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Crisis Services: Addressing Unique Needs of Diverse Populations

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CRISIS SERVICES: ADDRESSING UNIQUE NEEDS OF DIVERSE POPULATIONS

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CRISIS SERVICES: ADDRESSING UNIQUE NEEDS OF DIVERSE POPULATIONS

Executive Summary

Crisis services constitute an array of activities, from phone or text lines to crisis assessment centers outside of emergency rooms and include emergency services embedded in more traditional hospital and emergency department settings. These services employ and treat a diverse population with unique individual needs that warrant consideration. The Substance Abuse and Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit issued in early 2020 calls for crisis services to be ready to serve anyone who needs the services. The National Association of State Mental Health Program Directors (NASMHPD) has focused its technical assistance papers in 2020 on crisis services and has similarly called attention to critical issues related to access to care for diverse populations encountering crisis services.

As crisis services receive increased attention and expand, considerations for diversity among populations served and among the workforce needs to be at the forefront of the minds of program leaders and policy makers. Although most crisis services treat adults ranging from 18 to 65 years of age, youth and older adults frequently present in crisis settings. Additionally, individuals with neurodevelopmental disabilities, complex and co-occurring substance use and medical conditions, and other characteristics must also navigate the crisis mental health and substance use system. Racial, ethnic, and sexual minorities experience barriers to mental health and substance use care in crisis settings just as they do in their daily lives. Structural racism, discrimination, stigma, and racialized legal statuses including criminal justice involvement and immigration also require special consideration. With the lens of experience during the COVID-19 pandemic, these issues have been further highlighted.

This paper discusses the considerations, challenges, and implications of treating these diverse populations in any of the varied crisis settings. Although each population is discussed in turn, owing to the complexity of such population health perspectives, this paper also considers intersectionality in these diverse populations. Older adults from racially and ethnically oppressed groups, younger adults with intellectual and developmental disabilities, and immigrant groups with language barriers are some of the ways in which these intersecting identities pose unique challenges for ensuring a robust and comprehensive crisis services system that continues to promote equity and quality care to all individuals in a person-centered manner. With that in mind, the following recommendations stem from this paper's review of extant literature and practices related to crisis services and the vision for what is needed in the future.

Recommendations

Recommendation #1: Community stakeholders providing crisis services must be familiar with available funding mechanisms to access appropriate financial, clinical, and material resources to

support a diverse mental health workforce and unique patient populations with psychiatric needs.

Recommendation #2: Crisis services must employ a systems-based approach to focus on early intervention with individuals of all ages, including youth at risk of mental health crises and older adults. Services must be available at every level of the crisis system in order to support youth in school, community, residential, or hospital settings, while simultaneously considering the multiple complex needs including coordination with referring programs and facilities for older adult populations. This approach to individuals across the lifespan should have as a goal to minimize the crisis, prevent suicide and other negative outcomes and link individuals to other care as needed.

Recommendation #3: Clinicians may provide more culturally competent care by demonstrating an awareness of historical trauma in racial, ethnic and experiential minority populations. By encouraging patients' narratives in crisis settings, clinicians may foster a welcoming and supportive environment for patients from historically marginalized communities.

Recommendation #4: Clinicians should consider mental health stigma in communities of color, while identifying and addressing barriers to psychiatric care for racially and ethnically oppressed persons. Stigma remains high in many communities of color. A biopsychosocial approach to assessment and treatment that explores the roles of family, culture and religious beliefs may be helpful in addressing barriers to mental health services.

Recommendation #5: Crisis services should be familiar with their state's immigration policies and available systems of support and potential funding mechanisms to promote the health of undocumented persons with mental illness and substance use challenges. This includes addressing undocumented persons' fears about their legal status and the institutions duty to privacy and confidentiality under state and federal guidelines.

Recommendation #6: Clinicians providing crisis services should consider sexual identity as part of their biopsychosocial assessment in order to provide equitable treatment for a diverse population and understand personal narratives.

Recommendation #7: Clinical examination should include a broad assessment of individuals' functional strengths and limitations to provide individualized person-centered treatment.

Recommendation #8: A biopsychosocial approach is essential in determining the appropriate treatment for persons with complex needs who present in crisis. This includes consideration of how staff and physical environments may provide healing and supportive environments for persons with intellectual and developmental disabilities.

Recommendation #9: Crisis services must collaborate with community stakeholders to ensure early intervention for individuals with mental health and substance use needs and those at risk of suicide. These partnerships may help divert emergency department visits, focus on preventive and lifesaving care, and build alliances with other stakeholders.

