Ivette: Hello, I’m Ivette Torres and welcome to another edition of the Road to Recovery. Today we’ll be talking about community health centers and first responders, strengthening communities through education. Joining us in our panel today are Brenda Mannix, National Registry of Emergency Medical Technicians, Project Director of the Disaster Technical Assistance Center, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Rockville, Maryland; Keris Myrick, Director of Consumer Affairs for the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Rockville, Maryland; Dr. Donald Alves, Medical Director of the Maryland State Police and Emergency Physicians at Johns Hopkins University Hospital, Baltimore, Maryland; Officer Michael Chindblom, Crisis Intervention Team, Montgomery County Department of Police, Gaithesburg, Maryland.

Welcome to all of you. Keris, what are community health centers and what impact do they have on our country?

Keris: So community mental health centers—I used a new term on you, sorry about that but you asked about community health centers, and there are a couple of different terms we could use. So community mental health centers, for example, are places that are in the community where one lives that provide mental health services, a full array of mental health services, from treatment services to recovery supports. Community health centers could be things like federally qualified community health centers, FQHC’s, which provide primarily primary healthcare. And then there are some new programs called CCBHC’s which are, we love our acronyms, so it’s a Certified Community Behavioral Health Centers, and these offer like integrated full array of services from access to treatment services, support, can help with crisis stabilization, mental health, substance use treatment, primary care, prevention care, and it’s all done in a trauma informed care with an emphasis on recovery and wellness.

Ivette: Excellent. And those are funded by the Center for Mental Health Services?

Keris: Yeah, they’re funded by SAMHSA, the Center for Mental Health Services, and it’s a new pilot project so there are eight of them around the country and then over time they’ll grow.

Ivette: Very good. Dr. Alves, how important are these centers to the community?
Dr. Alves:
Really essential a lot of individuals, if they find themselves without resources or if they’re just out of jail, if they’re new to the area, if they don’t have primary care or mental health set up, they’ll come into the emergency department, we’ll do an assessment, make sure they’re stable, we’ll set them up with the community mental health centers for follow up. We contact them, they’ll either come see the patient in the emergency department or we can arrange transportation or follow-up at the centers for them so that we can get them established.

Ivette:
Very good and a lot of them come in through the emergency personnel that brings them in.

Dr. Alves:
A good percentage of them come in by 9-1-1 through the ambulance services through EMS.

Ivette:
Very good. Brenda, talking about EMS, what are EMS, what are first responders?

Brenda:
Well, the term first responders actually encompasses both law enforcement officers as well as fire personnel and emergency medical technicians and paramedics. Our role in the community is to respond to the 9-1-1, public safety. We also do a lot of public education, health education, injury prevention type demonstrations as well within the community.

Ivette:
Particularly in schools, correct?

Brenda:
In schools at community events like fairs, parades, hometown holidays.

Ivette:
Very good. Officer Chindblom, why is it important for first responders to know how to best manage individuals with a mental or substance use disorder?

Chindblom:
A lot of the times we’re getting calls for persons that are in crisis. Every call we run is some sort of a crisis or another so it’s important for our first responders to not necessarily be able to diagnose but be able to recognize certain signs and symptoms whether it be a thought or mood disorder, and then we want to take care of that individual and really kind of figure out what the best disposition is for that person whether it’s do they remain at home, do they go to an emergency facility such as a local hospital, can we take them to the crisis center in
Montgomery County, do we provide resources for the family. So there’s a lot of different potential factors and options, but it’s very important for us as police officers to understand and kind of be able to recognize those types of issues.

Ivette:
And Montgomery County in Maryland is—I think I would say one of the more prominent police departments to have such a unit.

Chindblom:
I may be a little biased on that but, yes, I think we have one of the best programs in the state.

Ivette:
What’s the unit called?

Chindblom:
My unit in particular is the Crisis Intervention Team. So we do a variety of tasks. We co-teach with our local crisis center with clinician crisis workers and we co-teach with our local law enforcement as well as our regional law enforcement in how to identify resources and identify mental health issues.

Ivette:
Very good. Dr. Alves, what is the extent—let’s start talking about some of the crises that first responders are dealing with particularly as we look at the opioid overdose epidemic in the United States really, not just in our area. So what role do first responders play in preventing deaths from opioid overdose?

Dr. Alves:
The first responders interventions are essentially immediately lifesaving. They encounter an individual who’s taken too much of their opioid of choice and has stopped breathing or is barely breathing and not adequately to save their life or to maintain their life. They’ll give them Naloxone or Narcan usually intranasally. My troopers do that. Many of the law enforcement jurisdictions do that and since they’re out on the street they often get there a couple of minutes ahead of EMS, and the extra couple of minutes is time that individual doesn’t have to essentially hold their breath.

