


A Critical Analysis of Debates Around Mental Health Calls in the Prehospital Setting

INQUIRY: The Journal of Health Care Organization, Provision, and Financing
Volume 54:1–5
© The Author(s) 2017
Reprints and permissions:
sagepub.com/journalsPermissions.nav
DOI: 10.1177/0046958017704608
journals.sagepub.com/home/inq


Polly Christine Ford-Jones, MA, AEMCA¹
and Claudia Chaufan, MD, PhD^{1,2}

Abstract

Paramedics, health care workers who assess and manage health concerns in the prehospital setting, are increasingly providing psychosocial care in response to a rise in mental health call volume. Observers have construed this fact as “misuse” of paramedic services, and proposed as solutions better triaging of patients, better mental health training of paramedics, and a greater number of community mental health services. In this commentary, we argue that despite the ostensibly well-intentioned nature of these solutions, they shift attention and accountability away from relevant public policies, as well as from broader economic, social, and political determinants of mental health, while placing responsibility on those requiring services or, at best, on the health care system. We also argue that the perspective of paramedics, who are exposed to, and interact with, individuals in their everyday environments, has the potential to inform a better, structural and critical, understanding of the factors driving the rise in psychosocial crises in the first place. Finally, we suggest that a greater engagement with the political and social determinants of mental health would lead to preventing, rather than primarily reacting to, these crises after the fact.

Keywords

mental health, paramedics, prehospital care, social determinants of mental health, health care workers

Introduction

Paramedics work within emergency medical services (EMS), providing prehospital care and transportation to facilities providing this care, as well as assessing and managing both life-threatening and non-life-threatening emergencies in the prehospital setting.¹ Increasingly, paramedics are being called to address patients’ mental health concerns.^{2,3} Current debates around increasing mental health call volume for paramedics, in the media as well as in academia, identify several factors as problematic, such as inappropriate use of paramedic services for mental health and other psychosocial issues, insufficient paramedic mental health training, and deficiencies in community mental health services.

Critical analyses of health issues have problematized dominant narratives around obesity,⁴ diabetes,^{5,6} and heart disease,⁷ calling attention to the lack of acknowledgment in these narratives of the political and social determinants of health. In contrast, dominant narratives around mental health calls in EMS (hereafter paramedicine/paramedic services), a relatively neglected field in the health care literature, have merited scant critical analysis.

In this commentary we address this gap, drawing broadly from the political economy of health^{8,9} and critical discourse

analysis literature¹⁰ to examine the debate around the observed increase in mental health calls in the prehospital setting. We do not attempt a systematic, empirical analysis. Rather, our goal is to draw from selected examples, from the academic literature and the media (from the English-speaking world), to shed light on what is missing in dominant discourses around the uses (and “abuses”) of paramedic services for mental health calls. We have a special interest in underscoring the relevance of these omissions for mental health practice, policy and equity, in highlighting the potential contributions of the experience of paramedic professionals to these fields, and in expanding the debate around the political and social determinants of mental health to include a relatively neglected area in the provision of health services.

¹York University, Toronto, Ontario, Canada

²University of California, San Francisco, USA

Received 6 December 2016; revised 12 March 2017; revised manuscript accepted 15 March 2017

Corresponding Author:

Polly Christine Ford-Jones, York University, 4700 Keele St, Toronto, Ontario, Canada M3J 1P3.
Email: pollyfj@yorku.ca



Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons

Attribution-NonCommercial 4.0 License (<http://www.creativecommons.org/licenses/by-nc/4.0/>) which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).

The Role of Paramedics in Psychosocial Care

Paramedics provide care in the field, en route to the hospital, and increasingly in community settings. Paramedics' scope of practice varies by region and level of training^{1,11}; it includes both basic (eg, medication administration) and specialized (eg, intubation) interventions, as well as direct transport to facilities for suspected cardiovascular emergencies (eg, myocardial infarctions), among other skills and protocols.¹ Skillsets and structure of paramedic services vary both within and between countries and continue to develop. This includes traditional response to acute emergencies, community health care and primary health care roles, as well as addressing more chronic health conditions, prevention, and education.¹¹

Paramedicine is seen as a hybrid of skillsets from a variety of occupations and, given the profession's relative infancy, its scope of practice is likely to evolve.¹² Increasingly, paramedics are addressing calls involving a significant component of what has been labeled psychological and social care. Given the diversity of environments and protocols under which paramedics work, there is undoubtedly variation in the frequency and management of this type of care. Here however, we draw on media from the Canadian context and paramedic academic literature from the Canadian, US, UK, and Australian contexts to inform this discussion.

