntary and having the option to withdraw at any time whatsoever for any reason. The voluntary consent form process provided the opportunity to ensure that I had conveyed all information clearly and provided the opportunity for questions. After reviewing everything with the participant, I obtained their signature and began the interview process such that they were immediately informed of the nature of the social issue and study (Xu et al., 2020).

Understanding the subjectivity of both my perspective and that of the participants was of utmost importance, so I needed to make certain that my personal experiences and thoughts did not influence the participant, nor my understanding of their perspective; I wanted their honest understanding of the situation they were describing. To obtain efficacy while at the same time reaching saturation, I used triangulation as a tool to reflect when a consensus was forming. Once completed with triangulation I reviewed documents pertaining to the program on the city's streets. I used the document review to ascertain prevailing themes that allowed for robust conclusions on the program impacts. The use of interviews and document review reduced any potential bias of any single form

of data collection method (McSweeney, 2021). The document review process provided a clear description of the program's organization fortified by the use of data that were collected (Braun & Clarke, 2021). I followed these guidelines in their entirety.

**Data Analysis Plan**

My generic qualitative research entailed transcribing from the audio-recording and coding for patterns and themes. To analyze the qualitative data**,** I gathered the transcripts from all stakeholder interviews and highlighted general topics and themes that appeared salient and significant per each question per each individual. I combed through all of the transcriptions, taking copious notes in which preliminary ideas for codes came to light. I then recorded these a priori codes in Excel spreadsheets to use for cross referencing with verbiage in the candidate responses. This research approach entailed deductive analysis, as I wanted to search for themes within the responses and verbiage used by responders involved in the study relating to public safety individuals responding to PMIs undergoing a traumatic situation. The next step in the thematic analysis process entailed collating the sections which fit into each code and using them to identify patterns within the verbiage contained in cells of the spreadsheet. While the codes revealed interesting and informative facts, I wanted to identify themes which would yield broader, active interpretation of the individual codes. Thus, I then began an iterative process to search for themes in efforts to find cogent and cohesive ideas and categories. During that iterative process, I noticed that I first produced sub-themes that supported more umbrella themes which covered a wider spectrum of ideas.

I identified participants' recurring topics that emanated from the responses to each question by impartial researcher judgement based on context and setting. As the primary researcher, I educated myself and continually apprised and reminded myself of the focus on objectivity. The results helped me define pertinent themes from the transcripts and piece together commonalities which helped organize and facilitate the ultimate goal of reaching participant perception and understanding via prevailing themes. I categorized these themes by specific naming conventions suitable for the topic under research.

I used thematic analysis in this qualitative study. Thematic analysis includes six steps: Familiarizing oneself with the data, generating codes to analyze specific traits in the data, searching for and identifying themes in the data, reviewing and refining these themes, defining and naming these themes, and analyzing and generating the report on these themes. Because thematic analysis is one of the most common approaches to analysis within the realm of qualitative analysis, I had a plethora of tools designed to assist in helping researchers reach viable themes. Because this analysis process facilitates identifying, analyzing, and interpreting patterns of meaning, the best tool for me to perform this work was Microsoft Excel. I have a vast background using not only the basic tools of the software, but I capitalize on my programming knowledge and use the Visual Basic programming language to perform searches of themes. I used Excel and developed Visual Basic code to help in the identification of paradigms. If any topics diverged (such as an outlier), I had tolerances, limits, and rules to follow for treating the data accordingly (whether to keep, remove, verify, and/or allow based on context). While I performed

much of this work manually, I utilized DEDOOSE for transcription and increased the reliability of results by corroborating or refuting my outcomes.

## Issues of Trustworthiness

Validity within the qualitative realm entails establishing credibility, transferability, dependability, and confirmability (Cooper & Endacott, 2007). My process to ensure credibility was to continually "check-in" with each stakeholder participant as the interview process progressed, confirming with the subject that the discussion and content made sense and were believable. To ensure transferability, my intention was to disseminate to short- and long-term social services programs and policy makers the supportable outcomes. In other words, if there are reductions in interactions between police and PMIs, and compassion is shown to those that are treated by the MHP/EMSPs or the program's team as they help to provide and supply short- and long-term services then it can be assumed positive regard and full buy-in by participants, stakeholders, and policy makers will be an outgrowth. These positive treatments facilitate public safety, improvements in community morale, awareness of social service programs, and so on. Expanding research to other types of communities may take some tailoring but considering the program has worked in a smaller sized community, the outlook appears good for generalizability (Osbeck, & Antczak, 2021). For dependability, I ensured a consistent setting and if changes did occur (for example, a pandemic) I was vigilant in normalizing and/or standardizing the backdrop by analyzing and controlling for the event (Korstjens & Moser, 2018). To ensure confirmability, I performed a data audit in which I

examined procedures related to data collection and analysis and checked and rechecked for potential bias and distortion throughout.

Validity and reliability of qualitative research are key elements in providing evidence of the quality of the study in the results (Hayashi et al., 2021). Just as in quantitative research, in the qualitative research paradigm, I realized triangulation can be useful in illuminating specific ways to test or maximize the validity and reliability of a study. At a minimum, before making a conclusion I ensured I had at least three different sources to validate any findings. Quality, rigor, and trustworthiness are key elements in assuring my validity in the qualitative research (Braun & Clarke, 2021).

In this research I vigorously worked to reach as many stakeholders in the interview process so as to reach a saturation point in which prevailing themes converged. To achieve quality in this research I remained diligent in terms of continually displaying objectivity as completely as possible. I integrated checks and balances along my interview process that allowed me to make sure I am not introducing bias in the process. My earnestness to truthfully represent the participant's story and narrative translated to trustworthiness to participants.

At the same time, I realize reliability requires consistency in results. This can be difficult to achieve in terms of working with individuals dealing with different perspectives but can be enforced in the analytic segment of the qualitative research process by not only searching for convergence in themes, but also recognizing the likelihood of some or all divergence (Hayashi et al., 2021). My explanation of these approaches conveys the rigor in the defined process for this study.

## Ethical Procedures

The recruitment process for the qualitative interviewing process was purposive; there was a list of current and recent staff members that were provided and since it was limited (due to the program only recently being piloted, and Covid restrictions), I decided to ask (Appendix C) all possible current and recent program personnel with the hopes of getting enough for a valid qualitative sampling to reach the saturation point (Campbell et al., 2020). I gave each individual a consent/confidentiality form providing a complete explanation of the purpose of the research, method, and approach. I advised the participants that they could pull out of the study at any point in time if they felt uncomfortable or had other conflicts or issues. As well, I assured them that they could not be identified in the study, but any information they revealed would be grouped in an overall summary. To provide transparency, I also offered to provide them a completed analysis and results report.

At the same time, I have taken measures to lock any database, spreadsheet, tables, etc. by enforcing a password with high complexity level such that data records could not be hacked in any way. All data is stored and secure for 5 years per university rules.

## Summary

This chapter outlined the research methods and rationale that I used to determine the appropriate design, setting and sample population, participants, sampling approach, treatment, and procedures, measures and variables, data collection process, and analysis approach. I performed the study upon a nascent treatment involving mental health and emergency medical teams, or the program's teams, assisting individuals involved in a

mental health crisis. I performed the interviews and collected, analyzed, and reported the data via a rigorously detailed process. The purpose of the study was to understand the attitudes of members of the program I studied on PMI adverse outcomes according to individuals associated with the program. I treated all participants in the research ethically and confidentiality regarding any specifics relating to identity or events were maintained. Chapter 4 describes the study with more depth and detail while also explaining data analysis and results.

# Chapter 4: Results

The purpose of this generic qualitative study was to explore and understand how individuals associated with the collaborative crisis team perceive the treatment's impact on the rate of PMI deaths when a PMI experiences a mental health crisis. To address this purpose, I conducted interviews in which I asked participants about their impressions of the effect of collaborative crisis teams on PMI adverse outcomes. I conducted these interviews such that they were open ended, therefore allowing participants to elaborate on the areas they felt were appropriate and relevant. I asked them what they had observed while working as a member of the team as they cared for PMIs before, during and after a crisis event.

In Chapter 4, I explain the demographics of the participants, the number of participants interviewed, the settings of the interviews, how I recorded the interviews, the data collection process and any deviations or diversions made from Chapter 3. If any unusual circumstances occurred during the data collection process, I report them when discussing the data analysis process. I discuss data codification, interpretation, and analyses exhaustively. I also discuss trustworthiness in terms of credibility, transferability, dependability, and confirmability at length within the study. Lastly, I provide the results of the study with any supporting materials.

## Setting

To ensure transparency, comfortability, and confidentiality, I requested that all participants seek out a private location for the interview. I sent the questions via email 24–48 hours before the interview to allow participants time to assimilate and reflect upon

the questions, as well as gain an understanding of context and perspective in relation to the kind of questions asked in the interview. The interviews took place at the designated times specified by the participants to work conveniently around their schedules. All interviews occurred via telephone or videoconferencing; no modifications were necessary nor were there any significant issues regarding the interview or interpretation process. All participants attended the scheduled interview times; I recorded, transcribed, and interpreted each interview without technical issues. There were no discrepancies or variances within the study that affected the interviews, the participant's experience during the interview, or the interpretation of the study.

## Demographics

The participants consisted of 11 individuals (six female, five male) who qualified for the study by acknowledging that they had formerly been or were currently associated with the program as an MHP or EMSP, nurse, or similar profession. The age of the participants (of those who provided the information) ranged in age from 26–54 years old. Eight of the participants were White (four female, four male), and the others were Puerto Rican (female), Hispanic (male), and biracial (female). All participants were residents of Denver, Colorado, or the surrounding areas. I gave the participants a pseudonym after their interviews. For the remainder of this study, I refer to them as P1 through P11.

- P1 was a 34-year-old, White, cisgender female. She worked with the program as operations manager for 2 years. She worked for 911 for 11 months and has been in the mental health field for a total of 8 years.

- P2 was a 44-year-old, White, cisgender female. She had been in EMS for 23 years and worked as an EMS personnel manager in the program for 7 months.
- P3 was a 33-year-old, White, cisgender female. She was an assistant program manager for 1 year. She also worked as a co-responder for 4 years and 3 months. She has been in the mental health field for 8 years.
- P4 was a 39-year-old, White, cisgender male. He was director of criminal justice services at the city Mental Health Center. He had worked with the program since its origination in June 2020. He had worked in the mental health field for 18 years (3 years in a dementia program and 15 in Alzheimer in Serious Persistent Mental Illness program).
- P5 was a 26-year-old Puerto Rican cisgender female. She was a mental health clinician in the program for 6 months and had been in the mental health field for 7 years.
- P6 was a 27-year-old, White, cisgender female. She was a mental health clinician in the program for 6 months and had been in the mental health field for 4 years.
- P7 was a 54-year-old, White, cisgender male. He had worked with the program for 5 months. He had worked in EMS for 30 years.
- P8 was a 44-year-old, White, cisgender male. He worked as a program paramedic for 7 months. He had been in the 911 system of EMS for 13 years.
- P9 was a 30-year-old, Hispanic, cisgender male. He worked as a program EMT for 6 months. He had been in the 911 system of EMS for 1.5 years.

- P10 was a 33-year-old biracial female. She was a member of the LGBTQIA+ community. She worked 8 months with the program. She also worked for 2 years and 3 months in the police department as a victim advocate. She had been with 911 for 8 months. She spent 3 years total in the mental health field.
- P11 was a 30-year-old, cisgender male. He had worked as an EMS member of the program since the pilot, over 2 years ago. He had been a part of EMS for 10 years.

Figure 2 provides a summary of demographics in terms of average age, number of years in the mental health, social work or emergency medical field, and number of years in the program as it pertains to the participants in this research population.

**Figure 2**

*Population Demographics*

| PROGRAM DEMOGRAPHICS | MHP | | | | EMS | | | |
|---|---|---|---|---|---|---|---|---|
| | MALE | | FEMALE | | MALE | | FEMALE | |
| | WHITE | OTHER | WHITE | OTHER | WHITE | OTHER | WHITE | OTHER |
| FREQUENCY | 1 | 0 | 3 | 2 | 3 | 1 | 1 | 0 |
| | 1 | | 5 | | 4 | | 1 | |
| | 6 | | | | 5 | | | |
| | 11 | | | | | | | |
| AVG AGE IN YRS | 39.0 | N/A | 31.3 | 29.5 | 42.7 | 30.0 | 44.0 | N/A |
| | 39.0 | | 30.6 | | 39.5 | | 44.0 | |
| | 32.0 | | | | 40.4 | | | |
| | 35.8 | | | | | | | |
| AVG YRS IN FIELD | 18 | N/A | 7 | 5 | 17.7 | 1.5 | 23 | N/A |
| | 18 | | 6 | | 13.6 | | 23 | |
| | 8.0 | | | | 15.5 | | | |
| | 11.4 | | | | | | | |
| AVG YRS IN PROGRAM | 2.0 | N/A | 1.2 | 0.6 | 1.0 | 0.5 | 0.6 | N/A |
| | 2.0 | | 0.9 | | 0.9 | | 0.6 | |
| | 1.1 | | | | 0.8 | | | |
| | 1.0 | | | | | | | |

## Data Collection

For this generic, qualitative study I recruited 11 individuals who had worked in the program since its inception in June 2020. I recruited participants via email from a list of facilitators of the program, which the program director provided. I attached a flyer, approved by the IRB, to an email soliciting individuals and detailing information pertaining to the study. In the flyer, I request interested participants contact me via email, phone, text, or chat to discuss participating in the study. I received requests to participate in the study through email, text, or social media messaging. For those who responded, I emailed the consent as well as recommendations for the interview process. After the participant gave consent, I scheduled an interview based on the participant's desires. All interviewees had the option of participating via phone call or videoconferencing. Two of the participants preferred the phone call while the remainder were comfortable using the secure videoconferencing tool. I used the recording feature of the videoconferencing tool for all interviews even if the video was not on (for the two phone calls).

I communicated reminders via email or text to the participants of the scheduled interview time as well as the interview questions (see Appendix A) 24 to 48 hours before the interview. I prefaced each interview with the statement that all interaction between me and participant was confidential and that, although the call was being recorded, the recording would be used strictly for this research and deleted after all data collection and analyses were performed. At the same time, I informed the participant that they had the option to withdraw at any point or to not answer any questions they were uncomfortable answering. I recorded the interviews using the videoconferencing recording tool.

I thanked each individual for their participation and informed them of the subsequent phases of the research and how I would communicate further information and requests for clarity if necessary. Once I completed a summary of the interview transcript (within 1 week), I asked the participant to review and inform me of any misconceptions or need for alteration. I sought their approval once all feedback integrated within the interview summary. At that time, I informed the participant their involvement is complete, and that I would send a summary of the entire study as soon as I had aggregated the information from all of the other participants.

I collected all data via video- or audio-recorded calls using the videoconferencing recording tool. I conducted one interview with each participant and the interviews ranged from 32 minutes to 1 hour and 22 minutes, with the majority of calls lasting between 30 and 40 minutes.

## Data Analysis

When I completed the interviews, I leveraged the speech-to-text service from the Rev.com site to transcribe the interviews. I transferred the transcription via the secure Rev.com download utility to my hard drive and opened in Microsoft Word. The transcriptions created within Rev.com were relatively accurate, but to feel 100% confident I pored over the transcriptions and recordings to ensure all words were translated from video and/or voice recorder to document. Any discrepancies were noted as I performed a manual line-by-line, word-for-word assessment until I felt the transcription was accurate. Once comfortable, I read the transcriptions multiple times and initiated the summary stage of the process. To provide a proper summary for the

participants to review, I checked each question and participant response, along with notes associated with body language, voice intonation, and inflection points to help understand context and participant perspective. I summarized each question or group of questions into paragraph form for the participant to review. I performed proofreading of the summary several times and when comfortable and confident with the representation, sent it to the participant via email. Within the email, I requested the participant read the summary and approve or correct any misunderstandings or misinterpretations. I respectfully integrated any feedback I received from the participants.

My first step in the coding process entailed using the comments section within the Word document for note taking and targeting of repetitive and redundant words, statements, thoughts, and ideas. If a phrase collectively summed up a sentence or multiple sentences, I would carefully assign that construct/phrase to the sentence or sentences, making sure I identified the summative word, phrase or thought as my own perception. I would put that summative statement or phrase in the comments section. Coincidentally, I would highlight comments within the transcript that corroborated and/or supported my conclusion. For example, if a participant stated, “I have always wanted to help people,” coupled with “This program was a vehicle for me to help people with mental illness,” I would highlight the two sentences and conclude in the comments that the “participant had a desire to help people with mental illness.” Since this was the first round of the process, I classified my conclusions as preliminary and informal; I would leverage inputs from Round 1 to inform me as I moved to Round 2.

For the second round of coding, I began using the Microsoft Excel application to pull each participant's responses for each question into a spreadsheet (with tabs for each participant labeled P1, P2, etc.). The first column contains the question, while the second column contains the verbatim responses and the third consists of margin comments from the word document. I preliminarily highlighted common and key points at this time.

At this point, each of the participants had been treated independently in terms of data collection. With the third round of coding, I created individual tabs within the worksheet for each question (i.e., Q1, Q2, Q3…. Q14). All 11 participants' responses and margin commentaries were then copied to the respective tab to facilitate the finding of commonalities and/or convergences as well as variations and/or divergences for each question. For example, Question 1, or the Q1 tab, would contain all participant (i.e., P1–P11) responses allowing for a visual assessment and ease in the analysis.