Ivette:
Very good. And that is the ideal scenario but, Brenda, is everyone trained about the use of Naloxone and…

Brenda:
In Montgomery County Fire and Rescue Service, absolutely and that includes all of the volunteers. We go through the same training as the career paid folks do. It’s something we re-certify every year as well and practice. It’s something we do on a drill. We also, unfortunately, right now are using it on every shift.
Ivette: Really? Very interesting. Brenda, tell us a little bit about the program that you’re connected to that is supported by SAMHSA.

Brenda: The Disaster Technical Assistance Center? So our role is to provide support to SAMHSA and states and communities around planning for or preparing for and responding to disasters, but from the behavioral health aspect. So we look at a range of things. We also are providing support on—we’re doing some work right now with first responders on behavioral health emergencies or crises in the community.

Ivette: Such as the opioid epidemic, for example?

Brenda: Yes, we’ve talked about that. We have a training course that we’ve developed for SAMHSA that’s free for any first responder, so we’re working on getting that released very soon we hope.

Ivette: And that will be available nationwide through your web pages?

Brenda: Through SAMHSA’s website we hope and, yes, it’s online, it’s free. We hope it will provide a good overview and provide some very practical tips for working with individuals in a behavioral health crisis. We do talk about mood disorders, thought disorders. We talk about some of the substance use crises that occur. So I think it’s gonna be a very practical tool that people should walk away with immediate confidence that they know more and they can do something effectively.

Ivette: Keris, related to natural disasters that Brenda just mentioned it’s terrific that we have the center to be able to deal with communities but tell us a little bit about what types of mental health supports do communities need when they experience one of these crises.

Keris: Well, I think there are different types of information and trainings that community members can take a part in. So just as a layperson in the community, if you’re in a natural disaster, there’s gonna be a lot of emotional response, psychological response, trauma response, so you can look to our “licensed professionals” to help us with that, or there are things like mental health first aid that people can take and on the SAMHSA website there’s information about mental health first
aid. So just like you would offer CPR to somebody who’s having a heart attack you would want to be able to offer some support to someone who may be going through an emotional response to either a disaster or traumatic experience, or just who happens to be in some kind of stress, having a stress response.

Ivette:
What does our audience and communities need to understand related to the posttraumatic stress disorder that people can experience as a result of these natural disasters that people may say originally well, you know, it’s really okay, I’m okay and I really don’t need to talk to anyone. Why would you encourage them to do it?

Keris:
I like to think of these things as many people go through experiences and go through hard times, so the more that we can “normalize” a person’s experience so that they’re open to talking to someone about what they’re going through, I think that can help them work through some of the “posttraumatic stress response” that they may be having to a traumatic event. So being with someone, encouraging them, supporting them, even going with them to an appointment, I think, can be incredibly helpful. Also talking with somebody who’s been there, done that like a peer is also very helpful because then it makes you feel less alone like, wow, that person went through it too, I don’t feel so alone. They certainly understand and have walked that experience in their own shoes.

Ivette:
When we come back, we’re gonna continue to talk about best practices that support the work of not only community health centers but first responders. We’ll be right back.

[Music]

Kana:
The U.S. Department of Health and Human Services defines serious mental illness as a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities during the past year. People with serious mental illness are more likely to be arrested and experience homelessness compared to those without mental illness. Individuals with serious mental illness may also experience difficulties and crises that concern others enough to call emergency services. Therefore, police officers and other first responders may routinely encounter and interact with people with serious mental illness. First responders must be able to recognize signs of mental distress and apply proven techniques for de-escalating potentially dangerous situations. Technical assistance is available to support training efforts in these areas. Mental Health First Aid for Public Safety provides police officers and other first responders with more response options to help them deescalate incidents and respond to related calls.
appropriately without compromising safety. In communities across the country, first responders are saving lives every day by using the opioid overdose-reversal drug, naloxone. SAMHSA has supported their vital efforts by providing the Opioid Overdose Prevention Toolkit, which equips communities and local governments with the material they need to develop policies and practices to help prevent opioid-related overdoses and deaths. SAMHSA's Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths program supports the training of first responders and other community members on the prevention of opioid overdose-related deaths. The program includes funds for the purchase and distribution of naloxone to first responders.

[Music]

**Male VO:**
It takes many hands to build a healthy life. Recovery from mental and substance use disorders is possible with the support of my community. Join the voices for recovery: visible, vocal, valuable!

**Female VO:**
For confidential information on mental and substance use disorders including prevention and treatment referral for you or someone you know, call 1-800-662-HELP. Brought to you by the U.S. Department of Health & Human Services.

**Ivette:**
Welcome back. Brenda, I want to go to you to talk to me about if there are any improvements in providing training to emergency personnel in the area of behavioral health.

**Brenda:**
I think it’s something that we’re all paying attention to very closely now as we’ve seen an increase in these needs. We have regular calls. We have a lot of people that we see frequently through the emergency and 9-1-1 system and so providing more care and more training on that care is really important. I know through the SAMHSA Disaster Technical Assistance Center we worked with first responders to develop the course and to meet their needs, seeing that there was really a lack of training available to many of the departments.

