CRISIS CARE AND SERVICE SYSTEMS PART 3: CRISIS CARE FOR VARIOUS POPULATIONS

Series Overview: This course is part of a 3-course series on Crisis Care and Service Systems

Substance abuse and mental illness crisis situations occur in all communities. This series presents SAMHSA's national guidelines and best practices for crisis care, which can be used to strengthen crisis care and reduce the impact of substance abuse, acute mental illness, and suicide in America. The courses in this Crisis Care and Service Systems series are:

SAMHSA's National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit
Crisis Services Implementation and Infrastructure
Crisis Care for Various Populations

LEARNING OBJECTIVES

Upon completion of this course, the learner will be able to:

1. Identify barriers to managing behavioral health crisis faced by individuals who experience homelessness.
2. Describe effective behavioral health crisis care for individuals experiencing homelessness.
3. Identify considerations for addressing substance use in each of the core components of behavioral health crisis care.
4. Explain challenges to and recommendations for providing equitable treatment to diverse and vulnerable populations in varied crisis settings.
5. Describe the negative effects of the existing crisis system on children and adolescents.
6. Recognize effective child and adolescent crisis care responses.

INTRODUCTION

Effective crisis systems must strive to assess and attend to the individual needs of anyone experiencing a crisis. According to SAMSHA's *National Guidelines,* an effective crisis continuum includes centralized crisis hotlines, mobile crisis teams, and crisis receiving and stabilization facilities that can care for "anyone, anywhere, anytime." Unfortunately, there is work to be done to ensure crisis care is accessible to all, especially for young people, members of diverse populations, and for those experiencing homelessness and/or struggling with substance use disorders. *Crisis Service Papers Building on SAMHSA's National Guidelines* discusses the special considerations and crisis care response needs of these groups of people. The purpose of this course is to support social workers, psychologists, marriage and family therapists, counselors, program managers, and direct care providers working within crisis care systems to

expand and enhance prevention and intervention crisis strategies that best serve the most vulnerable populations.

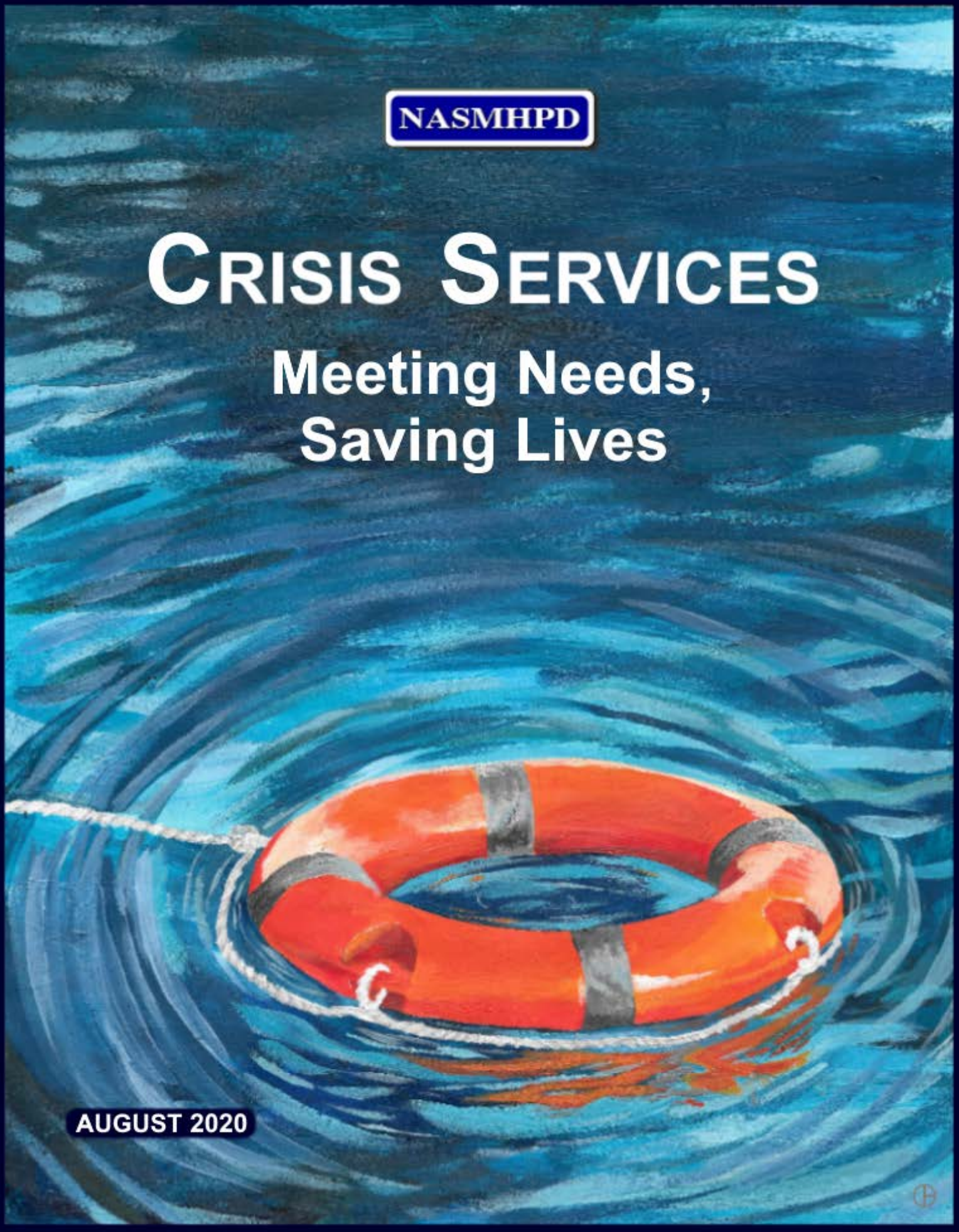
Clinicians can expand their knowledge on the barriers to managing behavioral health crises for specific populations and ways to combat those barriers, which will help them contribute more effectively within a crises system. This practice-focused learning material also offers providers an overarching view of the core crisis system components needed for vulnerable populations. Other topics covered include and are not limited to crisis practices specific to people with substance use disorders, challenges and implications of treating diverse populations, and strategies to prevent or identify early behavioral health challenges in children and adolescents. Upon completion of this course, providers will be able to improve crisis service implementation for a variety of population groups at risk of receiving inequitable and inefficient crisis support.

This learning material refers to a 988 dialing code that was under consideration by the U.S. Congress at the time the SAMHSA national guidelines were published in 2020. In the summer of 2022, 988 was adopted nationwide. It operates 24 hours a day, 7 days a week, connecting those who call or text immediately to the Suicide and Crisis Lifeline. It is a national network of more than 200 crisis centers that is funded through local, state, and federal sources. Unlike 911, the Suicide and Crisis Lifeline does not have geolocation available, but instead routes calls to the closest crisis center based on the phone number's area code. As 988 continues to be evaluated, modifications to the program are likely to be implemented to improve efficacy. Visit https://www.samhsa.gov/find-help/988 to learn more.

NASMHPD

Crisis Services

Meeting Needs, Saving Lives



AUGUST 2020

Accessible • Interconnected • Effective • Just

Crisis Services: Meeting Needs, Saving Lives

Debra A Pinals, MD

Project Support

This work was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the 2020 Technical Assistance Coalition of the National Association of State Mental Health Program Directors.

Disclaimer

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Recommended Citation

Pinals, D. A. (2020). *Crisis Services: Meeting Needs, Saving Lives.* Alexandria, VA: National Association of State Mental Health Program Directors.

Effective Behavioral Health Crisis Care for Individuals Experiencing Homelessness

July 2020

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Recommended Citation
Arienti, F., Mann-McLellan, A., Martone, K., & Post, R. (2020). *Effective Behavioral Health Crisis Care for Individuals Experiencing Homelessness.* Alexandria, VA: National Association of State Mental Health Program Directors.

EXECUTIVE SUMMARY

The *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* issued by SAMHSA in February 2020 provides guidelines for a comprehensive and integrated behavioral health crisis network that should exist in communities throughout the country.[1] Using the *National Guidelines* as a framework, this paper explores issues that should be considered in the design and implementation of core crisis system components, with specific consideration of the needs of individuals who experience homelessness.

Homelessness, now recognized as a national public health crisis, is highly correlated with behavioral health conditions.[2, 3] There is significant attention to homelessness through a housing lens, yet solutions to homelessness are complicated by a range of issues, including poverty, housing unaffordability, structural racism, and behavioral health conditions. As discussed in the National Association of State Mental Health Program Directors report, *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes,* ending homelessness is key to achieving the maximum possible success in strengthening behavioral health systems and improving mental health outcomes.[4]

Crisis programs are frequently engaged to respond to homeless individuals who are experiencing a behavioral health crisis. Just as the symptoms of untreated mental illness and substance use disorders (SUDs) often make homelessness more difficult to overcome, lack of stable housing creates extra challenges for engagement in treatment and recovery from behavioral health conditions. Many people who experience homelessness are disconnected from behavioral health systems and providers, and may distrust them. Such individuals often "fall through the cracks," having costly and frequent contacts with shelters, hospital emergency departments, inpatient units, and law enforcement. Once engaged and housed, people with the most significant behavioral health conditions are often better able to access treatment, services, and supports and to remain stably housed.

Local homeless response systems are charged with outreaching and engaging homeless individuals and "meeting them where they're at" by providing for basic needs, including helping to locate emergency shelter, resolving immediate housing crises, and connecting individuals to longer-term housing and supports. Behavioral health crisis programs provide short-term interventions that can play an important role in helping persons with behavioral health conditions who are experiencing homelessness to establish access to long-term treatment and services. Such programs can also proactively collaborate with homeless systems and providers and with law enforcement to ensure cross-system coordination, the use of effective engagement strategies, and meaningful connections — all key steps in breaking the costly cycle and reducing the human toll of homelessness.

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[1] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[2] Donovan, S., & Shinseki, E. K. (2013). Homelessness is a public health issue. *American Journal of Public Health*, *103 Suppl 2*(Suppl 2), S180. https://doi.org/10.2105/AJPH.2013.301727

[3] Substance Abuse and Mental Health Services Administration (2013). TIP 55: Behavioral health services for people who are homeless. Retrieved July 15, 2020 from https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4734_literature.pdf

[4] Pinals, D. A., & Fuller, D. A. (2018). Bolder goals, better results: Seven breakthrough strategies to improve mental illness outcomes. Alexandria, VA: National Association of State Mental Health Program Directors.

BACKGROUND

Homelessness, now recognized as a national public health crisis, is highly correlated with behavioral health conditions.[5, 6] There is significant attention to homelessness through a housing lens, yet solutions to homelessness are complicated by a range of issues, including poverty, housing unaffordability, structural racism, and behavioral health conditions. As discussed in the National Association of State Mental Health Program Directors report, *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes,* ending homelessness is key to achieving the maximum possible success in strengthening behavioral health systems and improving mental health outcomes.[7]

Mental illness and SUDs have been consistently associated with housing instability.[8, 9] Numerous studies have demonstrated that behavioral health conditions are a significant risk factor for becoming homeless, as well as a barrier to exiting homelessness.[10] The most recent U.S. Department of Housing and Urban Development (HUD) Annual Homeless Assessment Report (AHAR) to Congress, a point-in-time estimate of the number of sheltered and unsheltered[11] homeless people in the United States, found that 567,715 individuals were experiencing homelessness.[12] Data from the report shows that African Americans, Native Americans, and Hispanics/Latinos remain overrepresented among people experiencing homelessness. Twenty percent of those in the point-in-time count reported they were "severely mentally ill," while nearly sixteen percent reported "chronic substance abuse," though these percentages more than double (55 percent and 42 percent respectively) for those who were unsheltered (211,293). Because 18 percent of the total individuals counted in the AHAR were under age 18, the percentage of those aged 18 years and older who have serious mental illness or who have chronic substance use is likely substantially higher. A review of the literature by the Substance Abuse and Mental Health Services Administration (SAMHSA) cites several studies that estimate between 20 and 50 percent of people who are homeless have serious mental illness.[13] In 2018, SAMHSA's Projects for Assistance in Transition from

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[5] Donovan, S., & Shinseki, E. K. (2013). Homelessness is a public health issue. *American Journal of Public Health*, *103 Suppl 2*(Suppl 2), S180. https://doi.org/10.2105/AJPH.2013.301727

[6] Substance Abuse and Mental Health Services Administration (2013). TIP 55: Behavioral health services for people who are homeless. Retrieved July 15, 2020 from https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4734_literature.pdf

[7] Pinals, D. A., & Fuller, D. A. (2018). Bolder goals, better results: Seven breakthrough strategies to improve mental illness outcomes. Alexandria, VA: National Association of State Mental Health Program Directors.

[8] Kerman, N., Aubry, T., Adair, C. E., Distasio, J., Latimer, E., Somers, J., & Stergiopoulos, V. (2020). Effectiveness of Housing First for homeless adults with mental illness who frequently use emergency departments in a multisite randomized controlled trial. *Administration and Policy in Mental Health*, *47*(4), 515–525. https://doi.org/10.1007/s10488-020-01008-3

[9] Glasheen, C., Forman-Hoffman, V. L., Hedden, S., Ridenour, T. A., Wang, J., & Porter, J. D. (2019). Residential transience among adults: Prevalence, characteristics, and association with mental illness and mental health service use. *Community Mental Health Journal, 55*, 784–797. https://doi.org/10.1007/s10597-019-00385-w

[10] Nilsson, S. F., Nordentoft, M., & Hjorthøj, C. (2019) Individual-level predictors for becoming homeless and exiting homelessness: A systematic review and meta-analysis. *Journal of Urban Health, 96*, 741–750. https://doi.org/10.1007/s11524-019-00377-x

[11] For HUD's definition of sheltered and unsheltered homelessness, see p. 4 of "A Guide to Counting Unsheltered People," by HUD's Office of Community Planning and Development: https://www.hudexchange.info/sites/onecpd/assets/File/Guide-for-Counting-Unsheltered-Homeless-Persons.pdf

[12] U.S. Department of Housing and Urban Development (2019). HUD 2019 Continuum of Care homeless assistance programs homeless populations and subpopulations. Retrieved June 22, 2020 from https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2019.pdf

[13] Substance Abuse and Mental Health Services Administration (2013). TIP 55: Behavioral health services for people who are homeless. Retrieved July 15, 2020 from https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4734_literature.pdf

Homelessness (PATH) program documented the prevalence of co-occurring mental illness and SUDs among persons experiencing or at risk of homelessness at nearly 41 percent (28,945).[14]

Individuals with mental illness or SUDs who experience homelessness are among those most likely to be inadequately connected with and distrustful of behavioral health providers,[15] to have complex needs that cannot be met by any one system, and to cycle continually among shelters, emergency departments, psychiatric and medical inpatient units, and the criminal justice system.[16] Some behavioral health systems fund homeless outreach to engage this specific population. Local homeless systems also provide outreach in order to bring homeless individuals, including those with behavioral health conditions, into engagement with housing and services. However, while some behavioral health providers may be part of a homeless system's provider network, homeless and behavioral health systems operate quite distinctly in most communities. Thus, many homeless systems and providers are not naturally connected with behavioral health crisis systems, nor are they often equipped to manage behavioral health crises among the individuals they serve.

Barriers and Risk Factors Faced by Individuals who Experience Homelessness

In addition to being without a place to live, most persons experiencing homelessness face significant barriers to other positive social determinants of health, a lack of which can precipitate or exacerbate a psychiatric or substance use condition.[17] At a basic level, primary safety and security needs largely go unmet. Lack of food, money, employment, health insurance, clothing, transportation, and access to safe and clean spaces to manage hygiene are all conditions that compromise people's ability to manage their behavioral health.

People who experience homelessness also face a set of common risk factors that are likely to further complicate behavioral health crises. The prevalence of abuse and trauma among both sheltered and unsheltered homeless individuals is significant, particularly among those with co-occurring mental illness and SUDs; research has shown that trauma can be the cause of homelessness just as homelessness can lead to further traumatization.[18, 19] Many studies have also documented a remarkably higher prevalence of suicidal ideation and attempts among people experiencing homelessness as compared to the general population.[20]

Mental illness and SUDs co-exist in a significant portion of those experiencing homelessness, a condition which can be further complicated by untreated physical health conditions. One study found that 78 percent of unsheltered homeless individuals experienced mental health conditions, 75 percent experienced substance use

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[14] Substance Abuse and Mental Health Services Administration (2019). PATH annual report for FY18. Retrieved June 22, 2020 from https://pathpdx.samhsa.gov/Content/preGen/national/23/PATH_Annual_Report_For_FY18.pdf

[15] Hwang, S. & Henderson, M. (2010). Health care utilization in homeless people: Translating research into policy and practice. Agency for Healthcare Research and Quality Working Paper No. 10002. http://gold.ahrq.gov.

[16] Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate, 13*(1), 107-163.

[17] World Health Organization and Calouste Gulbenkian Foundation. (2014). Social determinants of mental health. Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=696605E826D2A544DA6E56CA24F93304?sequence=1

[18] Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-Informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*: 80-100. https://www.homelesshub.ca/sites/default/files/cenfdthy.pdf

[19] Christensen, R. C., Hodgkins, C. C., Garces, L. K., Estlund, K. L., Miller, M. D., & Touchton, R. (2005) Homeless, mentally ill and addicted: The need for abuse and trauma services. *Journal of Health Care for the Poor and Underserved*, 16(4):615-622. https://doi.org/10.1353/hpu.2005.0091

[20] Ayano, G., Tsegay, L., Abraha, M., and Yohannes, K. (2019). Suicidal Ideation and attempt among homeless people: A systematic review and meta-analysis. *Psychiatric Quarterly, 90*(4), 829–842. https://doi.org/10.1007/s11126-019-09667-8

conditions, 84 percent experienced physical health conditions, and 50 percent experienced all three.[21] The coexistence of these challenges, or "multiple morbidities," place such individuals at greater risk of premature death and overutilization of emergency departments and acute care, in addition to behavioral health crises.