I listed each of the questions with the participant's highlighted answers directly below each section. This allowed me to view all answers cohesively on one spreadsheet to facilitate identifying similarities as well as any discrepancies or diverging thoughts among participants. At this point, the color-coding process began. For instance, I mapped the light green color to statements having any empathetic connotations. I linked orange to program-oriented comments in which participants mentioned flexibility and autonomy. I linked the color gray to any statements relating to safety and risks on calls within the program. The overall initial color-coding process resulted in upwards of 20 colors. Once completed, I went over the topics and ascertained if any were similar or redundant. At this point, if I determined the topics to be similar, I would merge them under the most

appropriate label or theme. The pared-down list reduced the color codes to a more manageable six main themes and 12 subthemes.

I listed each of the questions with the participant's color-coded answers directly below each section. This allowed me to view all answers cohesively on one spreadsheet to facilitate identifying similarities as well as any discrepancies or diverging thoughts among participants. Seeing the participants' answers, along with the comments that were previously coded, helped me discover parallels between participants. I stacked the colored codes next to the responses on an accompanying tab entitled "Q1 themes," "Q2 themes," and so on. For example, the first question I asked was "What sparked their interest in the program?" I saw a dichotomy of colors, primarily mapped to empathy and alternative approaches. In other words, there was a trend of participants who mentioned having an inherent desire to help people, that their existing job had flaws and this program attempted to reduce them, and this alternative strategy in caring for persons with mental health issues was a novel and admirable approach. This round of coding gave insight into common ideas or statements made by the participants.

The fourth round of coding consisted of transferring the transcripts into the program DEDOOSE. Within this software, I leveraged the word cloud utility to verify the codes from Stages 1 and 2 that I had selected were contained within the cloud. The word cloud provided a graphical representation of word frequency that gave greater prominence to words that appeared frequently in the interviews. The word cloud provided validation with regards to already selected codes from the two stages, but also provided

more insight to other potentially significant themes. I gleaned no new themes from this step.

The fifth round of coding involved finding similar codes and grouping them into broad codes. I discovered that the participants frequently spoke about their partners with the utmost respect. I had initially placed the topic of the fluid, respectful partnership within the broader category of "Alternative Response to Traditional Emergency Response" but recognized that while it is an essential part of the program, it necessitated its own category due to the pure frequency and significance given by the participants of the theme. This was one situation where disaggregation occurred. System and attribution related aspects of the program for the "Alternative Response" main theme were more relevant as subcategories, such as "Fourth Tier of First Responder System," "Flexibility and Autonomy," "Continuum of Mental and Physical Healthcare," and so forth.

Some of the codes were intriguing and I was initially excited about them thinking they would be a vital part of the results, but I realized when journaling and focusing on my objectivity and credibility that I was inadvertently inserting my own biases and agenda into the outcomes. The journaling kept me focused on exactly what the participants had verbalized. Any removed codes were typically subcategories that were not significant in terms of number of mentions and gravity given to the topic. I repeated this process until I recognized and ascertained the final themes within the study. Six themes emerged that were relevant to the research question. All six themes, and several subthemes, will be discussed in the results section.

## Evidence of Trustworthiness

### Credibility

Clarity and transparency were two constructs I strived for throughout this research process. I documented each interaction exhaustively, for example while I taped interviews, I also took notes relating to body language, facial expressions, vocal tonality, and inflection points. I checked frequently with the participant to ensure they were comfortable and understood the interviews questions thoroughly. I also paraphrased some of the individual's answers and would recite back to them to ensure my understanding was accurate. I created dedicated, secure folders for each participant's data on my desktop hard drive. I generated at least two and sometimes three levels of security by enforcing strong passwords for computer entry, folder entry and any document entry. I was sincere and truthful when dealing with the participants, during the interview process as well as for the duration of the reading and coding of the data. After each interview, as I had promised, I sent a summary of my interpretation of the interview to obtain affirmation that the interpretation was correct and final confirmation that they agree with the summary. Three provided feedback and I incorporated their comments. The remainder agreed that I had interpreted their words and feelings correctly and made no alterations to the summary.

McSweeney (2021) recommended researchers reflect and ponder happenings along the research journey, particularly throughout the interview process. Journaling is an appropriate tool to facilitate and document thoughts and perspectives along the time continuum. By doing this I could record historical thoughts and revisit verbiage in

attempts to standardize thoughts and perspectives as objectively as possible between participants. As well, I focused on accomplishments but also emphasized roadblocks and obstacles that may have thwarted progress. I could take lessons learned from each interview in order to improve or reduce uncertainty or bias in my work. I ensured that I was transparent about beliefs, doubts, and presuppositions. An important goal for me in this research was to ensure individuals realized my respect and gratefulness for their assistance and that I would do my utmost to ensure my conclusions were true to their perspectives and perceptions of the program.

**Transferability**

This study explored how individuals associated with the collaborative crisis team perceive the treatment's impact on the rate of PMI deaths when a PMI experiences a mental health crisis. Although this study explored the specific case of ten individuals, it has the potential for transferability to other administrators and facilitators of the program. It also has the potential for transferability to other urban, suburban, and rural areas.

**Dependability**

Journaling was my main process mode of ensuring dependability. In other words, my journaling allowed me to anchor my thoughts, feelings, and emotions in a consistent fashion such that I would react to and interpret participants statements in a stable, logical, and uniform manner. To enforce this, I first documented potential biases, pros and cons that could impact my study prior to performing the interviews. This would allow me to spot preconceived notions, determine their efficacy within the context of the interview, and allow for objective assessment in terms of relevancy and inclusion. I documented

aspects of interviews that intrigued or perplexed me (i.e., influenced me such that I was left with a positive or negative impression). I frequently journaled and reflected often upon the happenings of the study. I analyzed and examined my perspectives regarding my discoveries and conclusions to ensure I was not biasing results based on my values or ideas, but on the participants' experiences and words. After summarizing, I sent results to the participants to confirm that my interpretation of the interviews was accurate in their eyes and that I had not imposed my values or biases onto their interview. Participants read, endorsed, and authorized all summaries, and the meaning and context of the words remained the same throughout the analysis process.

**Confirmability**

The original design for this research is clearly delineated in the methods section of Chapter 3. The research method did not vary from the original design. The journaling process was the primary tool to continually document interaction between myself and the participant. Concurrently, information pertaining to interviews, transcription, and notes relating to interpretations with potential biases, and rationale and logic behind how the final results surfaced, were diligently recorded within the journal. The worksheet acted as a tracker for participant progress and stages of the study to ensure all procedures were followed and completed in the time frame required for each participant. This procedure, with its documentation and tools organized into a well-defined process, allows for the study to be easily replicated.

## Results

The research question for this study was "What are the attitudes of the collaborative crisis team (MHP/EMSP) on PMI adverse outcomes among facilitators of the program?"

The thematic analysis identified several prevailing themes relating to the research question. To be exact, I discovered six themes during the analysis of the data. The themes consisted of the topics Alternative Response to Traditional Emergency Response, Partnership is Fluid and Respectful, Safety Priority on Calls, Police All-In, Policy Makers and Community taking Notice, and Short- and Long-Term Linkage Key.

### Alternative Response to Traditional Emergency Response

#### *Fourth Tier of First Responder System*

Participants were emphatic in their belief that a new type of emergency response was necessary. P7 stated "In the age of George Floyd, Black Lives Matter and Defund the Police, as a society, emergency services need an entirely new approach," and that a new type of emergency response would be "fundamentally changing the way that we care for people that need it." P5 said that "the capability to provide an alternative response is a really creative idea. Emergency services is so dynamic and not one shoe fits all and now we've provided another avenue for folks to get their needs met."

P1 noted that "traditionally we've sent these one-size-fits-all responses for all these different issues. I think what I find really impactful about the… program is sending the right response." P1 suggested that when one calls 911 or a non-emergency number with a low-level behavioral crisis, they can be confident they will "get the appropriate

professionals … it really made sense to us and started us thinking, 'how do we create additional response options for when folks are calling 911?', so that's kind of how we landed on the [program] model." P2 stated "we really are a part of the 911 operating system. My supervisor frequently calls us the fourth tier of first response. Because there's fire, there's police, there's emergency medical services and now there's [the program]."

Some participants described when they started to recognize the need for an alternative emergency response. P1 remembered that program members posed the question: "'How do we offload those [behavioral health] calls from our emergency response system?' and we started doing some research and heard about Cahoots in Eugene, Oregon who were sending a civilian team to those types of calls out in Oregon." P4 stated that, traditionally, "it's three options: police, fire, or EMS." P4 suggested that program members had the ability to suggest, "'We have a clinician program, why couldn't we expand this to take on those low-level acuity calls and keep police on the calls they're supposed to be on and let us do kind of more the social service aspect?'" P4 felt that this was "a natural fit with our spectrum of behavioral health, outreach and engagement."

Participants have received several reactions and interpretations from the public regarding new programs. P7 said that he felt people were able to "recognize this and embrace what we're trying to do, even if they don't totally understand it … They get that there's an alternative response to a cop, a fire truck and a big old ambulance showing up in their door." P1 stated when people think 911, they generally think "crime or ambulance or a fire. And there really is this category of calls that doesn't really fit those

traditional three response pathways, but people are calling because it's a number that they know that can call for help."

P1 noted that "there's a really good point of reference for what a police officer does, what a firefighter does, what a paramedic does; not such a great point of reference for what a community behavioral health worker does." P10 stated,

> As a society people don't know who else to call but 911. So why not have a civilian that's trained for these types of crises, just like police officers and fire and EMS are all trained in their specific areas?

P10 suggested, "Just add another option when you call 911, after police, fire, EMS; why not add mental health in there?"

Several participants described what their ideal alternative emergency response team would entail. P7 described "a fourth service in emergency services with police, fire, ambulance, and [the program]." P7 aspired to having the level of autonomy "where we could have our own internal policies and procedures that would be client-focused, person-centric to allow us to treat that individual in front of us right now and not have to worry about those other things."

Participants noted their belief that the program would be beneficial for police and EMSPs as well as clients. P7 stated "I hate the whole Defund the Police catchphrase, but I do think that society has been kind of starved for this alternative response at least a couple of years." P1 suggested that it makes sense "to take some of the things that we've historically tasked police that never really belonged on their plate in the first place but wound up there because a lack of a better option. We are righting that historical wrong."

P2 said “I think that this program just kind of opened a door for the paramedic division to kind of start looking at mental health, not even just to the services we provide to other people, but even for us.”

P9 noted that if the last few years have “exposed anything about the first responder system, it’s that we can’t be all things to all people. And whether it’s a police officer or EMS or fire, we are not social workers. We’re not trained in that.” P9 said “We have very distinct communication styles as opposed to how a social worker typically does.” P9 continued “And yeah, it’s kind of what inspired me to switch from being a paramedic within the EMS to [the program] and I’ve been really impressed with the work stars done in the meantime.”

Several participants described personal experiences that indicated the importance of a fourth type of emergency service. P2 remembered being “assaulted at work [as a paramedic], and just realized the importance of mental health… it really allowed me to kind of highlight mental health and the importance of it and the importance of it for first responders.” P9 explained that he “witnessed how [the program] took an individual to the DMV to help him get his ID so he could get his medications, and then helped him get his medications and then helped him get connected with resources.” P9 was surprised by “what a unique approach that was to how first responders traditionally handle a situation like that.”

P11 stated that he had been in EMS for nearly 10 years “and was looking for a different way to help people other than just purely from a medical standpoint, just solely taking an individual to ER.” P11 encouraged having

> alternative dispositions to get to the root of the issues and people in a more holistic way … I've also got some family history of people with some mental illness and substance abuse and stuff so it hits home for me.

Participants mentioned that they felt the program is innovative. P2 stated "I think that [the program] represents a counterculture, meaning we are approaching this mental health aspect of healthcare that other people are only just beginning to talk about, but we are actually doing it." P2 then said "I think that's what resonates most with me is that mental health actually means something in the program."

***Meet the Clients Where They Are***

Several participants emphasized meeting clients where they are in life as opposed to forcing them to conform to a certain standard. P6 said "I fully believe that we should be able to meet people where they are at and empower them to live the life they want to, even if that's not what we think it should look like." P6 continued "We're here to meet people exactly where they're at in non-police, non-violent, non-uniform approach. And just be like, hey, this thing is going on. What do you need? And how can I help get you there?" P5 stated "I think that's the wonderful thing about star, we get to meet you where you are at and where you want to be." P5 also said "you have the education that your life could be different, and we can also connect you to various resources out in the community that will meet you where you're at."

P3 said "I would say the fact that [the program] really comes from a place of meeting people exactly where they're at. So, meeting people in a sense where it's not always a traditional way." P3 explained "So, we're able to advocate support and stand

next to these people in situations where maybe they wouldn't have had that before." P11 emphasized the importance of "just being able to meet people where they're at and helping them in that moment. And just kind of having multiple things in my tool belt instead of just kind of like a set standard of protocols." P11 stressed the importance of being able to "connect with people on a human level. We're not here to just get you off the street just because you're a nuisance, we're here to meet you where you're at, find out what your needs are."

Participants stressed the importance of bringing this empathetic strategy into interactions with clients while on calls. P6 stated that "for many individuals it's very natural to remove the human element when a first responder shows up in a uniform, it can be disconcerting. Social workers and medics for [the program] are just meeting you person to person." P2 said "I think it really just boils down to acknowledging that it's not the same for everyone and providing those resources to people who maybe just don't even understand that what they're getting, isn't the same as what we get."

Participants noted the importance of withholding judgment of clients while on calls. P6 said that "it's easy to forget objectivity and start making assumptions about what people would need. I mean, we're human, so it's natural to think, 'Oh, this is one of those calls'" P6 explained that "Daily, I am humbled in terms of expectations regarding a call and seeing reality … and I'm like 'that was not what I envisioned at all.'" P2 stated ,"I think there's something about saying to someone, 'hey, I know that things aren't great for you right now and I'm here to support you.'" P2 recounted the importance of being able to say to a client that, "'I may not be able to get you all the things that you wish I could

give you, but I'm here to support you and help you navigate what your life looks like today.'"

Some participants acknowledged that different patients would have different needs on calls. P5 references a scenario in which a patient says they are "not looking to be housed. 'Fantastic. How can I make it safer for you to be on the streets?' Acknowledging their need for that self-autonomy, I am passionate about that." P6 said that clients are "the expert in their life. I can't tell them what they need, even if I think that something would be a good fit. My opinion doesn't matter. I can just say these are your options and we'll go from there." P6 explained that "We ask 'Do you need anything? Is there anywhere we can get yet? Do you need food? You need clothes. You need water. What do you want, basically?'" P11 stated "we're dealing with all sorts of people, you know, it's, it's not necessarily just the unhoused and minorities and things like that. We do deal with people in more affluent situations as well."

Participants discussed the importance of determining the client's needs simply by asking them. P6 said "our first thought is 'what can we do for you?" P6 said that, despite not being able to solve all clients' problems, "I can link you to resources and help get you to people that can help you and get what you need, whether that's harm reduction with safe needle exchanges, getting counseling or being assigned a case manager.'" P5 mentioned dealing frequently with specific clients and saying "'Your actions by being here with me tells me that you at some point want to be sober. And if it means that I'm responding to you frequently for that basis, then I know where you are.'" P5 continued,

as though to a client: "'I know that you trust me. I can get you into services or continue to have that conversation about long term services.'"

Participants have experienced scenarios in which this accommodative strategy was more successful than an interaction solely involving the client and police. P5 remembered a call in which a client was "standing on top of a Walmart buggy station and the police are there. It's clearly escalated, but they were able to take a step back, take a deep breath and let me do my thing." P5 then recalls "but before that they are handing me a piece of paper with his charge history. And a lot of it is crimes with assault charges, homelessness, and all sort of things." P5 was perplexed: "And I looked at it and said, thank you, and I handed it back and thought what am I going to do with that? It doesn't change what's in front of me now. It doesn't change the person that's here."

P5 said "although [the police] may have thought they were informing or protecting me, clearly they were biased. Bias is inevitable. Prejudice is something that's standard. However, it's what I choose to do with my bias." Regarding the bias, P5 said "I must put it away in my back pocket. And with that gentleman, I was able to get him down, get him to consent to going to the hospital… he wasn't aggressive to me because I wasn't aggressive towards him."

Participants acknowledged that there's an exception to this accommodative strategy, which is when there is an imminent threat to the health of a patient. P6 said "if they have a plan or intent … I can't leave them here alone. We say 'we have to get you to a hospital or to seek medical care.'"

***Empathy A Requirement***

Participants discussed the requirement of empathy for members of these programs. P1 said "we hire very intentionally for our program; our medics believe in the mission of [the program], believe in the work of [the program], they're harm reductionists, they're person-centered." P7 emphasized "having that open mindedness to understand people who live not like I do and that there's a whole world out there, people that look different and act different, and that's okay." P7 continued, "We can provide a service that maybe they're not accustomed to, and that hasn't ever been there before. We could also just talk to people and make them feel like there is somebody out there."

P7 posited "I think our reputation on the street is building and that people are now calling directly for us. But I think that it's like with sub-populations they feel more of a connection, and they are getting the help they need." P5 said "if you put the traditional medical model side by side with a person-centered model of care, there's going to be heads butting. But if you sit there and you talk to a person, and you get to understand their motives."