**Ivette:**
So you’re training not only police officers but you’re training fire personnel.

**Brenda:**
And emergency services personnel like EMT’s and paramedics as well.

**Keris:**
So the cool thing about that work is that it involved people with lived experience of mental health and substance use conditions as part of the training with first
responders, so it was really interesting because as we talked about our personal experiences of either being in crisis having to dial 9-1-1 and having someone come to help us; we could talk about what did that feel like, what was important, things to do, things to try to avoid doing like maybe slow down or be a little bit more patient because sometimes when you’re in crisis, it’s harder to get out and talk about what’s happening to you at the time. So working together with both the person with lived experience, a family member, and the first responders, it made the training quite robust as far as how best to work with folks who are experiencing a crisis.

Ivette:
Officer Chindblom, it is imperative isn’t it that particularly those in a situation that we have seen in this country have this type of training because we’ve seen that many instances individuals with a mental illness are approached and oftentimes the response is inappropriate to say the least in those cases. So how can we begin to get more police departments to understand that they need to have such a training?

Chindblom:
With law enforcement in general we have to learn to adapt to our community. We have to change our training every so often. So Montgomery County specifically we’ve been encountering more calls for mental health service but we also have an abundance of resources. There are a lot of jurisdictions out there that don’t have those different types of resources and that’s very unfortunate. So I don’t have an answer specifically but if we were to have some form of training whether it be mental health first aid or whether it be a crisis intervention training, give those officers a foundation, a basis because a lot of times when we do respond to situations, it’s very fast and it evolves very quickly. So as Keris said, we do have to learn how to slow it down. So it is, as you said, it is very imperative that we have this training.

Ivette:
Within the crisis intervention team that you have, if an officer in Montgomery County, for example, encounters an individual that may be displaying some type of violence, and we haven’t determined whether or not they have a mental illness or whether they’re under the influence, does that officer—do you train them to call in and say, I may have a situation here that I need help with?

Chindblom:
We do. Part of our training is—like I said, we’re not doctors but we are a frontline social workers so once you get on scene you want to be able to assess your situation. In Montgomery County we do have—we are fortunate where our backup of other responding units are very close by so part of the crisis intervention training is to take a step back, assess the situation, if you’re able to develop a rapport with that individual, wait for your backup. Obviously, if it appears to be some sort of medical issue or drug-induced issue, contact fire
rescue services immediately to get them started so that when we do finally get that person into protective custody, we can give them the appropriate treatment they need.

Ivette:
Very good and Brenda, related to this, do we have to have like a policy within emergency departments or police units to begin to really get them to address these situations that Keris was just presenting or who should start the dialogue about expanding these trainings?

Brenda:
I think honestly the first responders, the frontline officers are starting the dialogue themselves. We were actually really happy to learn, as we were doing the pre-work for this course and met and spoke with a lot of first responders from all three of the disciplines, and there was a real hunger for this information because it’s something that’s occurring in their communities very often. Like Officer Chindblom mentioned, there’s many departments whether it’s law enforcement or fire and rescue, that are not as well resourced as Montgomery County is or even this jurisdiction in general in Prince George, Washington, D.C., even the northern Virginia areas are very well resourced, but many of them are not and can’t afford some of the more expensive trainings that are available. The CIT, the Crisis Intervention Training, is actually considered the best practice but it’s 40 hours and for a very small department with a few officers or an all volunteer force that is fire and rescue which most of them still are in this country, it’s really hard to afford that from a departmental budget, from giving them leave to do that kind of training. And for volunteers, that training is often something they have to pay for themselves and they just can’t afford the training.

Ivette:
Brenda, forgive me but do the emergency personnel get training when they volunteer? Is there a procedure or a protocol? Could we be thinking about including perhaps some of the behavioral health components to that training?

Brenda:
We should. The National Registry for EMT’s test or exam actually includes a module on behavioral health emergencies but out of the entire course I think it was maybe an hour out of 180 hours of training. So it was about maybe an hour was spent in class on it. Then in the station houses we often do drills to continue to keep our skills up and I don’t know that we see a lot of behavioral health drills. I care very much about this issue so on my shift I make sure we do these types of drills and that we practice them and we’re trying to work on how to have a communication. I think Officer Chindblom gave some great answers about how to build that rapport and build a relationship, assessing the scene. We have to do the same thing for our own safety, for that person’s safety, so I think those are things that are critical to get into training. From a national perspective it would be
great to see some leadership encouraging the national certifying bodies to build this course or build this information and make it stronger.

Ivette:
Thank you, Brenda. Keris, how difficult is it to get, for example, something as simple as mental health first aid?