People experiencing homelessness have a higher risk for exposure to infectious diseases due to poor sanitary conditions in unsheltered environments. The current COVID-19 pandemic appears to be affecting people experiencing homelessness at a disproportionate rate, and if exposed, they may be more susceptible to illness or death due to the prevalence of underlying physical health conditions and a lack of reliable and affordable health care.[22] The impact of COVID-19 on crisis response for individuals with behavioral health conditions who are experiencing homelessness is addressed later in this paper.

Individuals with behavioral health conditions who are experiencing homelessness are also more likely to be arrested and incarcerated for low-level crimes than the general population, including public nuisance laws related to loitering, theft, or disturbing the peace.[23] These individuals, in turn, are more likely to return to homelessness and become disconnected from providers.[24]

The Intersection of Homeless Individuals with Behavioral Health Crisis Response Systems

SAMHSA's *National Guidelines for Behavioral Health Crisis Care* provide a framework for a no-wrong-door approach to crisis services that are available to anyone, anywhere, anytime. This core network of services includes 24/7 regional crisis call centers, mobile crisis team services, and crisis receiving and stabilization facilities. According to these SAMHSA guidelines, the absence of an organized crisis services network containing these core elements contributes to the revolving door of repeated hospital admissions, the overuse of law enforcement, and homelessness among individuals with behavioral health conditions.

Crisis programs are frequently engaged to respond to homeless individuals who are experiencing a behavioral health crisis. For some, crisis episodes are a result of uncontrolled symptoms of a mental illness or SUD because the individual cannot access treatment, or their symptoms are such that they are unwilling or unable to engage in treatment. For others, the stress of living on the street or in crowded shelters, exposure to the elements, lack of family connections, poverty, and social supports can precipitate a behavioral health crisis. Whereas a safe apartment can be a therapeutic setting that allows someone to manage a behavioral health crisis in the comfort of home, individuals who are homeless lack many of the basic necessities that are important to coping with a specific episode as well as to long-term recovery.

Behavioral health crisis call centers receive calls directly from homeless individuals, but more often from third parties such as homeless shelter and transitional housing providers, first responders, private businesses, or the general public. Frequently, the contact between homeless individuals and behavioral health crisis programs

[21] Roundtree, J., Hess, N., & Lyke, A. (2019). Health conditions among unsheltered adults. Los Angeles, CA: California Policy Lab. https://www.capolicylab.org/wp-content/uploads/2019/10/Health-Conditions-Among-Unsheltered-Adults-in-the-U.S.pdf
[22] Lima, N. N. R., de Souza, R. I., Feitosa, P. W. G., Moreira, J. L. de S., da Silva, C. G. L., & Meto, M. L. R. (2020). People experiencing homelessness: Their potential exposure to COVID-19. *Psychiatry Research, 288*. https://dx.doi.org/10.1016%2Fj.psychres.2020.112945
[23] The Sentencing Project (2002). Mentally ill offenders in the criminal justice system: An analysis and prescription. Washington, DC: The Sentencing Project. Retrieved on July 15, 2020 from https://www.sentencingproject.org/wp-content/uploads/2016/01/Mentally-Ill-Offenders-in-the-Criminal-Justice-System.pdf
[24] Greenberg, G. & Rosenheck, R. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services*, 59(2)

occurs when mobile crisis response is called to assist a homeless individual in crisis, or through referrals or "drop-offs" by first responders to crisis receiving and stabilization facilities.

Effective crisis programs recognize that providing for basic needs creates an opportunity; they employ the same types of person-centered engagement strategies that are the cornerstone of effective homeless outreach. This includes "meeting people where they're at," providing relief for the most immediate needs, and offering to make connections with resources that the individual both wants and needs in order to access housing, benefits and entitlements, and other services and supports that can address their underlying condition of homelessness. Nevertheless, it is important for crisis programs to retain a focus on resolving behavioral health crises and not assume responsibility for fully resolving homelessness and other social service challenges.

Responding to Homeless Individuals in Crisis: Essential Principles and Practices

Ensure that Crisis System Components are Responsive to the Needs of Homeless Individuals

Effective crisis care for individuals experiencing homelessness requires consideration of the basic needs and unique circumstances they face, along with attention to their clinical and social service needs that extend beyond the brief period during which crisis programs seek to resolve a behavioral health crisis. Here, we present considerations for each of the core components of a crisis response system identified in the SAMHSA guidelines.

24/7 Regional Call Center Strategies

As noted, crisis call centers may be more likely to receive calls *about* individuals who are homeless and experiencing a behavioral health crisis than to hear from homeless individuals themselves. This may be due to the fact that individuals experiencing homelessness are less likely to have access to phones. They may also be distrustful of behavioral health providers due to paranoia, past experiences with civil commitment or law enforcement, or racial discrimination.[25,26,27]

When a crisis call center receives a call either from or on behalf of a homeless individual, screening, assessment, and intervention strategies must be sensitive to a number of situational factors that may be influencing the behavioral health crisis. In addition to clinical considerations, crisis hotline screening and assessment should consider the following when receiving calls either directly from or on behalf of homeless individuals:

- What is the person's housing status — are they currently homeless?
- Is the person with anyone such as a friend or other support?
- What is the person's current location — are they on the street, staying in a shelter, or in an encampment[28]?
- How long has the person been homeless?
- Is the area safe? Are there any public health or safety threats in the area?

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[25] Sweeney, A., Gillard, S., Wykes, T., & Rose, D. (2015). The role of fear in mental health service users' experiences: a qualitative exploration. *Social psychiatry and psychiatric epidemiology*, *50*(7), 1079–1087. https://doi.org/10.1007/s00127-015-1028-z

[26] Institute of Medicine (US) Committee on Health Care for Homeless People (1988). *Homelessness, health, and human needs.* Washington (DC): National Academies Press (US)

[27] National Alliance on Mental Illness. Webpage: Identity and Cultural Dimensions. Retrieved on July 15, 2020 from https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American

[28] To learn more about homeless encampments, see "Understanding Encampments of People Experiencing Homelessness and Community Responses" by HUD's Office of Policy Development and Research: https://www.huduser.gov/portal/sites/default/files/pdf/Understanding-Encampments.pdf

- Does the person have a behavioral health provider, case manager, or housing supports?

Designing and implementing crisis call center strategies that are sensitive to these issues and that collect as much information as possible about a homeless person's individual circumstances, location, and other situational factors can help staff actively engage callers and appropriately triage a response. Good knowledge of specific community programs and resources available to address the needs of homeless individuals may enable call center staff to resolve the immediate issue and divert the individual from further crisis system involvement. In other cases, an individual may be encouraged to come to a facility for further assessment, require connection with mobile crisis response, or be linked to a warm line for ongoing support.

Close collaboration between crisis call centers and programs that are well-equipped or even specifically designed to respond to homeless individuals in crisis can be helpful in beginning to break the cycle of crisis and homelessness for an individual. White Bird Clinic is a Federally Qualified Health Center (FQHC) in Eugene, Oregon that is also a federally funded Health Care for the Homeless Program grantee. White Bird provides a range of health and behavioral health services including a 24/7 crisis hotline, a crisis walk-in clinic, and a 24/7 CAHOOTS (Crisis Assistance Helping Out On The Streets) mobile crisis team. The CAHOOTS team is well-versed in responding to behavioral health crises among homeless individuals; nearly 60 percent of its calls involve unhoused or inadequately sheltered individuals. CAHOOTS is dispatched by White Bird's crisis hotline and the Eugene police-fire-ambulance communications center, and by the Springfield police non-emergency line when calls come in to first responders.[29]

Netcare Access in Columbus, Ohio operates a range of behavioral health crisis services for Franklin County. Individuals, businesses, and other providers can call Netcare's 24/7 crisis hotline to request assistance from a specialized mobile outreach service called ROW ONE that transports approximately 1,500 publicly intoxicated persons per month off the streets to safe locations that include homeless shelters, substance use and mental health treatment centers, crisis centers, and hospitals.[30] The organization also recently began staffing the county's homeless services hotline, so staff have good working knowledge of community resources to prevent and address homelessness.

Mobile Crisis Response Strategies

When mobile crisis response is required for an individual in crisis who is also homeless, teams may be deployed to a variety of locations. Mobile crisis teams must always consider staff safety in responding to crises. Understanding both the various locations and environments involved, as well as any public health concerns such as the current the COVID-19 pandemic or a hepatitis outbreak, for example, is important when responding to a homeless individual.

A community's formal homeless provider network may include programs that offer street outreach, shelter, homeless health care or other safety net clinics, and transitional and permanent supportive housing, along with government-sanctioned homeless encampments, food banks and soup kitchens, and domestic violence programs. Informal settings can include unsanctioned encampments in remote areas and shelters at churches. In many jurisdictions, formal or informal shelters may be seasonal. During the day, many shelters require

[29] White Bird Clinic (n.d.). Crisis Assistance Helping Out On The Streets. Retrieved June 22, 2020 from https://whitebirdclinic.org/wp-content/uploads/2020/06/11x8.5_trifold_brochure_CAHOOTS.pdf

[30] Netcare Access (n.d.). ROW ONE program. Retrieved June 22, 2020 from https://www.netcareaccess.org/services/help-in-a-crisis-adult-youth/reach-out-program/

individuals to vacate the premises, leaving them to spend the day in locations like parks, downtown business areas, libraries, bus or train stations, public transportation, and in remote locations (e.g., under bridges, along trails, and in wooded areas).

Responses to a staffed shelter, an encampment, a train station, a vehicle, or out on the street each have their own circumstances that mobile crisis teams must consider. A homeless individual's location may determine whether the mobile crisis team has communication with a provider who can ascertain specific types of information that will help determine their assessment and response. Crisis programs should work in concert with existing street outreach teams that may have preexisting relationships with individuals. Typically run by homeless service providers, street outreach teams work to engage and stabilize the most vulnerable homeless individuals by placing them into shelter and housing. They provide outreach and care management to homeless people living on the streets who have severe illnesses, and team members may include doctors and nurses.[31] Crisis programs should also understand local shelter requirements, available low-barrier shelter or safe haven options, specific cultural norms at large encampments (i.e. how to enter and exit appropriately and safely), and common safety concerns in shelters or other settings that can exacerbate a behavioral health crisis. They should be familiar with the areas where homeless individuals may congregate, and whether there are site-based or outreach staff present.

In Eugene, CAHOOTS' mobile crisis response team staff are well-known to homeless individuals in the community because White Bird Clinic is also a Health Care for the Homeless provider. The team takes situational and environmental factors into account when responding to homeless individuals in crisis to ensure staff safety, engaging individuals in a non-threatening, trauma-informed manner. Staff wear plain clothes and work to verbally engage individuals while kneeling or using what they call the 'empathy squat', particularly when responding on the streets or in encampments. The team addresses immediate needs such as dehydration and hunger before fully assessing an individual's behavioral health crisis in order to build rapport and engage a person's optimal problem-solving skills.[32] CAHOOTS can directly refer and transport those needing crisis stabilization to another provider who operates those services in the community. CAHOOTS shares a dispatch radio with police and emergency services, allowing it to intervene if the police are called in response to a homeless individual, thereby diverting police contact. Should a homeless individual be considered, based on assessment, to need acute care in an inpatient setting, CAHOOTS can facilitate transport and transition of care at the hospital emergency department (ED) and ensure that the person is triaged as though an ambulance had transported them. Should an individual choose police transport, CAHOOTS stays with the person and similarly facilitates transition of care at the ED. The team is able to resolve most crises by focusing on immediate needs, thereby diverting homeless individuals from further crisis or acute care. The team continues to engage homeless individuals who request their assistance by calling back in to the dispatch line. Peer support workers and case managers are available for warm handoffs from the team when an individual is ready and willing to access housing and other needed treatment and supports.

Baltimore Crisis Response, Inc. (BCRI) operates a range of behavioral health crisis services in Baltimore City, MD; approximately 70 percent of the individuals served are homeless or unstably housed. BCRI's mobile crisis team, composed of a clinician and a nurse who respond in pairs, is accessed through its mobile crisis hotline.[33] The

[31] Boston Health Care for the Homeless Program. Retrieved July 16, 2020 from https://www.bhchp.org/specialized-services/street-outreach

[32] Phone interview with Tim Black, CAHOOTS Operational Coordinator, May 29, 2020

[33] Baltimore Crisis Response, Inc. (n.d.) Mobile crisis team. https://bcresponse.org/our-work/mobile-crisis-team.html

team is often called by shelter or transitional housing providers when a homeless individual is experiencing a crisis that is beyond the staff's ability to effectively manage. The team responds in those settings and is well-trained to be aware of the environment, using trauma-informed and gentle engagement techniques to encourage individuals to come into care. Should an individual be assessed as needing a bed in BCRI's Crisis Residential Unit, this is facilitated and the individual is returned to the homeless provider's setting once stabilized. While BCRI does not utilize a co-responder model, the team is sometimes called to accompany police to homeless encampments to help defuse a crisis or encourage individuals in crisis to come into care.

Crisis Receiving and Stabilization Facility Strategies

Crisis receiving and stabilization facilities offer an alternative to hospital ED assessment and inpatient care for those with more acute needs. They also may have an added benefit for individuals experiencing a behavioral health crisis who are homeless by providing basic necessities, such as food and shelter, which can help mitigate a crisis.

Homeless individuals may walk in on their own or may arrive via mobile crisis team if a crisis cannot be resolved in the setting where the team responded, or after being diverted from the ED. When law enforcement is the first responder to a homeless person in crisis, the person may be dropped off at a crisis facility; programs should have procedures in place that allow officers to quickly return to their duties.[34] RI International's (RI) crisis recovery response center (RRC) model is a crisis receiving and stabilization facility that provides an example of an alternative option to ED drop-offs by law enforcement and others. [35] Its RRC in Peoria, AZ, located 13 miles outside of Phoenix, receives more than 80 percent of its clients, including homeless individuals, via law enforcement drop-offs; whereas another crisis center located in downtown Phoenix receives more walk-ins than police drop-offs due in part to the facility's proximity to the city's homeless population.[36] Staff at crisis facilities should use the same types of trauma-informed and gentle engagement techniques used by mobile crisis teams in engaging homeless individuals, and should also consider how to manage any personal belongings or pets that may accompany an individual.

Effective crisis receiving and stabilization programs accept everyone who comes in the door, and given that they have only hours to resolve a behavioral health crisis and connect individuals with additional care, many operate short-term crisis residential or subacute stabilization beds or can refer people to a program where they can stay longer to stabilize.[37] These and other step-down resources from core crisis system components create much-needed flow in crisis systems, and provide added time for engagement and to link people experiencing homelessness with possible temporary, transitional, or permanent housing and other longer-term resources.

Short stays in these settings allow homeless individuals to continue to be engaged as they begin the process to access housing and other needed treatment, services, and supports, which can take several weeks. Having good contacts for referrals into the local homeless response system, as well as in-house staffing for warm handoffs

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[34] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration

[35] RI International (n.d.). RI Crisis Recovery Response Center. Retrieved June 22, 2020 from https://riinternational.com/wp-content/uploads/2015/10/RI-Crisis-RRC-General.pdf

[36] Vestal, C. (2020). As suicide rates climb, crisis centers expand. *Stateline*, an initiative of the Pew Charitable Trust. Retrieved on July 21, 2020 from: https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/02/24/as-suicide-rates-climb-crisis-centers-expand

[37] The length of stay in these programs varies from a few days to a couple of weeks to help resolve the immediate behavioral health crisis. They are not designed as a transitional or permanent housing option.

once an individual is ready to transition from crisis care, is an effective combination of strategies for ensuring continued engagement and linkages with longer-term resources.

Netcare Access in Columbus, OH provides step-down care for homeless individuals with mental illness following a stay in its Crisis Stabilization Unit (CSU) through a nine-bed crisis residential program called Miles House funded by the Franklin County Alcohol, Drug and Mental Health system. The program, which also serves individuals coming from psychiatric inpatient units, provides for a stay of up to two weeks, during which individuals can apply for and access transitional housing also funded by the county, or other available housing resources in the community. Peer Specialists work to support homeless individuals as they transition from the CSU back to the community, and provide recovery supports for those who choose a brief stay at Miles House while gaining access to housing and other community resources.

BCRI in Baltimore operates 21 psychiatric crisis beds and 18 SUD treatment beds that offer medically monitored detox; the average length of stay is seven to ten days. State and federal block grant funds support case managers who work to transition homeless individuals to ongoing treatment, housing, and other supports post-care. BCRI is able to effectively connect homeless individuals with housing once they are stabilized through direct partnerships with transitional and permanent housing providers. Case managers actively work to make referrals to these providers and to connect individuals with benefits and entitlements. The program provides individuals with 30 days' worth of medications as a bridge while they wait for prescribing appointments, or in the event their Medicaid has lapsed, a service that makes housing providers more receptive to warm handoffs following crisis care.

Incorporate Interventions that Effectively Engage Homeless Individuals

In addition to the above considerations, effective crisis response with individuals who are experiencing homelessness requires that crisis programs incorporate into crisis service design and delivery evidence-based and best practice interventions that are responsive to the population's needs, along with workforce development and training for staff on implementing these interventions.

Effective crisis service delivery with homeless individuals means moving beyond crisis response that is disposition-focused to incorporating more resolution-oriented practices. This involves being *person-centered* in terms of service delivery approach, collaborating with the individual on solutions. Such interventions recognize the individual in crisis as the expert in identifying the immediate needs to be resolved. By taking the time to establish rapport and understand the person's overwhelming situation, crisis program staff can help mitigate the behavioral health crisis and facilitate access to resources that can help address the person's homelessness, but which they may have been hitherto unable to navigate.