P2 stated "I think just acknowledging that some individuals haven't been given the same shake as everyone else is a good place to start." P2 continued: "I do think that when we acknowledge that people haven't had the same experiences and what I get every day compared to someone who's a person of color is different." P2 also said "We recognize that largely it's not the same for everyone. I don't know that I think that the paramedic population believes that. … And I think that that shades our experience differently. It's something that we talk about in training." P2 stated "It's something that is

a question in our interview process to try and make sure we are hiring people who at least understand it."

Some participants noted that first responders might become jaded over time. P1 said "there are some aspects I think of the police and medic world, that kind of first responder culture where they understandably get jaded or hardened." P11 stated "obviously throughout my career, I've had been close to burnout. I like to think that throughout my burnout stages, it's never affected the way I take care of people." P11 also said "I've always tried to take care of people as if they were my family members. It's easy to get jaded, but I've always tried to be an advocate even on the ambulance."

Participants understood that other first responders may become jaded because they don't see the positive outcomes from a different emergency response system. P1 noted that other first responders are "mitigating the crisis all the time. They're never getting to see a better outcome that might be on the other side of that." P1 explained that this is why some alternative programs "have been good for our first responders in the sense that now sometimes they do get to see that, or they get to hear about it or, in some cases learn more about addiction and how it works."

Several participants suggested that other first responders might gain an empathetic viewpoint from working with members of the program. P5 said "the paramedics and EMTs must assess, decide, and leave within a certain number of minutes." P5 explained "That's the nature of their work because there's another emergency for them to respond to; with [the program] we have more time to delve deeper. And when you get more layers of a person, you're able to be more empathetic." P1 stressed the importance to "embed

clinicians in those systems because when ambulances continually run to overdose calls and see the same people, because they don't have that clinical understanding of substance use treatment… or even that addiction is a brain disease."

Participants stressed the understanding of addiction as a disease that should be treated, not a transgression. P6 stated "we look at drug use and Narcan from a different lens. If it's the only thing keeping a person from suicide, then there's that, no judging." P5 said "I think co-occurring disorders are like the chicken and the egg: which comes first, mental health or addictions? I have had that experience with Narcan and folks being upset, but we have to look at it from a different lens." P5 empathized with a drug user's frustrations; in that they "get hold of these drugs and they were taken from you; I would be upset too. And if that's the only thing that's keeping you from suicide, then I would still look for my next high as well."

Some participants noted that racism is an important factor in interactions with clients. P6 stated "I think one of the saddest things that I've seen [the program] fill the need for, is where there's people that have trauma from racism, whether it's systematic, personal, or even just from healthcare." P6 relayed that clients have said "thank you so much; I'm glad that you showed up instead of a police officer. It's heartbreaking." P6 said "I can't tell you the number of times that I've had to hold back from crying because they're saying 'thank you for treating me like an actual person. You're the first person to treat me like a real human being.'"

***Harm Reduction***

Participants remarked on the emphasis of harm reduction in the program. P1 stated "our medics are harm reductionists, they're person-centered. We realize there are some aspects of police and medic that kind of first responder culture which can trend a little more towards jaded particularly of substance abusers." P1 also stated "I also think that's why it's so important to embed clinicians in those systems because when you are just responding to overdoses on an ambulance and you see the same people, it gets old." P1 continued "Unlike the clinician, they don't have that clinical understanding of substance use treatment or what the change process looks like, or that addiction is a brain disease."

P11 stated that he works "pretty closely with the harm reduction action center; they do awesome work. They've been advocating for safe use sites and stuff like that for a long time." Regarding community reaction, P11 said "We do get a lot of pushback from the community, but it's like, 'would you rather them just be using a Starbucks bathroom?' because that's what's happening now."

Participants noted that other first responders may not have harm reduction as their main priority. P4 recalled that "the paramedic division did not necessarily see what we were doing from a harm reduction perspective. In other words, alternative response like distributing Narcan was met with a lot of side-eye; a lot of 'you're just enabling people.'" P4 notes that "We're still working on that relationship, but those are also the ones that we're not overtly excited to have come join our team. [The program] has great people doing a lot of positives to meet people's needs."

P11 testified that "in working with mental health clinicians I've learned a whole lot; it's really just kind of changed my perspective on things. I respect the heck out of them; they've obviously got lots of schooling compared to what I do." P11 also said that "most of the people I work with really want to help people… They do have the capability to put people in mental health holds and we don't take it lightly when we take people's rights away." P11 realized "they need to be expert in harm reduction and sometimes focus on the path of least resistance to get people's needs met."

Some participants spoke about the shame that some clients have exhibited during calls. P2 said that "we do wake people up with Narcan and frequently they're like, 'no, I wasn't doing drugs, I don't have a drug problem.' But I think that's just a reaction to the shame that they feel." P2 also stated that this demonstrates that some clients do "have a problem and it potentially almost cost them their life… I do think it's easy for people in the medical community to think 'you chose this,'… you just need to stop. We know that… some cannot stop."

P7 said "I was never one to get burned out. But I've seen that a lot in in EMS, just kind of running the same call and the same people sometimes repeatedly, and somehow transferring your frustration into blaming the person." P7 also said "I always think these people are not going be in this job a long time or it's just going to eat away at them. So, they should probably go do something else." P6 discussed an instance in which "we showed up and were brainstorming on what we could provide these people … one guy came up and asked if they could have Narcan. He was one of three and admitted they are users and have used Narcan before." P6 said "They look out for each other in that

sense… him knowing he got Narcan from [the program], now they know how to get it in the future."

Participants mentioned that some first responders don't understand how to prioritize harm reduction as well as members of the program. P11 stated that one of the most difficult things to deal with is "the meth use in the meth psych in conjunction with mental health. But people are just stuck and adamant that the delusions are not mental health related or drug related, and they want to file police reports." P11 said that first responders "want to go talk to the FBI director and things like that. And there's no engagement ... and no specialized centers, at least that I'm aware of in the Metro area that is equipped to handle this kind of stuff."

***Flexibility and Autonomy***

Participants commented that the program allowance for flexibility and autonomy among workers was a significant benefit. P7 stated "if we talk to somebody, we are really trying to connect and we have the luxury of not being rushed. We can take an hour to sit there and talk to somebody." P7 continued "I think that people, if we can connect just with individuals, I think that's a huge impact. Whereas, in the past they may have been swept under the carpet or not given the time of day." P7 also noted that "the time to talk or to be allowed to at least verbalize what their feelings are and anytime you can make that connection, that's an opportunity to then hook them potentially up with the services that they need."

P8 described the limitations of previous programs: "It's written into a lot of the protocols for a regular medical call, you have 20 minutes on scene, and then you need to

be transporting on a serious critical call." P8 suggested that the alternative program gives them more leeway in this regard: "we're able to push that aside and spend as much time as needed with that person. We listen, we're troubleshooting. We're going through all the resources that the clinicians have that the medics can bring to the equation."

Several participants noted that the program was innovative and revolutionary in how much autonomy employees were allowed. P3 feels that the program "is going to continue to grow because there's no real limitations or restrictions on what the clinician and paramedic can and cannot do to support the individual they're serving in the community." P11 stated that "obviously, we have a lot of autonomy and freedom to do what we need and no restricting protocols for the time-being, but I'm not so sure about the future with potential liabilities and legalities and so forth."

Some participants noted that, while the program's flexibility is revolutionary, some people may be apprehensive to the change. P5 stated "We are doing something that is unprecedented for our country. I think every program has areas of development and again, for the … program, it must be very flexible. People are very uncomfortable with flexibility and change, though." P5 continued, "We can't identify the needs or make up rigid protocols because the program thrives on being flexible, because everybody's different and their needs are different." P5 concluded, "Trying to standardize the program is going be very hard. I do think for some things or procedures, it is very doable, but other things are just going to be based on individual need."

P10 commented on the program's revolutionary nature as well. "I think just the ingenuity that it is and the flexibility of our responses. It's not a one size fits all program,

we can spend 10 minutes on a call or five hours, we do whatever is necessary." P10 continued, "Typically, when people think emergency services, they obviously think lights and sirens calling all cars, we need a solution immediately … but we're going get to the best resolution." P10 also stated "As opposed to that cycle of in and out of the hospital, we try to mitigate that process as best we can to be as efficient as possible. How can we reduce the number of times they're calling 911?"

P10 also stated that simply "having that flexibility with resolutions and ability to brainstorm and the autonomy to improve, even in the slightest ways are my favorite things about [the program]… I have this curiosity to look and see how the person we serve is doing." P10 continued, "with frequent callers, my goal is to reduce the number of times they are utilizing emergency services and get them in a better place." P10 concluded, "Even if it's something simple like ensuring an individual gets their right size of adult diapers, finding an individual their proper probation officer, getting an individual a Greyhound bus ticket… or even going to breathing classes with them."

P6 loves the "amount of creativity with this program such that we can just approach the call as needed. Some of the issues that occur are situational and need a unique solution and this program is great for allowing that." P6 explained that the program is "a very competitive program because they want to trust who's out, and they encourage us to be creative and brainstorm to solve these problems … our supervisors trust our gut. They wouldn't have hired us if they didn't." P6 continued, "They realize we are trained, educated, and licensed and are very picky about who they hire for a good reason … there's not a policies and procedures rulebook that we have to follow." P6

stated that the program considered an intervention successful "as long as you get that person what they need and make sure they're safe and get where they're at… I can't be fully responsible for somebody's safety… but the program allows us to do our best during the call."

P7 stated "I think what resonates mostly is that we are not afraid to try a different approach. We're very comfortable operating in more shades of gray." P7 continued, "for example, when you're on an ambulance, there's only one place you're going, no matter what is wrong with you or what's behind in your life, the only place I can legally take you on an ambulance is the hospital." In contrast, P7 remarked that "the program is more willing to operate in shades of gray and look at more unique solutions to whatever is going on in their life." P7 weighed the pros and cons of the program: "we have a lot of flexibility, and we have a lot of talent behind the program… we do have so much flexibility, but it also makes it hard to nail down exactly what the program is sometimes."

P8 appreciates that "we have had minimal protocols or standard operating procedures, and we're building some, but management always says we don't want to box ourselves in and then not be able to provide anything." P8 continued, "I've always said, think outside the box sometimes. And sometimes that's just the best way of going about it. And that's a huge strength for us is being able to come in wearing street clothes, be comfortable." P8 concluded, "The people are not looking at a badge and a blue shirt. Not having time constraints or limitations; if it takes us four hours to figure out a situation for somebody, one of our clients, it takes us four hours."

P2 discussed the budgetary aspects of the program, mentioning that the program has "a pretty large budget for our first go at this which is big, but not sustainable. Given the services that we're trying to provide and the fact we are city funded, we are limited to an extent by the city's expectations." P2 remarked on another big difference between this program and others, which is that "they're based out of a mental health clinic. So, things don't take quite as long to make happen, because it's not a city funded program; it's through the mental health clinic." P2 concluded that "way their program is run is quite different from our program because of funding coming from one source. They can make changes and address things that they find to be problematic, in the moment. We don't have that luxury."

**Partnership is Fluid and Respectful**

***Strategic Toolkits Expand With Experience***

Participants have remarked that employees have gained strategies and methods to add to their toolboxes as they've gained experience. P7 discussed his partner's skillset: "she is so experienced at her job that, I don't even know if she's written a mental health hold the whole time, because she can just reason with people and typically get people to go in for services voluntarily." P7 further stated "it's pretty amazing to watch, especially coming from the EMS side of it, where we're so used to being rushed to make quick decisions." P7 continued "Watching her just talk to people, reason with people, calm them down, get them to the point where they feel comfortable to accept help and go with you, is inspiring. "

Participants emphasized the importance of increasing methodological toolboxes. P5 stated “each person’s needs are pretty undefined until we get there and do a full assessment and we may see a range of issues going on … it’s like having tools in your tool belt, right?” P5 continued: “The paramedic adds another layer of tools that we get to utilize to best serve that person. And if it does turn out that it’s not a mental health issue, it is a medical issue.” P5 discussed the benefit of having a clinician present because “when folks call for medical emergencies, they might be mental health related or not, but we’ve got them covered. And so again, giving us that range of skillset and tools to be able to practice a full scope.”

Participants extolled the benefits of having two partners present with different toolkits. P5 commented “it’s a fluid partnership. There’s so much to a call whether it’s providing resources or general information giving. I think we both also stay very much in our lanes.” P5 continued, “I’ve been in mental health a very long time and provide that and I don’t know a lot about medicine. So, my partner that’s his lane.” P5 concluded that “if it becomes clear to me that I can’t evaluate this person for their mental health, but there’s clearly something going on, then I take a step back and let him do his thing, he’s trauma informed.”

P4 discussed the benefits of the presence of EMSPs on calls: “I think they’re an amazing addition; I think I originally took them for granted when we first started off like, I don’t know how we incorporate you guys and your knowledge base” But P4 soon experienced the positives of their partnership, speaking from the EMSP’s perspective: “This is what we’re going to show you where we add to this and there’s something to be

said about anything you go on; anxiety, stress, mania, and then pulling on a stethoscope and just checking vitals." P4 further added "it calms someone to be able to go to that next stage of a conversation. Like the simple act of being like, hey, everything's healthy right now. So, let's talk about what's going on." P4 concluded: "It's such an easy act that I just didn't realize how much it can actually impact taking someone from a 10 to a six in stress level."

P4 discussed scenarios in which the pairing of the MHP and EMSP have become more fluid: "There's been a few times where they've been able to help with someone that had to go to detox. … There was one time where someone was identified as being intoxicated in a wheelchair. I'm not sure what's wrong." P4 described how the EMSP helped: "I'm doing my screening and I'm like, I'm not picking up on substances or mental health issues… the medic instantly started doing all his things… the guy was having a stroke and it just looked like he was intoxicated."

P10 stated, "for me, sometimes using our tools is a way to get [the patient] into the van… let's have you checked out and we have some clean socks for you, clean clothes for you, whatever." P10 continued, "Sometimes we do have to use that as a tool from our toolbox. But it, I mean, it's all out of actual concern, you know, to start that conversation."

P6 also commented on the benefits of having a EMSP present. "I think that it's awesome. My partner has been a medic for over 15 years and was one of the original [program] pilot paramedics. Our partnership has been amazing… paramedics bring a different skill set than social workers do." P6 continued: "I think it's a beautiful way to

merge the two professions and the overlap between them, there's skills that he has, that they don't teach us in social work school." P6 concluded, "For example, social workers, we're not trained to think in the eyes of public safety and awareness. We're trained to think that we are going to focus on the person."

P2 discussed the strategic toolbox: "I think that I have enough tools in my personal toolbox to be able to support whatever calls [the program] goes on. The clinician increases the number of tools exponentially. It's an optimal partnership for that fourth tier of first responders." P7, a paramedic, found the program partnership "a different way of going about my job, and when we deal with people in unique situations every day, we seem to have so many resources that we have built with this program." P7 states that, when he applied for the job, the lead paramedic stated "just like going from EMT to paramedic, your toolbox expands exponentially when going from a medic paired with a clinician by adding more education, tools, procedures and medications."

P11 commented that the program is focused "on the medical aspect. Obviously, I'm there for medical triage and deciding if appropriate, whether we take someone to certain destination or not, and I do have access to some medications but they're mostly BLS or basic life support." P11 said that they aren't there to "take the job of what paramedics do on an ambulance, more of an ancillary role. But having multiple things in my tool belt instead of just kind of like a set standard of protocols is what makes this program work."

P8, a paramedic, stated that after starting in the program, "you start to enjoy your job a little bit more. You can do things; you feel more productive on a call." P8 continued

"in my EMS job, when it comes to the people that we serve in this role, you had two options. You know, he was either take them to the hospital or leave them where they are." P8 commented that he wished "I could do more. And that's where this program kind of falls in. My toolbox has grown. I may have lost some stuff, not working on an ambulance… but I feel now I have some more tools to work with."

P8 discussed the medical toolbox available to EMTs: "they call it basic life support, you're a BLS provider, and you have six medications that you can give, one of them being oxygen." P8 described the toolbox as "very basic, but once you make that jump to paramedic as an advanced life provider (ALS), depending on the system… in my last job we had 57 different medications that a paramedic could give."

P8 described the responsibilities of managing this medical toolkit: "These are the medications that as a medic, you have to be able to know pros, cons, indications, and contradictions, and be able to give them on a moment's notice for the right reason." P8 described that, procedurally, one is able to "read EKGs for heart tracings, make decisions for cardiac alerts, trauma alerts, stroke alerts… this knowledge is gained from going from an EMT to a paramedic where that toolbox expands immensely." P8 discussed the makeup of providers in the program. "Most of us are ALS providers, but we do have a couple excellent EMTs. In [the program] we work primarily as a BLS provider. So, our tools now, run along the lines of your knowledge and street experience."

P8 mentioned that a common phrase among EMTs is "'sick, not sick" from across the room.' You don't have to put your hands on them or even talk to them; you can look at a person just by the way they present to you and say, 'oh, they're sick.'" P8 stated "the

role that [the program] uses is this assessment from afar. I let my clinicians engage, talk to them. And I'm just looking for any kind of signs of a medical condition that maybe hasn't presented yet or has presented." P8 continued, "We just don't know what it is yet. So that's why I think [the program] has really kind of leaned on the ALS provider. [The program] has experienced EMS providers and clinicians and work off each other."