Keris:
Well, you can go on a website. You can google mental health first aid, for example. You can go on the SAMHSA website and you can actually find where the courses are offered, and they’re offered at the community level. So it’s probably not that hard. It is a commitment of time for folks to do it.

Ivette:
Is it the 40 hours?

Keris:
I don’t know how many hours it is.

Brenda:
It’s eight hours.

Keris:
Is it eight hours?

Brenda:
It’s eight for mental health first aid.

Keris:
For mental health first aid it’s eight hours and you really do learn a lot around sort of mental health, substance use, what are some of the signs and symptoms, what are some of the warning signs. It teaches participants how to create an action plan with the person that you’re supporting and to help them get, again, access to treatment services and supports. And I use those three words because treatment may be more around seeking out a psychiatrist or a psychologist. Services and supports may be around housing, education, employment, a lot of those different things. They’re the whole aspect of your life. So if those things aren’t going well, if I don’t have housing, my mental health is probably not gonna be at its best, or I may be uses substances, for example. So if you can access like housing first and get into housing, so mental health first aid does teach about connecting folks to those treatment services and so forth.

Ivette:
So it’s a broader pool of information that people have, not just how to handle situations. Very good. And when we come back, we’re gonna continue to hear from some of our other panelists related to best practices. We’ll be right back.
Vincent Beasley:
The Crisis Intervention Team was actually started in 1987 when an African-American was killed who was suffering from a psychosis, and at the time we knew very little about mental illnesses or stuff like that so unfortunately, we ended up taking his life. He was armed with a knife and we ended up shooting him.

Randolph Dupont:
The traditional ways of intervening don't work as well with individuals who have certain types of issues that could be characterized as behavioral or substance-use related.

Daylun:
It’s always important to be quicker to listen and slower to react.

Vincent Beasley:
There was a collaboration of civic leaders, University of Tennessee Health Science leaders, community activists, NAMI, mental health agencies, we came together and said we have to do something better than this, we need to talk about how we’re going to deal with people suffering from mental illness and basically that’s how CIT came into being.

Randolph Dupont:
We want to be able to have individuals on the scene, who have the training, in a very short time.

Vincent Beasley:
We’re about 14% of our officers are CIT trained, active CIT officers, we have CIT officers at all 9 precincts, 24 hours a day, CIT is available.

Stephanie:
CIT is a very responsible and loyal group of guys and women, they’re more considerate and kind and vulnerable, they’re vulnerable as in they have heart and they’re concerned about you to see that you’re alright too.

Vincent Beasley:
We recognize it takes a special person to deal with someone with mental illnesses so therefore, they volunteer. After they volunteer, there’s a strenuous selection process, then there’s 40 hours of training. The role-playing is probably one of the most valuable parts of the training because in role-playing we talk de-escalation, we talk slowing it down, we talk giving the patient, the person who’s in crisis, giving them your undivided attention.
**Stephanie:**
CIT helps you open up because they’re more supportive and they want you to talk.

**Randolph Dupont:**
We changed police procedures a lot. This officer who now has the expertise might be in the patrol division but he becomes the leader at the event as soon as it’s determined we have a behavioral crisis. We give them authority we don’t give other officers.

**Vincent Beasley:**
We’re there to give them a bridge from crisis to a place of getting help.

**Daylun:**
These people are good, they understand what you’re going through and they’ll help you any way they can.

**Vincent Beasley:**
It’s probably one of the most rewarding things I’ve done on this job and I’ve done a little bit of everything on the job, but you know, there’s nothing like helping somebody.

[Music]

**Male VO:**
My family and friends are always with me, no matter where I may be. Sharing stories from home helps me sustain my recovery from my mental and substance use disorder. Join the voices for Recovery: our families, our stories, our recovery!

**Female VO:**
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[Music]

**Keris:**
So my recovery journey is one that it’s not quite that simple. I think it took a while for me to, number one, understand that there was this thing called recovery. I’d never heard of it before. When I got the diagnosis of—first it was depression, then it was schizoaffective disorder, then it was schizophrenia, and I was like, what do you do with all of that over a period of time? So I really had to, number one, understand what was going on, and number two, kind of think about what’s important to me. Was it important to know that I had the diagnosis or was it more important to me to figure out what is it that I want to do with my life because I
I wasn’t very happy with my life and I wanted to kind of get on with my life. I wanted to get back to work, I wanted to go back to school, and those are the things that I was articulating to my treatment team, and my treatment team was telling me, no, that’s not gonna happen. And that was really very difficult because if I’m not working, if I’m not challenging my mind, if I’m not engaged in meaningful activities, it actually made it worse. So no amount of therapy, no amount of medication, no amount of peer groups, none of that could really help until we were all working together to help me achieve those goals and dreams that I had set for myself. And I was reading an article and it was about what is needed in behavioral health in order to expand access to recovery for all Americans, and the person was writing about the need to focus on youth and increase youth engagement and behavioral health care as well as in leadership and participation and for people of color. So I called the person. I looked him up, called the person, and he said, I’m gonna introduce you to someone who has the same diagnosis, she’s an African American woman and next time I’m in your town—we talked about when he would be there—he said, oh my gosh, she’s gonna be there, too, so we’ll get you guys introduced. And when I met her, that’s when I knew that it was possible. If someone has doubts about their ability to recovery, google lived experience. Just go on the internet and google lived experience. Try to find another person, another family, somebody who can be that mentor that can show you by example that recovery is possible.