Recommendation #10: Crisis mental health systems must assess for underlying medical comorbidities, and take lessons learned from the COVID-19 pandemic to ensure individuals served receive adequate treatment and medical care when needed, and collaborate with vulnerable patients' families, healthcare providers, and other support systems to provide appropriate care. In this way, as part of the continuum of care, crisis services should partner with local medical systems and vice versa to help patients access the best door to care as needed.

Recommendation #11: In order to account for the various structural barriers to accessing services, crisis mental health systems should emphasize the unique needs and differences among diverse populations to encourage individuals to engage in care, even as structural barriers may otherwise limit their access to such care.

Crisis Services: Addressing Unique Needs of Diverse Populations

Introduction

Over 55 million Americans suffer from mental health or substance use disorders in the United States and account for nearly 10 million hospitalizations annually.[1] Of the many types of crisis mental health services, emergency psychiatric hospitalization represents the highest level of clinical care for individuals with acute mental health needs. In 2017, the National Association of State Mental Health Program Directors called for the need to look "Beyond Beds" and consider an array of services across a continuum of psychiatric care to meet the needs of individuals with mental health conditions, including an examination of the crisis services continuum.[2] The previous policy efforts underscore the importance of providing a robust mental health system, from adequate psychiatric bed availability and mental health workforce to criminal justice system diversion and public policy changes.[3]

In recent years, communities have established and utilized a broad range of crisis services such as walk-in and free community clinics, crisis line telephone and texting services, mobile treatment centers, crisis stabilization units, observation, crisis residential services, and hospitalization. The Substance Abuse and Mental Health Services Administration introduced in early 2020 the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, in which it is articulated that crisis services must be available for anyone, anywhere, anytime.[4] This means that such crisis services must address the needs of a large, diverse, and growing population. Individuals with complex care needs, including older adults, those with intellectual and developmental disorders (IDD), dementia and neurocognitive disorders, co-occurring medical and physical issues, and even infectious diseases as highlighted in the COVID-19 context, all can present themselves for crisis services. These individuals represent particularly vulnerable populations in the mental health system. Here we discuss the unique challenges and considerations for ensuring equity in providing crisis services for diverse populations in crisis mental health care.

As with any health care service—from primary care to advanced specialty care—person-centered care is critical to address the unique challenges of meeting complex care needs. To provide effective individualized treatments, mental health clinicians must (a) recognize the characteristic signs, symptoms and natural history of psychiatric illness; (b) appreciate the diversity of psychological differences among individuals across mental disorders; (c) account for the range of behaviors among individuals; (d) and understand how individuals' trauma and life-stories influence their illness experience and expression.[5] By appreciating these perspectives in all mental health services, the mental health and substance use systems may better provide evidence-supported treatments alongside psychosocial interventions that account for patients' unique genetic, behavioral, and environmental characteristics.

Special Age-cohort Populations in Crisis Settings

Youth, Children and Younger adults

Crisis services are a "continuum of services" provided to individuals experiencing psychological distress across the life-course.[6] Crisis mental health systems, however, are most adept at delivering services to adults between the ages of 18 and 65. There are unique challenges for community health systems caring for younger children and older populations requiring crisis services.

There is a growing number of children seeking psychiatric emergency care in the United States.[7] Although the details of child and adolescent crisis services is beyond the scope of this paper, it is important to highlight that although many communities may have robust crisis systems for adults, they may be less likely to have well-developed systems that meet the needs of a growing pediatric population.[8] Like adults, children may exhibit symptoms of psychological distress, including suicidal ideation, mood disorders, behavioral changes, and the effects of substance use. Because of this growing need, communities and stakeholders must have a vested interest in expanding the range of crisis services to provide the most appropriate level and type of care[9] for youth in crisis. Studies suggest that a full continuum of crisis services, including prevention, early intervention, response, and stabilization services, can divert youth from psychiatric emergency rooms, which may be associated with poorer clinical outcomes and increased cost of services.[10] Community stakeholders providing crisis services must be familiar with available funding mechanisms to appropriate financial, clinical, and material resources to support the mental health workforce and patient populations with psychiatric needs. Knowledge of available resources, which include funding, community partners, schools, and referring institutions, is essential in ensuring a robust crisis services system for children and younger adults. Sharon Hoover and Jeff Bostic[11] have provided a more detailed review about crisis services for children and adolescents.

Older Adult Populations

There is also a large and growing older adult population in the United States. Older adults over the age of 65 are expected to account for 1 out of every five[12] individuals in the United States by 2030. For mental health services, there is an expected two-fold increase in geriatric patients with mental health disorders.[13] Despite this increase in the elderly population,

geriatric populations have a disproportionately low rate of utilization of mental health and crisis resources. Older adult patients with mental health diagnoses such as schizophrenia are particularly underrepresented among individuals utilizing public mental health systems.[14] Some of this may relate to funding, policy and program architecture. This is especially true for many individuals who first present with mental health symptoms in their older years but may already be in care for medical conditions, as opposed to older adults who "grew up" in the public mental health system.