Paramedics are often a first point of access to the health care system, and one of few health professionals who encounter patients in their everyday settings. Paramedics encounter patients from diverse socio-economic backgrounds and may be a patient's only access to health care.¹³ Although their interventions are usually responses to identifiable medical conditions, there exists a great variety of non-medical, often labeled "psychosocial," situations to be managed in the prehospital setting, as well as information to be gained from this exposure.¹⁴ Among situations resulting in calls to paramedic services, "mental health calls" are increasingly frequent³ and these patients are identified as repeat users of prehospital ambulance care.¹⁵ Despite its relevance and magnitude, the academic literature on the subject is limited.

Paramedic Services in the News

A purposive sample of articles illustrates the dominant narrative around paramedicine and mental health calls in the media. One recurring theme is the issue of high, as well as increasing, volume of mental health calls. For instance, one article informs readers that mental health calls make up more than 40% of ambulance runs,¹⁶ another that mental health calls make up the bulk of paramedic calls,¹⁷ and yet another that there is an "aspect" of mental health crisis in *every* call.¹⁸ These articles suggest that the number of mental health calls

is greater than it was in some usually undefined past, thus burdensome on paramedic services. In addition, the media refer to mental health calls as a "misuse" of the emergency medical service system.¹⁶ They argue that these calls pull resources away from other emergencies, and that at any rate paramedic services are not the appropriate resource to address these calls.¹⁹

Another recurring theme is the need for more and better mental health training for paramedics. Indeed, paramedics are said to have minimal mental health training and it is generally felt that they would benefit from more. One media article reports on a paramedic who states that much of his knowledge of managing mental health calls comes from experience on the road rather than professional training. The article also notes that most paramedic training involves physical findings on assessment, whereas physical findings are largely nonexistent in mental health calls. It therefore suggests that more mental health training may benefit the mental health of paramedics themselves as well as patients.¹⁸ Yet another news article presents the findings of a coroner's inquest that includes recommendations for additional sections on psychiatric training within the paramedic Basic Life Support Patient Care Standards manual, as well as for further training of paramedics in the use of sedatives.²⁰ Training of paramedics in basic self-defense is also deemed necessary so as to better manage aggressive patients during mental health calls.¹⁷

Yet another theme is the need for more mental health services in the community. One news article reports that the Local Health Integration Network (LHIN), a community health authority, is considering the establishment of a 24-hour crisis center for those struggling with mental health and addictions, and is also calling for more therapists.¹⁹ An article on Thunder Bay, the Canadian city with the highest number of mental health calls per capita in the province of Ontario, states that more paramedics and ambulances will not solve the problem of increasing mental health emergencies, and calls instead for a more holistic approach to the problem, as well as for greater government funding for community mental health services.¹⁶

Paramedic Services in the Academic Literature

In the academic literature, key concerns within the dominant narrative include the downplaying of the urgency of mental health issues within emergency medicine, the deinstitutionalization of mental health patients without proper compensatory community mental health services, and an (over) emphasis on biomedical, to the detriment of psychosocial, aspects of health during the training of paramedics. Thus, one discussion of predictors of demand for prehospital care notes that emergency departments do not necessarily consider mental health problems to be life-threatening

emergencies, but rather problems often related to routine (“non-urgent”) needs. It also identifies deinstitutionalization over several decades as having played a critical role in increasing mental health call volumes, by shifting patients serviced within institutions toward community settings that are ill-prepared to meet their needs.¹⁵

Other identified problems include overuse—often labeled “abuse”—of paramedic services, by patients struggling with mental health issues and improper identification and transfer to adequate services of patients with mental health issues.³ Researchers thus recommend restructuring emergency mental health care systems³ and further addressing mental health calls in the training of paramedics, an approach that the profession supports.²¹⁻²³

Last, the academic literature suggests that the increasing psychosocial component of calls requires moving beyond traditional, biomedically oriented training and assessments based largely on physical findings.¹² It also recommends that alternatively, paramedic services may consider including a social worker to address patients’ psychosocial needs so as to allow paramedics to focus on their field of expertise, that is, emergency medical care.¹⁴

What Is Missing in Dominant Approaches?