Again P8, "I'm a provider, my knowledge of sick, not sick is from a visual standpoint, no monitors required. We do have the ability to take vitals, but it's more of a presentation we're looking at." P8 discussed the necessity of an ambulance: "We do not need to have all the stuff that an ambulance carries and if an ambulance is necessary, we'll call them. But that toolbox, being able to lean back on my EMS ambulance days, is vital."

P8 described the benefits of the amenities available under the new system with a chronically sick person: "Let's get them to the doctor's office instead of the emergency room, or let's get them set up with a clinic that caters to the indigent population throughout the city such as the unhoused." P8 said that there are more resources available in this scenario: "There's a lot of in-house case management, follow ups, housing opportunities through them that the hospital's just not going to do, and they don't have the time or the resources to do."

***Unintentional Cross Training***

Participants described how beneficial cross-training and experience is gained via the program, and that EMSPs and MHPs can learn from each other's techniques and training. P6 stated "it's helpful when [clinicians are] trained to be able to relay to

paramedics, if we need to call an ambulance, the paramedics that come on scene, they have a specific way of giving over the details of what's happened." P6 explained that, as a social worker, "I tend to state anything and everything that occurred not in the most concise and informed way I don't know the medical side of those things… I'm not trying to practice outside my scope of practice."

P6 described a situation in which a man "who looked to be over 60 or 70 was experiencing delusions and what looked like mental health symptoms… if a social worker [without a paramedic] witnessed this, we might think to put him on a 72-hour mental health hold." P6 explained that, instead, "having the medic partner, he had the expertise to recognize this as a physical health issue, an altered mental state that ultimately was due to a UTI." P6 also thinks it is very helpful "that my medic partner has a history of working with the city's EMS and that rapport and comradery they have allows him to run a transfer call such that everyone respects each other, and all goes smoothly."

P2 admitted that the program would be impossible "without the clinicians. We are kind of thrown into this realm where we're expected to have these skills that we're never really taught… I think over time as paramedics and EMTs, we develop those out of necessity." P2 commented that "it is really nice to sit alongside someone who actually has the training and the ability to navigate these situations."

P7 discussed the benefits of partners with different roles on calls. "I'm on EMS side of things, and my partner is an LCSW, [licensed clinical social worker] and we have the dynamic between the two different communication styles that really works out to

create a unique dichotomy." P7 stated that EMSPs and first responders tend to have "a very direct communication style only conveying what's relevant information. Whereas social workers have a much more motivational interview style, and they can see things in ways that we don't, and it's really one of the most intriguing things."

P7 mentioned the positive impression these combined roles have had on the public. "It's been the response that the public has to the social workers, it's impressive to watch. And I am blown away by the power of a water bottle these days." P7 describes a water bottle as a beneficial tool for interacting with clients: "It leverages that hierarchy of needs and just starting at a conversation of 'let's get you water, let's get you food, let's make sure you have a place to sleep tonight.' It really goes back to Maslow's hierarchy."

P7 described how this strategy calms subjects. "No matter how many times my social worker encounters that very kind of typical pressured, tangential word salad level of speech, they're calm. We deal with frankly, in an incredible amount of schizophrenia affected patients." P7 explained the importance of patience with these clients. "I've never ceased to be amazed at their level of patience when dealing with some of the circular rationale and it can be frustratingly defeating because as much as I love the program, it's not like we win every time." P7 described the fact that not all calls end positively. "It's not like every call ends in sunshine. We certainly have our 'frequent flyers' as we call them. Some we see on a regular basis and it's like, 'oh yeah, you're going to be clean next week. Okay.'" P7 said that despite this, "the social workers continue to calmly care for them in a person-centered way."

***Continuum of Mental and Physical Health***

P7 described the triaging system when in EMS. “Our choice was to determine if they weren’t going to the hospital or they were going to the hospital, trying to take the time to hook up those kind of access points.” P7 suggested that if they were in immediate crisis, “we would take them to the hospital. If they were kind of borderline or needed some longer-term answers to what was going on, we just didn’t have the ability to do that because we were busy running other calls.” P7 commented that the primary focus of EMS was “medical and not psychological issues and calls, which is weird to me because I don’t know who split the two, but I truly believe, and obviously [the program], that mental is physical health and vice versa.”

P6 recounted a call in which her partner understood she was too close to a client and suggested she distance herself. “When I first started… I stood really close to a client. So, my partner just picked me up by my jacket… I have a great relationship with my partner, we look out for each other.” P6 continued to describe the benefits of partnership: “That’s part of the teamwork, making sure we’re safe. The other side is to serve our people. I think it’s beautiful because people are holistic. That means that your physical health is also going to impact your mental health.” P6 described a call in which “someone was going through alcohol withdrawal and my partner knows more of the manifestations and how to deal with that from a physical standpoint.”

P8 described learning much from the program. “I have learned so much in the last couple of months; how to keep the conversation moving, letting our clients drive the conversation instead of being authoritarian; like ‘we have a job to do, we need to move

on.'" P8 explained that the clinicians "taught me how to talk to people who have mental health issues and to the homeless. They have helped me understand that mental health kind of just always tends to be ignored in most cases."

P8 discussed the benefits of learning from the program. "It's every day we're talking to people, and we're getting dispatched to people who are having mental health crises. And when in EMS I didn't have the time given by my protocols. Or the patience for people, to be honest." P8 described his lack of patience before experiencing this training. "I'm going to be the first one to tell you I was not the most patient person in the world, and I have learned how to be patient and how to listen."

P8 witnessed the clinicians' method of interacting with clients. "You can just see how the clinician is able to connect with these people by their body language; their shoulders drop, their face softens, their body just relaxes." P8 explained why the strategy is more successful: "First, we're not telling them what to do. Second, we are there to listen and troubleshoot. And most people have never had that. It's a whole new perspective them."

A clinician, describing to P8 what was required of EMSPs in the program, "brought me in and says 'it's a certain type of person that we need out here. You can't put Joe Blow paramedic or EMT in this role and not have empathy and understanding with the people that we serve.'" P8 realized that "you can't come in with this authoritarian attitude, like 'you are a lesser person and I'm forced to help you.' To be honest, I believed myself to be very empathetic and understanding and always wanted to do more for people." But while P8 felt he "wasn't perfect for this position, I learned so

much more about empathy and compassion from the clinicians. I think that was able to learn and take a step back and realize these are people."

**Safety as a Top Priority**

***Dispatchers as Risk Assessors***

Consensus among participants was that 911 dispatchers are a crucial aspect of triaging. P1 initially worked in the program van responding to calls and is now an operations manager within the 911 department and works closely with dispatchers. P1 stated that "it's the call takers who are getting those calls and triaging those calls for [the program]," and that "clearly their whole focus is to assess risk and urgency… and get you the help that you need most quickly because… oftentimes people's lives depend on it." P4 stated that dispatchers have "done a great job of making sure we're getting to the right buckets of calls."

P1 said that dispatchers "have decision trees…and nature codes." Nature codes are designated to each call and describe, according to P1, "the general issue going on with this call: what are people's needs?" P1 explained that there is "a set of nature codes that are [program]-appropriate if they are screened for risk and emergency."

Participants described the responsibilities of the dispatcher in the context of new programs as nascent and inchoate. P1 stated that "there's a really good point of reference for what a police officer does, what a firefighter does, what a paramedic does; not such a great point of reference for what a community behavioral health worker does."

Nearly all the participants expressed strong, positive opinions regarding the dispatchers, but felt that effort varied depending on the specific dispatcher. P10 said "I

love our dispatchers so much," but admitted that sometimes dispatchers have the goal of "clear(ing) this backed up call log." P10 said "it really depends on the dispatcher for that day."

P9 described the relationship with dispatchers as "we're figuring it out, it's a great relationship, but we're not quite there yet because it does take a little bit more nuance to dispatch a [program] call… dispatching a [program] call, there's a little bit more digging; you have to ask a couple more questions and recognize subtext."

P1 said that "a lot of my position has been training the call takers and the dispatchers on what our skillset is, what we can help with, what our kind of profession experiences."

Participants believe dispatchers are integral to monitor the safety of responders. P1 stressed the importance of having "a dispatcher who knows my location at all times, and if I'm not on the radio for 30 minutes, they're going to check in on me and make sure I'm okay." P1 also notes that "we also have a radio to call for help, if something were to go badly. P4 noted that "safety is always a huge thing that kind of comes up, especially with these civilian units," and that the dispatchers "probably make me feel safer than I ever have, and I think they're more concerned about my safety than I usually am."

P3 stated "certain questions that are asked to the individuals that are calling in can determine whether [the program] will respond… for example, if a weapon is involved, then police need to be there; those are things that would automatically rule us out." P3 divulged further that dispatch "is more than welcome to ask questions… they're really encouraged to get involved in the calls that they're responding to and get as much

information beforehand to make sure they're ensuring safety … for the people that we serve."

P6 said they feel comfortable enough to express when a call does not "feel like a program call," stating "sometimes we end up going on those high acuity calls, not knowing what we're going into, but if dispatchers have enough information, they can kind of filter it." P6 continued, "if I don't feel safe going on a call," they'll "pull (us) off the call." P11 stated "we have a great working relationship… from a safety standpoint too, we feel more safe with them knowing where we are… this program wouldn't be here without them."

P8, when sent out on a call that dispatch was uncertain about, stated "I'll grab my clinician and say, no, there's something hairy about this and we pull back." P8 praises call takers and dispatchers for "listening for keywords… and if they have any questions, they always just ask if we can call them real quick and talk through the call."

***Safety as a Top Priority***

All participants discussed the issue of safety and risk on program calls. P1, now a program manager, has made it clear to the team members that "clients are important, but at the end of the day, if you are hurt, you can't help anybody." P1 suggested that the police will prevent clinicians from responding if safety is an issue: "There are times where the police are hesitant to send me on a call because of a safety issue."

Participants noted the positive aspects of a partner being present for increased safety. P7 stated "what the paramedics bring to this is kind of that street smarts, the scene safety," and that a paramedic is responsible for "reading people's body language…on

every call, looking for an egress." P7 further stated that he views a paramedic's role as "orchestration and logistics so that my partner [clinician] can do her job." P6 agreed: "That is one way that my partner [paramedic] has made me aware when I'm not focusing on safety."

The teams are also known to debrief after completing a call, in efforts to improve safety levels. P5 stated that in one instance, her partner commented "you want to do this in this particular way?" and followed with "then I need you at least two arms-length away from the person so that I can get to you before they can get to you." This discourse is meant to improve the program for everyone involved.

***Clinicians Familiar with High-Risk Jobs***

Many of the clinicians spoke of a history of high-risk jobs. P5 said "I was a case manager before this," and that many people that she has served in the community were on her caseload before, where she had no police presence: "I'd have to respond to these places by myself without EMS or the police," and "I'd go into their home, sit down and have a cup of tea." P4 said that as a former long-time case manager he would "go into hotels and alleys and people's apartments and houses and really meet them where they're at… nobody knew where I was." P4 stated "I didn't come to people as someone to be feared or someone to be scared of… it's how do I help you?" The operations manager, P1, said "we're used to going into people's homes, unarmed, on our own."

***A different Role Than the Police and Traditional EMSPs***

Participants noted a previous lack of specialized care for sufferers of mental illness in their roles. P7 said "I really have always recognized there's a gap in our care

and how we provide services to people and help to people that actually need it. From the EMS side, our only choice was taking to people to the hospital… this position came up and I'm like, this is exactly what I've been kind of frustrated with my whole career." P4 described the difference in roles: "(The police) are going to come and back us up, but also know that the role is not for them to just bum rush and take over the scene and put someone in handcuffs."

Participants described the learning curve that the public may experience in differentiating the goals of the program and the reputation of the police. P5 said "I think it, again, ties back to that we're doing something completely different, and with that it's a cultural change. It's an attitude change to, um, preconceived notions." Participants expressed the importance of clients understanding that they aren't the same as the police. P5 said, "Especially if you're in plain clothes, that's even better for me because I wear plain clothes, and I think what people are not understanding is the power dynamic of the uniform… and the trauma that's also associated with it." P4 stressed the responsibility of program members to convey the difference: "[the program's] personnel need to know how to represent themselves so they are not thought to be one of the bad guys."

**Police All-In**

***Police Perceptions Mostly Positive***

Participants commented on their perceptions of the police officers' opinions of the program. P5 said "I think that for the most part, it has been a very warm reception because we're taking some things off of their plate." P4 stated "we have a good relationship with police." Most participants opined that the police had been receptive to

the program since its inception. P4 stated that he was "pleasantly surprised by the overwhelmingly positive reception by the police… a solid percentage of the calls are actually police officers who arrive on the scene and realize it is not a traditional law enforcement call and they call for us to come down." P5 said that her experience with the police department's response to the program has been "a very warm reception because we're taking some things off of their plate."

Participants P2 and P6 also noticed relief among some police officers. P2 said that some indicate that they "finally have somebody who could come take these calls that I don't want to run, that I'm not good at running." P6 said that they hear from police officers that they "want you guys and need you guys because these mental health calls are frustrating". P8 said that "everyone is calling for us, fighting for us… they want the program there to help; they want better!" P8 believes there is "a comradery between the members of the program and the police."

A majority of the participants expressed the belief that police supported the program because they recognized that it benefits the people they serve, and that they are open to hearing what the program would contribute. P6 said that "if [police officers] are still on the call, when we show up, they sit and they listen and they start to gain information. They learn how to use that in the future."

P6, P7, P8, P10 and P11 recognized that some police appreciated the benefits of the empathetic approach of the program. They noted the police wanted these individuals to be helped and realized the program is best suited to care for and ultimately link them to services that will likely get them 'out of the cycle'. P1 stated "we would not be doing the

work we are doing on the program unless the police said these are calls that you can respond to because they are technically police owned calls." P1 added, "15% of our calls are police officers showing up on scene first and recognizing that it's more appropriate for the program and then requesting that we come take over."

P7 noted that sometimes disagreements with police officers occur. "We're not going to forcibly take somebody. That's not our role, but [police] are very reluctant to take that role on after the events of the last three or four years." P1 said "we're not trying to reduce the impact of law enforcement in our city overall, but the truth is that they're under-resourced to deal with our crime and our public safety issues. This actually allows them to focus on that, which is where we need them." P2 stated that, when reflecting on the program, "some [police officers] think "Defund the Police" and are threatened". P10 noted that "there's always going to be ones that are so old school that they want to be the savior that does everything and doesn't need any help, and they don't call us." P11 acknowledged "obviously, there's some pushback from some of the old school guys and they just don't know who we are, and it's the fear of change and things like that." P7 believes that "the street cops get the program, yet the top brass is not quite there yet."

***Co-responder Paved the Way***

Participants described the power dynamics between clinicians and police while on calls. P7 explained that the police officer is generally deferred to regarding final decisions during calls, suggesting that the police officer "could misinterpret or be dead on accurate about the safety needs of the co-responder and the officer and the client that they're trying to take care of… if the officer says it, then that's basically the end of it."

P1's background in community behavioral health and criminal justice work allowed her to witness firsthand what mental illness in jail really looks like. "It helped me see how many folks with behavioral health issues really get entangled in that system." P1 stated she got her start in the early stages of the co-responder program, which pairs a mental health clinician with a policeman. Due to its success, the program grew from four clinicians to 37.

P1 gained experience from listening to calls: "While we were developing that program and growing that program, we all had police radios and were listening to all the different calls and all the traffic that was going on across the city, in the different districts." These calls did not require a police presence and were deemed low acuity calls. This recognition was integral in coordinating the program with its roots stemming from the co-responder program.

P4 had been working at the city's mental health center for about 15 years, treating individuals with severe and persistent mental illness with co-occurring issues, when he became involved in the co-responder program. P4 supervised the clinicians and continues to do so in his current capacity, leading clinicians for both the co-responder program and the program I studied. Like P1, P4 recognized that, while on co-responder runs, many of the calls they were responding to did not involve crime or violence, nor were life-threatening. They were primarily behavioral health related.

P4 stated that "police just kept saying, well, it's just how our system is; it's three options, police, fire, or EMS. And we had the ability in that time to say, you know, we have a clinician program…" P4 asked why the program couldn't be expanded to "take on

those low-level calls and keep police on the calls they're supposed to be on and let us do kind of more the social services, behavioral health calls." The participants now in management positions believe that the program was born out of the co-responder program.

P4 has also researched other city co-responder programs and had found some of them to have issues relating to relationship dynamics. Some of the participants commented that the authoritarian behavior of police officers tended to override others on the call, while some police officers complain of the social worker's persistent agenda. P4 stated that at this city program, the police have made it clear "if the program calls for backup, the police will still let the program be the lead. It's a sign of respect for the roles of the program."

P10 gave his account of joining the program. "I moved to the city in 2017 and didn't know anything about the co-responder program, but was intrigued by that mixture of law enforcement and mental health and what it looks like." P10 explained that he then "heard about the pilot program and was impressed how it preceded some of the events of the last couple years and I thought again, a very forward-looking city."

Several participants explained how safety issues are navigated during calls. P6 explained that "the co-responder team is for higher acuity calls where there may be a weapon involved and we have no problem communicating to the dispatcher if we think a call is more suited for them." P6 stated that "if I do not feel safe, the dispatcher has no problem diverting the call to a more appropriate team." P2 opined, "I do think there is a need for both our program and the co-responder teams. Co-responder teams partner a

mental health clinician and police officer because sometimes the clients we encounter are dangerous." P2 remarked on the goal of the program: "Our goal is not to have the police who historically traumatize some of these individuals… I believe there's room for both."