The American Association of Geriatric Psychiatry has characterized the shortage of geriatric mental health specialists as "a national crisis".[15] Older adults often have more complicated mood and affective disorders and are more likely to have comorbid medical and psychiatric illnesses that require careful coordination with other medical providers. Older individuals with chronic mental illness may also be less likely to achieve full symptom remission early in treatment.[16] Moreover, they may require combinations of medications and other therapies that increase other risks such as drug interactions, shifts in mood states, or the risk of development of conditions like delirium or other medical complications.[17] Suicide rates are highest among white males[18] with increased risk among older adults with concomitant physical illness.[19] Substance use significantly increases the risk of morbidity and mortality, with a two-fold increase in the risk of suicide among older adults with dual diagnoses.[20] Rural and unmarried elder persons may be particularly less likely to utilize crisis services.[21] Despite these complex treatment and demographic considerations, treatment of older adults may be associated with low reimbursement rates for clinicians, creating a paradox that imposes additional barriers to accessing mental health care in the community. As crisis services expand across the country, it will be important to identify the unique needs of the older adult population and address barriers to their use of crisis services.

Older adults tend to have higher medical complexity than younger patients.[22] It can be challenging to distinguish medical symptoms from psychiatric symptoms in this complex population. Comorbid physical conditions may be more prominent than underlying psychiatric symptoms in geriatric populations. These medical comorbidities also lead to higher risks related to polypharmacy, which may contribute to worsening medical and psychiatric symptoms, especially in geriatric populations. In treating mental health disorders among geriatric populations, clinicians must also focus on the "competing demands" of underlying medical comorbidities that may simultaneously erect barriers to psychiatric treatment.[23] Comorbidities may include diabetes, hypertension, obstructive and other respiratory illness, cardiovascular diseases, cancer, immunologic and rheumatologic conditions, chronic pain, as well as vision and hearing deficits, to name a few. These conditions may require more coordination and accommodations to ensure individuals have access to their physical aids for ambulation, equipment, medications, and other supplies necessary to support the individuals with these conditions.

Additionally, in the array of crisis services where individuals spend time (as opposed to text lines or phone lines), regulatory requirements include minimum standards for patient census, safety, staffing, training, and medical personnel. There may be increased licensing requirements to provide services for older adult populations, with many of the facilities limiting

treatment to patients who can attend to their own basic needs. Thus, functional impairment in activities of daily living and self-care, which is often more prevalent among geriatric populations, is an additional barrier to eligibility and access to crisis services. This is especially true if the crisis service is outside of a more traditional medical setting. Given these considerations may pose barriers to caring for aging populations frequently need additional medical services (e.g., care for medical, psychiatric, cognitive, and physical impairment), the current mental health system must continue to develop social and structural interventions that ensure access to high-quality crisis services to all individuals across the life course.

Older persons are considered a protected population and may require additional psychosocial support and case management needs. The increased vulnerability of elderly patients to undue influence and abuse may be due to the physical and cognitive changes associated with late-life. Elder abuse affects over 4.3 million persons each year and accounts for an estimated $36 billion in losses to elderly individuals.[24] Moreover, studies suggest an "iceberg" effect, where the number of actual cases is likely higher than reported cases.[25] [26] Older individuals are at increased risk of physical and sexual abuse, neglect, and financial and material exploitation by strangers and individuals in positions of trust.[27] [28] [29] [30] [31] Crisis mental health systems must be prepared to not only recognize the warning signs of different types of abuse but also be equipped to take the necessary steps to appropriately identify, support, reduce, and mitigate these issues. Minimally staffed crisis services serving more acute psychiatric patient populations may be less able to care for this population without further education, training and guidance. As crisis services evolve, careful collaboration with referring facilities to coordinate care during treatment and upon discharge will be essential for ensuring elderly patients receive appropriate care upon recovery.