In the former sections, we have attempted to characterize the dominant narrative concerning mental health calls in paramedic services. We now move on to discuss what is missing in this narrative, what the implications of these omissions are for practice, policy, and equity in mental health, and how the paramedic profession can contribute to expanding the debate toward a greater acknowledgment of the political and social determinants of health. We begin by noting that properly addressing a greater than ordinary or desirable volume of “mental health” calls requires that we understand what constitutes a patient with “mental illness.” The terms are not explicitly defined in the literature, although without a clear understanding of what counts as health and what counts as illness, significant challenges for establishing effective and appropriate health care policy emerge.^{24,25}

The World Health Organization (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”²⁶ We would like to suggest that were the WHO to include the social, cultural, and political contexts that create inequities, this definition would lead us to question what counts as normal or abnormal states, and concomitantly what counts as normal or abnormal responses to a given set of circumstances.²⁵

This is rarely, if ever the case in debates around mental health calls in paramedic services. Put another way, it is not

asked whether the behaviors and emotional states of the protagonists of these calls are not actually *reasonable* responses to increasing social exclusion, as the neoliberal state retreats from providing more basic social services toward promoting expanding opportunities for capital accumulation.⁸ We propose that given the *already* extraordinary amount of research conducted, and understanding achieved, around the social determinants of mental health,²⁷ interrogating the nature of mental health and illness would lead us to question the labeling of at least certain individuals as suffering from “mental health” issues, or as having placed a “mental health” call. Furthermore, as mentioned earlier, the wide range of reported proportions of mental health calls in paramedic services—from as low as 5% to “a component of mental crisis on every call”¹⁹—speaks to the significant ambiguity in what constitutes a mental health call rather than a reasonable response to a stressful situation.

Questioning dominant definitions of mental illness and conceptions about the nature of mental health calls also leads us to problematize claims that these calls are a “burden” or even a “misuse” of the prehospital system.^{3,28} Such claims assume that paramedic services are not the most appropriate way to address this issue, and we agree. Our point however, again, is that construing mental health calls as a “problem” of individual patients burdening or misusing the system rather than of situational and broader processes that may be driving these calls blames the victim.²⁹ By this we mean that construing mental health calls thus draws our attention toward “mentally unhealthy” individuals, or “adequate/inadequate” paramedic services at best, and away from broader conditions and their underlying power dynamics that drive individuals’ need for assistance. Attention on individual factors affecting health reflects the concept of “lifestyle drift,” that is, the tendency of policy initiatives to refer broadly to social conditions that affect people’s lives and health yet conclude by proposing action at the level of health behaviors. The concept is readily applicable also to mental health. A focus primarily on lifestyle drift or individual behaviors draws attention away from the driving forces behind such behaviors and away from the root of the problems resulting in health inequities.^{30,31}

Yet another issue we would like to explore and problematize is the suggestion that increased mental health call volumes for paramedics should be addressed with further training^{18,20-22,32} and more and better mental health services in the community.^{3,14,16,19} Surely both suggestions are useful—all else equal. However, not everything else is equal: Further training of paramedics, or more and better community mental health services, however necessary, will do little to improve the living conditions of the increasing number of persons placing “mental health calls” when, overwhelmed by these conditions, they find nowhere else to turn to but to “emergency” medical services. In fact, interventions that fail to consider these broader, structural issues, may have unintended, undesirable consequences: Such is the case of deinstitutionalization, which led to shifting the burden of care

from institutions to families and communities.^{33,34} In sum, mental health training and community mental health services undoubtedly warrant further attention, but repeated appeals to more or better training and more or better services makes the reality of living conditions less visible and drives the search for solutions away from the policy and political levels.

Moving Beyond “Crisis” to the Political and Social Determinants of Mental Health

Evidence for the social and political determinants of health and mental health is overwhelming. It can be traced as far back as, if not earlier than, the 19th century,^{5,35} and continues to grow,³⁶⁻³⁸ even if it remains unaddressed in practice. Mental health disorders are more prevalent among individuals living in poverty, experiencing material and emotional distress in early childhood, with precarious or no employment, lacking adequate housing, and so forth.³⁹⁻⁴¹ There is little doubt that these conditions are neither “natural” nor inevitable, and that action on the social determinants of mental health improves mental health and well-being.⁴¹ When such a wide range of social conditions significantly affects mental health outcomes, health policy must engage, yet reach beyond, the health care system.³⁹ However, ideological barriers continue to place the source of distress largely or solely at the level of individuals, shifting responsibility away from social and political structures.^{10,25,42}

Extant debates around the role of paramedicine in psychosocial care and around the increase in mental health calls, in the media as well as in academia, present an ostensibly well-intentioned discourse that rightly brings attention to a growing concern within a usually neglected, and relatively new, field within the health professions: paramedicine. Yet the debates currently dominating the field draw attention away from the structural inequalities that are driving a large, and increasing, number of “mental health” or psychosocial calls, and risk framing what is a reasonable response to structural oppression as “abnormal” emotions and behaviors.²⁵ We suggest that a better approach is to engage with these broader structures and determinants affecting mental health, and work toward preventing mental health and psychosocial crises instead of reacting to them after the fact.

