ILLINOIS STATE MEDICAL SOCIETY

Resolution 12.2020-28
(A-21)

Introduced by:	Tariq Issa, Anastasia Rubakovic and Divya Meher Surabhi, ISMS Members
Subject:	Advocating for the Utilization of Health Care Professionals to Serve as First Responders for 911 Mental Health Emergency Calls
Referred to:	Council on Medical Service

Whereas, individuals with mental health illnesses are overrepresented in the criminal justice system[1]; and

Whereas, researchers estimate that 7-10% of all police interactions involve mental health crisis assistance[2]; and

Whereas, the number of violent incidents that occur during mental health-related calls might have been mitigated with the assistance of medical professionals; and

Whereas, police officers are not universally trained in mental health crisis control; and

Whereas, many police departments have tried to address police mental health training through crisis intervention team (CIT) models where police are trained in de-escalation tactics and provided with resources to refer individuals to mental health services rather than criminal justice services[3,4]; and

Whereas, researchers have demonstrated that even police officers trained in CIT models were only able to recognize half as many cases of mental health illness as clinically trained graduate students[5]; and

Whereas, qualitative analysis of officers in the Chicago Police Department have demonstrated that officers are frustrated with their inability to effect long-term change for people in mental health-related calls due to the constraints of the current system[6]; and

Whereas, the Illinois Criminal Justice Information Authority found that nearly 70% of Illinois police departments consider mental health issues as one of the top issues for their department[3]; and

Whereas, the number of mental health-related police detentions and hospitalizations are greatly reduced in mental health and police co-responder models compared to police-only models[4,7,8]; and

Whereas, the average cost per mental health crisis is lower in existing street triage models compared to a police-only response[4,9,10]; and

Whereas, the Community Emergency Services and Support Act (SB3449) was introduced into the Illinois General Assembly in order to establish an alternative response system in all Illinois 911 districts[11]; and

Whereas, major cities including Chicago and New York City are launching co-responder programs so that police officers are paired with a healthcare professional when responding to mental health crisis calls; therefore, be it

RESOLVED, our ISMS support efforts to increase primary deployment of health care workers and mental health professionals for nonviolent mental health-related 911 calls; and be it further

RESOLVED, our ISMS recommend that police resources be dispatched as a backup support service for subjects who threaten violence or are known to harbor a weapon; and be it further

RESOLVED, our ISMS propose a resolution at the AMA A-21 meeting supporting the use of mental health professionals as first responders to mental health emergencies across the United States.

References:

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3. Law Enforcement Response to Mental Health Crisis Incidents: A Survey of Illinois Police and Sheriff's Departments | ICJIA Research Hub. Accessed November 15, 2020. https://icjia.illinois.gov/researchhub/articles/law-enforcement-response-to-mental-health-crisis-incidents-a-survey-of-illinois-police-and-sheriff-s-departments

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6. Wood JD, Watson AC, Barber C. What can we expect of police in the face of deficient mental health systems? Qualitative insights from Chicago police officers. J Psychiatr Ment Health Nurs. n/a(n/a). doi:https://doi.org/10.1111/jpm.12691
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8. McKenna B, Furness T, Oakes J, Brown S. Police and mental health clinician partnership in response to mental health crisis: A qualitative study. Int J Ment Health Nurs. 2015;24(5):386-393. doi:10.1111/inm.12140
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11. Illinois General Assembly - Bill Status for SB3449. Accessed November 15, 2020. https://www.ilga.gov/legislation/BillStatus.asp?DocNum=3449&GAID=15&DocTypeID=SB&LegId=125173&SessionID=108&GA=101

Relevant AMA Policy:

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Res 412, A-06; Appended: Res 907, I-12

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Res. 116, A-12; Reaffirmation A-15

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.
Res. 923, I-15; Appended: Res. 220, I-18

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.

4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
Res. 406, A-16; Modified: BOT Rep. 28, A-18

Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill H-345.995
Our AMA urges physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement.
Res. 16, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmation A-15

ISMS Policies:

A. The Importance of Mental Health Education and Services: ISMS recognizes the importance of mental health in the quality of a person's life and the devastating impact mental illness can have for an individual and one's family. Knowing that modern medicine has much to offer, ISMS supports the training of physicians in mental health care, the education of the public in recognizing mental illness and the development of private and public services for care. B. The Physician's Role in Mental Health Services: ISMS recognizes the primacy of the physician in the diagnosis and treatment of mental illness. Involuntary psychiatric hospital certification of any patient must, without exception, involve a physician licensed to practice medicine in all its branches. The discharge of any patient from a psychiatric institution must remain the responsibility of a physician. C. Continuing Medical Education for Department of Mental Health and Developmental Disabilities Physicians: The Department of Mental Health and Developmental Disabilities (DMHDD) [Department of Human Services] should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians. D. Cooperation between County Medical Societies and DMHDD: Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage: (1) Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle; (2) Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature; (3) Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for

psychiatric problems to the extent possible; given facilities and physician time available; (4) Arrangements for emergency mental health care, i.e., crisis intervention, to be available area wide. E. Patient Visits: The number of times a patient is seen should not be the sole criterion of the necessity or adequacy of psychiatric care. The level of care needed by the patient must be a major factor in determining the delivery of that care. Each hospital or hospital system should establish its own standard of psychiatric care to include the level of care needed by that patient, and should monitor the adequacy of psychiatric care by means other than frequency of visits. F. Community Mental Health Services: ISMS supports and encourages the development of community options for services to the chronically mentally ill in the private and public sectors, although the Society opposes using such alternatives to inappropriately discharge these persons to inadequate services and living conditions, thereby increasing the number of homeless mentally ill. (HOD 1987 Amended; Last BOT Review 2013)

Fiscal Note:

n/a

Existing ISMS policy related to this issue:

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