Racially, Ethnically, and Experientially Diverse Populations in Crisis Settings

Racially and Ethnically Diverse Populations

To date, barriers to access to care for racially and ethnically diverse populations has been a major concern.[32] [33] [34] [35] [36] Disparities in health care resources and outcomes among these populations create and maintain racial inequities in mental health care. For example, African American men are more likely to be diagnosed with personality disorders such as antisocial personality disorder despite evidence that the incidence of these disorders is relatively consistent across populations.[37] Black men are 13 times more likely to be routed to the criminal justice system for substance use issues than the general population, contributing to increased criminalization of mental illness and substance use particularly among oppressed populations.[38] Black youth are 2.5 times more likely to be diagnosed with conduct disorder and five times more likely to be diagnosed with adjustment disorder than ADHD compared to their white counterparts.[39] These disparities may influence whether patients receive behavioral, pharmacotherapy, or are routed to criminal/juvenile legal systems.[40] Disparities in mental health outcomes in other population such as American Indians and Native Alaskans, are also well-documented.[41] Thus, blacks and other minority or non-dominant populations may receive

inappropriate treatments when presenting in crisis, further contributing to disparate health and social outcomes.

Indeed, in nearly every domain heretofore discussed (i.e., youth, geriatric, intellectually challenged, dual diagnosis, persons with disabilities, or the medically complex), racially and ethnically oppressed identifying persons face increased barriers to mental health and substance use services with consequent poorer health care outcomes. Black youth are less likely to seek care or be referred to psychiatric care.[42] They receive suboptimal therapeutic and psychopharmacological treatments compared to their white counterparts.[43] The cumulative disadvantage of race in healthcare operates in tandem with other structural barriers to care, which dramatically limits the health outcomes for racially and ethnically oppressed youth, elderly, IDD, and medically complex patients.

As the current data is equivocal on the relative estimates of health services utilization among racial and ethnic subpopulations, further research is needed to fully understand use patterns across populations. Although African Americans face several barriers to mental health care, some studies estimate that they are half as likely to utilize professional mental health services[44] [45] irrespective of differences in class or access to resources. Some studies suggest that stigma, reduced access to care and family structure may explain the underutilization of mental health resources, while others suggest that discrimination and implicit bias may be at play. In a recent audit study, middle-class black clients were "considerably less likely than whites to be offered an appointment" for psychotherapy and psychological services compared to their white counterparts.[46] Such barriers to regular care may account for emergency and crisis mental health services utilization among African Americans.[47]

A legacy of abuse and exploitation in medicine may also contribute to distrust in the health care system.[48] [49] [50] Physicians and clinicians who demonstrate an awareness of such historical trauma while encouraging patients' narratives are more likely to provide culturally competent care and engage effectively with these patients, particularly in crisis settings.[51] [52] [53] Clinicians must try to understand how cultural differences in stigma, religion, coping styles, mistrust of the medical system, and family[54] [55] [56] influence the willingness of oppressed populations to seek mental health resources. These differences may explain why African Americans are more likely to find care from general physicians or religious figures.[57] Still, the evolution of more racially and ethnically conscious approaches to care may allow for expansion of more adept and racially-attuned crisis services. Indeed, there are opportunities to consider early examples of successful approaches to crisis services. For example, some researchers have found considerable success in "comprehensive, community-based, mobile-crisis intervention[s]" among indigent African American populations.[58] Clinicians should identify and address barriers that prevent racially and oppressed persons from accessing and benefitting from psychiatric care. Stigma remains high in many communities of color. A biopsychosocial approach to assessment and treatment, including social and religious history, may be helpful in addressing barriers and stigma related to mental health services.

Immigrant Populations

Racialized legal status is an under-recognized social determinant of health.[59] Immigrants and undocumented persons comprise a vulnerable population that often appears in crisis mental health settings. Certainly, not all immigrants are treated similarly. Immigrants' health status varies by ethnicity and citizenship, with undocumented immigrants experiencing a higher risk of affective and other mental health disorders.[60] These outcomes may reflect social and political stressors, decreased access to health care, and fears of deportation. Moreover, fears of legal consequences have both direct and indirect effects on immigrant health status: undocumented individuals are at increased risk of affective disorders and are less likely to interface with the health system if they feel their family's legal status may be criminalized.[61] Just as funding varies by state, exclusionary immigration policies that erect additional barriers for immigrants seeking mental health and crisis services may also vary across states.[62] Undocumented persons may fear involvement with the health system due to fears of detainment and deportation. Thus, when an acute mental health situation erupts, it is likely that individuals would be brought into contact with the crisis service system.

Even among immigrants and undocumented persons who seek access to care, mental health services are generally underfunded in the United States. In addition to reluctance to access traditional healthcare services of immigrants, undocumented immigrants have historically been ineligible for federal benefits and resources at the state and national level. There may be little to no funds earmarked for undocumented persons. At the federal level, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 further limited access to public health insurance and social resources for legal immigrants with fewer than five years of US residence.[63] Although the CHIP Reauthorization Act of 2009 allowed some states to extend benefits to legal immigrant children, the Affordable Care Act of 2010 continued the 5-year waiting period imposed in prior policies for legal immigrants. Although immigrants and undocumented persons may receive emergency care and some additional services through Medicaid, state and federal laws might create "perverse incentives" that favor acute care in emergency departments over providing crisis services in less acute settings.[64] Undocumented persons may benefit from unrestricted funding mechanisms, such as California's Short-Doyle Act of 1967[65] and other unrestricted state and local funds and safety-net programs. Crisis services should become familiar with their state's immigration policies and identify and utilize available funding mechanisms to promote the health of undocumented persons with mental illness. Moreover, they should address undocumented patients' fears about their legal status and protect patient's privacy and confidentiality under state and federal guidelines, given that individuals in crisis care may be concerned about a host of legal repercussions for a variety of reasons.