That being said, and having identified an increase in mental health calls in the prehospital setting, paramedics can help shed light on the living conditions and experiences generating much of this increase. Drawing on their experience as they interact with individuals in their everyday circumstances, they can join other practitioners in the critical health tradition by informing the understanding of these circumstances, and shift the conversation toward addressing their root causes. As the role and scope of practice of paramedics continue to evolve, paramedics are moving beyond acute

physical health care and have the potential to become increasingly involved in both health and social advocacy as has already begun to occur and continue to shed light on the relationship between social context and health,¹¹ including mental health. This perspective may aid in working toward problematizing claims about the “mental illness” of individuals living in poverty and other challenging circumstances so as to ensure that their distress is not decontextualized or depoliticized.

Acknowledgments

The authors wish to thank the Department of Health Policy and Management at York University, Toronto, and especially the Director of Graduate Studies, Professor Dennis Raphael, for making this collaboration possible.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

1. Bigham BL, Kennedy SM, Drenan I, Morrison LJ. Expanding paramedic scope of practice in the community: a systematic review of the literature. *Prehosp Emerg Care*. 2013;17(3):361-372.
2. Clark MJ, Purdie J, FitzGerald GJ, Bischoff NG, O'Rourke PK. Predictors of demand for emergency prehospital care: an Australian study. *Prehosp Disaster Med*. 1999;14(3):167-173.
3. Larkin GL, Claassen CA, Pelletier AJ, Camargo CA Jr. National study of ambulance transports to United States Emergency Departments: importance of mental health problems. *Prehosp Disaster Med*. 2006;21(2):82-90.
4. Chaufan C, Yeh J, Ross L, Fox P. You can't walk or bike yourself out of the health effects of poverty: active school transport, child obesity, and blind spots in the public health literature. *Crit Publ Health*. 2015;25(1):32-47.
5. Chaufan C, Weitz R. The elephant in the room: the invisibility of poverty in research on Type 2 diabetes. *Humanit Soc*. 2009;33(1-2):74-98.
6. Yu V, Raphael D. Identifying and addressing the social determinants of the incidence and successful management of Type 2 diabetes mellitus in Canada. *C J Public Health*. 2004;95(5):366-368.
7. Raphael D, Farrel E. Beyond medicine and lifestyle: addressing the societal determinants of cardiovascular disease in North America. *Leader Health Serv*. 2002;15(4):1-5.
8. Navarro V. Neoliberalism as a class ideology; or, the political causes of the growth of inequalities. *Int J Health Serv*. 2007;37(1):47-62.
9. Waitzkin H. The social origins of illness: a neglected history. *Int J Health Serv*. 1981;11(1):77-103.
10. Van Dijk T. Principles of critical discourse analysis. *Discourse Soc*. 1993;4(2):249-283.