Motivational interviewing (MI) is a strengths-based, client-centered engagement intervention that enhances motivation to change and resolves ambivalence. It is a particularly effective approach for working with long-term homeless individuals with mental illness and/or SUDs who have not responded well or have been resistant to more traditional forms of treatment engagement. MI is frequently used by homeless outreach workers and other homeless system providers to engage individuals in a sensitive and nonaggressive manner. Tenets of MI that can inform crisis program staff response to individuals experiencing homelessness include:[38]

[38] Substance Abuse and Mental Health Services Administration (2010). Spotlight on PATH practices and programs: Motivational interviewing. Retrieved on June 22, 2020 from https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/path-spotlight-motivational-interviewing.pdf

- Asking permission to talk with individuals instead of assuming they want to talk
- Finding a safe space for the individual to talk
- Learning what is important to the individual and addressing their immediate needs
- Finding out what services the individual wants and has the motivation to pursue
- Refraining from pushing individuals into services they do not want
- Exploring ambivalence using open-ended questions and reflective statements

Trauma-informed care is included in the SAMHSA guidelines as a core principle. Because so many studies have shown high prevalence rates of trauma among persons in the behavioral health and homeless system, effective crisis response programs assume that individuals presenting will have personal experiences with prior and/or more recent trauma. During a crisis, such experiences may result in an exacerbation of one's behavioral health condition and affect people's problem-solving capacity. Trauma-informed approaches are particularly crucial with individuals experiencing homelessness due to high trauma rates that may be both a risk factor and a cause of homelessness.[39] Poorly designed crisis response that is not trauma-informed can have negative effects and cause more trauma and distrust.

Culturally responsive services are critical to engaging populations that are disproportionately represented within a community's homeless population. To the extent possible, staff should be representative of the racial, ethnic, and gender identities of a community's population, inclusive of those experiencing or at greatest risk of homelessness, and competently trained and supervised in culturally responsive practices. Attending to these considerations will better prepare staff to address racial and other disparities that may be factors in people's behavioral health crises. Designing services to be culturally responsive promotes the ability of staff to build the trust, rapport, and continuous engagement required over long periods of time to fully engage individuals experiencing homelessness.

SAMHSA's crisis care guidelines recommend the **inclusion of peers as crisis program staff**. Similarly, the homeless system frequently includes individuals who have previously been homeless in various staff roles.[40] Because homelessness is prevalent among individuals that crisis programs encounter, programs should employ individuals who have lived experience with mental illness, SUDs, and homelessness in each of their core crisis services. Peers with these qualifications can be particularly effective in engaging those who are experiencing long-term homelessness and who may be reluctant to engage with behavioral health professionals or first responders. Peers can also be very effective at helping to transition and link individuals to follow-up care and resources in the community post-crisis. RI International's peer-operated "Living Room" programs ensure that participants are paired with a team of Peer Support Specialists in recovery.[41] Each guest is encouraged to work with the team and empowered to develop their own recovery plan. RI employs more than 500 peers who have experience with addiction and/or homelessness in addition to mental illness.[42]

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[39] European Federation of National Organisations Working with the Homeless (2017). Recognising the link between trauma and homelessness. Retrieved on July 16, 2020 from https://www.feantsa.org/download/feantsa_traumaandhomelessness030734712190529468107 38.pdf

[40] Barker, S. L., & Maguire, N. (2017). Experts by Experience: Peer support and its use with the homeless. *Community Mental Health Journal*, *53*(5), 598–612. https://doi.org/10.1007/s10597-017-0102-2

[41] RI International (n.d.). RI's crisis services improve care and reduce costs. Retrieved on July 21, 2020 from: https://riinternational.com/crisis-services/

[42] Covington, D. (2016). Yes, I can! What if we all embraced recovery? RI International blog. Retrieved on July 21, 2020 from: https://riinternational.com/2016/09/

The ability of staff to **respond to co-morbid medical conditions** is particularly critical in crisis response with homeless individuals given high rates of tri-morbidity in this population. White Bird Clinic's CAHOOTS mobile response team pairs behavioral health clinicians with a nurse or EMT and also has access to other health care services thanks to its status as an FQHC and Health Care for the Homeless provider. In addition to psychiatrists and an addiction medicine physician, Baltimore Crisis Response, Inc. has in-house nursing staff who can manage both physical and behavioral health conditions, including administration of medications, enabling the program to care for homeless individuals who might otherwise require a hospital setting to receive needed health care.

In addition to ensuring **workforce development and training** specific to the interventions above, crisis programs should incorporate training for staff on a range of topics, including population-specific issues and challenges related to homelessness, SUDs, chronic health conditions, and co-occurring disabilities (e.g., developmental disabilities). Staff training should facilitate clinical assessments that consider these needs. Further, while the primary role of crisis programs is to resolve an immediate behavioral health crisis, staff should receive basic training on the range of social service needs that homeless individuals have and how these resources are accessed in the community in order to refer and link individuals as necessary. This includes homeless housing programs and services offered by the local homeless Continuum of Care (CoC), Health Care for the Homeless and other safety net health clinics, mental health and substance use treatment providers, peer and recovery support programs, SOAR[43] or other programs that assist with accessing benefits and entitlements, and programs that provide food assistance, to name a few.

Proactively Collaborate with Homeless Housing Systems and Law Enforcement

Effective behavioral health crisis response for individuals experiencing homelessness also calls for proactive collaboration with homeless housing systems and providers and with law enforcement to ensure effective handoffs and connections to those who can help address the underlying causes of people's homelessness. Such cooperation also serves to mitigate responses that might otherwise be harmful to a homeless individual or escalate their crisis. Collaboration strategies can include:

- Implementing training across systems to understand the resources and roles of each, and to encourage best practices
- Establishing procedures for information- and data-sharing and for warm handoffs
- Formalizing partnerships and roles through memorandums of understanding (MOUs) and other opportunities for formal cross-system involvement

Strategies for Working with Homeless Systems and Providers

Training opportunities. Crisis and homeless systems and providers each have expertise that can be leveraged to improve outcomes for people experiencing homelessness, and should engage in cross-training so each is knowledgeable about what the other has to offer. In some communities, behavioral health providers may be part of the homeless provider network, but this is often not the case. Some homeless service agencies may have very little contact or coordination with behavioral health providers, and may not be aware of how to access crisis services other than by calling 911. Crisis providers can train homeless providers on the services a crisis program can provide, when and how to call crisis services, when and how it can respond, and limitations to its scope or resources. Crisis providers can also train homeless providers with basic knowledge on recognizing the

[43] SSI/SSDI Outreach, Access, and Recovery (SOAR) helps states and communities increase access to Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits for people who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder.

signs of a behavioral health crisis, including those associated with substance use and overdose, and de-escalation strategies.

Likewise, homeless systems and providers can train crisis system providers on effective approaches for working with homeless individuals, with an emphasis on meeting basic needs and strategies to develop rapport. Crisis providers should also learn the basics of the local CoC, its scope and role, and the process by which its resources are prioritized and accessed by homeless individuals. Most planning and funding for homelessness is done at the local community level through the HUD CoC process. HUD awards funding for emergency shelter, affordable housing, and services such as outreach to assist those experiencing homelessness through competitive grants to providers who are part of local CoCs which are typically administered at the county or city level.[44] Crisis programs not familiar with their local CoC and its provider network can inquire with the contacts in their community.[45]

Crisis programs should have a basic understanding of their community's approach to the prioritization of HUD-funded housing resources available through the CoC. While other sources of affordable housing administered by housing authorities, private developers, or state- and locally-funded programs may be accessed by individuals experiencing homelessness, HUD's CoC program is the largest form of targeted federal housing assistance dedicated to resolving homelessness. Demand for these limited homeless housing resources far exceeds capacity in each community, so CoCs use a process known as coordinated entry (CE) to prioritize resources for those with the greatest vulnerabilities. While it is outside of most crisis programs' role and resources to assist homeless individuals in accessing permanent housing, crisis providers should become familiar with the basics of their CoC's CE system and policies, which are often posted publicly on the CoC's website, and include:

- *Priority populations:* The populations that are prioritized most frequently for a CoC's housing resources. Often, priority populations include those who have been homeless the longest, or those with the greatest vulnerability to adverse outcomes while living unsheltered. Psychiatric crises and behavioral health conditions are often taken into account.
- *Access Points:* CE systems typically have one or more access points where people experiencing homelessness can be assessed for CoC housing resources. These access points are often published online and distributed widely to community stakeholders. In some communities, behavioral health providers, health care providers, and hospitals have volunteered to become access points in a community's CE system due to the overlap in populations served. Access points typically offer problem-solving assistance to rapidly resolve a homeless crisis, and assessment and referrals to potential housing options for which an individual may qualify.

Information sharing and warm handoff. If the crisis program is called to respond to a homeless individual, the program should engage homeless providers to share information on the best ways to contact homeless outreach teams, shelter staff, or case managers in order to garner as much information as possible to support crisis triage and response, and to facilitate a transition back into services as applicable once the individual is stabilized.

[44] States also manage larger geographic areas through Balance of State CoCs.

[45] CoC contact information is available on the HUD Exchange at: https://www.hudexchange.info/grantees/contacts/?params=%7B%22limit%22%3A20%2C%22sort%22%3A%22%22%2C%22order%22%3A%22%22%2C%22years%22%3A%5B%5D%2C%22searchTerm%22%3A%22%22%2C%22grantees%22%3A%5B%5D%2C%22state%22%3A%22%22%2C%22programs%22%3A%5B3%5D%2C%22coc%22%3Atrue%7D##granteeSearch

Each CoC is required to input homeless services data into a Homeless Management Information System (HMIS). At a minimum, HMIS captures data on homeless services usage; however, many communities have customized their own HMIS to collect additional data points such as where people are residing (i.e. encampment location, exact emergency shelter), vulnerability factors an individual has experienced that may contribute to prolonged homeless episodes, collateral contacts, and even touches with medical or corrections systems. Crisis programs could benefit from entering into data-sharing arrangements (and corresponding data-sharing agreements that address HIPAA, 42 CFR Part 2, and other issues) with homeless service providers to access important information that could help facilitate crisis response. Similar collaborations have been developed between health care and homeless service providers to integrate HMIS with electronic medical health records to provide seamless intake, assessment, and referral of individuals between systems of care. Data-sharing collaborations such as these could assist crisis services to quickly locate participants, as well as tap into collateral contacts that can be leveraged to create sustainable warm handoffs from crisis services.

Recognizing opportunities for warm handoffs from crisis programs to homeless system providers who are most able to assist, and ensuring that such handoffs are accomplished, can provide meaningful and lasting connection to resources that go beyond resolving the immediate crisis, and can also mitigate the risk of future crises. Homeless systems should ensure that crisis programs have contact information for homeless provider staff who can be leveraged for warm handoffs. In each community, the staff who can assist in finding permanent housing, refer to community-based treatment and supports, maximize income options, and in some cases provide ongoing behavioral health treatment as a part of the services will be different. They may include case managers or peer support workers/navigators embedded in street outreach teams, emergency shelters, and supportive housing programs. As previously noted, crisis programs like BCRI and CAHOOTS use flexible funds to support their own staff who link people who are willing but not otherwise engaged with housing, treatment, and supports. Staff such as these in either system can be important connectors between the two.

Finally, some communities have incorporated case conferencing strategies into their efforts to end homelessness, bringing together stakeholders to create tailored pathways to permanent housing for homeless individuals who are a community's most vulnerable or who are experiencing long-term or chronic homelessness.[46] Some crisis providers join case conferencing when their caseload significantly overlaps with the community's homeless population in an effort to create care plans with service providers that mitigate the risk of continued behavioral health crises.

Formalizing partnerships and cross-system involvement. Many partnerships and referral processes begin informally through relationships built over time. Often these provider-level arrangements are formalized through MOUs that establish clear roles and responsibilities for each entity. Such partnerships can lead to broader knowledge and collaboration at the systems level where MOUs can be created as well.

In some communities behavioral crisis providers like the CAHOOTS mobile response team have MOUs with the CoC or with the entities that manage their CoC's CE system so they can refer homeless individuals to be assessed and triaged for housing resources. While these types of referrals may not be made directly by crisis program staff, they are an important step in the process of connecting individuals to housing resources that can support long-term recovery. Crisis programs should also consider building relationships and establishing MOUs with homeless outreach teams as the entities that are often most familiar and engaged with homeless individuals in a

[46] To learn more about chronic homelessness as defined by HUD, see "Here's What You Need to Know about HUD's New Chronic Homelessness Definition" by the National Alliance to End Homelessness: https://endhomelessness.org/heres-what-you-need-to-know-about-huds-new-chronic-homelessness-definition/

community. Crisis service providers can participate more formally in their local homeless response system by becoming a homeless system provider as well. For example, Netcare Access is the behavioral health crisis system provider in Franklin County, OH and also operates the county's homeless services hotline, an arrangement which has opened the door to further collaborations with the homeless response system.

Crisis providers can also seek to become a member in their CoC's governing body. HUD has charged its nearly 400 CoCs across the country to convene a diverse set of community stakeholders, including those from other systems of care that frequently have contact with homeless individuals. Membership is often open, but each CoC has its own process for becoming a member. Benefits of membership in a CoC's governing body include helping to inform the deployment of resources that are mutually beneficial to multiple systems of care. Many CoCs have strategic plans to actively guide their efforts and resources to address homelessness, and behavioral health crisis service providers can identify mutually beneficial goals to work toward through CoC involvement.

Strategies for Working with Law Enforcement

Law enforcement is often the first to receive the call in response to a homeless person who is experiencing a behavioral health crisis. Thus, good planning and coordination between behavioral health crisis systems and law enforcement is essential to properly de-escalate the situation as necessary, engaging individuals and diverting them from unnecessary justice system involvement.

Training opportunities. As noted above, training can be beneficial to encourage the adoption of best practices in responding to homeless individuals experiencing a behavioral health crisis. Many communities offer specialized Crisis Intervention Training (CIT) to a subset of their emergency responders who can be deployed when responding to 911 or crisis line calls where law enforcement is required. CIT-designated first responders are trained to be familiar with available local crisis response resources and protocols for securing additional services. The CAHOOTS mobile crisis team regularly collaborates with law enforcement, a relationship which also involves CIT and Mental Health First Aid training for officers. BCRI similarly offers CIT training for local law enforcement, in addition to offering a training module on 'trauma-informed policing." BCRI invites officers to visit its crisis facility to talk with consumers about the experiences that have contributed to their conditions in order to encourage more collaborative problem-solving in response to the crises they encounter.

Information-sharing and warm handoffs. If law enforcement is the first to respond to a homeless individual experiencing a behavioral health crisis, they should be able to contact a crisis call center for support, rely on a mobile crisis team to respond, and have the capability to bring a person to a crisis receiving facility to divert individuals from the criminal justice system through brief warm handoffs so that officers can get back to their work. In an interview included in the SAMHSA *Guidelines*, Nick Margiotta (president of Crisis Service Solutions in Phoenix, AZ) discusses this element as being critical to law enforcement buy-in and collaboration with crisis services.[47]

Some communities have developed specialized consortiums to coordinate between service providers and first responders on appropriately triaging people experiencing homelessness when a psychiatric or substance-use-related crisis occurs. These consortiums often focus on frequent utilizers of emergency services and consist of law enforcement, EMS, hospitals, managed care organizations, street outreach, and other homeless service providers. Client-level interventions are developed by these groups with the aim of reducing the use of emergency services, acute care, and jail by leveraging partnerships and existing community-based services.

[47] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Solutions developed include strategies for law enforcement to divert individuals from jail to available shelter or detox beds, and for EMS to identify frequent users of the service who may benefit from more stable housing.

Formalizing partnerships and cross-system involvement. The CAHOOTS mobile crisis team was designed as an alternative to police intervention in response to mental health crises in the community. Thus, its partnership with local law enforcement is formalized through an MOU and the two work together closely to divert individuals in crisis, including those experiencing homelessness, from police contact as much as possible. The CAHOOTS team responds to calls involving individuals with behavioral conditions that come in through 911 as well as the police non-emergency line. The team also works to actively find and engage those identified by patrol officers for quality of life offenses to divert them from further justice system involvement.

BCRI works formally with the Baltimore Police Department on two programs that regularly interface with individuals in behavioral health crisis who may also be experiencing homelessness. Its Crisis Response Team (CRT) pilot program pairs a CIT-trained police officer with a licensed clinical social worker to jointly respond to police calls involving individuals experiencing a behavioral health crisis. Officers receive training and support in order to safely engage these individuals, improving outcomes for all involved. The second collaboration involves diverting individuals who are homeless and have been identified by police for certain low-level offenses to the Law Enforcement Assisted Diversion (LEAD) program in lieu of arrest. LEAD case managers engage these individuals by meeting basic needs for food, clothing, and housing prior to addressing treatment needs. Nationally, the LEAD program has shown promising outcomes for individuals who are homeless and in need of housing.[48]

COVID-19 Considerations for Responding to Individuals Experiencing Homelessness

Behavioral health crisis programs will need to continue to adapt to the effects of the COVID-19 pandemic and related economic crisis, with unique considerations for persons living with behavioral health disorders who are experiencing homelessness. In many communities across the country, homelessness was growing prior to the pandemic, and there could be increases in homelessness ahead, as lost incomes are likely to result in more evictions despite legislative efforts to prevent people from losing housing. Coupled with increased need for behavioral health services against strained or decreasing services, crisis response programs will likely experience more encounters with individuals who are experiencing or at risk of homelessness, particularly with racial and ethnic minority groups disproportionately affected by the pandemic[49] and the resulting economic crisis.[50]

Crisis programs should be aware that many individuals who are homeless have nowhere to shelter in place, quarantine, or isolate without public health disaster response resources. Those living in encampments are subject to social distancing protocols placed upon them by public health, public safety, and homeless service providers that interfere with outreach, engagement, and service delivery, even while reducing viral spread. Providers in emergency homeless shelters have also been significantly impacted and are having to implement new and potentially stressful safety protocols that create physical distance between the individuals being served, staff, and volunteers. These new disease management measures, which may also prohibit homeless

[48] Collins SE, Lonczak HS, Clifasefi SL. (2017). Seattle's Law Enforcement Assisted Diversion (LEAD): Program effects on recidivism outcomes. *Eval Program Plann*. 64:49-56. doi:10.1016/j.evalprogplan.2017.05.008

[49] Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved on July 16, 2020 from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html

[50] Brown, S. (2020). The COVID-19 crisis continues to have uneven economic impact by race and ethnicity. *Urban Wire,* blog of the Urban Institute. Retrieved on July 16, 2020 from https://www.urban.org/urban-wire/covid-19-crisis-continues-have-uneven-economic-impact-race-and-ethnicity

individuals from accessing their friends and other naturally occurring support systems, may further exacerbate behavioral health conditions and have a lasting impact for years to come.