Linguistic Diversity

Lack of language concordance can present another potential barrier to accessing crisis services. In order for a crisis system to function as intended, meeting the unique needs of individuals across various community settings, demographics, clinical needs, and other contexts, it must be able to communicate effectively with the populations that seek crisis support. As with any hospital, clinic, or other healthcare facility, crisis programs along the crisis

continuum should be accessible to individuals who may not speak the dominant language of the region. Moreover, various states and jurisdictions have enacted policies that require healthcare facilities to provide translation services for threshold languages. In California, for example, threshold languages are defined as languages spoken by 3,000 individuals within a county or that comprise at least 5% of the spoken languages in that locale.[66] [67] Threshold languages typically vary by region, and include Spanish, Russian, Vietnamese,[68] Mandarin Chinese, Vietnamese, Korean, Tagalog, Russian, Arabic, Farsi, Hmong, and others. Although these may be encompassed in legally mandated requirements, as noted in the SAMHSA guidance, a robust crisis system should strive to meet the basic needs of all of its constituents in order to serve anyone who accesses these services.[69] These minimum requirements are also federally mandated for many facilities; the Civil Rights Act of 1964 requires federally-funded facilities to provide linguistic services, whether in-person or remote aids, to its constituents.[70] Nevertheless, these policies may not be frequently enforced and represent only a minimum requirement. As a true crisis system must meaningfully respond to the needs of its community, all crisis systems arguably must be able to provide culturally competent care and interpreter services. This should be available to facilitate care for individuals across the continuum of crisis services.

Sexual Minorities

Experiential minorities, including individuals who identify as lesbian, gay, bisexual, transgender, queer, asexual, intersex, and non-binary individuals (LGBTQAI2+) or other sexual minorities also face unique challenges navigating crisis and non-crisis settings. Existing data has not yet included these various identities, yet it does point to concerning trends that are relevant to crisis contexts. For example, LGBT populations are more likely to suffer from affective, anxiety, and substance use challenges than the heterosexual population (49) and approximately twice as likely to attempt suicide.[71] Actual suicide rates for LGBTQAI2+-identifying individuals are not available given sexual orientation is not reported at death,[72] but studies suggest that sexual minorities are four to six times more likely to attempt suicide resulting in injury that requires medical treatment.[73]

LGBTQ-identifying individuals may face overt and implicit discrimination based on their sexual identity including discrimination in the clinical setting.[74] There may be additional concerns about safety and privacy for sexual minorities in crisis residential settings, issues which remain difficult to fully assess given the extent of variation across systems and institutions. Nevertheless, research suggests that crisis services tailored to LGBT populations may help mitigate suicidal behavior[75] and other symptoms. Clinicians and health systems should consider sexual identity as part of their biopsychosocial assessment in order to address the needs of this diverse population, improve access to care for experientially oppressed persons, and provide equitable treatment for a diverse population of individuals in need of crisis services.

Persons with Neurodevelopmental Disorders in Crisis Settings

Intellectual developmental disorder (IDD) encompasses a spectrum of disorders that limit intellectual functioning such as reasoning, learning, and integration (e.g., problem-solving), and adaptive behavior (conceptual, social and practical skills).[76] Autism spectrum disorder is one of the most common neurodevelopmental disorders, characterized by impairments in social communication, restricted and repetitive behaviors, and abnormal language development and ability, and may or may not be accompanied by intellectual developmental disorder. Neurodevelopmental disorders frequently co-occur with mental health disorders.