P2 explained that there is sometimes consternation between responders. "I'm not a mental health center employee, so my understanding is a bit limited, but from my understanding there's a weird turf battle between the two organizations in the each believes their model is best." P2 expressed optimism, though: "I believe there is room for both and that one cannot exist without the other… I think there really just needs to be both."

P3 has a history in the co-responder program and the program I studied. Initially, though, P3 started in the mental health center as a case manager. She recounted "I moved over to the co-responder team and did that for three and a half years. And while I was still a co-responder, the… pilot program launched, and I would ride along a lot in the pilot." P3 described gaining affinity for the program: "I just fell in love with the concept of it, the idea of it, and moved to that program and was soon promoted as supervisor to oversee all of the clinicians." P3 explained that if a clinician is uncomfortable with the safety of a call, there "are multiple options for the [program] team: defer to the co-responder team, call the supervisor for thoughts, sending back to dispatch to re-disperse to a different entity, or even call for backup from the police."

P3, who is "supervisor of the clinicians for the overnight co-responder group as well as for [the program in this study]," gained experience in the co-responder program. She stated that "in our city, partners on these teams are not permanent; in other words,

different clinicians can be matched up with different police officers at any one time." P3 further elaborated on the roles of the clinician and policeman: "With so many teams, everybody has found their niche of working together and figuring out who should take the lead and vice versa on each call." P3 added that "the program is popular and visible to everyone, so it only makes sense that the individuals get along and flesh out their roles."

P3 explained that she is proud of the co-responder program, explaining that the program began "in 2016 and has steadily just grown and grown over the years. I think a lot of the officers have just bonded with the clinicians and it's almost one big team. Now we all bounce ideas off each other." P3 suggested that "the co-responders work really nicely with officers and vice versa. So, it's a really great partnership with a lot of shared respect. These programs complement each other and work well in parallel."

P8 contended that any city could benefit from having both programs. "They could layer the program as we have done… [directing] the calls with any kind of weapon or violence concerns to the co-responder program. They're wearing a vest because city police mandates they wear vests as part of their uniform." P8 explained that the response can be modified dynamically. "…we can step back and say 'this is a co-responder type call.' Or based on the notes that we're getting from dispatch, we advise when a call would probably be better handled by an officer and a clinician."

P11 explained that the dispatching of calls between the two programs has improved over the two years since the program started. "I think, initially, some of the co-responder teams were feeling like we were taking all the calls they had been going to. And there are definitely certain calls that are more appropriate for them…" P11 specified:

"…some of those just higher acuity [calls], if it's a barricaded party or somebody that's being aggressive or violent with weapons, stuff like that. Obviously there needs to be an officer present."

P11 expressed positivity regarding the diversion of calls: "I think they're doing a good job about speaking up on the radio when calls come up that sound more appropriate for them and same thing for us. P11 insisted that program members never say "no right away or over the air or anything like that, but we'll dig a little bit more or just request police cover, but essentially, we are co-responder at that point… we have the right to call police for backup."

***Humility on Both Sides Was Integral to Building a Rapport***

According to participants, police were not used to ceding authority or responsibility on calls at first, and that humility was required to facilitate a good relationship with police. P4 mentions that "a lot of the stuff that we encounter both on the mental health side and on the first responder side is this idea of a little bit of ego." P1 noted that he "was one of the first clinicians in the co-responder program," and noticed that "the police are all about controlling the scene, that's what they are taught… you really don't force your way into that sort of a situation… it's a new environment for clinicians and it was awkward for the police to have us in riding in the car with them." Stemming from personal and family experience in law enforcement, P8 remarked that the police "are taught from day one to control a scene at all costs. As soon as you lose control, you have the chance of not making it out of there."

Participants noted that building a rapport with police required humility. P1 said that "coming in as a clinician, working on active policing, less is more at first. You don't try to run the show. Clinicians hang back, let the police do their thing, and you offer, 'Hey, could we do this? Could I talk to [the patient]? I think I might have a solution.'" P7 stated that clinicians were present "to make their lives easier… we are here to help people, but as an added benefit of decreasing contact with person with mental health issues that's better for police and hospitals too." P4 noted that building the rapport entailed "building relationships with the patrol people that are out on the streets… we didn't force an agenda, we didn't force our political ideologies. We just said, 'we're here to help and support you guys and be an extension of how we keep people safe and happy and getting connected to resources that we know historically have been pretty non-existent to police officers.'"

Participants also commented that, once the police watched clinicians in action, they began to understand the benefits of their assistance. P1 said that "after they saw that you are valuable and you were solving these problems, or that person that was calling them 20 times a day isn't calling them, it seemed to sink in… you have to build that trust and build that partnership." P7 noticed that "basically proving by example, I think a lot of the street cops appreciate our subtle approach." P6 noted that police even began to seek out the help of clinicians: "The police don't know how to link the people we serve to resources. It's not their job and that's where we come in… some officers will call me and ask, 'are you working today?' or 'do you happen to know who's in, who would be closest to my district?'"

After some of this building of trust, participants noticed more cooperation from police. P4 remembered that "everyone just put their egos away and said, 'how do we make this partnership work? How do we build collaboration?'" P1 said "once they see it works, then it becomes much easier… we got a lot more flexibility. And it became like a true partnership. Now our clinicians that work in the districts, they're part of the team." P1 said that "we truly evolved and now we don't have to ask, 'Hey, can I get in there?'"

Participants acknowledged that buy-in from superiors is important to inspiring confidence among officers. P4 noted that their Chief "said 'this is the way we're moving forward in our 21st century view of policing.' And then it was just our team."

**Policy Makers and Community Are Taking Notice**

Participants mentioned policymakers and community leaders' reaction to the program and plans for it in the future. P7 stated "I believe policymakers are debating: how do these institutions need to change? We are always thinking 'what do we need to create so that we can actually serve better?'" P7 continued, "It does seem like people are listening and want to know what it is that we need. And as we identify needs, for instance, a novel but relevant idea is a night gathering area."

P7 described this concept: "A lot of people, especially people that are on the streets, don't want to go to the shelter. Because, unfortunately, it's dangerous; stuff gets stolen, people fight, and for some people, it's just not a real healthy environment." P7 explained how this could be remedied. "So, a lot of people just stay up all night and sleep in the day. But if there was an overnight gathering place to grab a cup of coffee, get out of the weather and just be."

P5 believes that the "community knows that we exist to an extent; I think the expectations around what we can do has probably been our main barrier… I do think they are taking notice, we are expanding, so people can see the need." P5 described issues conveying needs to policymakers: "There are challenges because our program, to work effectively, cannot be standardized. So, I think looking at outcomes is going to be challenging. And to influence politicians, you must have tangible proof that outcomes, whatever they are, are positively affected." P5 stated that he believes that "our city is very proud to have a program going in this direction and they realize it's very much needed. Our community is very powerful… they are very much pro-alternative response. So, that passion, is helping to promote this program."

P1 discussed the community's understanding of the program. "We're working on spreading the word through community education and the like. We are expanding and that shows our strength and ability." P1 described some resistance to the program: "I will also be perfectly honest that there is a small group of community advocates that are not happy that this is a city program."

P1 continued to describe some of the misgivings of some community members. "While they are supportive of [the program] and what we're doing in the field, in terms of the larger systems aspect they're not super pleased. And I get that, but I also think that there is kind of a balance." P1 relayed some of these community members' concerns. "We just had a meeting with them last week and they stated that… this program should just be run by people from the community and they feel they know how to do this work best." P1 added "they do not agree with using city systems…but I'm part of the city too,

you know, like I'm part of the community too… they're definitely more anti-police and… city."

P1 stated "I think policy makers are paying attention… In fact, there's a lot of talk across the country about using the ARPA funds to fund programs like [the program]. So I think there is some buy-in, from policy makers nationwide." P1 continued: "I've had the opportunity to look at 911 policies through a clinical lens and make suggestions to meet this kind of expanding field of crisis response. So, we are changing policy on a more local scale as well."

P4 stated "having community leaders in those areas advocate for a program like this can be beneficial because they are instrumental in making that change happen." P4 speculated that "there's something in the state legislature passing or going through the process to actually fund across the state more of a civilian type of response like [the program]."

P4 expressed a pleasant reaction to the fact that "they took one of our esteemed colleagues and moved her to 911. She's the first social worker that has been at 911 to look at these calls from a mental health lens, so she's changing policy within that system." P4 elaborated that calls "need to be flagged as a [program]-specific call and then a [program] van can go assist rather than sending the traditional police response." P4 explained that it was important to "have a [program] advocate at 911 to support diverting calls to the teams rather than the traditional alternatives. To facilitate that shift city council and the mayor have been very eager to continue to support a program like this."

Participants mentioned that other locations might take notice of the successes of alternative programs. P4 stated, “I think they’re trying to double check that they have everything to influence hopefully other cities to do this as well… like I said, our city hit the lightning in a bottle kind of situation.” P4 explained that this can be difficult in other locations. “Because other communities definitely have much more barriers than I think we do, I think they make it a much bigger more complicated deal than it needs to be.”

P10 expressed belief that “policy makers are taking notice. Since I live in the city, I tend to pay attention a little bit more to our city council and our politics.” P10 stated that “there’s a community advisory board; I guess it’s a group of people that just go over [program] calls every month and it it’s all stakeholders within the community. So, there is an eye on us.” P10 explained this accountability can be a benefit: “We must keep that in mind when we’re going on calls, and not in a bad way, but this is such a new, highly visible program and it’s fragile. I just don’t want it to be derailed or taken away.” P10 suggested that future contracts may be in jeopardy if “we have a misstep, because of one bad call or mistake… So, there’s definitely an eye on us and this certain city council members are more vocal than others when it comes to police interaction and police response to community.”

P6 also indicated that policy makers are noticing alternative programs. “I think policy makers around the country are taking note. I think they’re seeing the success; people are posting to TikTok and other social media platforms pushing for this program. So, I don’t think it’s just policymakers.” P6 stated that “I think it’s the general public that’s really excited about this program. And as a result, they’re going to call

policymakers and whether policymakers are taking note directly or through their constituents I think it's resonating."

P3 stated "I think as much as the [program under study] and the co-responder program have been utilized… it's pretty hard not to notice the impact…the numbers really speak to the differences that are being made." P3 expressed hope that the program's positive attention grows "because it's a great and new perspective and it's a wonderful perspective to look at how we reach individuals in the community and how do we do that in a non-biased way."

P9 noted that an increasing number of calls are being directed to the program, suggesting that the trend of 911 calls "has been moving in our favor, at least three or four times today, we've had calls where that in the dispatch notes, the community member requested [the program] specifically. It was certainly not that way in January when I started." P9 reflected on the growth of calls over time, stating that before, members of the program heard, "'Are you familiar with the [program under study]?' 'No, I have no idea what that is.' And that was probably about 80% of the time. And now, six months later, I'd say it's probably, it's closer to like 50-50."

P9 continued, "I see is pretty much what the public sees. I have all the Google alerts set up for any [program under study] articles or write-ups and it seems like policy makers are really receptive to what [the program] is doing." P9 expressed disappointment that local government had recently "essentially restarted the war on drugs today with the passing of our most recent fentanyl bill. [The program] definitely practices harm reduction as much as we can … we pass out fentanyl test strips and Narcan." P9

indicated that this shows dissonance between the program and local government: “So there might be a little bit disconnect between our program’s philosophy and the governments there, but I do feel at least somewhat supported by our policy makers.”

P8 expressed that the police have indicated positive opinions regarding the program. “When the city police chief sees us while on the street, he’ll say there’s my [program] people. You know, he sees it as such a positive thing.” P8 added that program leadership “was just over at city the other day running a call for somebody they had brought into the capital because she was having a mental health crisis. Legislatures and community members witness [the program] in action which sends a great message.”

P8 expressed having heard positive inclinations from other parties as well: “there’s people who are involved with legislation, and I’m hearing good things, they’re like, oh, the [program] teams, we’re taking care of them.” P11 noted that “community support’s been great. We have the support of a lot of different agencies and just the resources, to be honest with you, is proof of that support.” P11 testified that “interacting with community members is very positive. Everybody’s super happy we’re out here. And, you know, a lot of people hope we replace police, which I don’t see ever happening in a real world, but you know, it’s the sentiment.”

P2 remarked that the program has several stakeholders. “It involves the [police] department of [the city], public health and environment, the [city] 911, public safety communications, mental health center of [the city]… and then the [city] health paramedic division. So that’s four pretty significant players.” P2 expressed that this can be a bureaucratic burden: “Because this is a city-mandated program, it means that the city gets

to say everything has to have approval from city… a lot of things require approval from city council which just takes a lot longer...” P2 said that this can cause delays: “Things for us take weeks and weeks, sometimes months to change.”

***Several Stakeholders in Decision Making***

Several participants remarked that some organizations involved too many parties in decision making, which resulted in responders being less dynamic and flexible. P6 stated that there are many people involved “and a community board, so it is really hard to make changes when so many hands are involved… we have [the city’s mental health center], along with [the city’s] 911, [the city’s] Police Department, and [the city’s] health paramedics.” P6 added “I think at the local level, there could definitely be some barriers in Denver with a lot of people’s hands involved in it.” P6 concluded “I think the community aggressively wants more [of the program] but I just think a barrier has to do with so many people involved in the decision-making regarding growth of the program.”

P9 stated there are “many different hands in the pot (police, city, [the city’s] health, the community) that must be accommodated which makes it difficult and more complicated to get things accomplished.” P9 further stated “there is some perception by some of our governing bodies, whether it’s the city or the community council, that expect us to be a panacea, to be all things for all people.” P9 suggested that another question being asked of them is “‘What does a [program] call look like?”, which is, with the flexibility and autonomy, a very difficult question to answer.”

P1 stated “now that we’re getting bigger, the overall community is very supportive of [the program]… but I will also be perfectly honest; there is a small group of

community advocates that are not happy that this is a city program." P1 stated that "they wanted this to be more of a grassroots, volunteer, 100% community -led effort… while they are supportive of our work that we're doing in the field with people, they take issue with the larger systems aspect." P1 acknowledged that "we've always had the community at the table when we were building the pilot and we're running the pilot with lived experience advocates because that's an important perspective."

P1 said "I'm part of the city and community too… [community members are] definitely more anti-police and maybe even anti-city and believe this program should only be run by people from the community who knows how to do this work best." P1 assessed, "I think there's this sort of inherent distrust, so we kind of deal with that… [community members] are very vocal, but they are not a huge group of people." P1 stated her main goal: "…while I prioritize community voices, the folks that we're serving are really my main focus."

P10 discussed the opinions of community members: "I live in the city, so I tend to pay attention to city council and politicians." P10 remarked that there is "an eye on us by multiple governing bodies. We must keep that in mind when we're going on calls, because this is such a new program and it's fragile. I just don't want it to be derailed or taken away." P10 referenced some confusion in dealing with community voices. "We just never know who we're responding to sometimes… I keep that in mind, in the back of my head. With so many different entities interested in the program with different agendas, it just makes it difficult to appease everyone."

***Multiculturalism and the Community***

Participants weighed the program's level of success in having diverse staff. P1 stated the belief that "this program is an effort in good community policing and that includes minority communities or vulnerable populations, whoever we may encounter. These populations oftentimes, have more interaction with law enforcement… the city is committed to good community policing."

P7 stated, "From the hiring perspective it's not just the male-female partnerships on each individual team, but there's kind of a diversity there too. Which I'm not sure if it was planned, I would find it hard to believe it wasn't." P7 believes this is an auspicious aspect of the program: "But it really makes sense, if a client has a problem with a male, then if you have a male-female team, then you're covered there." P7 suggested that racial diversity is beneficial in addition to the gender diversity: "If you have a Black and Brown person and a White person, then you can cover more ground there and kind of serve people better because you can cover more bases."

P7 reflected on his experience as a White male in the program: "As a White male, there's been tons of times where I feel my White maleness on some of these calls and kind of just maybe take a step back and play more of a support role." P7 said sometimes the trait is helpful: "But there's been other times where people will talk to me and not my partner. I'm not sure if anybody designed it that way, but it does make sense."

P10 mentioned the benefit of being a member of a different demographic than most first responders. "I think when it comes to working with subpopulations, it's disarming to see somebody that looks like me. I just know that they're so used to 80% of

social workers being white women." P10 remarked that clients are "used to seeing their idea in their head of what we look like, and then I come in with my identities and you see an immediate relief… as an MSW we are taught to have a sufficient understanding of cultures."

P10 remarked that the company has been fairly successful in its attempts at diversity and inclusivity. "They have a specific group called the DEI team, it's diversity equity and inclusiveness team. And their job is to come up with trainings, to take input from staff and, and clients as to how we can be better." P10 suggested that the process beings at hiring and continues thereafter. "It's all part of the new hire training as well as ongoing training for anything that falls underneath that umbrella. They have that every month, they'll recognize all the holidays the year for other cultures and other countries." P10 mentioned that the city has a highly diverse population: "The PD has an ongoing list of all the languages that we had to use our language line for, up to 20 or so, even though there are closer to a hundred languages spoken in the city."

P10 stated that she was she worked for the police department first, because she learned that "a lot of people don't leave their circle. They're people who they've had for years and unless they know somebody from a different background, I mean they'd have no idea how to approach anyone from a different culture." P10 concluded, "So, I think my organization could do better, but I do like how they have specific team and the specific vice president, the executive management, that is dedicated to diversity, equity, and inclusiveness."