Early in the pandemic, shortages of personal protective equipment (PPE) inhibited crisis mobile response teams from responding to many calls and often required a default to crisis hotline and telehealth triage strategies, especially with callers such as first responders and providers. Access to PPE is critical for mobile crisis teams when working with individuals who are homeless due to high rates of infection in this population. In Boston, nearly 40 percent of homeless individuals tested positive for the virus at one large shelter.[51] Responding to homeless shelters may require mobile teams to engage an individual just outside of the shelter. Even in open air encampments, living conditions may result in tight spaces that impede physical distancing standards, and mobile teams must have policies and strategies in place to address these scenarios.

Several communities have established temporary housing and temporary quarantine sites in hotels or other settings for individuals who are homeless.[52] Crisis providers should explore ways to collaborate with, respond to, support, and utilize these sites for mobile crisis response, crisis stabilization, and temporary crisis residential support.

Some crisis stabilization and residential programs have had to decrease capacity in order to implement physical distancing protocols. This can limit access to step-down options from crisis care that homeless individuals may need as they are coming out of a behavioral health crisis and being connected with longer-term resources to resolve their homelessness. Access to transitional and permanent housing programs may also be limited for similar reasons during the pandemic which may impact flow through some crisis systems for people experiencing homelessness who are interested in accessing these resources.

State and local policymakers and payers must ensure that behavioral health crisis programs retain capacity in order to respond to crises rather than default to law enforcement or other first responders. Crisis hotlines and mobile teams must be able to respond to calls in a timely manner. For mobile teams and crisis receiving facilities, this also requires an adequate supply of PPE.

CONCLUSION

Effective crisis response for people experiencing homelessness requires attention to each individual's unique clinical and social service needs, as these can further complicate a behavioral health crisis. The current pandemic and attention to structural racism have increased the visibility of the challenges in working with individuals who are homeless and experiencing behavioral health conditions. By collaborating with homeless system providers, behavioral health crisis programs can ensure that their screening, assessment, and intervention strategies are sensitive to these and other situational and environmental factors, thereby informing an appropriate crisis response for individuals who are experiencing homelessness and helping to ensure the safety of crisis program staff.

Beyond individual crises, behavioral health crisis programs have a unique opportunity to facilitate access to resources that can help resolve homelessness among persons with behavioral health conditions. Evidence-based

[51] Baggett, T., Keys, H., Sporn, N., Gaeta, J. (2020). Research Letter: Prevalence of SARS-CoV-2 infection in residents of a large homeless shelter in Boston. *Journal of American Medicine*, *323*(21)

[52] University of Wisconsin, School of Medicine and Public Health, Department of Family Medicine and Community Health (2020). Responding to COVID-19: Operational guidance and considerations. Retrieved on July 16, 2020 from https://www.fammed.wisc.edu/files/webfm-uploads/documents/covid19/operational-guidance.pdf

and best practice interventions shown to be effective with homeless individuals who may be unable or unwilling to engage should be incorporated into crisis services design and delivery, including the use of peer specialists, and supported through workforce development and training. Interventions should meet individuals experiencing homelessness "where they're at," not only providing relief for immediate and basic needs during a crisis, but making connections with housing and longer-term resources that can address their underlying condition of homelessness.

To ensure continued engagement and linkages with longer-term resources, it is important to have both good contacts for referrals into the local homeless response system and in-house crisis program staffing for warm handoffs once an individual is ready to transition from crisis care. Peer specialists with lived experience of homelessness and/or mental health and addiction challenges, in addition to case managers, can work to transition individuals back to the community, making referrals as needed.

Behavioral health crisis programs should not be relied on to resolve homelessness and other social service challenges; however, step-down resources from crisis systems are a critical "back door" for homeless individuals as they come out of behavioral health crisis and seek longer-term resources. Access to short-term residential, subacute crisis stabilization beds, or to other programs where homeless individuals can stay longer to stabilize, allows them to stay engaged as they begin the process of accessing housing and other needed treatment, services, and supports.

Crisis programs should proactively collaborate with homeless systems and providers and with law enforcement — both to ensure effective handoffs and connections with those who can assist a homeless individual longer-term, and to avoid responses that might be harmful to them or escalate their crisis. Cross-system training should encourage understanding of each system's respective resources and roles, and should encourage best practices. Protocols should be established for information-sharing and warm handoffs to inform crisis triage and response and to facilitate smooth care transitions for the individuals served. Informal partnerships and collaborative relationships should lead to more formal ones, including broader systems-level efforts that recognize people with behavioral health conditions who are experiencing homelessness as a commonly encountered population requiring a coordinated response to break the cycle of crisis and homelessness.

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

Addressing Substance Use in Behavioral Health Crisis Care:

A Companion Resource to the SAMHSA Crisis Toolkit

August 2020

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Recommended Citation
Boss, R., Daly, B., & Sadwith, T. (2020). *Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit.* Alexandria, VA: National Association of State Mental Health Program Directors.

Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit

Introduction

A comprehensive crisis response system has an opportunity to direct the turning point of a behavioral health crisis for the better. In a webinar hosted by the National Association of State Mental Health and Program Directors (NASMHPD) on the recently published Substance Abuse and Mental Health Services Administration (SAMHSA) "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit,"[1] the United States Assistant Secretary for Mental Health and Substance Use, Dr. Elinore McCance Katz, stated that "crisis services and systems play an integral role in the delivery of care … provide acutely needed care and they also serve as a very important entry point for so many people in to the mental healthcare delivery system … [and] serve as a means of immediate mental health intervention by trained professionals." In essence, for individuals experiencing a behavioral health crisis, first impressions are important. As an illustrative point of reference, the American Psychological Association, Dictionary of Psychology includes in its definition of the word crisis: "a turning point for better or worse in the course of an illness."[2]Especially for individuals with substance use disorders (SUD), crisis response may be the first and only chance to get it right, and impact not only the outcome of the crisis itself, but the entire recovery process.

The publication of SAMHSA's Toolkit for Behavioral Health Crisis Care (hereafter referred to as the SAMHSA Crisis Toolkit) serves to coalesce a national effort to draw attention to the importance of crisis response for behavioral health. In 2005, the Technical Assistance Collaborative published "A Community-Based Comprehensive Psychiatric Response Service",[3] an informational and instructional monograph that laid the foundation for identification of essential service components in the crisis care

[1] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[2] VandenBos, G. R. (2015). APA dictionary of psychology (2007 ed.). Washington, DC: American Psychological Association.
[3] Technical Assistance Collaborative, Inc. (2005**).** A community-based comprehensive psychiatric crisis response service. Boston, MA: Technical Assistance Collaborative. http://www.tacinc.org/knowledge-resources/publications/manuals-guides/crisis-manual/

continuum. In 2016, the National Action Alliance published the "Crisis Now"[4] policy paper which identified exceptional practices desired in crisis services. NASMHPD has consistently voiced the need to prioritize crisis response for adequate funding, emphasizing community solutions to better address psychiatric needs outside of institutional based care in its 2017 paper "Beyond Beds."[5] And now the SAMHSA Crisis Toolkit serves to give the national voice of leadership in a call to action.

It is essential that the "Anyone" from "Anyone, Anywhere, Anytime" cited in SAMHSA Crisis Toolkit include substance use disorders meaningfully. Substance use disorders cannot be an afterthought in our approach to crisis care. Full integration of mental health and substance use disorders in treatment needs to be embraced across the continuum, which includes the crisis system. We know that 7.7 million adults have co-occurring mental and substance use disorders. Of the 20.3 million adults living with a substance use disorder, 37.9% also had a mental illness. Of 42.1 million adults living with a mental illness, 18.2% also had a substance use disorder. Only 9.1% of those with co-occurring conditions received both mental health care and substance use treatment.[6] And the percentage of people that receive the simultaneous *recommended* care for both is even lower.[7] An assessment of factors that prevent systems from embracing full integration of SUD must include screening for the presence of negative perceptions or attitudes related to SUD. Such perceptions can manifest in prejudicial attitudes about and discriminatory practices against people with substance use disorders. These and other forms of stigma at the organizational and individual levels pose major challenges to the integration of SUD into crisis response systems.

Of great significance in the SAMHSA Crisis Toolkit is the clear inclusion of substance use crisis within the behavioral health definition. It could be interpreted that previous descriptions of crisis care focused solely on mental illness, excluding substance use diagnoses. There is no doubt now that funding, policies, planning and operationalization of a community-based crisis system needs to incorporate the specific needs of individuals with co-occurring mental health (MH) and SUD as well as individuals with substance use only diagnoses and crisis needs related to substance use itself. This report highlights states and programs that are demonstrating success integrating substance use disorders in the three core services described in the SAMHSA Crisis Toolkit – crisis call centers, mobile crisis response services, and crisis stabilization services. This report also identifies the essential principles that are crucial for effective integration, as well as practices that are more specific to the SUD population not identified within the SAMHSA Crisis Toolkit but may be useful for consideration of implementation.

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[4] National Action Alliance for Suicide Prevention: Crisis Services Task Force (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc. https://www.sprc.org/resources-programs/crisis-now-transforming-services-within-our-reach

[5] Pinals, D. & Fuller, D. (2017). Beyond beds: The vital role of a full continuum of psychiatric care. Arlington, VA: Treatment Advocacy Center *and* Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf)

[6] Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs, 36*(10), 1739-1747. doi:10.1377/hlthaff.2017.0584

[7] Substance Abuse and Mental Health Services Administration (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

Person-Centered Care: Integrating Mental and Substance Use Disorders within the Crisis System

Crisis care cannot be diagnosis dependent, and the "no wrong door" approach is therefore critical, especially when there remains such a fragmentation of SUD and MH treatment delivery systems. Historically, the entire continuum of care for behavioral health from prevention to recovery, including crisis intervention, has segregated care for mental and substance use disorders. The SAMHSA Crisis Toolkit "Interview 6 with Nick Margiotta" illuminates this fragmentation.[8] The interview provides his account of a frustrating effort to access help for an individual in crisis who was turned away from psychiatric care because they were actively using substances, only to be subsequently turned away from substance use disorder care because they were suicidal. This cycle of denying care due to active symptomology of co-occurring disorders is a clear demonstration of a poorly integrated system of care. As noted by NASMHPD in its 2019 Technical Paper "Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now?", much work had been done beginning in the late 1980's through early 2000s to support an organized implementation process for integrated services for mental illness and substance use disorders. Then as attention focused on costs and negative outcomes associated with comorbid physical and behavioral health conditions (specifically mental and substance use disorders), momentum shifted to integration within the physical health realm, as if mental health and substance use integration were completed.[9] It was not.

Low perceived need and barriers to care access for both disorders likely contribute to low treatment rates of co-occurring disorders.[10] Individuals with substance use disorder often do not perceive the need for help, as the illness is often accompanied by a denial of its existence.[11] A moment of crisis may open the window of opportunity to break through and engage individuals to see the consequences of continued substance use more clearly and plant the seed of hope for recovery. Intervention at the time of crisis using evidence-based practices such as motivational interviewing combined with seamless connection to treatment and effective follow up may increase the rates of treatment initiation for a population typically hard to engage. Understanding the stages of change model prepares crisis responders to identify interventions that will have the greatest impact. This report offers specific examples of programs and States that have implemented person-centered approaches for individuals with substance use disorder through a crisis response system.

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[8] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit, pp. 73-55. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[9] Minkoff, K. & Covell, N. (2019). Integrated systems and services for people with co-occurring mental health and substance use conditions: What's known, what's new, and what's now? pp. 4-5. Alexandria, VA: National Association of State Mental Health Program Directors.

[10] Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs*, 36(10), 1739-1747. doi:10.1377/hlthaff.2017.0584

[11] American Society of Addiction Medicine (2011). Public policy statement on relapse in healthcare and other licensed professionals. Chevy Chase, MD: American Society of Addiction Medicine. https://www.asam.org/docs/default-source/public-policy-statements/111pip_relapse_4-11.pdf?sfvrsn=b274212a_0

As described further in this report, universal incorporation of Screening, Brief Intervention and Referral to Treatment (SBIRT) throughout the continuum of care can improve our identification of substance misuse and use disorders. It is critical that our crisis response system be fully prepared to address substance use disorders from triage to connection to care. Screening and assessment tools need to be inclusive of substance use and connections to care need to include referrals made to appropriate levels of care within the SUD treatment continuum, including medication-assisted treatment (MAT). As concluded by the National Academies of Science, Engineering, and Medicine, MAT prevents death, stabilizes patients, and should be available to all people – including people interacting with the crisis system.[12]

Core Services and Best Practices

The SAMHSA Crisis Toolkit identifies three essential elements of an effective behavioral health crisis response system incorporating a no wrong-door, integrated approach: crisis call centers; crisis mobile teams; and crisis stabilization facilities and services. This section identifies examples of states and/or programs that have effectively and meaningfully integrated substance use or co-occurring disorders into these core components of a crisis response system. It is important to note that SUD integration is most effective when integrated throughout the entire service delivery system. Some states, such as Georgia, have achieved integration across the three domains. Other states are evolving to become more inclusive of Co-occurring Disorders (COD) and SUD. For example, Delaware is in the process of re-procuring its crisis response system to comprehensively include SUD in all response services. Washington requires its central crisis administrator, the Behavioral Health Services Organization, to manage both SUD and MH crisis and has invested in cross-training its mobile crisis responders to develop and improve the competencies for addressing the needs of individuals with SUD experiencing crisis.

Regional Crisis Call Centers

People contact crisis lines for different reasons. Individuals who are feeling overwhelmed and unable to cope reach out in desperation seeking help and hope. Family members, teachers, friends, faith-based leaders, loved ones, and co-workers also call crisis lines seeking help for someone else and guidance on how to support the individual. A crisis call responder must provide a compassionate presence and quickly assess the needs of the caller as well as safety risks and concerns. Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide, accident, medical complications, and other causes. Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10–14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior.[13] Additional risks associated with substance use disorders include non-suicidal accident, injury, victimization (including intimate partner violence) and trauma sometimes related to increased risk-taking behavior. Crisis lines must be equipped to take all calls; therefore, to adequately address needs of individuals using substances, with or without a co-occurring mental illness, training for call responders must include substance specific information. Crisis responders need to assess for risks specific to

[12] National Academies of Sciences, Engineering, and Medicine (2019). Medications for opioid use disorder save lives. Washington, DC: National Academies Press. https://doi.org/10.17226/25310.

[13] Esang, M. & Ahmed, S. (2018). A closer look at substance abuse and suicide. *American Journal of Psychiatry, 13*(6): 6-8.

substance use, such as acute intoxication, withdrawal requiring medical monitoring or management, or overdose in order to adequately triage and determine appropriate response and referral options.

The SAMHSA Crisis Toolkit establishes minimum expectations for a regional crisis call services which include: 24/7 operation; a workforce of clinicians and trained team members overseeing triage; ability to answer all calls; ability to assess suicide and other danger risks; and ability to connect individuals to mobile crisis teams as well as facility based care. Examples of crisis call centers that meet these expectations as well as combining real-time service availability and scheduling capacity include New Mexico's NMCAL, Colorado's Crisis Services and Support Line, Georgia's GCAL, Behavioral Health Response in St. Louis, and the New York City NYC Well program.

For states and municipalities with crisis call services geared for mental health conditions, one option is to integrate SUD-specific capacities and competencies into the existing system. For example, Delaware has developed a comprehensive hotline workflow chart to incorporate SUD as well as social needs or emotional support. Retraining its crisis staff, Delaware is working to ensure individuals with SUD are connected to the right level of care using their real-time open beds platform, the Delaware Treatment Referral Network.

In addition, many states provide substance use-specific hotlines. A crisis for individuals with primary substance use may present differently than individuals with primary mental health or co-occurring disorders. Crisis response for these individuals often involves connections to a specialty addiction treatment system that may be hard to understand or navigate. The caller may present with a defined desire to discontinue their use of alcohol or other drugs. For this reason, substance use specific crisis lines have been developed in many states. For example, the Indiana Addiction Hotline is available 24/7 for individuals seeking addiction treatment services in Indiana. Referral to state-approved agencies is provided by master's degree counselors with bilingual capabilities. Hotline counselors can directly transfer calls to a treatment provider when available. While Tennessee has made significant investment in building a community-based behavioral healthcare system that is co-occurring capable, it also provides a SUD specific hotline. The Tennessee "red line" offers not only a warm handoff to treatment services; it also makes a real-time connection to "lifeliners" – individuals in recovery, employed by local behavioral healthcare providers.

Mobile Crisis Team Services

Community-based mobile crisis services provide face to face interventions for individuals in crisis with trained clinical professionals and peers. These teams meet the person where they are, at the time of need, reaching the individual in the community in order to achieve the best outcome for that person. Historically, mobile crisis teams have been components of community mental health centers (CMHCs), serving a population with primary mental health diagnoses. Across the country, CMHCs have varying capabilities – and deficiencies – related to addressing co-occurring disorders and substance use primary diagnoses. However, there are several strong examples of states and programs that developed mobile crisis team services to meet the needs of individuals with SUD experiencing crisis.