Psychiatric disorders such as major depressive disorder, bipolar disorder, and neurocognitive disorders may be three to four times more prevalent in the IDD population.[77] Individuals with autism spectrum disorders are at an increased risk of presenting with psychiatric emergencies.[78] Moreover, while inadequate bed availability has led to prolonged boarding times and delays in care for many individuals with mental illness,[79] individuals with IDD are at increased risk of longer emergency department boarding times.[80] Individuals with IDDs often have more varied and complex presentations when compared to the general population. Individuals with deficits in communication may have anxiety, mood, or psychotic experiences that manifest in aggressive, externalizing, or disruptive behaviors that may be poorly understood when presenting to crisis service providers less familiar with these underlying conditions or the individuals themselves. Deaf and other hard of hearing individuals also face additional barriers to crisis care and may be misdiagnosed as having intellectual or developmental disabilities.[81]

Given the rate of psychiatric comorbidities in the IDD population and the eligibility restrictions for developmental disability services (these state agencies have different names in different states), persons with IDD may also be inappropriately referred for psychiatric treatment.[82] In these cases, psychiatric treatments for functional or adaptive behaviors where there is no mental illness may be ineffective at best and potentially harmful at worst. However, cognitive symptoms may often overshadow psychiatric symptoms among IDD populations presenting for crisis services, especially among individuals with a more severe cognitive disability. Individuals with more significant cognitive symptoms may be less adept at communicating the burden of their affective and psychotic symptoms, leading to crisis assessments that may not fully capture symptom severity.[83] Individuals with mild intellectual disabilities may often display a "cloak of competence," demonstrating functional and adaptive skills that may mask underlying cognitive and psychiatric impairment.[84] Crisis services must work with community mental health providers to create partnerships that divert emergency department (ED) visits, enable other care providers to recognize and intervene in crises, and build alliances with school systems.[85]

Additionally, individuals with IDD may be particularly vulnerable to psychosocial stressors.[86] For example, self-injury may be a symptom of a psychiatric disorder or functional behavior in individuals with IDD to communicate pain, discomfort, and unhappiness. Similarly, aggressive behaviors may result from disinhibition that is seen in many psychiatric disorders or "escape-avoidance" behaviors commonly used in IDD populations to avoid activity.[87] In delivering crisis services, it is important to differentiate whether behaviors in individuals are

employed to serve a purpose (i.e., functional) or are the result of some interactional environment and processing component. For example, environmental stimuli may include lighting, small spaces, and noise. Crisis services, which often treat patients with acute mental health needs, may be particularly overstimulating for this population. Additionally, since often behavior is the focus of attention for individuals with neurodevelopmental disorders, underlying mental health and medical conditions may be overlooked. Thus, clinicians' psychiatric evaluations should include a broad assessment of individuals' functional strengths and limitations to provide individualized patient-focused treatment.[88] A biopsychosocial approach is essential in determining the appropriate treatment for patients with complex needs. Crisis services must provide healing environments with appropriately trained staff to meet the needs of patients with IDD.

Many individuals with IDD may not be embedded in the systems designed to address their unique needs. Because of system structure and funding streams, individuals with mild to moderate disability, or disabilities that developed after adulthood, may not meet eligibility criteria for state developmental disability services, yet they are still likely to require psychiatric consultation and emergency services.[89] Given these trends, it is not surprising that individuals with IDD are more likely to use psychiatric emergency services compared to the general population,[90] and could benefit from an expanded crisis service continuum that is adept at understanding their needs.

Medically Complex Care in Crisis Settings

Underlying medical illnesses are common among persons with serious mental illness. This well-known fact—that persons with mental illness are likely to have other preexisting medical conditions— likely contributes to the higher risk of death from chronic disease in individuals with chronic persistent mental illness. In fact, individuals with serious mental illness die 8-25 years earlier than the general population.[91] The causes of these deaths are linked to accidents, homicide, suicide, and the increased burden of physical and medical illnesses.[92] Also, persons presenting in crisis may present with depressed or elevated mood, changes in energy and motivation, impulsivity, agitation, and cognition. Cognitive changes are often the most difficult to assess and diagnose, and may arise from medical, neurologic, and psychiatric conditions including substance use disorders and normal age-related changes. Medical causes may include metabolic deficiencies such as hypoglycemia, thyroid disease, or electrolyte abnormalities, as well as trauma, epilepsy, and delirium, acute intoxication or substance withdrawal, to name a few. Altered mental status may include agitation, disinhibition, and psychosis from underlying psychiatric conditions, neurocognitive disorders, toxic metabolic causes, or medical conditions.

One challenge faced by individuals with complex medical needs is that crisis services such as residential and crisis stabilization units may restrict admission to them. Depending on the placement, an individual may be required to be "medically stable" or "medically clear" before admission. This status may be assessed by a recent history and physical exam, laboratory and imaging tests, documentation excluding infectious or communicable diseases (see below for more on this), and an assessment of the individual's physical ability or

limitations. Persons must generally be able to move about independently (even with a wheelchair) and able to feed, groom, and care for themselves. These requirements are usually based on the limitations of crisis services in providing higher levels of medical care. These limitations can pose considerable barriers to access of crisis services for elderly, persons with chronic co-occurring psychiatric and medical conditions, complex substance use disorders, or disabled patients, as noted above, which often leaves these populations to have their mental health needs addressed within emergency rooms when that level of care for their mental health situation, or their medical situation, is not be needed.