P7 remarked that he didn't feel sufficiently trained in certain areas. "I don't think we're adequately trained in multiculturalism. But you can have training, and yet still have your own biases." P7 suggested that personal experience can help with this aspect. "A lifetime of being exposed to certain things, and it really takes somebody with the right kind of mindset and the personality traits to be accepting and open to accepting people that don't necessarily look like them." P7 added, "I do believe in the training; I think we're for the most part not really adequately trained, but I think that's probably why the team members are part of this program because they have those empathetic and compassionate personality traits."

P5 explained that having members of the program of the same demographic as clients is important. "Often, humans are creatures of habit, and they only know certain outcomes when engaging with certain people." P5 stated "…we throw this new character into the mix of first response and at least from my experience with communities of color, when they hear I am a social worker, tighten their grip on their kids." P5 said this is important regardless of in which community the program is operating: "I think for any community, it all draws back to cultural competency.

P5 discussed the importance of trust between responders and clients. "It's the same thing when I go in and I have this preconceived notion of what I can do. And the only way to build trust is to put trust out there." P5 explained the importance of "trusting that they're not going to harm me and I'm not going to harm them….and we're going to find a solution together. It's a humble attitude that I take, especially with communities of color." P5 emphasized the importance of understanding the nuances of specific

demographics as well. “And for Asian and African countries, it’s important to understand behavior-wise what may be characterize d as an illness in one culture is very much a cultural norm in another.”

P5 discussed the time constraints of training. “The company does try, but there’s just so little time. You must be self-motivated to keep yourself competent. One thing that I love is the Missouri model for trauma informed care and really holding myself to that fidelity.” P5 mentioned a study that demonstrated that most people “were not trauma informed. And the biggest piece of being trauma informed that I get from that model is that of cultural humility. I don’t know most things, but I do come from a perspective of curiosity.”

P5 stressed the value in understanding the motivations behind a client’s viewpoints, for example when they are giving their perspective of a situation, “whether they are telling me for a direct or indirect reason, I must take that and inform my decision making based on what they’re giving me, and holding it as true, because it is their truth and their reality”. P5 theorized that clinicians may have difficulty with this experience. “I think that is a bigger barrier for those that believe in the medical model, which we do not tend to hire in our program.  It might not be the world that you are in, but it is their world.”

Some participants indicated that traditional systems involve a lack of trust between parties. P4 stated “I think multiculturalism knowledge is an area that we’re going to consistently improve on. Because there are historically areas that just refuse to call 911, because they know police are going to be a response.” P4 explained that this

lack of trust results from an understanding that the result of a 911 call can be "misuse of force… [or] a stigma attached to that population. Some or our areas are known for housing undocumented individuals. And I think there's that idea of if I don't call 911, the problem will go away."

P4 described having hope that this will change with time. "I'm hoping as we build this out, the next thing must be, how do we message this? How do we really enforce, informing and educating those populations? How do we get into the communities and talk?" P4 stated confidence in the program potentially "building that network around the program for people to identify it as safe." P4 envisions an example of a pastor "who sees a marginal population every Sunday and he's going to bring this up in church is like, here's an opportunity if you ever have someone in crisis that doesn't need law enforcement or anything, but still needs help."

P4 described the enthusiasm of program members to improve its success. "We do a lot of mental health training and focus on the reviewing and breaking down of calls at team meetings. What could we have done better? What would've been something that's a gap that maybe we need to address?" P4 suggested that team members will ask themselves what "could benefit in the future? And we're very big on bringing community members that know specifically what works for their population to our team meetings."

P4 acknowledged that members of the program "are good at mental health, but we're not experts in everything… we have had individuals from Adult Protective Services (APS), come in and tell us about aging." P4 described the point of this training: "What do we need to know about dementia and what your services are? And it's nice.

Because not only do they train us, but we also get to say, well, how do we utilize you guys?" P4 mentioned various demographics that have positively interacted with the program. "Then if we have someone that we come across, it's like a two-way street. We've done that with APS, with child services, and the LGBTQIA+ community." P4 concluded, "We've had a lot of people come in and just say we'd love to be able to talk with you about the unique needs of our population and how you may respond to them and best practices."

P6 stated that, while training is important, another integral aspect is "your personality. You must be open to learning from other people and open to empathizing with people that aren't the same as you, that don't look like you, that don't believe in the same things as you." P6 emphasized that "you still need to be able to have that mindset of they're still a person and I'm still going to respect them as a person."

P6 stressed the importance of empathy. "Even if they don't believe what I believe in or see things eye to eye to me, they still deserve food. They still deserve water. They still deserve housing." P6 noticed that "some of the people we run into are on probation or parole or might have just gotten out of the prison system and cannot find a place to live. And in some cases, they don't want to be in housing." P6 remarked that many of these people "felt trapped in prison or the jail. So, in some cases, the priority is safety and wellness, and they deserve that. Because you're still a person. I'm not sure you can get that from training, it's more of a mindset." P6 concluded that this can be understood regardless of demographics: "It's just humbling to interact with the different populations

and if you tell me that I can't understand something because I'm just a White woman, I ask to help me understand."

P3 reflected on the benefits of the novel system. "I think the lack of program restrictions creates such a positivity within the community because we're basically letting go of stereotypes or historical ways of addressing individuals. And I think that's important." P3 stated that regardless of age group, gender, race, or other traits, "the program is able to tailor to each individual need… we're looking at the individual as an individual, and then we're learning about them from them and then asking them what they need or what support they need."

P2 remarked that diversity is important in hiring for the program. "I do think that like for hiring purposes, we try to make sure that our people look like the people we're serving, because it is important to have more than just white people show up to serve people of color." P2 noted that even before race is considered, "there's already a power dynamic because we're the people in power anyway. There probably is a lack of trust in what we do, but I do think largely there is buy-in from some minority populations, Latino , and LGBTQIA+ and more."

**Short- and Long-Term Linkage Key**

***The Program Highlights the Gaps in our System***

Participants reflected on the highlights of the program, as well as its weak points. P1 stated "I think a strength of [the program] is our ability to leverage our community partners, to connect folks to ongoing supports and services that can help get them out of the crisis cycle." P1 elaborated: "I really see [the program] as sort of a two-pronged

approach. [First], the people that show up on the van. [The program] will support those folks, mitigate whatever crisis situation they're coming in contact with." P1 described that the second prong "is to connect folks to, say, a food bank, a shelter, or detox to help solve this problem in kind of the long term as well." P1 stated "So, I think that one of our strengths is that we've partnered really well with different community organizations to be able to make that happen."

P7 explained the difficulty of "butting up against these institutions that have been in place for years and are not as willing to change, not only their culture, but their structure as well to make it more accommodating for people to actually receive services." P7 stated that, despite this difficulty, "we do have access here in the city to a lot of services and we're identifying more and more every day that we don't have." P7 expressed optimism that this will improve. "But I think that's kind of part of the process, if we can recognize it and if we can get people to listen to us, then I think that there'll be more and more actual services that help people.

P7 added "just this week we had two people ride from the state. And their reason for riding was to find out what kind of resources we need, not only within the program, but within the city." P7 recounted that these people "stated 'okay, so we send you on this call, what do you need?' And 'how do these institutions need to change? Or what do we need to create so that we can actually serve better?'" P7 added "I think that we're the most reliable sourcing, because we're doing it." P7 stated that if they were able to present their case "to the person who is ultimately going to decide, if we can articulate

our needs, I think we're probably the best people to judge what we need because we're out there with the people who need it."

P7 stated further "So it makes sense, but I think we also have to be careful. I look at this as kind of a new venture and an opportunity to change the whole entire system." P7 speculated that if "you have managers that have managed these institutions that have been part of the problem and failed to serve the people properly… if it's the same management style and technique that has failed, that's kind of why we're here."

P7 added "In the hospital, the city, the police department, fire department or EMS, if they continue to manage in the same way, then the likelihood of us being successful is diminished for sure." P7 stated that "even the managers and our immediate supervisors, they have to manage a different way as well… but we've definitely made an impact on policy as far hospital policy and city policy." P7 indicated that decisions are made for multiple reasons. "I do know that some of that was maybe just based on public opinion and just the climate. Hopefully, now that they've made those policy changes, we as the members of the team can start suggesting other changes, you know?" P7 remarked that such decisions are rarely made in politics: "But that takes political will and, you know, sometimes it's just not convenient for people in that position to make those decisions."

P5 explained that the process becomes more efficient with experience. "My partner and I have been working together for four or five months now. And so it gets a little bit more intuitive." P5 added "We definitely have conversations where I have to be on point with what I know that way when situations come up, we always do a debrief and

we sit there and we take on that curiosity piece." P5 suggested that the program thrives on "curiosity and innovation, because there are so many gaps in the system, so you must be creative about what services to tap into to help a person we are serving. It can be frustrating when there is a void."

P4 expressed some issues with the program. "One of our biggest weaknesses [is] access to services in the community. They aren't readily available. Specifically, inpatient substance use on demand." P4 explained that the "biggest heartache is when someone gets vulnerable and begins speaking in detail about their life and their trauma experiences or what they're dealing with, or maybe it is their first time talking about mental health or substance abuse issues." P4 mentioned regret when unable to "put them in services immediately, it's a wasted opportunity. Sending them back into the community with a scheduled appointment in the future, they may never make that week… I think that's the biggest stressor that we have experienced."

P4 described other issues. "Another difficulty we experience is how do you get services to the more spread-out communities so that transportation doesn't become an issue? Downtown has a lot of resources and is rich in mental health, housing, food stamps, all that stuff." P4 mentioned that these resources don't extend very far from the city: "…you get 10 miles outside of the city, say, very far south getting someone mental health support in their neighborhood could take someone an hour in those situations."

P4 explained that the amenities available to the program must be widely available. "Being able to connect someone to something is great, as long as the resources are available, but it has to be spread out across the city and have equity across the city…" P4

stated that the resources must not be "so downtown centric where it causes a problem where they're like, yeah, I'm never making it down there because it's five buses and, you know, in rain, to get there."

P4 expressed positivity about the available amenities: "And we've actually got a pretty robust crisis type service. And we also have a walk-in crisis center. As well, we have a behavioral health solution center that just opened that is strictly a law enforcement crisis drop off." These centers, P4 explained, are extensive: "I think someone could stay for like 45 days there. It's triaging the first day, it's stabilization for a week and then it's residential past that. So, [the program] has been grandfathered in to be able to actually drop off."

P4 stated that technological improvements have occurred as well, including a "telehealth option, which is basically four sessions, virtually with a therapist. An intake appointment with a provider is coordinated along with a link to a doctor. It's like a bridge almost, which is excellent a positive access point for many." P4 reminded that certain demographics can't utilize these technologies, though. "The issue becomes our homeless population that historically continually loses their phones one way or another and then don't have access to technology. They fall through the cracks."

P10 also described several of the services available to the program, including "outdoor spaces which is sanctioned camping. They have ice fishing nets that are donated. I think there's three sites in the city and one ten miles out. And I think there's anywhere from 40 to 50 tents in each location." P10 described that these spaces have necessities for clients: "They have restrooms, shower facilities, and onsite case

management. They have nurses and physicians that go around to the campsite weekly. We did have an example though of a gentleman who we got DNR (do not return) on."

P10 explained that there are limits to these services, such as the scenario of the aforementioned client who received the DNR because he was "drinking himself to death. He was never leaving his tent, using it for everything, so the staff said we do not want to see him die. And, furthermore, we cannot have that in this type of already vulnerable environment." P10 explained that even then, there are actions that can be taken: "…he was a veteran… we took him to the VA that day to get checked out. It's a housing solution, not full-blown housing, but a safe space. They are run by the state's coalition of the home for the homeless." P10 explained that not every amenity is in adequate condition: "Some of our longer-standing facilities though, such as our one detox facility, are not appealing at all, so I don't blame anyone for not wanting to go to detox.

P10 stated "Some folks that have been kicked out of every single shelter and aren't allowed at those shelters, for example… there going to be somebody that's wheelchair bound, say with a foot or both feet amputated who you can't place" P10 elaborated on the difficulty of helping these subjects, who cannot be placed into a "shelter, but also are not getting any active case management to get into housing. Our options are quite limited. This is where I try to be as creative as I can sometimes as much as the call can allow for." Sometimes, P10 explained, there is not an available solution. "But sometimes we just don't know what the answer is. We beat our heads against a brick wall every day with some of our people that we serve in terms of what is that perfect ideal society for you?"

P10 stated “Harm reduction is a big part of it. We do have a couple of harm reduction centers that we do transport people to and talk and give people literature about all the time.” P10 explained that sometimes policymakers don’t make decisions that benefit the program. “And now the legislature just passed a god-awful bill; I don’t know what number they settled on for grams, but somewhere between one and four grams or ounces of fentanyl on your person, is now a felony.” P10 expressed frustration at this strategy: “…we’ve tried this war on drugs for 30 years and we know it doesn’t work. And it’s just a knee-jerk reaction to five people in an apartment who overdosed on fentanyl at the same party… Wow. Scary.” P10 expressed that this decision “seems like a knee-jerk reaction to an admittedly terrible situation. We must just put all those people away and lock them up.”

P6 explained some of the positives of the program: “We have connections to short- and long-term [resources]... We have a behavioral center that is a walk-in crisis center, but it’s for first responder drop off only that can kind of help get people back on medications.” In addition, P6 stated that there is “a crisis stabilization clinic; they can do help in de-escalation and link them to services.” P6 explained that there are solutions if a client’s health insurance isn’t accepted: “…then their goal is to help find somebody else that can take their insurance that can help meet this need even get them to a hospital to kind of get linked to services.”

P6 expressed some of the program’s difficulties. “I think the long-term care is kind of hard. We’ve definitely run multiple calls for the homeless that do need more intensive care or a higher level of care.” P6 explained that these clients are repeatedly

sent back to the hospital because they "aren't a good fit for stuff like walk-in crisis centers in those short term. Those walk-in crisis services in the behavior health solution center will help get them services if they want but they must be willing and open." P6 reminded that the program is entirely "voluntary when connecting them with long-term resources, such as a case manager. There are case managers, pharmacy therapists, psychiatrists, and more at the mental health center which is one of the largest mental health providers in the city."

P6 explained that other resources exist as well. "I believe in nonprofits too. And there's a lot of different cultural and religious organization as well as a family center for, say, Hispanic or English-speaking individuals. If you are Hispanic, Latino, Latinx, like there's resources for families there too." P6 added "They have a ton of different facilities, things like that. But at the end of the day, like getting access to those higher level of care, they must go through a hospital. And I think one of the barriers is it's just hard getting them in because I don't think there's enough available." P6 stated in summation, "I think the long story short is we do have access to services, but I don't believe that the city has enough for people that are living here because this city is not built to manage a large population."

P2 described positive resources available to the program: "The one thing that we do have, which I think is truly like going towards the root of the problem, is that we have wraparound services with the partnership with mental health center of [the city]." P2 explained the benefit of this resource: "They have so many different like fingers in different parts of mental health. They have their pharmacy, they have their crisis center,

they have the recovery center, the solution center, all these different community-based programs that are really helpful." P6 predicted that until those resources become more developed, the program is still going to "have struggles within [the program] to meet the needs of the community. But I think that they're making a really like good push to make that come to fruition and then [the program] really will be a full circle."

P3 expressed the opinion that the program "definitely does their best to connect people with a warm handoff to maybe what the next step is, whether that's long term mental health services or medical. So, I think they're going to continue to do that." P3 explained that the location specifically presents some issues: "I will say that I think that in [the state], there is just a lack of accessible resources and not to anyone's fault. It's just [the state]'s population has quickly, quickly increased and continues to do so." P3 explained that the existing resources are "meant for a smaller population. So one of my biggest hopes in the next five, 10 years is more and more of these resources being developed and open to people in the community to further their support.

P9 described one of the available resources that the program tries to connect with clients: "the solution center, which is kind of a middle ground between a walk-in crisis center and a full-on M1 hold, is a voluntary inpatient where they can come and go, also a crisis stabilization for up to 30 days." P9 described this resource as "a safe outdoor space for people experiencing homelessness where they have these really nice kind of ice fishing tents exists. There are social workers on site that hook them up with resources, food, etc."

P9 expressed that there is "a lack of some of medium resources; I talked about the solution center where it's not quite an M-1 hold. We don't have a lot of resources for these people. They just kind of fall between the cracks." P9 described a hypothetical client who is "not qualified for an M-1, but does need some help. And there's only so far we can go. I mean, I'm sure I don't have to tell you how stretch thin case workers are." P9 explained that interactions are often brief: "…sometimes they're as short as 20 minutes… that is really a short window to try and help get someone into housing or on a path towards healing addiction. So, we don't have a lot of these like medium resources."

P9 expressed some current difficulties of the program, stating that there are "absolutely not enough resources. Some of our shelters are interesting arrangements. And the access to long term services, I think it's rare, there's only a couple that I'm aware of and they're very difficult to get into and they're outpatient." P9 described several scenarios in which patients were "discharged from long term facility care and they had someone who wanted to be there when they got out, but that person was never contacted. So that patient just ends up on the street and there's someone looking for them." P8 described an example of a woman using the short and some longer-term services: "we've got a lady who has extreme vision issues with a drug and mental health history that is very agitated upon anybody approaching her. It doesn't matter if you're first responder or not." P8 explained that the client would repeatedly go to 7-11, the convenience store. "She always finds her way to one, and so it took some time but we have built a rapport with her on the… program. So we'd get her into the vehicle." P8 stated that they had brought the client to the "walk-in crisis center, the solution center, and the hospital so

many times that there was enough collateral information being brought in by the clinicians that I think has really spurred her to be put in place in inpatient care."