For example, the Georgia crisis response system incorporates all three of the essential services described by the SAMHSA Crisis Toolkit and integrates substance use disorders throughout its services.

The Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) established a clear guide outlining the appropriate use of mobile crisis teams (MCT) in the community.[14] MCTs are dispatched to response to SUD crisis after determining this as the appropriate response as outlined below The Georgia DBHDD acknowledges SUD as a core component of the mobile crisis system by articulating the intent of mobile crisis:

- De-escalate crisis situations;
- Relieve the immediate distress of individuals experiencing a crisis situation;
- Reduce the risk of individuals in a crisis situation doing harm to themselves or others; and
- Promote timely access to appropriate services for those who require ongoing mental health or co-occurring mental health and substance abuse services.

Prior to dispatch of an MCT, the call center makes an effort to engage the individual in crisis in order to create an alliance, involve the individual in care decisions, and assess safety concerns. Individuals are screened related to substance use which includes type of substance(s) used, amount, and presence of withdrawal symptoms. Based on acuity, a decision is made as to whether an MCT is appropriate or if an individual needs a more intensive response involving emergency medical services and/or law enforcement. For example, the MCT will be dispatched as long as the individual is not in active withdrawal from alcohol, benzodiazepines or barbiturates as the associated risks require medical intervention. Alternatively, opioid withdrawal may be appropriately responded to by MCTs that can provide the connection to the appropriate level of care with the ability to provide MAT induction.

In addition to determining clinical appropriateness for an MCT response, there are other community collaborators to facilitate MCT responses. For example, when MCT is the appropriate response, established guidelines help determine when to request varied levels of support from law enforcement, and when it is safe for MCTs to respond alone. This support ranges from asking law enforcement to accompany, follow behind, or be on standby for the team. MCTs are uniquely positioned to address SUD crises in the community when team members have received specific training in SUD risk assessment.

While not aligning with the best practices detailed in the SAMHSA Crisis Toolkit, **co-responder models** in which behavioral health specialists respond to crisis calls in collaboration with law enforcement exist in many states. There are generally two approaches to the co-responder model: an officer and behavioral health specialist ride together in the same vehicle for an entire shift; or the behavioral health specialist is called to the scene and the call is handled together. Aside from reducing costs, diversions of this sort are extraordinarily important for minimizing the criminalization of mental illness and substance use disorders and ensuring people are treated in the least restrictive environment possible. Also, identifying high volume time periods can help maximize this approach given the funding required to support the co-responders. In this way, co-responder models represent a promising tool to help achieve the goals of

[14] Georgia Department of Behavioral Health and Developmental Disabilities (undated). Guide: Using mobile crisis services in lieu of an order to apprehend. https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Guide%20to%20Mobile%20Crisis%20Services.pdf

the American with Disabilities Act as reflected in the *Olmstead* decision for individuals with mental health and substance use disorders.[15]

In response to the opioid crisis, many co-responder programs have been established in states, with a concerted focus on outreaching to the SUD population post-overdose. In Rhode Island, the Hope Initiative is a statewide collaboration between law enforcement and substance use professionals to help guide those in need toward recovery. These teams respond to individuals who have recently survived an overdose as well as responding to community referrals for outreach from friends and family members. If engaged individuals are interested in treatment, the team will provide transportation if needed. Treatment referrals and transportation include access to MAT. The outreach teams continue follow up with individuals who may not be interested in services at point of first contact to offer support and recovery resources. Teams will also provide support to family members impacted by the addiction. West Virginia has taken steps to expand the statewide capacity of similar co-responder models called Quick Response Teams. Quick Response Teams are composed of emergency response personnel, law enforcement officers and a substance use treatment or recovery provider who contact individuals within 24-72 hours of their overdose to offer and assist those individuals with recovery support including referrals to treatment options.[16] And the Massachusetts Post Overdose Support Teams program involves teams of first responders, public health advocates and harm reduction specialists returning to the site of a non-fatal overdose to provide follow-up services to overdose victims and their families.

[15] Martone, K., Arienti, F., & Lerch, S. (2019). *Olmstead* at 20: Using the vision of *Olmstead* to decriminalize mental illness. *Access: The TAC Blog*, September 2019. Boston, MA: Technical Assistance Collaborative. Retrieved from: http://www.tacinc.org/blog/september-2019/september-2019-olmstead-at-20-using-the-vision-of-olmstead-to-decriminalize-mental-illness/

[16] https://dhhr.wv.gov/News/2018/Pages/DHHR-Awards-Funding-for-Quick-Response-Teams.aspx

Crisis Receiving and Stabilization Services

Behavioral health crisis centers serve as an alternative to emergency departments for an individual experiencing a mental health or SUD crisis. These centers are staffed 24/7 with a multidisciplinary team of behavioral health specialists, typically including access to peers, nurses and prescribers and they receive referrals, walk-ins and first responder drop-offs. Crisis centers are designed to address the behavioral health crisis, reducing acute symptoms in a safe, warm and supportive environment while observing for safety and assessing the needs of the individual. Over the last two decades, crisis centers have been expanding across the country, evolving to become more comprehensive, recovery-oriented, and welcoming to individuals receiving care as well as first responders and other referral sources.

Crisis stabilization centers vary in their approach to individuals presenting with co-occurring or primary substance use disorders. On one hand, some have established criteria that exclude individuals who may need withdrawal management services (detoxification), representing a clear opportunity for improving this pillar of the crisis response system to better meet the needs of individuals with SUD experiencing crisis. However, many crisis stabilization providers are connected to detoxification programs and can coordinate rapid admissions for crisis center patients who require that service. In areas where methamphetamine use is prevalent, such as California, Hawaii, and Georgia, crisis providers have become skilled in addressing methamphetamine induced psychosis, recognizing the need to treat the psychosis first and then connect individuals to the right level of care.

For example, to improve the clinical capacity to address both MH and SUD, the Department of Public Health in Los Angeles County instituted incentives to promote workforce enhancements by providing increased rates for agencies with increased levels of licensed clinicians on staff. LA County inpatient detoxification programs can address mild symptoms of psychosis that are often a part of the treatment for methamphetamine. An adequately trained workforce is a key element in effectively addressing SUD in a crisis setting. Crisis centers often employ peers with lived experience with substance use disorders as well as peers with lived experience with mental illness. Training the crisis response workforce in evidence-based practice for SUD can improve outcomes. In early stages of interaction with a SUD population, incorporating the transtheoretical model of behavior change to assess stage of change and guide the use of evidence based practice such as motivational interviewing has demonstrated improvement of treatment engagement and retention rates. In Pima County, Arizona, leaders recognize that the number of individuals with behavioral health conditions in the correctional system represents a problem that cannot be addressed solely through legal means. The Tucson Police Department invested grant funding for comprehensive training in Motivational Interviewing and Trauma Informed Care. This training empowers officers to play a role in encouraging individuals to make recovery oriented decisions. In the provision of SUD crisis response, meeting the individual where they are is both a literal and figurative imperative.[17]

The “Rediscover Assessment and Triage Center” (ATC) is a regional crisis center located in Kansas City, Missouri that addresses both mental health and substance use disorder related crises. Originally established through collaboration with the criminal justice and hospital healthcare systems, the center has expanded to include walk-ins and referrals from community based providers. Case management and

[17] Carroll, K., Ball, S., & Nich, C., Martino, S., Frankforter, T., Farentinos, C., Kunkel, L., et al. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81*(3). 301-312.

connection to peers are areas of significant focus at the triage center. As a regional service, peers come in from across all of the mental health agencies. The ATC dedicates equal attention and resources to both disorders. At the ATC, individuals with opioid use disorders (OUD) are offered induction on buprenorphine or methadone and connected to opioid treatment programs (opioid treatment programs are the sites legally allowed to offer methadone for OUD) in the community. Rapid access to MAT offered through onsite inductions can drastically increase the rates of follow-up and continuity of care and save lives. As ATC is a Certified Community Behavioral Health Center (CCBHC) and operates an opioid treatment program (OTP), their ability to provide continuity of service in the community is enhanced. The success of this program has led to plans for expansion in the state.

The Crisis Response Center (CRC) in Tucson, Arizona provides another example of a comprehensive crisis receiving and stabilization Center. Established in 2011, CRC has a longstanding history of providing services in coordination with community stakeholders through implementation of a no wrong door policy and has access to a comprehensive treatment system for SUD available 24/7. The CRC and Community Bridges provide 24/7 access to detoxification and 24/7 access to medication assisted treatment (e.g. Methadone and Buprenorphine induction) in outpatient settings through community partners. CRC provides access to MAT 24/7 for individuals with high acuity co-occurring mental health need. Individuals presenting at CRC receive assistance with accessing the appropriate level of care, including care coordination, transportation, and a warm handoff.

The SAMHSA Crisis Toolkit identifies short-term residential facilities as an additional element in the system of care. While not necessarily meeting the definition of a "crisis" facility required to take all referrals, these programs are often referred to as crisis stabilization units (CSU) and involve longer stays, usually between 4-7 days. In general, these programs serve individuals who need a longer period of time to return to the community but do not require a hospital-based level of care. Like receiving and stabilization centers, CSUs vary in their ability to address co-occurring or SUD primary patients. In West Virginia, CSUs are facilities with less than 17 beds that accept individuals with MH, SUD and co-occurring disorders. The CSUs provide psychiatric stabilization services, withdrawal management, and induction on buprenorphine for OUD. Individuals who are more appropriate for, or prefer methadone, are transported to the nearby OTP for methadone induction and then daily for continued dosing. While early in implementation, the state is already seeing positive outcomes related to MAT induction, including reductions in readmissions.[18]

Core Principles and Essential Partnerships

Beyond the three components constituting a comprehensive crisis response system as described in the SAMHSA Crisis Toolkit, there are core principles and essential partnerships necessary for effectively addressing co-occurring and SUDs before, during, and after crisis. These principles may be incorporated into services described above; however, for the SUD population, there are key nuances for consideration.

The SAMHSA Crisis Toolkit identifies six core principles that, when fully implemented, represent excellent crisis care systems that incorporate best practices:

- Addressing Recovery Needs;

[18] Interview with West Virginia Bureau for Medical Services official. May 2020.

- Significant Role for Peers;
- Trauma-Informed Care;
- Zero Suicide/Suicide Safer Care;
- Safety/Security for Staff and People in Crisis; and
- Crisis Response Partnerships with Law Enforcement, Dispatch and Emergency Medical Services.

The identified principles of **Trauma Informed Care, Zero Suicide/Suicide Safer Care, and Safety/Security for Staff and People in Crisis** directly apply to individuals with SUD in crisis and are thoroughly addressed in the SAMHSA Crisis Toolkit. The remaining principles require additional exploration with respect to how they relate to SUD specifically.

Applying Core Principles to SUD: Addressing Recovery Needs

The principle of **Addressing Recovery Needs** deserves expanded consideration for a SUD population. *Recovery is possible*. This statement has such significance in the world of substance use disorders. It is easy to give up hope and hard to have compassion for one whose disorder is understood as a moral failing as opposed to a health care condition. For many years, and unfortunately to a significant extent to this day, society has viewed SUDs in this light. This belief is reflected in the oft-heard statement that a person with SUD does not want to change. This is an unfortunate variant of the "Stages of Change" construct in substance use treatment, which typically recognizes the enormous importance of motivational techniques to help people move from one stage of readiness for change to another.

A large percentage of those admitted to SUD treatment cite legal pressure as an important reason for seeking treatment. And some expert sources suggest that outcomes for those who have choices where participation might eliminate some legal consequence to enter treatment are as good as or better than those who were not. In addition to legal consequences, outside influences are also relevant- such as views of families, employers, significant others, desire to not compromise parenting, etc. Individuals with such outside influences, such as those who face some legal consequences if they are in the criminal justice system tend to have higher attendance rates and in remain in treatment for longer periods, which can have a positive impact on treatment outcomes.[19] Implementation guidance suggesting pursuing a "no-force-first" approach is important in SUD crisis, but must not negate the important role that the criminal justice system has had for those facing criminal legal consequences on connecting individuals to care. This is especially the case when such legal "pressure" can itself be seen as a motivational force rather than an unwanted mandate. Indeed how the legal pressure is formulated as part of the treatment can be a crucial difference if presented as a motivational opportunity rather than something being imposed on one who is "not ready." These types of conversations to aim toward engagement can be nuanced, and it is useful to have training in techniques like motivational interviewing, even to help individuals make decisions where there can be criminal justice consequences to a particular decision about treatment engagement.

[19] National Institute on Drug Abuse (last updated April 2014). Principles of drug abuse treatment for criminal justice populations — a research-based guide. Retrieved on 3/27/20 from https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide

Applying Core Principles to SUD: Significant Role for Peers

The **Significant Role of Peers** in crisis response for individuals with SUD can differ from roles of peers in the traditional MH system. Despite the prevalence of co-occurring disorders previously noted, there continues to be some division amongst peers defined as having MH or SUD lived experience.

The nascent yet growing recovery movement has been game-changing for individuals affected by substance use disorder, and the power of peers with lived SUD experience sharing their experiences, hope, and resilience has had significant impact not only on affected individuals but also on the system of care as a whole. Despite a foundation of addict helping addict through traditional 12 step programs, the SUD delivery system was slow to engage the power of peers throughout the continuum. With the launch of the SAMHSA Access to Recovery (ATR) discretionary grant program in 2004, peers with SUD experience were increasingly considered to be essential members of the overall system of care. The Connecticut Community for Addiction Recovery (CCAR) led the nation in the development of training, standards, and the activation of peer experience to influence care.[20] In addition, Georgia has a rich history of peer involvement in the continuum of care for mental health. However, even there, the number of peers working throughout the continuum with SUD lived experience is significantly less than those with MH lived experience. As is the case with virtually every state, Georgia seeks to increase the number of SUD peers in their crisis system, as they do not yet have enough who are trained and certified to meet the need.

The opioid crisis has prompted states to consider new ways to leverage and employ the SUD recovery community to share hope and resilience with individuals who are hard to engage and at risk.

Pre-crisis programs like AnchorMore in Rhode Island deploy Peer Recovery Specialist to overdose hotspots to engage high-risk individuals.[21] Weekly team calls identify areas where overdoses have been most prevalent and may convene more often if there is a marked increase in an area not previously identified. Teams of peers are sent to these areas and dispense Narcan kits as well as fentanyl test strips. During these interactions, peers are establishing connections with active users and will provide referral to treatment and recovery services when individuals are interested. This program has demonstrated a high rate of engagement for services with an at-risk population.

Peers have also been deployed to respond to crises, including overdoses, in EDs. While preferable to address crisis in community-based settings, the nature of SUDs may necessitate the use of ED in crisis, and it is important to have SUD-focused supports across settings in the crisis continuum to effectuate the "no wrong door" approach. Individuals who have overdosed or those whose substance use has resulted in serious injury must receive appropriate medical care first. In the wake of the opioid crisis, EDs have become an important component of the crisis system in addressing SUD. Many states have incorporated peer response to overdose survivors and other individuals with SUD presenting in EDs and have seen this crisis point as a successful point of intervention and engagement for care. For example, Kentucky implemented the Bridge Program which not only provides peer support post overdose, but also involves hospitals providing induction on MAT. Pennsylvania integrates peers in community based

[20] Connecticut Community for Addiction Recovery (2010). CCAR history (2000-2010). Retrieved on 5/27/20 from: http://ccar.us/about-ccar/history/ccar-2000-2010/

[21] Waye, K. M., Goyer, J., Dettor, D., Mahoney, L., Samuels, E. A., Yedinak, J. L., & Marshall, B. D. (2019). Implementing peer recovery services for overdose prevention in Rhode Island: An examination of two outreach-based approaches. *Addictive Behavior 89,* 85-91. doi:10.1016/j.addbeh.2018.09.027

care management teams that reach out to clients in EDs post overdose, but also extends outreach to correctional facilities, primary care settings and other community- based settings. The aim of the outreach is to engage individuals in their successful Center of Excellence program, expanding access to MAT, providing case management to address other social determinants of health, and encouraging continued involvement with health and mental health treatment.

Crisis receiving stabilization centers, such The Restoration Center in San Antonio, Texas employ peers, identified as recovery support specialists to provide follow up care for individuals discharged from the crisis centers. These peers provide services to individuals up to 45 days post crisis which include assistance in obtaining housing, accessing medications, transportation to appointments, peer support, follow up phone calls and welfare checks.