11. Tavares M, Bowles R, Donelon B. Informing a Canadian paramedic profile: framing concepts, roles and crosscutting themes. *BMC Health Serv Res*. 2016;16:477.
12. Brady M. Pre-hospital psychosocial care: changing attitudes. *J Paramed Pract*. 2012;4(9):516-525.
13. Allen M, Allen J, Hogarth S, Marmot M. *Working for Health Equity: The Role of Health Professionals*. UCL Institute of Health Equity. March 2013. www.instituteoftheequity.org/projects/working-for-health-equity-the-role-of-health-professionals. Accessed December 15, 2015.
14. Campbell H, Rasmussen B. Riding third: social work in ambulance work. *Health Soc Work*. 2012;37(2):90-97.
15. Knowlton A, Weir BW, Hughes BS, et al. Patient demographic and health factors associated with frequent use of emergency medical services in a midsized city. *Acad Emerg Med*. 2013;20(11):1101-1111.
16. Porter J. EMS workers overloaded with mental health, addictions calls. *CBC News*. July 6, 2012. <http://www.cbc.ca/news/canada/thunder-bay/ems-workers-overloaded-with-mental-health-addictions-calls-1.1171833>. Accessed December 15, 2015.
17. Vandonk T. Peterborough paramedics experiencing an increase of mental health calls. *MyKawartha News*. November 14, 2014. <http://www.mykawartha.com/news-story/5025248-peterborough-paramedics-experiencing-an-increase-of-mental-health-calls/>. Accessed December 15, 2015.
18. Sollows E. Paramedics may be lacking mental health training. *UNews*. February 5, 2015. <http://unews.ca/paramedics-may-be-lacking-mental-health-training/>. Accessed December 15, 2015.
19. Few options for those dealing with mental health crisis. *CTV News London*. March 25, 2015. <http://london.ctvnews.ca/few-options-for-those-dealing-with-mental-health-crisis-1.2297451>. Accessed December 15, 2015.
20. Give paramedics psychiatric training: coroner's jury. *Ottawa Citizen*. November 8, 2007. http://www.canada.com/story.html?id=2de9be73-d834-42fc-ad40-6d1bf84bf543#__federated=1. Accessed December 15, 2015.
21. Roberts L, Henderson J. Paramedic perceptions of their role, education, training and working relationships when attending cases of mental illness. *J Emerg Prim Health Care*. 2009;7(3):1-16.
22. Shaban R. Accounting for assessments of mental illness in paramedic practice: a new theoretical framework. *J Emerg Prim Health Care*. 2005;3(3):1-10.
23. Shaban R. Paramedics and the mentally ill. In: Grbich C, O'Meara P, eds. *Paramedics in Australia: Contemporary Challenges*. Sydney, Australia: Pearson Education; 2009:1-15.
24. Kelman S. The social nature of the definition problem in health. *Int J Health Serv*. 1975;5(4):625-642.
25. Ratner C. Pathological normalcy: a construct for comprehending and overcoming psychological aspects of alienation. *Humanist Psychol*. 2014;42(3):298-303.
26. World Health Organization (WHO). *Mental Health: A State of Well-Being*. http://www.who.int/features/factfiles/mental_health/en/. Published August 2014. Accessed December 15, 2015.
27. World Health Organization (WHO). *Mental Health Evidence and Research (MER)*. Date unknown. http://www.who.int/mental_health/evidence/en/. Accessed August 10, 2016.
28. Cuddeback G, Patterson PD, Moore CG, Brice JH. Utilization of emergency medical transports and hospital admissions among persons with behavioral health conditions. *Psychiatr Serv*. 2010;61(4):412-415.
29. Ryan W. *Blaming the Victim*. New York, NY: Pantheon Books; 1971:574-583.
30. Popay J, Whitehead M, Hunter D. Injustice is killing people on a large scale—but what is to be done about it? *J Public Health*. 2010;32(2):148-149.
31. Marmot M, Allen J. Social determinants of health equity. *Am J Public Health*. 2014;104(suppl 4):S517-S519.
32. Shaban R. Mental health and mental illness in paramedic practice: a warrant for research and inquiry into accounts of paramedic clinical judgment and decision-making. *J Emerg Prim Health Care*. 2004;2(3):3-4.
33. Simmons H. *Unbalanced: Mental Health Policy in Ontario, 1930-1989*. Toronto, Ontario, Canada: Wall & Tompkins; 1990.
34. Hartford K, Schrecker T, Wiktorowicz M, Hock J, Sharp C. Four decades of mental health policy in Ontario, Canada. *Adm Policy Ment Health*. 2010;31(1):65-73.
35. Waitzkin H. The social origins of illness: a neglected history. *Int J Health Serv*. 1981;11(1):77-103.
36. Marmot M, Wilkinson R. *Social Determinants of Health*. Oxford, England: Oxford University Press; 2005.
37. Navarro V. What we mean by the social determinants of health. *Int J Health Serv*. 2009;39(3):423-441.
38. Raphael D. *Social Determinants of Health*. Toronto, Ontario, Canada: Canadian Scholar's Press; 2009.
39. Fisher M, Baum F. The social determinants of mental health: implications for research and health promotion. *Aust N Z J Psychiatry*. 2010;44(12):1057-1063.
40. Mikkonen J, Raphael D. *Social Determinants of Health: The Canadian Facts*. <http://www.thecanadianfacts.org/>. Published May 2010. Accessed December 15, 2015.
41. Allen J, Balfour R, Bell R, Marmot M. Social determinants of mental health. *Int Rev Psychiatry*. 2014;26(4):392-407.
42. Raphael D, Brassolotto J, Baldeo N. Ideological and organizational components of differing public health strategies for addressing the social determinants of health. *Health Promot Int*. 2015;30(4):855-867.