Ivette:
Welcome back. Dr. Alves, we haven’t talked a lot about the intersect between the state police and the local police department and the types of training that state police get. I know that you are the director of medical services for the Maryland State Police. Can you take us through the type of training that the state police have?

Dr. Alves:
The state police and their academy have a few hours of training at the outset and it covers specific topics: Alzheimer’s, suicidal behaviors and awareness both in the community members we serve as well as amongst law enforcement, individuals that are differently able particularly like the deaf. If they’re not responding to you, it may be because they can’t hear you. It plants the seed that it also may be because they don’t speak your language and have no idea what you’re telling them, things of that nature. Then it comes up reinforcement each year in their in-service training. But, again, it’s only a couple of hours here and there. There’s optional trainings available but most of those vary based on the officer’s interest. One of the biggest challenges as a state agency is that each barrack essentially functions as almost its own different police agency. If we’re in a municipal area, for example the Rockville barrack can key off of the resources of the Montgomery County Police Department and the programs they’ve established. If they’re way out on the shore or in the mountains, they may not have those resources available, they may not have any providers to partner with so it fluctuates area to area.
Ivette:
Should we be looking even for state police to perhaps not making it mandatory but making it more accessible so that they don’t—I see here that time is a factor in all of these. It’s a recurring theme that people just don’t have enough time. Are there ways that perhaps people can consider providing more training?

Dr. Alves:
There definitely are and it’s gonna be a function of availability and format. Do they come to the barrack, is it something they can do online? If we can arrange self-paced training that adequately covers the material for novices or people that are not experienced in psychological emergencies or other medical issues, that would be the most user friendly in terms of access. They could get to it anywhere, they could get to it in their car if they’re not working.

Chindblom:
I would also have to agree with that as well. I mean I’m from Pennsylvania originally and when you look at a lot of the police departments in Pennsylvania specifically, there’s boroughs, townships, but there’s not a lot of mental health resources. You may have addiction resources, you may have individual hospitals. So trying to get those different agencies to come together when there may or may not be resources available it’s very difficult. The whole auspices of CIT is the collaboration between the local police department as well as the local health and human services. That’s what is really the core of the training.

Ivette:
Local meaning Montgomery County or do you receive state aid as well?

Chindblom:
That, I honestly couldn’t speak to. I know there is aid that comes in from the state for our crisis center to assist with the trainings for our agency as well as regional agencies but you really need that collaboration there. So if you don’t have those appropriate resources for your jurisdiction, maybe something similar as online training would be appropriate just as the doctor said, to start planting that seed to get people thinking. For an example, a call such as somebody behind the wheel that may be intoxicated, we train our officers that may not be intoxication, it may be a medical emergency such as a diabetic coma so you need to slow down, take a breath and evaluate and assess the situation.

Ivette:
And it goes back to what you were saying with a first aid type of training, to slow down. Anything in addition, Keris, that SAMHSA is contemplating in light of the fact that we’ve established that time is a factor, we’ve established that the resources for training emergency personnel are scarce.
Keris:
I think what we’re doing through Brenda’s work is an example of how to shore up the gap so that the work actually is online self paced, so it’s not that you have to sit in a classroom for 40 hours straight or you have to go anywhere quite frankly. You can actually do it while you’re sitting at your desk, you can do it at home on the weekend, so that is one way to help shore up. I think the other thing to think about, and SAMHSA has this work and the states have it and localities have it, is how to use your community based organizations to help support throughout. So the onus, if you will, can’t be put on first responders. They can’t be the only ones who are responding. So our community-based organizations, our peer-run organizations, recovery community organizations also help become a part of the response as well as I think the prevention. I can speak from personal experience about the importance of officers having training and the difference between when I was not doing well and officers had to show up at my door when they didn’t have training. It was not the best experience. It was actually quite traumatic. And then where I was from at the time, when the officers did go through the CIT training and an officer and a social worker came, it was a completely different experience. It was much more of meeting me as a person who was really having a hard time. So I think, again, speaking from personal experience, how important it is for everybody to have a better understanding of how to work with people who are experiencing distress.

Ivette:
That’s interesting. I like the notion of what you said, peer coaches or peer support. Dr. Alves, in the emergency department that you work in do you have some peer support personnel that can actually—or access to calling them in to be able to help you out?