Applying Core Principles to SUD: Crisis Response Partnerships

Effective response to SUD throughout the crisis care continuum entails developing **Crisis Response Partnerships** with partners and in settings above and beyond those described in the SAMHSA Crisis Toolkit. As noted previously, EDs can provide a place of engagement for individuals with SUD. Intervention efforts can extend beyond connecting individuals with SUDs to peers. Forty percent of ED visits are due to trauma, and of these, between 40% and 50% are alcohol related. Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in ED settings allows an opportunity for identification, engagement and intervention. Massachusetts' Project Assert uses health promotion advocates (HPAs) to perform SBIRT as part of routine emergency department care. These encounters with HPAs provide patients with the opportunity to explore change through non-judgmental conversations combined with access to health and treatment services. EDs can also be an effective site for treatment initiation.[22] A study published in 2015 demonstrated the impact of MAT induction within an ED setting for individuals presenting with Opioid Use Disorder (OUD). This study concluded that ED-initiated buprenorphine, "compared with brief intervention and referral, significantly increased engagement in formal addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services."[23] In California, the Bridge Program supports hospitals to provide buprenorphine and embeds Recovery Support Navigator staff in EDs with the goal of meeting individuals with SUD where they are and improving connections to care following an SUD-related ED visit.[24] The Bridge Program shows comparatively high rates of completed follow-up visits to community-based providers among patients who received buprenorphine and Recovery Support Navigator services in the ED.[25]

Forming partnerships with first responders also have the potential to achieve significant impact on assisting individuals experiencing SUD crisis in areas of crisis prevention, response and post crisis outreach. For example, the Safe Stations program initiated in Manchester, New Hampshire has now been replicated in cities across the country. The Safe Station program provides fire stations as open doors for individuals seeking help for substance use disorders, 24/7. Fire Department personnel

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[22] Massachusetts ED SBIRT Initiative: https://www.bu.edu/bniart/sbirt-experience/sbirt-programs/sbirt-hospital-emergency-department/

[23] D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., & Fiellin, D. A. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *JAMA*, *313*(16), 1636–1644. https://doi.org/10.1001/jama.2015.3474

[24] http://www.californiamat.org/matproject/california-bridge-program/

[25] California Bridge Program. *Barriers, Gaps, and Opportunities*. Treatment Starts Here convening. January 2020.

conduct a brief medical assessment before connecting these individuals to treatment and recovery resources. Similarly, partnerships with law enforcement also represent a promising opportunity for responding to the needs of individuals with SUD experiencing crisis. The Police Assisted Addiction & Recovery Institute is a national network of police departments spanning 32 states that offer simple, stigma-free, non-arrest pathways to treatment and recovery based on the Angel Program established by the Gloucester Police Department in Massachusetts in 2015.[26]

Financing Strategies

There are several federal funding authorities that states can leverage to finance crisis care systems, including those that deliver services for individuals with co-occurring and SUD-only diagnoses experiencing crisis. States can use traditional federal funding sources available for mental health-oriented crisis response services to achieve progress towards a more fully integrated crisis care system. Given the patchwork nature of mental health and SUD crisis service funding highlighted in the SAMHSA Crisis Toolkit, states can develop a braided funding approach to finance system improvements and pay for service provision.[27] In a braided funding approach, policymakers coordinate the use of multiple, discrete funding authorities to support a single strategy while retaining the identity and expenditure data specific to each authority.[28] SAMHSA has identified strong examples of states that braid funding sources to develop crisis service systems and provide crisis care, including with state general funds, federal grants, and various Medicaid authorities.[29]

Discretionary SAMHSA grant funding opportunities can be used to pay for certain costs of crisis care systems not covered by payments from health care plans, such as infrastructure and "startup" costs associated with developing crisis care system capacities, crisis response care for uninsured individuals, and components of crisis response care that are not included in individual plan coverage. States can use the annual Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant programs to develop and enhance crisis response systems with SUD-specific capacities.[30] In addition, states (and often providers) can apply for other SAMHSA grant funding opportunities to implement crisis response efforts with SUD-specific capacities. States are leveraging the State Opioid Response (SOR) grant funding opportunity to implement some of the best practices described in this report. For example, California and West Virginia are allocating SOR funding to scale up the Bridge Program and Quick Response Team SUD crisis interventions described above to meet

[26] The Police-Assisted Addiction and Recovery Initiative: https://paariusa.org/about-us/
[27] Page 36
[28] AGA Work Group on Blended and Braided Funding, operating under the auspices of AGA's Intergovernmental Partnership (2014). Blended and braided funding: A guide for policy makers and practitioners. Alexandria, VA: Association of Government Accountants.
https://www.agacgfm.org/AGA/Intergovernmental/documents/BlendedandBraidedFunding.pdf
[29] Substance Abuse and Mental Health Services Administration (2014). Crisis services: Effectiveness, cost effectiveness, and funding strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848
[30] FFY 2020-2020 Block Grant Application (Community Mental Health Services Block Grant Plan & Report *and* Substance Abuse Prevention & Treatment Block Grant):
https://www.samhsa.gov/sites/default/files/grants/fy2020-2021_blockgrantapplicationandplan_091718_508.pdf

individuals with SUD literally where they are and improve connections to care following an SUD-related crisis event.[31]

States can also design their Medicaid program to maximize federal matching funds and secure a sustainable source of funding for crisis response services in ways that account for local circumstances. There are longstanding federal policy and regulatory options at states' disposal to cover crisis response services for Medicaid beneficiaries with SUD, including the core components described in the SAMHSA Crisis Toolkit. For example, components of crisis call center, mobile crisis response, and crisis stabilization services can be covered under Medicaid:

- in the state plan through the rehabilitation, other licensed practitioner, and clinic services at Section 1905(a);
- in the state plan through the home and community-based services option at Section 1915(i);
- in the home and community-based services waiver programs at Section 1915(c); and
- as administrative costs, especially for crisis call centers.[32]

In addition, states have additional flexibilities to receive federal Medicaid funding for crisis stabilization services provided in facilities that meet the definition of an institution of mental disease (IMD) and would otherwise be excluded for federal Medicaid reimbursement. Specifically, in states delivering crisis services through risk-based managed care, federal Medicaid funds are available for capitation payments to managed care plans whose enrollees receive psychiatric and SUD crisis residential services provided in IMDs as an "in lieu of" service so long as the length of stay is less than 15 days.[33] In addition, states can apply for the Section 1115 demonstration opportunity announced in 2018 that offers federal Medicaid funding flexibilities for mental health services provided in IMDs, including crisis stabilization services.[34] Notably, the 2018 guidance identifies improved availability of crisis response services, including crisis call centers, mobile crisis response, and crisis stabilization services, as a milestone that states must meet over the course of the demonstration.

Impact and Lessons Learned from COVID-19

The COVID-19 pandemic has created a new set of challenges for policy makers and providers serving individuals with SUD, including those who may experience a crisis episode. Yet amid these challenges are key opportunities to leverage for developing comprehensive crisis response systems designed to meet the needs of individuals with SUD experiencing a crisis, and mitigate disparities in public health and crisis care that are being brought to the forefront during this pandemic.

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[31] California MAT Extension Project: California Bridge Program (updated April 2019). Retrieved on 5/28/20 from: http://www.californiamat.org/matproject/california-bridge-program/

[32] U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (2018). State Medicaid Director 18-011: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf

[33] 42 CFR 438.6(e)

[34] U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (2018). State Medicaid Director 18-011: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf

For one, individuals receiving MAT are at increased risk for morbidity and mortality caused by interruptions in their pharmacotherapy as discontinuing MAT often leads to relapse and overdose.[35] Despite federal agencies such as SAMHSA and DEA issuing guidance offering states and providers considerable flexibility for maintaining access to medications, access to certain SUD treatment services has nevertheless been jeopardized during COVID-19. Intensive levels of care provided in congregate care settings such as inpatient and residential treatment programs have been especially impacted by COVID. For example, a survey of behavioral health providers reveals that 91 percent have reduced operations, with two-thirds closing at least one of their programs.[36] It is essential that the crisis response system be aware of these capacity limitations and develop strategies to maintain engagement with individuals if they must wait for admission.

Another important consideration for the crisis response system is the increase of substance use in general. A survey of patients, families, and individuals in recovery revealed that 20 percent of respondents have increased their substance use since the start of the pandemic, and 14 percent were unable to access needed services due to COVID-19.[37] Individuals in recovery may be challenged by increased stressors resulting from COVID-19, such as loss of a job and income, lack of child care, and increased isolation. Some data indicates increase in alcohol sales up to 32% compared to a same point in time one year prior, and several states show an increase in per capita alcohol sales in April 2020 compared to the prior 3-year April average.[38] Excessive alcohol use can increase not only susceptibility to COVID-19 but also severity. Alcohol use is also indicated in increased Intimate Partner Violence. The United Nations Secretary General called for measures to address the "horrifying surge" in domestic violence associated with government lockdowns and stay at home orders.[39] Increased use of alcohol and other substances during COVID-19 heightens the need for crisis responders to be fully aware of assessing and addressing SUD during intervention.

The associations between certain SUDs and COVID-19 risks are not fully known. However, there are several areas worth noting as data is still emerging. For instance, individuals who smoke or vape as a route of administration may be more susceptible to infection and face poorer prognoses due to respiratory health issues, which might include higher case-fatality rates. Conversely, COVID-19 positive individuals who develop compromised lung function could be at heightened risk of hypoxia associated with opioid and/or methamphetamine use given the potential for pulmonary damage associated with

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[35] National Academies of Sciences, Engineering, and Medicine 2019. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310.

[36]National Council for Behavioral Health. (April 6, 2020). "COVID-19 Economic Impact on Behavioral Health Organizations". National Council for Behavioral Health. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2020/04/NCBH_COVID19_Survey_Findings_04152020.pdf?daf=375ateTbd56.

[37] Hulsey, J., Mellis, A., & B. K. (June 8, 2020). "COVID-19 Pandemic Impact on Patients, Families & Individuals in Recovery from a SUD." Addiction Policy Forum. Retrieved from https://www.addictionpolicy.org/post/covid-19-pandemic-impact-on-patients-families-individuals-in-recovery-fromsubstance-use-disorder; Meadows Mental Health Policy Institute. (April 28, 2020).

[38] Macmillan, Carrie (June 4, 2020). "Drinking More Than Usual During the COVID-19 Pandemic?" Yale Medicine. Retrieved from https://www.yalemedicine.org/stories/alcohol-covid/.; National Institute on Alcohol Abuse and Alcoholism. "Alcohol Sales During the COVID-19 Pandemic". Retrieved from https://pubs.niaaa.nih.gov/publications/surveillance-covid-19/COVSALES.htm.

[39] United Nations (April 6, 2020). "UN chief calls for domestic violence 'ceasefire' amid 'horrifying global surge'". UN News. Retrieved from https://news.un.org/en/story/2020/04/1061052.

each of these conditions under various circumstances.[40] Harm reduction strategies such as "never use alone" and ensuring naloxone is available may not be effective or possible when individuals are socially distancing and sheltering-in-place consistent with public health guidelines.

As data is starting to come to light, some of the worst fears about the connection of the pandemic to the SUD population may be coming true. Suspected overdoses have increased by 191% in January-April 2020 compared to January-April 2019, according to the Overdose Detection Mapping Application Program, an initiative developed by a federal Office of National Drug Control Policy grantee.[41] The COVID-19 pandemic is reinforcing the value of crisis response strategies especially tailored for individuals with SUD. During the pandemic, it will be critical to ensure overdose response teams as described earlier in this paper have sufficient personal protective equipment and funding to perform these vital engagement, follow-up and referral services to overdose survivors and their families.

Crisis Services for Substance Use Disorders Examined with a Racial Equity Lens

The COVID-19 pandemic is also reinforcing the need to address disparities inherent in the public health emergency and in the systems designed to address crises and SUDs. Research shows that racial and ethnic minority groups are disproportionately affected by the coronavirus and the resulting economic crisis.[42] In addition, data that parses out the impact of various substances and access to services among racial and ethnic minority groups is shedding light on disparities in outcomes. Disparities in health care may actually have attenuated the impact of the "first wave" of the opioid epidemic associated with prescription opioids in the Black/African American community, as Black/African American patients are 29 percent less likely to be prescribed opioids for pain than white patients.[43] However, as part of the "third wave" of the opioid epidemic associated with skyrocketing rates of overdose deaths involving fentanyl, between 2011 and 2016 the Black/African American population experienced the highest increase in fatal overdose rates of deaths involving fentanyl.[44] Between 2015 and 2016, the rate of increase in overdose deaths was highest for the Black/African American population among all racial and ethnic groups. In addition, Black/African American individuals with OUD experience disparities in access

[40] Volkow, Nora (July 2020). "Collision of the COVID-19 and Addiction Epidemic." *Annals of Internal Medicine, Vol.* 173(1).

[41] Alter, A., Yeager, C (May 13, 2020). "The Consequences of COVID-19 on the Overdose Epidemic: Overdoses are Increasing." Overdose Detection Mapping Application Program. Retrieved from http://www.odmap.org/Content/docs/news/2020/ODMAP-Report-May-2020.pdf.

[42] Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved on July 16, 2020 from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html; Brown, S. (2020). The COVID-19 crisis continues to have uneven economic impact by race and ethnicity. *Urban Wire,* blog of the Urban Institute. Retrieved on July 16, 2020 from https://www.urban.org/urban-wire/covid-19-crisis-continues-have-uneven-economic-impact-race-and-ethnicity;

[43] Centers for Disease Control and Prevention. "Understanding the Epidemic". Retrieved from https://www.cdc.gov/drugoverdose/epidemic/index.html; Pletcher MJ, Kertesz SG, Kohn MA, Gonzales R. Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. JAMA [Internet]. 2008 Jan 2 [cited 2019 Dec12];299(1):70-8.

[44] Substance Abuse and Mental Health Services Administration: The Opioid Crisis and the Black/African American Population: An Urgent Issue. Publication No. PEP20-05-02-001. Office of Behavioral Health Equity. Substance Abuse and Mental Health Services Administration, 2020.; Centers for Disease Control and Prevention. "Understanding the Epidemic". Retrieved from https://www.cdc.gov/drugoverdose/epidemic/index.html.

to evidence-based treatment for OUD, with studies showing that buprenorphine-based treatment is less accessible and delivered less frequently to Black/African American patients than white patients.[45]

American Indians and Alaska Natives (AI/AN) also experience disparities in both the COVID-19 pandemic and opioid epidemic. The AI/AN population is hospitalized for COVID-19 at five times the rate as the white population.[46] In addition, Tribal governments and communities are facing relatively greater economic devastation than many states during this severe fiscal environment. Because Tribes do not have tax bases similar to local and state governments, casino and other enterprise represent Tribes' main revenue stream. As these industries have been put on hold as a public health measure, Tribes are grappling with even greater budget shortfalls than states; COVID-19 threatens to "completely reverse" the progress that Tribes have made in community economic development.[47] With respect to SUD, relevant data for American Indian and Alaska Native populations are often compromised by racial misclassifications in surveillance and vital statistics systems. The racial misclassifications – whereby AI/AN individuals are reported as belonging to racial/ethnic groups other than AI/AN – result in undercounting the true prevalence of health conditions among AI/AN communities. For example, a recent study matched drug and opioid-involved overdose-related death records from the Washington State Center for Health Statistics with the Northwest Tribal Registry, a database of AI/AN patients seen in Indian Health Service, tribal, and Urban Indian health clinics in Washington state. The Washington death records were corrected for AI/AN classification using the Northwest Tribal Registry data, and the corrected death records were then compared with federal CDC data. The comparison suggests that CDC data underestimate drug overdose mortality counts and rates among AI/AN by approximately 40%.[48] Underestimation notwithstanding, AI/AN individuals still experience above-average rates of drug overdose deaths.[49]

Disparities in public health and overdose deaths represent an opportunity for states to develop innovative, community-specific outreach and engagement strategies, especially for individuals with SUD experiencing a crisis. For example, Black/African American individuals were found to be three times more likely to die during a police encounter than white individuals, even though they were more likely to be unarmed.[50] Given the recognition of police violence as a public health risk by organizations such as the American Medical Association and American Public Health Association, states are more poised than ever to reallocate resources and responsibilities for crisis care services away from law enforcement and

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[45] Ibid.

[46] Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.

[47] Akee, R (April 10, 2020). "Re: allocation of COVID-19 Response Funds to American Indian Nations." Harvard Kennedy School ASH Center for Democratic Governance and Innovation. Retrieved from: https://ash.harvard.edu/files/ash/files/hpaied_covid_letter_to_treasury_04-10-20_vsignedvfinv02.pdf.

[48] Seven Directions: A Center for Indigenous Public Health (September 2019). "An Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure". University of Washington. Retrieved from https://www.nihb.org/docs/04092020/Environmental%20Scan%20of%20Tribal%20Opioid%20Response%20Booklet.pdf.

[49] Centers for Disease Control and Prevention. "Injury Prevention in American Indian and Alaska Native Communities." Retrieved from https://www.cdc.gov/injury/fundedprograms/tribal.html.

[50] DeGue, S. "Deaths Due to Lethal Force by Law Enforcement." *Am J Prev Med.* 2016 Nov; 51(5 Suppl 3): S173–S187.

towards appropriate crisis response systems such as those described in the SAMHSA Crisis Toolkit and this brief.[51]

SUD crisis care during COVID-19 is revealing a confluence of disparities. Yet from crisis comes opportunity: this moment in time presents an excellent opportunity for policy makers to catalyze on public sentiment and political will to ensure crisis response systems are adequately funded and positioned to respond to behavioral health crises. The momentum provided by a heightened national and state interest in transferring public and social service functions from law enforcement entities to human service agencies also offers states a platform to continue evolving their crisis systems to adequately address the needs of individuals with SUD experiencing a crisis event.

Conclusions

Behavioral health parity requires some insurers that provide coverage for mental health and substance use conditions to ensure those benefits are subject to limitations that are not more stringent than similar benefits physical health conditions.[52] The healthcare system can no longer tolerate services that are disparate for individuals with substance use disorders. SAMHSA's specific inclusion of SUDs in its Crisis Toolkit should serve as notice that service parity needs to exist in all behavioral health crisis response systems. The "Anyone" in the "Anyone, Anywhere, Anytime" from the SAMHSA Crisis Toolkit must include individuals with co-occurring SUDs or sole SUD diagnoses. The degree to which states' crisis response systems encompass SUD varies and states are continuously evolving these systems to meet needs.

A comprehensive system of crisis response can positively impact the entire continuum of care for individuals with SUD from prevention through recovery. Incorporating SUD meaningfully into a crisis response system requires training of staff at levels, implementation of evidence-based screening and assessment tools, employment of peers with lived SUD experience, access to services that can support withdrawal management and medications to treat conditions such as OUD, and monitoring fidelity to evidence based practices as well as outcomes. Crisis providers should be able to demonstrate success of interventions with SUD and implement processes for continuous quality improvement with this population. Providers should also routinely assess staff for presence of negative perceptions or attitudes related to SUD, as stigma poses a challenge to strategic planning and implementation efforts to better meet the needs of individuals with SUD.