Although crisis mental health and substance use services treat patients with a range of the above-mentioned acute psychiatric issues, many states require ambulances to deliver patients to hospital emergency departments for reimbursement as an "emergency", and often crisis services, such as crisis stabilization and crisis drop-off as well as crisis residential programs do not directly accept patients transported by ambulance for an emergency. Ensuring that individuals access the best door to care that is needed makes this an area ripe for further development. Consensus statements and state efforts have been established that help outline a common understanding of medical clearance as a way to manage some of the tensions and limit delays that can arise in this interface.[93] [94] [95] These protocols can help delineate more clearly whether medical screening has been sufficient to allow for access to a crisis service especially after such screening in a hospital emergency department. They can also help minimize the risk of missing a critical underlying medical concern. Given the important balance to ensure proper safeguards for well-being of crisis service recipients, the interface with medical systems and the partnerships between crisis systems and medical systems is critical. Rather than operate totally in parallel, these partnerships should be established in intentional ways to help people access the best door to care as needed.

Infectious Diseases in Crisis Settings with Lessons Learned from COVID-19

Crisis services provide care for patients with increased risks of transmission of infectious and communicable diseases. Many individuals with severe persistent mental illness and serious substance use disorders are un-domiciled, may live in congregate living environments, residential settings, board and care facilities, multiple unit dwellings, dormitories, and other arrangements that may bring them into close contact with other individuals with high-risk for communicable disease. Moreover, mental health and substance use care is often provided in shared spaces and groups that bring individuals in close proximity. While the global spread of the coronavirus disease 2019 (COVID-19) arising from severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has changed the landscape for all types and levels of medical care, its effect on mental health and substance use services has been dramatic.[96] Crisis services sites and even mobile crisis services vary widely in their funding, specific practices, state and local restrictions, and access to resources and supplies needed to provide infection-related safe care and limit the spread of communicable disease.

In general, crisis services must meet various Food and Drug Administration (FDA), Occupational Safety and Health Administration (OSHA), Centers for Disease Control and

Prevention (CDC), and other regulatory requirements and local and institutional policies regarding infection control. They must also be prepared as a critical part of a community's disaster response to help address the emotional needs of individuals who are dealing with trauma, shifting economics, substance use and a host of other factors. Yet the COVID-19 pandemic created an urgent need to re-tool practices to meet these requirements.

The care provided throughout behavioral health systems including crisis services has undergone dramatic shift in the context of COVID-19, with telecare becoming more widely used. Physical distancing is endorsed when care via video or telephonic interface can be provided safely and effectively. Strategies for acute psychiatric bed availability have ranged from reduced census levels to minimize the number of potential exposures to allocating beds for general medical use to meet the demands of potential surges in infections.[97]

With regard to infection control, residential based facilities have long required screening documentation for tuberculosis. Now, more work will need to be added related to management of other infectious conditions. Given frequently evolving standards and requirements, the challenge of meeting new standards will require adapting to new information resulting in shifting expectations. These include identifying the types of resources needed and available, including sanitation practices and supplies, personal protective equipment (PPE), testing and laboratory access, and other materials.

The lessons of COVID-19 are many, and highlight the social, structural and infrastructural inequalities in various health systems. Many underfunded, understaffed and overtaxed systems have had difficulty providing services with greater need despite fewer resources. The burden of physical illness has had a disproportionate impact on ethically and racially oppressed persons, who as have been discussed earlier, face a number of barriers and systemic disadvantages when navigating the mental health care system. Perhaps more importantly, the health system's challenges in mounting a timely and effective response highlighted the vulnerabilities in behavioral health systems including crisis services. Logistical challenges in managing COVID-19 in settings that were not as readily geared toward infectious disease spread prevention, as well as persistent disparities in access to resources and health outcomes raised increased awareness of the community. Through advocacy and leadership, state and local behavioral health leaders have been able to respond to evolving trends in these areas. As crisis services develop, their ability to nimbly continue to operate, to use tele-practices as appropriate and still to be able to adequately assess individuals in need wherever they are will continue to be critical.[98] Crisis service supports will continue to necessitate certain instances when a face-to-face encounter is required in the crisis context, and when that happens, the providers will need to ensure proper protection from viral spread for staff and the person being assessed. As part of the care continuum, crisis services will undoubtedly continue to take lessons learned from this pandemic and apply them to the program design of the future.