Dr. Alves:
At Bay View in the emergency department we have psychiatric social workers that are available to assess individuals and we can consult them. Even if it’s not a patient that’s primarily there for those purposes we can consult any patient and say, you know, I’d like to get this person additional resources in regards to substance abuse, psychological support, medication management; and they’ll give us resources that we can then provide to the patient so that we can also get psychological follow up as an outpatient once our visit is done.

Ivette:
Brenda, are we incorporating peer support into some of this concept of training, or the use of peer support?

Brenda:
Our course called Creating Safe Scenes actually does have an entire module on building relationships within the community to provide additional support and referral options. I think it’s really important—I think Keris made a really good
point—it’s really important to remember that the first responder has a very specific role and it’s a very time-limited role but it can be an incredibly powerful role in terms of the experience of the individual in crisis. So in the few minutes I might have them in the back of the ambulance, how I treat them and the opportunities I can show them that they might have for additional help beyond their time with me, can give them an experience that hopefully lets them know people care, that there are options available to them and that we actually know where they are. So that’s going to be very unique to each community but I think the peer resources is going to be a key one because in some parts of the country professional licensed psychological care is so scarce.

Ivette:
Absolutely. Officer Chindblom, with all the stressors that come with people having to respond to crisis scenarios on a constant basis, what should we tell our audience that is engaged in this type of work and where are the triggers of when to take pause and sort of self care?

Chindblom:
So that’s a big piece; especially over the last few years the spotlight has really been on law enforcement and interactions with the community, as well as it should be. You know, we should always reevaluate things but I often say nobody calls us because they win a trophy that particular day. They call us because they are in a state of crisis, because their ability to reason and cope is so off kilter they’re no longer able to deal with the situation themselves so they contact us. My personal experience, you know, it was very difficult at a certain point in my career. I became physically and emotionally burnt out. So it’s not always easy to evaluate your own self. It’s easy to give advice but it’s very difficult to take it. So as first responders it is very important that we are aware of our mental health, our stressors, what particular triggers, and it could be cumulative stress. It doesn’t have to be necessarily one traumatic event. It can be an entire career. We often say in the academy you start out with a small duffle bag when you begin your career and by the end you now have a gigantic suitcase that’s overflowing and unless you are aware of that and are able to deal with that appropriately, whether it’s taking time off, whether it’s proper diet, proper exercise, proper sleep. Also we’re also human, too. We have families ourselves so those different types of situations often feed into our professional life as well, so it’s extremely important and I think a lot of police departments are now looking at that because of recent events over the last few years nationally and locally as well.

Ivette:
Very good point. And when we come back, we’ll talk more about resources for first responders. We’ll be right back.

[Music]
Randolph Dupont:
There are several levels in which the community has benefited in a pretty dramatic way. Obviously, the fact that the people are doing better that are in crisis and are more likely to get into treatment, get connected to treatment … obviously very strong benefits 1:11:30

Vincent Beasley:
[:37] 13:22 we answered 18,435 calls last year. Out of those 18,435 calls, we only transported 529 individuals to a penal facility. The national average on transports is about somewhere between 2 and 2.5. 13:37 we’re happy to say our numbers were at .031 as far as transports. So what we’re doing, our officers are out there thinking of other options than taking them to jail because we realize that if they are suffering from mental illnesses they don’t need to be incarcerated. 13:56 they need to be somewhere they can get the help they need. 13:59

Randolph Dupont:
[:10] 1:19:33 we did find over the years that the need for commitment dropped dramatically and people were being diverted into community resources that were less restrictive and we thought that was obviously a very positive thing. 1:19:43

Vincent Beasley:
[:18] 11:55 We started CIT right here in Memphis, I’m proud to say that. 12:00 Since then, about 3500 agencies have adopted the Memphis model of CIT 12:05 and it’s growing. That’s 3500 agencies in the US, that does not include the agencies outside the US 12:13

Randolph Dupont:
[:11] 1:25:06 One thing that’s nice about CIT is cost is very low and they don’t need to be maintained, if you just get it started, it has enough energy and strategies that you don’t need additional funding, they really do well. 1:25:17

Stephanie:
[:12] 2:06:47 knowing CIT is there to help you you feel awesome and blessed and you can feel that there is hope still in this world :59

Daylun:
[:11] 1:54:01 keep doing what you’re doing. It’s working. Just don’t give up. Don’t give up on people 1:54:12

[Music]

Paolo:
Section 223 of the protecting access to Medicare act is an effort that we believe is a game changer when it comes to community mental health and addictions treatment in America. And basically what this program does is establishes demonstration program to evaluate taking a federally qualified health center
model and applying that to community mental health and addictions treatment where these centers, what meets their quality standards and criteria that we established for them to provide a range of evidence based quality care as a result of those clinics providing that range of care, they will be eligible for enhanced Medicaid financing and what this really does is raises the bar when it comes in terms of quality and financing for community mental health and addictions treatment in this country like we haven’t seen in some 50 years. One of the essential services that these community behavioral health clinics are to provide are crisis services and so when a first responder, when a law enforcement officer or an emergency medical technician may encounter a person who is in a mental health crisis or an addiction crisis, these clinics can be places where they can take these individuals where they can get seen and assessed and be provided the right level of care. This is a win-win for everyone, the police, the EMTs may not have the necessary training so bringing them to a location that has the necessary services, the expertise. It helps the individual, they don’t have to end up in jail or prison or end up in the emergency room perhaps and being boarded there for days at a time. Instead they will receive high quality care ultimately helping them get back home in the community with their loved ones.