Effective partnerships are crucial for positive outcomes in crisis response. Partnerships ensure appropriate resources for preventing crisis, responding to crisis, and providing effective warm handoffs for care and continued recovery support. Including SUD in a behavioral health crisis response may require the system to expand these partnerships to include community based organizations and providers outside the historical networks. Law enforcement, EMS, health care providers, hospital

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[51] Strazewski, L (June 8, 2020). "Why police brutality is a matter of public health." American Medical Association. Retrieved from https://www.ama-assn.org/delivering-care/health-equity/why-police-brutality-matter-public-health; American Public Health Association (November 13, 2018). "Addressing Law Enforcement as a Public Health Issue." Policy Number 201811. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence.

[52] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. The Mental Health Parity and Addiction Equity Act. Retrieved on 5/28/20 from: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

systems, peer-based recovery organization and substance use specific treatment providers all have a critical role in SUD throughout the continuum. This call to action also requires SUD providers to come out from the shadows to be front and center as partners is responding to the emerging needs of individuals in crisis with SUD. It is no longer sufficient for the SUD treatment world to stand back and wait for individuals to show up at the door. The absence of SUD specific providers as active partners in the crisis system only perpetuates the potential for discrimination toward individuals with SUDs.

There is clear opportunity for all states to use and incorporate the SAMHSA Crisis Toolkit to improve, enhance and expand their crisis response systems to be more inclusive of individuals with SUDs. The potential for positive impact throughout the behavioral healthcare system, and most importantly for the individuals in need of care, their families, and their communities cannot be overstated.

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

CRISIS SERVICES: ADDRESSING UNIQUE NEEDS OF DIVERSE POPULATIONS

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Project Support

This work was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the 2020 Technical Assistance Coalition of the National Association of State Mental Health Program Directors.

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Recommended Citation

Pinals, D. A., Edwards M. L. (2020). *Crisis Services: Addressing Unique Needs of Diverse Populations*. Technical Assistance Collaborative Paper No. 8. Alexandria, VA: National Association of State Mental Health Program Directors.

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.

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

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Improving the Child and Adolescent Crisis System:
Shifting from a 9-1-1 to a 9-8-8 Paradigm

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Recommended Citation
Bostic, J., Hoover, S. (2020). *Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm.* Alexandria, VA: National Association of State Mental Health Program Directors.

Perhaps the most potent element of all, in an effective crisis service system, is relationships.
To be human. To be compassionate.
We know from experience that immediate access to help, hope and healing saves lives.

- SAMHSA 2020,
National Guidelines for Behavioral Health Crisis Care
Best Practice Toolkit

Background

The lack of a comprehensive coordinated crisis response system for children and youth has resulted in inconsistent care, repeated emergency department (ED) visits and hospitalization, and arrests and detention for youth whose crises are responded to by law enforcement rather than behavioral health providers [1] [2] [3]. SAMSHA has recently emphasized the importance of crisis services that are available to **anyone, anywhere, and any time**, and which do not lead to delays, detainment, or denial of services, or create undue burdens on those afflicted, or on EDs, law enforcement, or the justice system [4]. This vision is perhaps most critical for our youngest citizens, whose behavioral health challenges can often be prevented or identified early, yet are often neglected, at a high cost to society and to the quality of life of many children and families.

Behavioral health disorders are described as serious changes in the way children typically learn, behave, or handle their emotions, leading to distress and problems getting through the day.[5] The prevalence of chronic behavioral health disorders continues to grow among youth, doubling in the past decade, and impacting 20–25 percent of school-aged youth [6] [7]. In children aged 3-17, the most commonly diagnosed behavioral health conditions in children are anxiety (7.1%), ADHD (9.4%), disruptive behavior disorders (7.4%), and depression (3.2%); these conditions often are comorbid, and are more common among children impacted by poverty and other social determinants of health [8] [9]. Suicide is currently the second most common cause of death in young people (ages 10-24) in the United States, and suicide rates in youth have increased 56% over the past decade, with the greatest increases occurring since 2014.[10] People younger than 25 years of age account for 45% of the global burden of disease from behavioral health conditions.[11]

With the rise in behavioral health disorders, we have seen a parallel increase in behavioral health crises among children and adolescents in the United States [1]. These crises are typically addressed by engagement with EDs, law enforcement, or psychiatric inpatient care [2] [3]. Children in crisis are frequently boarded for long periods in EDs or receive short inpatient stays, often resulting in readmission. Many concerns that result in hospitalization may have been prevented or better served via community-based care models with appropriate wraparound supports.

Challenges with the Current Child and Adolescent Crisis System

Limited prevention, early identification and intervention

Emotional and behavioral health challenges in children can often be prevented or diminished with early, immediate identification and action, yet our care systems often do not reflect this reality. The benefits of prevention and early intervention for physical health are now well-recognized. Routine screenings and checkups, and awareness of signs and symptoms that allow early detection and intervention, are increasingly implemented in pediatrics. Such routine screening and behavioral health checkups have lagged in child behavioral health,[12] with those under age 25 experiencing the greatest delay to initial treatment after initial symptom onset.[13] Currently, less than half of children with a behavioral health condition receive any behavioral health treatment,[14] resulting in estimated costs of approximately $247 billion annually from this lack of behavioral health treatment.[15] A number of factors, including persisting stigma and lack of providers, have slowed the emphasis of behavioral health early intervention, leading to much more costly downstream or late intervention, when behavioral health crises necessitate urgent, dense, and often lengthy interventions.[16] The World Health Organization recognized that addressing childhood adversities, particularly those associated with maladaptive family functioning, such as parental mental illness, child abuse and neglect, would lead to a 30% reduction of any lifetime mental disorder, and a 39% reduction in child mental disorders.[17] Moreover, these childhood risk factors and adversities contribute to children having further recurrence of mental disorders later in life.[18] Promoting early detection of behavioral health symptoms and implementing prevention and early intervention strategies that enhance children's emotional and behavioral regulation slows and alters the progression and impacts of child mental illness.

Misuse of Emergency Departments (EDs)

Pediatric behavioral health ED visits nationwide have increased dramatically across the United States in recent years. EDs are typically the first point of contact for children having any type of crisis. Despite its frequency of use, the ED has become an unattractive option to manage behavioral health crises for multiple reasons.[19] First, EDs have become overburdened with non-emergent, inappropriate behavioral health referrals. The ED has become a prime route for patients after hours, once clinics close, and at least one-third of these referrals are not truly urgent. Similarly, about half of the students sent by schools to the ED for behavioral health conditions are inappropriate (i.e., low severity of presenting complaint, low harm potential, absent suicidality or psychosis, and/or no recommended behavioral health follow-up).[20] Second, children with limited resources are routed to the ED amidst an escalation or conflict, yet rarely does ongoing behavioral health care result; children with public health insurance or no health insurance are four times more likely to seek mental health treatment at the ED than children with private insurance.[21] Third, ED staff are poorly prepared to respond to behavioral health crises beyond suicidality and psychosis, despite most behavioral health crises arising from aggressive

outbursts or escalations.[22] Fourth, despite efforts to route families to community providers after an initial ED visit, the ED often becomes the ongoing site for recurrent behavioral health crises.[23] [24] So behavioral health crises routed to the ED more often result in subsequent ED visits, more testing, longer stays, and boarding for hours to days until transfer from the ED to a suitable placement can occur.[25]

Law Enforcement Involvement in Child Behavioral health Crises

As first responders, police are frequently accessed for behavioral health crises in children and families. Police are usually poorly prepared for managing behavioral health crises, and feel time pressured to deescalate situations quickly or to then employ more familiar policing strategies, which too often lead to arrest and detention. An adult with a behavioral health condition is six times more likely to get arrested than someone without a serious mental illness,[26] and 16 times more likely to get injured or die during encounters with the police.[27] Nearly 70 percent of children in the juvenile justice system have a diagnosable behavioral health disorder,[28] 60% of children with an emotional disturbance will be arrested at least once within 4 years after leaving high school, and 39% report being on probation or parole.[29] Most police academies devote less than 1% of training to interactions with adolescents,[30] yet 20% to 40% of juvenile arrests are for "contempt of cop" offenses, such as questioning or "disrespecting" an officer.[31] Incarceration of adolescents fails to decrease recidivism and compounds the negative impacts on the 60-70% of youth in correctional facilities who have significant untreated behavioral health problems.[32] [33]

Racism and Inequity

Despite many emotional and behavioral crises in children and youth resulting from unmet behavioral health needs, crisis events are often responded to with disciplinary or legal action, disproportionately affecting Black and Latinx/Hispanic students compared to White youth[34]. System challenges contribute to a preference for disciplinary versus behavioral health response, including implicit bias and racism among educators and health providers, and fewer behavioral health resources and instead greater law enforcement presence in communities of color [35]. In schools, where most ED referrals for child and adolescent crises arise, educators are usually inadequately trained to identify and address behavioral health concerns [36]. Further, "zero tolerance" policies remain common, despite evidence that they are counterproductive and disproportionately negatively impact youth of color [37]. Ultimately, when youth of color experience emotional and behavioral health crises, they are often met with education and health systems that favor a discipline response over a behavioral health response. In addition, inequities in behavioral health care access, utilization, and quality persist for children and adolescents [38]. Disparities are often attributed to challenges such as stigma, cost, and transportation, but also result from the systemic racism within our behavioral healthcare institutions that lead to limited access and poor quality of care for youth and families of color [38].

A paradigm shift

The challenges outlined above illuminate the need to reconfigure the behavioral health crisis system to better provide coordinated, specialized and equitable crisis prevention and intervention for all children and youth. In 2020, SAMHSA introduced national guidelines for behavioral health crisis care, calling for system transformation toward a more proactive, compassionate, efficient and effective system for those experiencing crises [4]. Core principles of the guidelines include addressing recovery needs, engaging peers, utilizing a trauma-informed and zero suicide

approach, and collaborative partnerships with law enforcement, dispatch and emergency medical services (EMS). While many of the principles and practices apply across the lifespan, some additions and adjustments must be considered for application with children and adolescents and their families. Fortunately, the core principles of the new national guidelines align well with System of Care principles that have been adopted and adapted by many state and local systems for children and adolescents, including family- and youth-driven care, cultural and linguistic competence, preference for community-based services, and interagency collaboration [39].

Multiple current conditions uniquely position us to establish a comprehensive, high-quality child and adolescent crisis system: (1) the 2020 introduction of SAMHSA behavioral health crisis practice guidelines; (2) the recent Federal Communications Commission (FCC) approval of the 9-8-8 behavioral health crisis hotline (to expand our existing 9-1-1 emergency response); and (3) a multitude of lessons and innovations from the global COVID-19 pandemic to inform crisis system transformation. In this brief, we offer best practice considerations for achieving a paradigm shift in our child and adolescent crisis system, away from a reactive and fragmented approach toward a full continuum of supports and services, built on the collaboration of child-serving systems and leveraging current technology. We will first highlight opportunities to "work upstream"; that is, to prevent crises before they occur and diminish them when they do arise by leveraging the natural support systems already available to children and families, including schools, pediatric primary care and community partners. We then outline child-specific considerations to augment the SAMHSA Crisis Best Practice Toolkit, with an emphasis on developmental attunement, youth and family engagement, and cultural responsiveness and equity. Finally, we derive policies from lessons learned in the context of COVID-19, including ways to harness and expand technology to augment care quality and access.

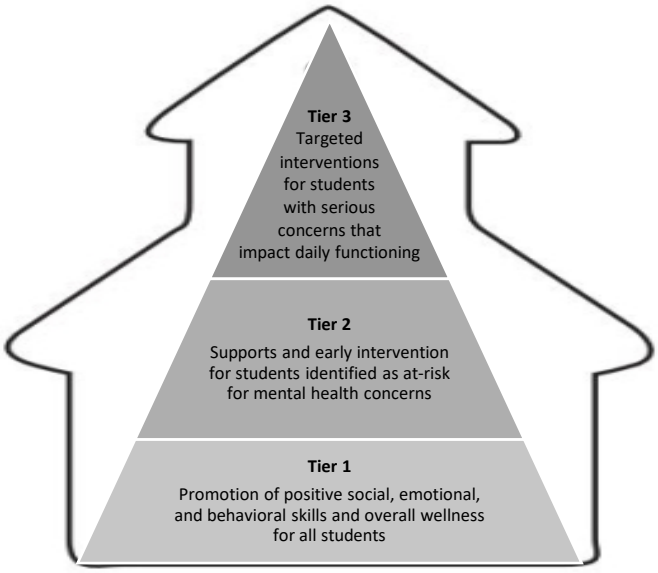
Working Upstream: Prevention and Early Intervention in Child and Adolescent Crisis

In a 2018 brief to the National Association of State Mental Health Program Directors (NASMHPD), states and communities were described as increasingly shifting delivery systems for children's behavioral health to an upstream approach that minimized unnecessary use of acute care settings, such as emergency departments, psychiatric hospitals, and residential treatment facilities.[40] The brief described the value of Mobile Crisis Response and Stabilization Services (MRSS) as an approach that identified problems early, before intensive psychiatric care (e.g., inpatient or residential treatment) were needed. Moving further upstream than the MRSS, other resources and interventions exist that may both prevent and intervene early to diminish children's emotional and behavioral health crises. Many mental illnesses that lead to behavioral health crises could have been identified and treated earlier in their trajectory, likely lessening the negative outcomes for children and families, including the experience of crises. Further, many of our youngest citizens, especially youth of color, experience disciplinary responses, such as juvenile services and incarceration, for behaviors that could have been prevented or best addressed with a behavioral health response [34 38]. This is a fundamental tenet in building a comprehensive behavioral health care system which cannot be overstated and should be a focus of every conversation regarding crisis response systems. Although we must address current failings in our current crisis response system for children, we should only do so while simultaneously building universal behavioral health promotion and early identification and intervention systems to minimize crises from occurring in the first place.

Schools

Increasingly, schools are installing *comprehensive school mental health systems (CSMHS)*, reflecting partnerships between education and behavioral health sectors to support a full continuum of behavioral health supports and services, from promotion to treatment [41]. CSMHS provide a full array of tiered services, often referred to as multi-tiered systems of support (MTSS; see Figure 1), including universal behavioral health promotion activities for all students, selective prevention activities for those most at risk to develop behavioral health conditions, and indicated early intervention services such as clinical assessment and treatment for those students who screen positive for behavioral health conditions. CSMHSs rely on meaningful partnerships between school systems and community programs so that children are supported by collaborative school-employed behavioral health professionals and community behavioral health providers.

Figure 1. Multi-Tiered Systems of Support (MTSS) in Schools

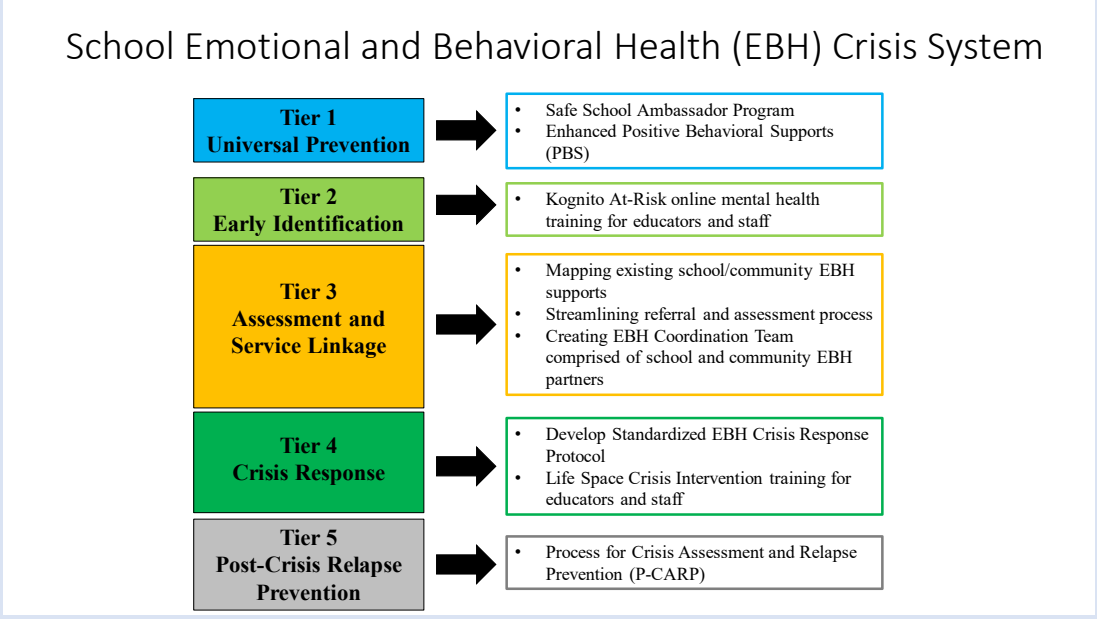


When treatment is delivered in the school setting, youth are far more likely to be identified early, and to initiate and complete care [42 43 44]. Further, interventions delivered in schools have demonstrated positive impact on multiple of children's psychosocial outcomes. Schools across the nation are increasingly delivering universal programming, with students participating in social emotional learning (SEL) programs demonstrating significantly greater social-emotional skills (e.g., emotion regulation), prosocial behavior and positive self-image, and significantly fewer conduct problems, emotional distress and substance use problems than their peers who do not receive such programming [45 46 47 48]. Behavioral health treatments delivered in schools have demonstrated success at reducing mental illness, including anxiety and depression [49 50], post-traumatic stress [51 52 53], behavior disorders [54 55], and substance use problems [56 57].