P8 explained that this tipping point may have helped the client. "We really hadn't seen her for almost four months because she was in inpatient care for so long. And one of the teams ran into her the other day for the first time she back on the street." P8 recounted that the client was in much better shape: "She was clean and she was talking and she recognized the… van. I mean, she's got a vision problem, but she can still see. She recognized the… van and she was cordial."

P8 reminded that she most likely won't be totally cured of her ailments: "Now she's never going to get rid of a lot of her past mental health issues… she does not seek the medic medicine anymore as she's on mandated shots, so she has to get her medications." P8 described this damage mitigation result as a success: "So, I think this is the new norm for us. You will probably still see her but it's not as horrible as it could be. Very huge success story. P8 added "I think it could be a success story of bridging short to long term services. She gets picked up by the [city's] sheriffs every week to go get her shots, they're being nice to her. We're being nice to her." P8 explained how this is preferable to traditional prosecution: "We get her some bottled water and take her to the clinic and get a shot, a lunch and we'll get her back over to where you were at. It's not going to jail or to the hospital."

P8 expressed optimism at such a scenario. "I think it's going to be a long-term success story for her. Good bridging from that short term. Some of the short-term things we have in the city is called the solution center." P8 said that this might be difficult to

achieve for a high percentage of subjects. “You can only be referred to there by us as a program or law enforcement… people can’t just walk in. It is a crisis center, but it’s not a walk-in crisis center, medication stabilization, mental health stabilization.” P8 explained that after clients are stabilized, they go into a “five-day program. If they graduate, they go into the 15-day program. If they graduate there, they go into a 30-day program… the higher you get up there, the longer you’re going to be there with housing and food and care.” P8 explained that patients receive “mental healthcare and medication and administration. And then they have, I’ve seen people, who’ve heard of people being placed into long term services. Group homes from there. Obviously, we don’t have enough of them, but it’s a start.”

P11 described that “my cohorts working have kind of a direct line to some of the short term and long-term healthcare. So just being able to do an intake on the spot or get somebody somewhere where they can start that process.” P11 continued, “We’ve already had a walk-in crisis center. Then the solutions center takes that model and just expands upon it. They get that 24 hour of crisis stabilization.” P11 elaborated on other resources; if the client opts to engage further, they can be provided “with some new medications or kind of some talk therapy, they have a step-down crisis stabilization unit. That’s about seven days. And if they’re successful there, they have a residential program for 30 days.”

P11 explained that this can expand the client’s options further, as this decision “opens the process for them to have a direct line to their case manager.” P11 explained that many “people on the street, they lose their case manager for months at a time, you know, their phones get stolen, maybe it’s just a lot more difficult to access people, to get

them to engage in these resources." P11 stated that if a client loses a case manager but still wants one, there are multiple "places that do case management for [the city's] coalition: [the state's] coalition for the homeless, there's [the city's mental health center]… and a few other different groups. And there are places like Catholic charities and Samaritan house rescue mission."

***Program Improves PMI Outcomes With First Responders***

Participants discussed whether the program improves outcomes for PMIs compared to traditional responders. P3 opined: "Yes, I think that [the program] has the capability of reaching individuals in a non-traditional way that could potentially decrease risk of death or harm and can increase support for individuals within the community." P7 stated "I've seen it… on a day-to-day basis, I've seen our team and clinicians change the outcome and the trajectory of people; not only their immediate crisis, but their long term needs too."

P8 stated confidently that the program produces better outcomes for PMI, but that the aid of police is integral. "100%. I have definitely seen people that were extremely agitated just because the person standing in front of him was an officer, but that officer had enough forethought to call us and back away." P8 recounted that the officer was able to successfully transfer the subject to members of the program. P8 recalled the officer saying "'look, these guys are gonna talk to you' and gave us the time to be able to deescalate the situation… we've had multiple officers say to us, 'I was four seconds away from slapping cuffs on the ground.'"

P9 concurred: “Absolutely… knowing the people that we interact with, some of their stories, the things they’ve gone through and knowing that even just five years ago, it would’ve been: ‘Well, that sounds really sad… anyway, here’s your trespassing ticket.’”

Participants observed a reduction in adverse outcomes among clients. P5 said “I know we’ve reduced people going to jail. I know we’ve reduced hospital rates. I can assume, depending on some of the behaviors of the people that I serve, that there’s a reduction in death rates as well.”

Some participants expressed less confidence in making such a claim. P1 stated, regarding the program reducing death or injury, “we are lucky to live in a city where we have not had many tragedies associated with PD and individuals who are mentally ill, but that doesn’t mean that there have been zero incidents.” P1 wasn’t as confident in a direct comparison of outcomes, stating that one “could make this claim, but I think it focuses more on police being dangerous and violent versus the true purpose of our program, which is to send the right response to folks in crisis and connect them with appropriate resources.” P1 explained that the program “was not born out of concern regarding our officers’ behavior, but a collective desire to serve the vulnerable members of our community in a more meaningful way.”

P4 also expressed less confidence in the claim that novel programs reduce adverse outcomes for PMI compared to traditional responder systems. P4 suggested that the question tended to be “misleading and can be taken out of context... [the program] does reduce risk because of approach, the nature of calls we go on, and the less stigmatizing appearance we present to the community than a historic police response.” P4 explained

that “we are also a service that doesn’t philosophically take a physical hands-on approach to someone we encounter. It’s a voluntary service that if someone doesn’t want us present, we have the ability to walk away from the situation.”

P4 explained that more tense situations have a higher risk of adverse outcome, and that police are more often present in those scenarios: “There are, however, occasional situations where an individual is so highly acute that safety for themselves and the community is at risk and that would require an individual to have a more hands on approach.” P4 explained that “[the program] wouldn’t act on this as a team; it would be a coordinated effort by other first responders to assist with getting this individual to the safest location to meet the current need that may require more secure transport.”

P10 expressed hope that they were making a difference but wasn’t confident regarding empirical evidence. “I think we’re doing well and that we are making a difference… people are gonna have the lives that they’re gonna have. And I can only do so much. And I have to like tell myself that a lot.”

P11 said “I certainly hope so,” when asked if the program might have better outcomes for PMI than traditional responders. P11 recounted a scenario in which the program used a different strategy than traditional responders would to identify a serious mental issue with a client. “Recently we had this gentleman who has a history of bipolar, and his manic episodes are very severe, and he’s always had to be hospitalized… recently, a physician called welfare check…”

P11 described the welfare check: “Most of the time we just open the door and say, ‘Hey, are you doing okay?’ We’re here just doing a welfare check. And from the face

value appearance, like everything seemed fine." P11 explained that, as program workers were able to observe the client, which traditional responders wouldn't have had the resources to do, they noticed severe mental illness: "The more time we spent with this gentleman, his thought processes were just not there. He wasn't safe. He had left food in the oven all day in his apartment… he's in a million-dollar condo downtown."

The program, according to P11, was able to help the client in a way traditional responders would not have. "From the outside, looking in, everything looks fine. But the more time you spend with him… [it's] very dangerous. So working with family, we were able to get him into a hospital, get him evaluated and hopefully get him placed." P11 worried what would have happened if the program hadn't had the resources to observe him longer. "…based on everything I was talking to with the providers, it sounds like he's getting placed into an appropriate facility… If we would've left him there, maybe he would've fallen and not gotten up again."

P11 stated that, even without empirical evidence that the program produces better outcomes for PMI than traditional responders, scenarios like these are examples in which it almost certainly did. "I think that that case in particular… we did great work… if I was just on the ambulance and just took him for whatever the call was got to the hospital, maybe I wouldn't have known all those important factors."

Some participants indicated that, at least, some people calling for emergency services have the perception that the alternative program is safer to call than traditional first responders. P5 stated "I've responded to calls that were like, 'yeah, if I called the

police, I have no choice because I'm unsafe, but if I'm unsafe, they might make me more unsafe.''

P6 has followed up on some cases and explained that he has witnessed improved outcomes. "There have been some that I've followed up on that seems like they're doing a little bit better, and they thank us, like 'thank you for linking to services.' So I think it does produce it based on my interaction." P6 has also seen the program follow up with family members of a client, such as a "geriatric person that might be sundowning that we've… gotten falls on a lot from where she's living. And we linked with her son and he's like, 'Hey, I want to make sure that she gets the care she needs.'" P6 wondered what the outcome might have been without a more thorough type of response program: "If we weren't able to like link with the son who knows what could have happened, essentially."

Figure 3 provides a summary of all the themes and subthemes revealed from the thematic analysis research. Each theme and subtheme are accompanied by some of the more salient and summative participant thought(s). This quick guide provides a shortened version of the more detailed results presented earlier.

## Figure 3

*Abbreviated Guide to Participant Thoughts Relating to Research Themes*

| Major/Sub Themes | Participant Statements |
|---|---|
| **4th Tier of First Responder System** | |
| 4th Tier of First Responder System | P1 "Some of the things that we've historically tasked police that never really belonged on their plate in the first place but wound up there because a lack of a better option, we are righting that historical wrong." |
| | P10 "Add another option [when you call 911], after police, fire, EMS; why not add mental health in there [for lower acuity calls]?" |
| | P11 "[The program provides] alternative dispositions to get to the root of the issues and people in a more holistic way [physically and mentally]." |
| Meet the Clients Where They Are | P6 "I fully believe that we should be able to meet people where they are at and empower them to live the life they want to, even if that's not what we think it should look like." |
| Empathy A Requirement | P2 "I think just acknowledging that some individuals haven't been given the same shake as everyone else is a good place to start." |
| Harm Reduction | P11 "We work closely with the harm reduction action center; they do awesome work. They've been advocating for safe use sites and stuff like that for a long time." |
| Flexibility and Autonomy | P8 "We listen, we're troubleshooting. We're going through all the resources that the clinicians and that the medics can bring to the equation." |
| **Partnership is Fluid and Respectful** | |
| Strategic Toolkits Expand With Experience | P5 "The paramedic adds another layer of tools that we get to utilize to best serve that person. And if it does turn out that it's not a mental health issue, it is a medical issue." |
| | P7 "It's amazing to watch [my clinician partner] just talk to people, reason with people, calm them down, get them to the point where they say 'I do need help and I'm willing to go with you." |
| Unintentional Cross Training | P1 "I really loved partnering with a medic, we learned so much from each other. I think there was a lot of unintentional cross training that happened in that van...when you're riding together for eight, 10 hours a day." |
| Continuum of Mental and Physical Health | P6 "I think it's beautiful because people are holistic…that means that your physical health is gonna impact your mental health." |
| **Safety as a Top Priority** | |
| Dispatchers as Risk Assessors | P4 "They've done a great job of making sure we're getting to the right buckets of calls." |
| Safety as a Top Priority | P7 "What the paramedics bring to this is kind of that street smarts, the scene safety…reading people's body language…on every call, looking for an egress." |
| Clinicians Familiar with High-Risk Jobs | P4 "[As a case manager] I'd go into hotels and alleys and people's apartments and houses and really meet them where they're at… nobody knew where I was." |
| A Different Role Than The Police and Traditional EMS | P5 "Especially if you're in plain clothes…and I think what people are not understanding is the power dynamic of the uniform…and the trauma that's also associated with it." |
| **Police All-In** | |
| Police Perceptions Mostly Positive | P9 "...the most pleasant surprise [has] been the overwhelmingly positive relationship and reception by police...I'd say a large majority, a solid percentage of our calls are actually police officers who arrive on scene and they realize that this is not a traditional law enforcement call and they have us come down." |
| Co-Responder Paved the Way | P3 "The co-responders work nicely with officers and vice versa. It's a great partnership with a lot of shared respect. These programs complement each other and work well in parallel." |
| Humility On Both Side Was Integral to Building A Rapport | P4 "...building relationships with the patrol people that are out on the streets…we didn't force an agenda, we didn't force our political ideologies. We just said, 'we're here to help and support you guys and be an extension of how we keep people safe and happy and getting connected to resources that we know historically have been pretty non-existent to police officers.'" |
| **Policy Makers and Community are taking Notice** | |
| Several Stakeholders in Decision Making | P9 ...[the program] involves the department of [city] public health and environment, the [city] 911 public safety communications, mental health center of [city]...then the [city] health paramedic division...pretty significant players. And because this is a city mandated program...a lot of things require approval from city council, which just takes a lot longer than if a business is like 'Hey, let's do this.' They can literally shift that that day, things for us take weeks and weeks, sometimes months to change. |
| Multiculturalism and the Community | P2 "It's just humbling to interact with the different populations and if you tell me that I can't understand something because I'm just a White woman, I ask to help me understand." |
| **Short- and Long- Term Linkage Key** | |
| The Program Highlights the Gaps in Our System | P4 "...biggest heartache is when someone gets vulnerable and begins speaking in detail about their life and their trauma experiences or what they're dealing with, or maybe it is their first time talking about mental health or substance abuse issues...and I can't deliver to them to get them to that help, it's a wasted opportunity." |
| Program Improves PMI Outcomes with First Responders | P1 "[We] could make this claim, but I think it focuses more on police being dangerous and violent versus the true purpose of our program, which is to send the right response to folks in crisis and connect them with appropriate resources" and "it was not born out of concern regarding our officers' behavior, but a collective desire to serve the vulnerable members of our community in a more meaningful way." |

## Summary

Chapter 4 discussed the setting, demographics, data collection, data analysis of the study, as well as the credibility, transferability, dependability, and confirmability of the results of the study. Chapter 4 covered the main themes that arose while performing the study. The first of these themes was that several participants advocated strongly in favor of the importance of a new, fourth tier of the first responder system. Participants felt that traditional first response programs had proved to be inadequate in dealing with PMIs, as well as other demographics. The second theme involved participants stressing the importance of a fluid and respectful partnership between clinicians and traditional first responders. Participants explained that a respectful and fluid relationship between partners (clinicians and medical professionals paired with police and EMSPs) is integral to a successful program. The third theme was the importance of safety on calls for responders as well as clients. Participants explained their experiences with strategies and prioritization of safety on calls, and the importance of safety for the viability of the program in the future. The fourth theme involved participants explaining the importance of police (and other traditional first responder) buy-in and confidence in the program. Participants explained that, despite some misgivings expressed by police officers in their experience about the effect of the program on their authority and influence, the program requires the enthusiastic support of police officers and leadership. The fifth theme pertained to participants observing policy makers and community members taking notice of the program and the effects of this increased attention. Participants expressed positive reactions to increased attention since this might lead to further adoption of the program,

however they expressed worry that more attention and scrutiny may result in a reduction in autonomy and flexibility, and potentially more bureaucracy. Finally, the sixth theme included participants stressing the need for both short- and long-term linkage to resources that aim to provide aid to clients and patients encountered on calls. Participants had noticed that traditional first responder programs did not generally lead clients to longer-term resources for mental health and addiction issues (among others) and did not have the resources to follow up on the wellbeing of clients, whereas new responder programs with clinicians and medical professionals have worked towards including these resources.

Overall, participants were adamant that a new responder program was necessary and would drastically improve both the safety of acute interactions with PMIs as well as long-term outcomes of PMIs and other clients. Participants expressed strongly that further institution of these programs would be a significant benefit to PMIs, other disadvantaged communities, responders themselves, community members, and policy makers.

Chapter 5 will compare results from this study with prior studies, as well as summarize some further information gleaned by this study, including:

1. Emphasis on meeting clients where they are physically and mentally
2. Cross-training and tools expand from partnership
3. Team and dispatchers are experienced and prioritize safety needs
4. Stakeholders, community, and police recognize the need for the fourth leg of first responder structure to care for mental health crises

5. The program highlights the gaps in short- and long-term services needed for wrap-around support of the people they serve

Limitations of the study will be acknowledged, and recommendations for other, supplemental studies will be given. Finally, implications of the information gleaned from this study will be discussed.

# Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this generic qualitative study was to explore and understand how individuals associated with the collaborative crisis team perceive the treatment's impact on the rate of PMI deaths when a PMI is involved in a mental health crisis. To address this purpose, I conducted interviews in which I asked participants about their attitudes regarding the collaborative crisis team's effect on PMI deaths and adverse outcomes. I conducted these interviews so that they were open ended, therefore allowing participants to elaborate on the areas they felt were appropriate and relevant. I asked them what they had observed while working as a member of the program team as they cared for PMIs before, during, and after a crisis event. There were six themes discovered during the analysis of the data: (a) alternative response to traditional emergency response, (b) partnership is fluid and respectful, (c) safety priority on calls, (d) police all-in, (e) policy makers and community taking notice, and (f) short- and long-term linkage key.

## Interpretation of the Findings

The results of this study confirmed previous research regarding perceptions of mental health-medical crisis team impact on police violence on PMIs. Although research is limited within the field of mental health-medical crisis team impact, there were three areas in which the findings of this study supported previous findings related to mental health-medical crisis team impact on PMIs. These consists of having flexible policies and procedures to allow for autonomy in program implementation, participants tending to work in harmony towards the same goals and have similar experience levels in mental health intervention, and access to ample and cultivated community relationships being

key to program success (Callender et al., 2019; Daggenvoorde et al., 2018; Friedman, 2021; Morabito et al., 2018).