[Music]

Male VO: For more information on National Recovery Month, to find out how to get involved or to locate an event near you. Visit the Recovery Month website at Recoverymonth.gov.

[Music]

Ivette: Welcome back. Dr. Alves, Officer Chindbloom was mentioning self care. What other tips do we need to be aware of for individuals that are first responders?

Dr. Alves: First responders, law enforcement in particular, tend to be very bad at paying attention to their own needs. They’ll downplay those because they’re in the middle of responding to an emergency. So it’s essential that we have peers that are trained as to what to look for, for early signs of performance decrement or fatigue. The five-dollar word is compassion fatigue. Are you getting to the point that you’re just exhausted so you’re not able to pay as much attention to the person that you’re trying to help as you should? And that way you have a trained peer who can kind of say, okay, we need to have a glass of water and a cookie and sit down for a minute, take a break, and then go back in when you’re ready to play. It’s very essential that the officers and the other responders feel that they can speak to their peers in a protective environment so that they don’t feel like that’s gonna be used against them, and that’s the latest wave sort of in the legislatures is to give peers protections the same way they would if they found
me on the scene and said, doc, I just really feel X, Y, and Z; okay we can fix that, dust them off, turn them around and put them back in play.

Ivette:  
Very good. Brenda, I still want to go back to the development of policies to make sure that emergency personnel are trained. If I am out there and I’m part of this audience that’s listening to this show, should I be going to my state health department, you know, obviously if I have an interest in making sure that my community first responders are trained in behavioral health issues?

Brenda:  
I think each jurisdiction has its own rules about what level of training they need and what that training content is. So I would actually start with your local department and check it out first to see what level of training they’ve gotten in behavioral health, how many hours it is, what it encompasses. And then I think there’s certainly nothing that stops them from advocating for additional training, and most departments probably support that. It’s just needing the resources, identifying the resources and making sure that first responders have an opportunity to take advantage of them.

Ivette:  
Keris, anything to add on that note?

Keris:  
I think you can also work with local community organizations, NAMI, National Alliance on Mental Illness. You can work with, again, recovery community organizations to also work with police departments and departments of mental health or substance use, SSA’s, to figure out what is needed in that particular area and how can they support them.

Ivette:  
Is there a role for the community health centers and community mental health centers in this regard?

Keris:  
I think there’s a role for everybody in this regard. Again, I think we were talking about self care of officers, as an example. If officers are always responding to seeing folks in crisis, I think it’s also important for officers to see folks when they’re doing well for people with lived experience to work with officers when they’re well and to meet them on their own terms; have coffee and a donut. That’s actually what we did at one of our community health centers back where I’m from is our place was a place that folks could stop off and have coffee and a donut so that they could see people in treatment, see people when they’re doing well. Lots of hugs. I’ve never seen so many hugs go around between police officers and people who are receiving services. But what I found out from all of that was what it meant to the officer as well as what it meant to the folks
receiving services. They were more apt to see that person as a peace officer and a supporter versus somebody who might be kind of scary for them.

Ivette: Officer Chindblom, this is a very critical aspect of what we’ve been talking about because what Keris was just talking about really reduces what used to be called stigma and now is called discriminatory practices against those that may have a substance use disorder or mental health. Is there a need for that type of insight particularly for units that have a CIT program?

Chindblom: I'll answer that in two parts. The first part, you mentioned the stigma. That’s a big barrier for law enforcement when it comes to dealing with our own mental health issues. We’re afraid if we step forward and say, hey, I’m having some issues. For most of us this is our livelihood, this is who we are, this is what we enjoy doing, and if we come forward, then we’re saying we’re not well and then all of a sudden maybe that career is gone. So breaking that stigma within our own agencies as police officers is incredibly important. For the second part of that, my personal experience, we have a drug diversion program within our county. I will personally tell you I did not agree with it. I didn’t see it as a success. But I will tell you now I am a changed person. After interacting with these folks, after interacting with these professionals, it is working. It may not be the proper answer for everybody but at least we do need to try something and breaking that stigma whether it be addiction, whether it be mental health issues, is extremely important for not just us as a law enforcement agency but also within the community. Keris had mentioned earlier about bringing people in, success cases. We don’t see that that often so a lot of the pressure gets put on law enforcement but it’s a community issue as well and I think, as she pointed out, everybody has to get involved.