Criminal and Juvenile Justice System involvement in Crisis Settings

Individuals with serious mental illness and substance use disorders are overrepresented in the criminal justice system,[99] and this is also true for the juvenile justice system.[100] Increasingly, stakeholders have advocated for addressing the under-recognized influence of underemployment and poverty, housing instability and un-domiciled status, educational, vocational attainment, residential segregation and environment mental health and criminal justice system involvement.[101]

Crisis mental health and substance use services often work alongside jail diversion programs, veterans' treatment, mental health and drug courts, and reentry programs.[102] The sequential intercept model is a framework for understanding the criminal justice system as a series of decisions, inputs, and mechanisms along a continuum of penetration into the carceral system.[103] Whereas the model generally began at intercept with individual involvement with police often leading to arrest, scholars have more recently expanded this model to advocate for earlier intervention to include intercept 0, recognizing community crisis services as critical to diverting individuals from criminal justice system involvement.[104]

Fully implementing crisis services would address many of the issues identified as needed at the intercept 0 to help route individuals of all ages into treatment in lieu of criminal-legal or juvenile justice involvement. The workforce and service design of crisis services must therefore be able to appropriately engage individuals who have been or are at risk of involvement in criminal justice and juvenile justice systems. There are numerous challenges to working across these populations.

One formidable challenge to community collaboration with these programs stems from differences in jurisdiction and funding. Jail diversion programs may be often local or county-run programs operating in conjunction with sheriffs, jails and courts. As crisis services are typically funded and regulated in a complex interplay of local, state and federal levels, they may prioritize resources differently.

Barriers to communication across prosecutorial, correctional, and criminal and mental health and substance use systems may impose additional obstacles to intervention and diversion. Individuals such as those found incompetent to stand trial are an example of a population that is often caught between these systemic issues.[105] [106] Barriers to communication and coordination has also been particularly exemplified recently during compassionate release initiatives as a result of the COVID-19 pandemic. Without careful planning for these populations, their risks related to other conditions including opioid use disorders, worsening mental health conditions as well as medical conditions could collide toward negative outcomes in the community or a return of mental health symptoms.[107] With the fear of viral exposure, many of these individuals also may not be accessing emergency or crisis services, or they will be accessing them when their needs are direr. Recent data highlighting increased opioid overdose rates[108] makes these concerns even more salient. Over time more will be learned about population outcomes as systems shifted responses to the epidemic. Still, crisis services

undoubtedly serve as the safety net for those that have been involved in, or are at risk of involvement in criminal and juvenile justice systems and thus must offer opportunities for diversion from criminal-legal involvement.

Implications and Conclusions

In summary, crisis services work with a variety of unique populations whose needs warrant consideration and planning to make these services welcoming for anyone who presents with crisis needs. Individuals with severe and persistent mental illness or those with chronic substance use disorders in crisis are only some of the populations served. Older adults, youth, individuals with neurodevelopmental disabilities, those with co-occurring complex medical conditions and others present in crisis as well. In addition, systemic issues including structural racism and developing services for vulnerable populations such as LGBTQAI2+ and immigrants must be addressed across the psychiatric care continuum including crisis services.

Although public health and community mental health systems cannot solve structural violence, poverty, and discrimination alone, crisis mental health and substance use systems need to help foster integrated systems of care that recognize these disparities and create safeguards against further perpetuating existing inequalities. As such, providers working within them must be aware of these unique threats and develop and implement strategies to mitigate the risk of worsening the risk factors that vulnerable populations already face. Finally, with the lessons learned from the COVID-19 pandemic, it is clear that crisis services will also need to be adept at dealing with infectious disease and partnerships with local health services with evolving policy and practice.

This review highlights some of the diversity reflected in populations that can present in crisis settings. A robust, comprehensive, and responsive crisis system should be equipped to address the needs of anyone who accesses it, regardless of the point of entry in the crisis continuum, and regardless of the individual's socio-economic status. Given this significant task demand, community stakeholders, mental health and substance use providers and clinicians, as well as crisis services programs must emphasize holistic person-centered care, value and prioritize health equity, protect patient autonomy, confidentiality, and preferences, and consider their community's cultural and demographic composition in providing crisis services. This requires more than understanding the social determinants of health or merely reflecting the culture of populations in services, as individuals with diverse needs often have more structural barriers that can make it more difficult to access care in mental health systems. Crisis services must not simply endeavor to provide evidence-based care using a biopsychosocial and cultural lens. In order to account for the various barriers to entry into care, crisis services should, in fact, emphasize these unique needs and differences among these populations in order to encourage individuals to engage in mental health and substance use support even as barriers may otherwise limit their access to such care. This will require partnerships and advocacy. The time is ripe to develop the crisis service continuum to meet these challenges.

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