Unique factors and subthemes that resulted from this research (over and above what other researchers had found in the prior research and the six specific themes listed above) are philosophies relating to the underlying subthemes of

- Emphasis on meeting clients where they are physically and mentally
- Cross-training and tools expand from partnership
- Team and dispatchers are experienced and prioritize safety needs
- Stakeholders, community, and police recognize the need for the fourth leg of first responder structure to care for mental health crises
- The program highlights the gaps in short- and long-term services needed for wrap-around support of the people they serve.

Researchers believe mental health-medical crisis teams may be the optimal approach in handling PMIs during a traumatic incident as they are programmed to be flexible and creative in responding to persons in crisis' needs (Climer & Gicker, 2021). The participants in this program repeatedly expressed their appreciation of the flexibility and autonomy awarded them as they brainstormed solutions to the traumas and crises a client may be undergoing in any given moment. The participants realized that management has confidence in their skills and abilities. It became evident to these participants that this form of management allowed them to flourish and feel the satisfaction of accomplishment in their mission of helping others.

The mental health-medical crisis teams programs are also streamlined in terms of communication protocols for all parties and provide access to ample (and culturally adept) community relationships and services to refer clients (Climer & Gicker, 2021). Participants in this research concluded that short- and long-term services are key to the success of these programs. As many of the participants interviewed for this research stated, while the city is striving to support the mental health community with short- and long-term services, it is difficult to keep up with the city's increasing population.

Some of the many facilities listed by participants included walk-in crisis centers, the city mental health center (multiple services), detox facilities, the state coalition for homeless, behavioral health solutions center (24/7 crisis stabilization, temporary 30-day housing, mental health, and addiction services), and the city's outdoor safe space collaborative (sanctioned camping with donated ice fishing tents and social worker physician and staff along with food services and basic needs). Religious organizations, local rescue missions, and other nonprofit organizations provide opportunities and services as another avenue for the program to divert clients. According to the participants, though, while these services are helpful and encouraging, they are not located closely enough to serve the city's population of individuals needing support.

The program promotes respectfulness and fluidity among the participants which leads to high quality responses to client needs (Seo et al., 2021). The participants mentioned the teams have the combined tools of a well-versed clinician with years of mental health experience and those of a paramedic with expert ALS knowledge. The participants enthusiastically expressed, when speaking of their roles, that because there

are few restrictions, protocols, or rigid rules, the team can be creative. This means that the team can brainstorm and optimize what each team member has to offer, and fluidly and holistically care for and attend to individuals dealing with a mental health crisis. Participants expressed that they felt that the program cultivates a strong partnership between mental health clinicians and medics through refining roles, developing knowledge and skills, improving communication, and sharing information.

Ultimately, participants suggested that the facilitation of this model alleviated the police of the responsibility of serving a population with ailments in which they are not adequately trained. The participants in this research believed PMIs need the care of MHPs and EMSPs trained and specialized to care for individuals experiencing a mental health crisis. It was unanimously expressed that the more these individuals were aligned with the optimal first response, the likelihood of a positive outcome.

## Limitations of the Study

This study was a generic qualitative study, thereby limiting the study to these individuals. Generic qualitative studies are limited to the participants within the study and are not designed to generalize to the public or specialized populations (Prabhu, 2020). This study observed the attitudes and perspectives of 11 individuals associated with the program. Of those participants, five were men and six were women. All the participants were in the first responder realm for varying lengths of time, which limits the views of the study to a first responder's perspective.

The participants in the study (of those who responded) ranged in age from 26–44 years, limiting the study to individuals within that age parameter. Those younger than 26

or older than 44 may hold differing attitudes toward alternative emergency response methods. All the participants discussed having a predisposition towards helping others in a time of need, thereby limiting the results to those who inherently carry the empathy trait. Eight out of 11 of the participants were White, which may suggest a cultural bias. Eight out of 11 of the participants had prior experience in the traditional first responder system, which limits the study in terms of experience levels within the first responder organization. Further analysis may show differing results than those garnered from the participants within this case study, such as using quantitative analysis, a study of individuals who leave the program or with a higher percentage of people from minority groups, and/or of people who had little prior experience in the first responder system.

## Recommendations

As the recognition that individuals are suffering a mental health crisis increases, traditional first responders are realizing they are not equipped with the expertise to help them. Further research is recommended for perception from other stakeholders in the process such as police management, police officers, co-responder teams, 911 operators, recipients of the program services, community members, and policy makers. As well, further research in terms of the program's defined process or methodology (or lack thereof to allow for flexibility) would benefit cities that may want to emulate the program. Further research is recommended to assess linkages between the program and short- and long-term services. This is a key area of concern for the program, as identified in one of the themes, and is integral for determining whether the goal of wrap-around service is to be achieved.

## Implications

The results of this study may provide validation, understanding, and encouragement to municipalities looking for a program to help expand their first responder system by integrating an MHP and an EMSP with the goal of improving outcomes relating to caring for PMIs during a crisis.

This study can bring about social change through acknowledging the trials and pressures faced by police departments as they are forced to attend to persons enduring a mental health crisis. The individuals would be better served by MHPs and EMSPs, thereby freeing up the police's time and energy to focus on higher acuity calls. Introducing a fourth tier to the first responder system could improve first responder outcomes relating to engagement of PMIs when under significant duress.

This research exposed several characteristics shared by both mental health clinicians and medical personnel. Empathy and compassion were qualities that were shared by all these individuals. It became evident, particularly from the resulting theme "meet them where they are," that ideally no judgement would be placed on a PMI no matter what condition they are in, how they got to be in such condition, or where they want to go (regarding treatment or housing). These individuals' goals are to ensure the safety of the PMI and provide a service for them to ensure they are heard and seen. Tying them to short- or long-term services, if that is what they desire, is the next priority after establishing trust and stability. It is apparent that whatever process is put in place in a specific municipality, empathy and understanding are the most effective traits in helping individuals with mental health issues deal with a crisis.

## Conclusion

The proliferation of cell phone cameras and social media over the last two decades, which highlight disparate adverse events during traditional first responder interactions with PMIs and people of color, has led to increased scrutiny paid to the actions and procedures of traditional first responder systems. As many of these interactions have resulted in adverse outcomes for PMIs and people of color, this has catalyzed policymakers and leaders of first responder departments to find more appropriate and ethical ways to assist individuals experiencing a mental health crisis.

Mental illness episodes can manifest as adversarial, out-of-control, or hallucinatory behavior. Despite police officers lacking medical or mental health training, communities have tasked police departments with the responsibility of taking care of unpredictable individuals experiencing mental health crises, in many cases incurring adverse outcomes. Furthermore, sometimes medical problems manifest in ways that appear as mental illness. The research of this program addresses that gap in services by implementing MHP/Para as a fourth tier in the first responder system.

Based on the interviews conducted with members of this program, it is clear that a majority of the participants held the opinion that minorities and PMIs benefit significantly from a co-responder program in which a clinician is paired with a traditional first responder. This is because limited access to mental health resources, as well as fear of potential authoritarian and punitive behavior exhibited by traditional first responders, causes these individuals to avoid essential care, particularly when they are afflicted with mental health ailments.

The participants in the research were generally adamant that alternative programs such as the one I studied are an important potential solution to adverse outcomes from interactions between first responders and PMIs. The participants understood the necessity of the long-existing traditional first responder systems (police, fire and EMSP) and highly respect and regard them. Various participants explained that these alternative first-response systems were not part of a "defund the police" platform; instead, they allow traditional first responders to focus on calls and subjects for which they are specifically trained.

Participants proposed that PMIs are not being cared for properly by these services through no fault of either them or traditional first responders. In fact, it has become clear through many videos of interactions between traditional first responders and PMIs that persons with mental health issues need a tailored group of responders who are educated and trained in mental health crisis management, particularly on lower acuity calls. That optimal team, according to the consensus of the research participants, is the program studied in this research.

These individuals were identified and sought for this program as they are extensively trained to be empathetic and pragmatic when interacting with PMIs. These professionals are trained in concepts such harm reduction and supervised, safe consumption of controlled substances. These are strategies not generally instilled in traditional first responders via training. According to the participants in this study, this extensive training allows for a much more focused response to people experiencing a mental health or substance abuse crisis. According to the participants, this allows for

police to focus on calls that are more relevant to their training, and drastically reduces the opportunity for adverse or violent outcomes from these interactions.

Participants repeatedly and independently described a goal that they felt was important in servicing PMIs. This was the concept of meeting subjects where they are (physically and mentally), and subsequently directing them to where they want or need to be. This statement is powerful in that the participants do not simply dictate what they believe should be done with the patient. In this context, participants also described an intentional aversion to allowing cultural norms or mores to taint or bias the team's problem-solving process. For example, if the individual would like Narcan for future use, so be it. If they need a safe space for using, the team will find them one. If they need a place to sleep but refuse a shelter, other options are entertained.

The team does not impose their solution onto the individuals; they work with them and ask them what their preferences are. They strive to not judge them as they do not know their history and endeavor not to prejudge or assume; they do not know their trials and tribulations, their strife, oppressions, or subjugations they have experienced. They described their strong aversion to passing judgement or deciding whether someone is worthy of their help: they know their job is to be there for the subject. For those reasons, when hiring, program leaders search intentionally and deliberately for candidates that will work to avoid being biased or prejudging clients.

Several participants expressed that they were proud to be residents of a city whose leadership and policymakers would recognize the issue of adverse outcomes when PMIs interact with first responders. They extolled leadership taking the challenge to ameliorate

these outcomes using non-traditional approaches. The participants also stressed the importance of autonomy given to members of the program, which city leadership must choose to afford them. One important aspect of the autonomy that participants considered important was the level of independence the team is allowed when brainstorming solutions for the individuals under mental duress. The lack of bureaucracy and time restrictions allow for a dynamic and flexible emphasis on each person.

While these positives are evident, areas of significant improvement still exist. Previous research aligns with the results of this study, in that the availability of short- and long-term services are necessary for a program such as this to work. An ecosystem (i.e., starting from dispatch to the initial point of contact, then problem solving between team members and PMIs, and finally team members leveraging short- and long-term services) can only be sustainable if wrap-around services are supported and funded by the stakeholders. Without that support and funding, program members will find it very difficult to achieve the goal of reducing adverse outcomes suffered by PMIs during an interaction with first responders.

The program's traits of meeting clients where they are, as well as the autonomy and flexibility of program members to do their jobs without time constraints and no strict rules, have been the most provocative in terms of acceptability in American society. According to participants, though, policymakers and city officials are beginning to notice the benefits of pragmatic, unbiased, and empathic strategies. This outlook of responders not concerning themselves with negative or judgmental assessments of why clients behave in the way they do, and instead focusing on determining an optimal solution to

that PMI's current crisis (and, if asked, connecting them to long-term resources as well) is beginning to pay dividends according to participants.

I discovered six general themes that were repeatedly referenced and discussed by participants: (a) alternative response to traditional emergency response, (b) partnership is fluid and respectful, (c) safety is a main priority on calls, (d) police all-in, (e) policy makers and community taking notice, and (f) short- and long-term linkage are key. Further research would be beneficial to determine the most efficient and beneficial pairings of clinicians and traditional first responders, as well as triaging practices utilized by dispatchers.

Participants generally were emphatic that the police and other traditional first responders, despite some reservations and dynamic issues exhibited by traditional first responder while involved in these programs, were integral to the process. Participants expressed that, from their experience, police departments benefited from the program since it allowed for more specifically trained clinicians to help PMIs, as opposed to the police, who are not as trained in interacting with PMI, allowing for the police to focus on more appropriate, higher acuity calls. Participants also generally lauded the flexibility and autonomy afforded to them by these programs, although they expressed worry that policymakers and community members, who are taking more and more notice of these programs, may eventually reduce their autonomy since there will be more oversight.

The research in this study demonstrates that, according to testimony of participants who have worked with and in collaborative crisis teams, all parties (team members, PMIs, police departments and other traditional first responders, and

policymakers and community members) will benefit from further adoption of collaborative crisis teams. Further research would be beneficial to corroborate these findings and provide further evidence that these positive outcomes would occur.

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# Appendix A: Program Interview Questions

**RQ:** What are the attitudes of the collaborative crisis team (MHP/EMSP) on PMI deaths according to individuals associated with the program?

1. What brought you to this program/sparked your interest?
2. What resonates most with you about the program?
3. What is your perspective on your partner (MHP/EMSP) and their impact on program efficacy (PMI death rate)?
4. What are your thoughts on how this program impacts subpopulations?
5. What do you perceive as the most significant impact this program has on recipients?
6. What do you perceive as strengths and weaknesses of the program?
7. How do you perceive the police's thoughts regarding the program? Community? Their attitudes?
8. What is your perception of the 911 operator's relationship with the program?
9. How successful do you believe linkage between the program and short-term and long-term social services are? Can you provide some examples of success stories that you recall? Failures and why?
10. How do you think this program impacts Policy? In other words, do you believe policymakers are taking notice? Are they apt to promote the program in wider terms?
11. Throughout the evolution of this program can you recount necessary changes that were made to accommodate needs, were there major changes?

# Appendix B: Interview Protocol

**Purpose**
To gain an understanding of how facilitators of the collaborative crisis team (MHP/EMSP) perceive the treatment's impact on the rate of PMI deaths when involved in a mental health crisis.

**Target Population**
Current and former facilitators (i.e., MHP/EMT) of the program's collaborative crisis team program.

**Advertisement**
Thank you for considering my research. I am seeking the assistance of individuals who have been a part of the program so as to gain a comprehensive understanding of perceptions of the program. I am looking for volunteer participants and hope to only take a moment of your time. If you would like to take part in my study, please contact me at any of the following:

**Phone:** call or text: xxx-xxx-xxxx
**Instagram:** xxxxx
**Email:** xxxxx@xxxxx

**Participant Introduction**
I will call, text, message, or email each participant who has requested to be in the study. I will use the following script to ensure consistency as well as ensure that they have all information they need regarding the characteristics of the study.

"Thank you for requesting to be part of this study. This study is exploring the perceptions of facilitators of the Denver Program as it relates to deaths of PMI's. There are a few questions I need to ask first to determine if you qualify for the study.

1. Have you worked with the Denver Program as a facilitator (MHP/EMSP) of the program?
2. Have you worked with the program for a minimum of 2 months?
3. Are you comfortable discussing your thoughts and ideas about the program to a research student via online interview?

Please reply with your answers and I will determine if you qualify for the study. If you qualify, I will be in contact shortly to schedule an interview call. Thank you so much for your participation."

Once they have returned or verbally answered the questions, I will use the following guide to move them forward in the study or to remove them from the study.

**If they do not qualify:**

I will inform them that they do not qualify and thank them for their time.

**If they qualify:**

If they qualify for the study, I will use the following guide to facilitate the initial stages of the study:

1. Inform them that they have qualified to take part in the study.
2. Ask them what medium they prefer, phone or videoconferencing, for the interview.
3. Reveal that of utmost importance all information will be confidential and anonymous.
4. Explain that there are under no obligation and can choose to leave the study at any time prior to completion.
5. Schedule the interview at their convenience.
6. Inform them that I will send an email with study related information (consent form, process of interview, interview questions) to review. I will ask that they not share these questions with anyone and again express the importance of confidentiality.
7. Provide them with my contact information such that they feel they can call, text, message, or email me at any time.
8. Thank them for volunteering to participate.

**Interviews**

I will then use the following guide to begin the interview stage of the study:

1. Discuss and inform the participant about the necessity of a recorded call.
2. Inquire verbal consent in continuing the interview.
3. Provide a synopsis of the research.
4. Ensure and confirm anonymity and confidentiality.
5. Initiate with simple, comforting questions to help put the participant at ease.
6. Slowly begin the interview process using outlined questions
7. Use probing questions to clarify or gain more understanding.
8. When concluding the interview process, I will thank them for their time, inquire if they would like a copy of the transcript. If so, I will inform them that I will send them a synopsis of the interview within the next 7 days.
9. I will ask that they review the document and correct any areas that were misinterpreted or missed.
10. Once I receive feedback, I will incorporate any necessary corrections. Upon approval, I will thank them for their participation.
11. I will send the summary of the study at the final stage of the study.

# Appendix C: Updated Interview Questions

**RQ:** What are the attitudes of the collaborative crisis team (MHP/EMSP) on PMI deaths according to individuals associated with the program?

1. What brought you to this program/sparked your interest?
2. What resonates most with you about the program?
3. What is your perspective on your partner (MHP/EMSP) and their impact on program efficacy (PMI death rate)?
4. What are your thoughts on how this program impacts subpopulations?
5. What do you perceive as the most significant impact this program has on recipients?
6. What do you perceive as strengths and weaknesses of the program?
7. How do you perceive the police's thoughts regarding the program? Community? Their attitudes?
8. What is your perception of the 911 operator's relationship with the program?
9. How successful do you believe linkage between the program and short-term and long-term social services are? Can you provide some examples of success stories that you recall? Failures and why?
10. How do you think this program impacts Policy? In other words, do you believe policymakers are taking notice? Are they apt to promote the program in wider terms?
11. Throughout the evolution of this program can you recount necessary changes that were made to accommodate needs, were there major changes?
12. What are your thoughts on the phrases "Defund the Police", or "Reimagine the Police"?
13. How do you feel about working with cultures different than your own (i.e., Blacks, Hispanics, Asians, etc.), do you feel you are trained for multiculturalism?
14. Ultimately, do you feel the program reduces injury and/or death to PMIs? Why or why not?