Ivette: Very good. Anything to add, Brenda, on that?

Brenda: I think I would agree. In terms of self care it’s more of a challenge. We have resources that are available to us, that are promoted to us, but there’s still probably a little bit of a reluctance to take advantage of them, or there’s a lack of recognition that they’re needed. So I think good peer recognition and peer training for officers and first responders to recognize it in each other and be a support. I think creating a culture and an organization that’s resilient as well would be really important so that we’re recognizing the build up of stress so that an officer gets the assistance they need and gets a break; maybe a shift change or a different rotation can ease some of that stress before they get to that point where their livelihood would ever be jeopardized with a fitness for duty exam or anything like that. So I think creating that kind of organization should be our goal as first responders, and I think for me, seeing people I’ve helped when they’re
well is the best part of the job. It doesn’t happen enough. And I know that Keris helped us identify and NAMI of Maryland helped us identify some individuals who had experienced crises and interacted with first responders as a part of our course and that was one of the most successful features when first responders took the BETA course.

Ivette:
That really is what helps to break down that bias, right Keris, in a way?

Keris:
Yeah. It’s called the contact model from a scientific standpoint that Dr. Patrick Corrigan did some research and he found out that the best way to break down the stigma, discrimination, prejudice attitudes and so forth around mental health conditions is to actually have positive interactions with people who have mental health conditions.

Ivette:
Excellent. Well, we’ve come to the point where I get to hear from you as your last thoughts and we’re gonna start with you, Brenda.

Brenda:
I just really appreciate you hosting a conversation like this. It’s an opportunity for us to share not only what we need but what we are learning as we work in the communities. And all of us in the first responder community come to it from a public service mindset and that is who we are, and wanting to be helpful.

Ivette:
Thank you. Keris.

Keris:
If anybody needs treatment services or supports, I hope they can find it on our website with the SAMHSA treatment locator or the HRSA, Health Resources Services Administration, find a health center. So there are places where people can and do get help and as one officer, I heard him say, hurt people hurt people. So my biggest thing is that for people as individuals, communities, organizations, and first responders is we all need to take care of each other.

Ivette:
Excellent, thank you. Dr. Alves, final thoughts.

Dr. Alves:
We need to expand the knowledge and the understanding amongst all the public safety realm that access to regular mental health, just like seeing the dentist, just like seeing primary care, there shouldn’t be a stigma attached to it. And as long as it’s early, if you wait until you’re having chest pain, you’re gonna have a harder time of it. If you take good care of yourself on the front end, you won’t have as
many complications, we can keep you at work, keep you in the game, keep you at play.

Ivette: 
And we need more training, correct?

Dr. Alves: 
Absolutely. Any professional who wants to learn more about what they do and why they’re doing it so it needs to be available to them and encouraged rather than cut short due to funding and hour limitations.

Ivette: 
Officer Chindblom.

Chindblom: 
I really appreciate the opportunity and, as Brenda mentioned, this is a unique experience and hopefully we can engage in more conversation with first responders and members of the community as well as the health and human services community.

Ivette: 
And where can they find out more? Can they visit the Montgomery County—

Chindblom: 
If you go to Montgomery County’s government website, there are links in there that talk about the crisis center. Certainly, we work with NAMI, National Alliance of Mental Illness, as well and those folks at the crisis centers. So there are a lot of different resources out there, yes ma’am.

Ivette: 
And you would recommend that for all police departments?

Chindblom: 
Yes, absolutely.

Ivette: 
Because it’s working extremely well, I suspect, in Montgomery.

Chindblom: 
I hope so, ma’am.

Ivette: 
Absolutely. I want to remind our audience that September is National Recovery Month. I want you to go to recoverymonth.gov to be able to access all the materials for the 2017 observance, and it is not just in September. Recovery
month is every year. We have programs such as the Road to Recovery there. You find a great deal of materials and information related to recovery and activities that a lot of our stakeholders and planning partners are engaged in. So recoverymonth.gov. We hope that you get encouraged and do an event for next September and join us in that celebration. I want to thank you for being here. It was a very, very good program. Thank you.

[Music]

Male VO: To watch this program or other programs in the Road to Recovery series, visit the website at recoverymonth.gov.

[Music]

Female VO: Every September, National Recovery Month provides an opportunity for communities like yours to raise awareness of mental and substance use disorders, to highlight the effectiveness of prevention, treatment and recovery services, and show that people can and do recover. In order to help you plan events and activities in commemoration of this year’s Recovery Month observance, the free online Recovery Month kit offers ideas, materials, and tools for planning, organizing, and realizing an event or outreach campaign that matches your goals and resources. To obtain an electronic copy of this year’s Recovery Month kit and access other free publications and materials on prevention, recovery, and treatment services, visit the Recovery Month website at recoverymonth.gov, or call 1-800-662-HELP.

[Music]