An essential component of CSMHS is crisis prevention and response. The installation of a comprehensive MTSS has been demonstrated to reduce emotional and behavioral health crises [58]. Despite many emotional and behavioral crises in schools resulting from unmet behavioral health needs, crisis events too often lead to unnecessary disciplinary or legal action by schools, [59] which disproportionately affects Black and Latinx/Hispanic students compared to White students [60]. System challenges also contribute to disciplinary over behavioral health

responses in schools, such as inadequate training of school staff to identify and address behavioral health concerns [61] [62], overburdened educators and inadequate student instructional support staffing, and limited response mechanisms to support behavioral health interventions relative to typically well-specified disciplinary procedures [63]. Successful school crisis prevention and response involves a comprehensive approach that installs a continuum of behavioral health supports and services, including universal focus on positive school climate and social emotional learning, behavioral health literacy for teachers and students, crisis preparedness for all school personnel, a focus on educator and school staff well-being, and availability of on-site school behavioral health providers, including both school- and community-employed professionals. Box

Box 1. The School Emotional and Behavioral Health (EBH) Crisis System was installed and studied as part of a randomized controlled trial (RCT) funded by the National Institute for Justice. As illustrated, at the universal level (Tier 1), the Safe Schools Ambassadors program offered peer training for students from various social groups in conflict management and bullying prevention. At Tier 2, an online virtual simulation technology trained teachers in how to support students experience psychological distress. In addition to creating clear referral, assessment and coordination of school and community behavioral health supports (Tier 3), all education staff received crisis response training using the Life Space Crisis Intervention program (Tier 4). Finally, a structured process was implemented for post-crisis response relapse prevention (Tier 5).



The system is now established as a "Promising Program," with the initial RCT demonstrating increases in school staff knowledge and preparedness to address emotional and behavioral health issues and increases in student actions and behaviors to prevent mistreatment and improve school climate. Intervention schools also had 56% fewer suspensions, 75% fewer office referrals, and more on-site crisis response and threat assessments as opposed to off-site referrals to EDs or law enforcement. For more information: https://www.crimesolutions.gov/ProgramDetails.aspx?ID=677&utm_source=govdelivery&utm_medium=email&utm_campaign=csreleases

1 illustrates a comprehensive school-based crisis prevention and intervention initiative recently studied as part of the National Institute of Justice Comprehensive School Safety Program.

Pediatric Primary Care

Pediatricians remain a trusted and frequently accessed avenue for children and families to obtain behavioral health support. Over 70% of children and adolescents under age 18 see a primary care provider annually,[64] and parents and youth report feeling comfortable discussing behavioral health issues with their primary care providers.[65] [66] Pediatricians may be particularly helpful in apprising families of a 9-8-8 system as that emerges, and in providing families de-escalation approaches and behavioral health checkups during routine physical checkups. For more complex issues, collaboration and behavioral health support for pediatricians by behavioral health providers has emerged as an effective approach, with improved behavioral health outcomes for youth compared to usual care.[67] The elements most effective for collaborative care include population-based care (systematic efforts to screen or track all patients for a condition and track outcomes), measurement-based care (using validated tools to identify and monitor responses to treatment of particular behavioral health conditions), and evidence-based behavioral health services (specific psychological interventions such as motivational interviewing, problem-solving, psychotropic prescribing, psychoeducation).[68] A guide for initiating collaborative behavioral health care within pediatric primary care has been devised by the American Academy of Child and Adolescent Psychiatry and is freely available on their website (https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf).

Multiple approaches have improved infusion of behavioral health promotion and early intervention into contemporary pediatric care. First, *child psychiatry access programs* (CPAPs) are a "facilitated referral model," (coordinated care model) where pediatricians have rapid (within an hour) access to behavioral health providers located off-site, and who consult to pediatricians about mental conditions, including crises, but do not absorb the direct care of these patients. CPAPs have now been implemented in over 30 states in the past decade. The initial Massachusetts Child Psychiatry Access Program (MCPAP) has remained the model most states now emulate. Initial calls from the pediatrician are immediately triaged by a MCPAP care coordinator who either (a) provides the pediatrician viable behavioral health resources (e.g., a counselor appropriate for the child's condition, who is geographically feasible, and who takes the family's insurance), or (b) connects the pediatrician, within 60 minutes, to a MCPAP child psychiatrist, psychologist, or social worker to discuss the case and plan treatment. While the MCPAP behavioral health provider does not assume care of the child/family, they remain a consultation support for the pediatrician to manage the case, or until care is transitioned, if necessary, to a local behavioral health provider for ongoing treatment. Over 95% of Massachusetts pediatricians participate in the program, and satisfaction with services has remained high since creation of the program.[69] [70] There is now an existing national infrastructure, the National Network of Child Psychiatry Access Programs (NNCPAP) of now 30+ state programs, to support pediatric primary care physicians as they manage psychiatric issues of their patients.[71] These programs initially relied on remote calling centers, but now many include face to face evaluations patients with unclear diagnoses, and also telepsychiatry meetings with patients. In addition, most of these CPAP programs maintain active websites (e.g., www.mcpap.org, www.dcmap.org) with efforts to provide pediatricians effective screening tools for both general and specific behavioral health monitoring, and provide ongoing guides and

recommendations to address common behavioral health concerns. These CPAP programs provide an alternative rapid route for children and families experiencing urgent behavioral health needs, and also an opportunity for mass distribution of relevant mental information (e.g., 9-8-8 information, de-escalation approaches for families) through the NNCPAP network that allows relevant information to be applied to specific regions or States.

Second, co-located models, in which behavioral health clinicians are housed in primary care settings to provide direct care and consultation provide another model where families can be more easily seen by a behavioral health clinician on-site (or virtually by telehealth) familiar and more easily accessible to the pediatrician. Data are promising for on-site co-located behavioral health providers, with reports that 85% of patients follow through to attend their first appointment, and 84% of patients report showing improvement over a 6-month interval.[72] Co-located providers appear effective in diverting patients from visits to the ED; over a six month period, embedded predoctoral psychology interns in one pediatric clinic were able to provide 184 "warm handoffs," 250 same-day behavioral health consultations, 223 follow-up appointments, and to manage onsite 21/23 (91%) patients who reported suicidal/homicidal ideation (and who otherwise would have been referred to the ED for further evaluation).[73]

Community Partners

Schools and primary care providers are parts of most communities and can serve a critical role in crisis prevention and response. Additional important partners for addressing behavioral health care are local community organizations, sometimes unique to the area. Identifying those community organizations that have aligned goals and interests is important for configuring a collaborative behavioral health system, including crisis prevention and response. Multiple types of organizations may enhance the collaborative care system for a community, such as:

- Mentorship programs (e.g., Big Brother/Big Sister)
- After school programs
- Recreation and parks programs
- Youth sports leagues
- Youth and family advocacy organizations
- Faith organizations, youth groups

To create a behavioral health crisis management system for children and adolescents, mapping the local resources to identify important partners can significantly expand local, familiar, trusted supports for both children and families who have experienced behavioral health crises.

Best Practice Considerations for Child and Adolescent Crisis Systems

Consistent with the premise described by SAMHSA that crisis services must be available to **anyone, anywhere, and anytime**, best practices indicate that a child and adolescent crisis continuum should be available 24/7 to all children, regardless of payer[74]. A comprehensive crisis continuum includes screening and assessment; mobile crisis response and stabilization; residential crisis services; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination. These components, articulated in the 2018 NASMHPD *Making the Case for a Comprehensive Children's Continuum of Care*, align with the 2020 SAMHSA practice guidelines for crisis behavioral health. The guidelines specify

three organizing categories of support that must be embedded in any comprehensive crisis system:

1) Regional Crisis Call Hub Services (*Someone to Talk To*)
2) Mobile Crisis Team Services (*Someone to Respond*)
3) Crisis Receiving and Stabilization Services (*A Place to Go*)

We will describe each component briefly, followed by considerations for how to best fit these to the child and adolescent system context.

Regional Crisis Call Hub Services (*Someone to Talk To*)
Regional crisis call services allow for real-time access to a live person 24/7/365 to support those experiencing behavioral health crises. As of July 2020, the FCC approved a national 9-8-8 behavioral health crisis number, to be fully installed by July 2022, that will increase access to immediate crisis support via this one easily recognized and remembered number. Minimally, regional crisis lines are staffed by clinicians with expertise in behavioral health crises and suicide risk assessment, and who are equipped to triage callers to appropriate mobile teams or facility-based care, as warranted. Best practices call for regional crisis services to have Caller ID functionality, utilize GPS-enabled technology to dispatch mobile care when needed, utilize real-time bed registry data to connect to facility-based care, and schedule community-based follow-up care akin to a warm handoff following the crisis episode.

To meet the needs of children and families in crisis, regional crisis call hub services should consider the following:

- **Expand technology options for callers**, including the use of texting, telephone and telehealth. Children and adolescents may prefer to seek crisis support via texting or videoconferencing, as they may feel that these mechanisms are more familiar or less stigmatizing.
- Akin to how we begin teaching children about 9-1-1 in preschool, **educate children in preschool and throughout K-12 schooling about how to access regional crisis call services** (e.g., OK2SAY program, https://www.michigan.gov/ok2say/), preferably as part of behavioral health literacy education in the curriculum. Education should emphasize help-seeking efficacy and destigmatizing of mental illness and seeking support.
- All regional center calls pertaining to child and adolescent concerns should be staffed by individuals with **specialized training in child and adolescent development and behavioral health and illness**. This would include an understanding of typical developmental milestones, how to promote positive behavioral health, and how to distinguish typical challenging behaviors of childhood and adolescents from behaviors that reflect a more serious concern. They should be familiar with child behavioral health and developmental disorders and behaviors or symptoms that differ from those experienced by adults, including autism, sensory processing disorders, developmental delays, separation anxiety, and Attention Deficit Hyperactivity Disorder. See Table 1 for examples of common behavioral health concerns among children and adolescents and how they might be presented during a crisis call.

- Call center staff should have **skills to navigate family systems** during crisis call, including how to diminish conflict and increase safety, engage additional support people, and determine whether speaking with the child or adolescent in crisis will be useful for information gathering and de-escalation. These skills would include how to best engage families as co-supporters and experts about their child, when possible, and addressing any parent/guardian concerns about child safety, including family concerns about being reported to protective services or law enforcement if they seek help.
- Call centers should have **developmentally attuned guidance for de-escalating children and adolescents** and their family members, as needed. This may include how to support family and school personnel in managing conflict and behavior dysregulation, and how to separate, support, and/or distract a child experiencing a crisis.
- All calls should be delivered in a **culturally responsive manner**, with call center staff receiving ongoing training on racism and bias, and the unique strengths and needs of Black, Indigenous and People of Color (BIPOC) youth and families, and how those intersect with behavioral health crises. Interpretation services should be made available to the extent possible (see Pinals, Edwards, 2020)[75].
- Call center staff should have training in **adolescent reactivity to peer rejection or romantic breakups**, both predictors of suicidality and risk behavior.
- Given the high risk for suicide, bullying, substance use and other behavioral health concerns among **LGBTQ+ children and adolescents**, call center staff need to be versed in supports responsive to this population.
- Call center staff need to be **familiar with school-specific concerns** such as chronic absenteeism or school refusal, aggression and bullying (including cyberbullying) in schools, and emotional and behavior dysregulation that disrupts the school environment, and how these may best be managed in the school setting.
- Call center staff should understand the array of **child and adolescent supports and service delivery options**, including pediatric primary care, school supports and services, local child and adolescent behavioral health providers, and other community supports. These may include mentorship opportunities, extracurricular activities, faith-based supports, and service, and community service.

Developmental Differences Manifest Differently in Youth

Approximately 75% of behavioral health conditions begin before adulthood. Crisis responders need to be aware of how youth may describe symptoms compared to adults. For example, young children rarely describe being "anxious" or "depressed," but may instead complain of physical ailments, often week after week, as they may only notice that they feel badly rather than understand why. Youth with depression are often more likely to report feeling angry or irritable than to report feeling depressed or sad, and may stop doing previously enjoyable activities (e.g., riding a bike, playing a sport, etc.) when they become depressed.

In addition, some behavioral health symptoms more commonly occur in youth, and result in crises, such that crisis responders require specific child behavioral health training to be prepared to recognize underlying conditions that may result in a behavioral health crisis. Table 1 describes how parents/guardians may describe a current crisis to a 9-8-8 phone responder.

Table 1: Behavioral health Symptoms Presenting as a Crisis in Youth

Behavioral health Category	**How This May Present as a Crisis Call to a 9-8-8 Phone Responder "My Child:"**
Autism	"doesn't speak or look at me or seem to want to engage." "won't listen or respond to me." "freaks out if we don't do our usual schedule or change our plans" "doesn't play or show any interest in other children." "freaks out over normal noises." "does weird stuff with toys instead of playing with them." "just wants to swing or rock for hours and won't stop."
Anxiety	"won't go outside, worries about everything." "won't be apart from me, wants to know where I am." "describes having bad dreams every night and comes to my room."
Attention Deficit Hyperactivity	"doesn't think before doing dangerous, foolish things." "refuses to listen to me and do what I ask." "runs into the street or jumps off high places."
Communication Disorders	"is making stuttering sounds." "got into another fight with a peer today because of misunderstanding."
Conduct	"is stealing/shoplifting/vandalizing, assaulting others." "is lying and I can't take it anymore." "is staying out late, disobeying my rules." "is hiding guns/knives/bullets in room." "hurt our family pet/set a fire for no reason."
Disruptive Mood Dysregulation	"is having horrible meltdowns over nothing every other day." "is in a bad mood all the time and can't calm down for hours."
Elimination Disorders	"is peeing all over the place; keeps wetting the bed after told not to." "is leaving poop under the couch; won't clean self after pooping."
Feeding and Eating Disorders	"will only eat a few things." "eats weird stuff—like dirt or hair" "refuses to eat because they'll get too fat." "will eat but then do things so they'll throw up."
Intellectual Disability	"isn't doing or keeping up with schoolwork." "isn't doing what other kids their age."
Learning Disorder	"hates school and refuses to do math/reading/writing assignments."
Movement Disorder	"is making weird movements with arms/legs/mouth/head." "is suddenly now blinking all the time/making weird noises uncontrollably."
Obsessive-Compulsive Disorders	"does this long ritual before they will leave home and freaks out if interrupted." "has pulled all their hair out over the weekend." "has hoarded all kinds of food into a closet, and it's all rotting now."
Somatic Disorder	"keeps saying they have a stomach/headache, refuses to walk." "is very sick, eyes rolling back in their head, and no one believes me."
Traumatic Disorder	"won't stay with a sibling alone at night in a room." "keeps avoiding my relative, who they used to like." "has bad dreams often and will scream or come to my room."

Mobile Crisis Team Services (*Someone to Respond*)
To respond to crises as they occur, mobile crisis teams that offer community-based interventions must be available to support individuals in crisis wherever they are, including home, school, or any other community location. Two-person teams are preferred, with diversion from emergency department or the justice system preferred. Minimally, mobile crisis team services must include a licensed and/or credentialed clinician who can respond wherever and whenever a crisis occurs. This can include home, stores, schools, offices, streets, and even juvenile courts outside of a locked facility in some states. The team will conduct warm hand-offs to facility-based care as needed and coordinate transportation if the situation warrants location transition. Best practices call for peer support (i.e., those with direct experience with the behavioral health system and who are trained to support individuals in crisis) as part of the mobile crisis team to decrease engagement of law enforcement. As above, mobile crisis teams should partner with the regional crisis call center to utilize GPS-enabled technology.

To meet the needs of children and families in crisis, mobile crisis team services should consider the following:

- **Expand technology options for crisis response teams, including the use of telehealth**. Children and adolescents may prefer to engage in crisis support via videoconferencing, as they may feel that these mechanisms are more familiar or less stigmatizing. In addition, telehealth may allow for broader access and improved response time and efficiency.
- For all crises pertaining to child and adolescent concerns, mobile crisis team members should be staffed by individuals with **specialized training** (as outlined above for call responders) including training in:
    - child and adolescent development and behavioral health and illness, including manifestations of child traumatic stress (e.g., difficulties at school, withdrawal);
    - skills to navigate family systems, including how to diminish conflict and increase safety, engage additional support people, and how to best engage child and family in a developmentally appropriate manner to gather information and de-escalate crisis;
    - the escalation cycle across the developmental spectrum, and developmentally attuned de-escalation skills, including approaches like collaborative problem solving and specific strategies (e.g., validate feelings but not actions; see Box 2 for specific child-specific de-escalation strategies from The Crisis Prevention Institute, https://www.crisisprevention.com/).
    - culturally responsive crisis management, including skills in supporting the unique strengths and needs of BIPOC and LGBTQ+ youth and families;
    - assessing for child abuse, neglect and family violence and supporting families if a report to child protective services is warranted;
    - assessing parent readiness and ability to implement recommendations and interventions, with consideration for parental behavioral health, cognitive ability, social supports and stressors and economic resources.
- Mobile crisis team members responding to child and adolescent crises should be **familiar with school-specific concerns and school procedures to support students with emotional and behavioral needs.** Team members should be versed in the special

education process, including how families can access and advocate for special education programming (e.g., 504 Plans and Individualized Education Programs).

- Mobile crisis team members should understand the array of **child and adolescent supports and service delivery options**, including pediatric primary care, school supports and services, local child and adolescent behavioral health providers, and other community supports. These may include mentorship opportunities, extracurricular activities, faith-based supports, and service, and community service.

Box 2. 18 De-escalation Strategies for Children and Adolescents

1. Don't yell to be heard over a screaming child
2. Avoid making demands
3. Validate their feelings, not actions
4. Don't try to reason
5. Be aware of your body language
6. Respect personal space
7. Get on child's level
8. Use a distraction
9. Acknowledge child's right for refusal
10. Reflective listening
11. Silence
12. Be non-judgmental
13. Answer questions and ignore verbal aggression
14. Movement break
15. Avoid the word "no"
16. Decrease stimulation
17. Deep breathing exercises
18. Calming visuals

Crisis Receiving and Stabilization Services (*A Place to Go*)

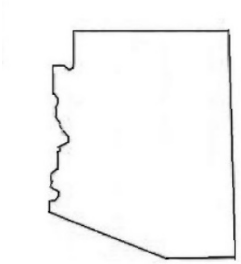
During a crisis, it is essential that individuals have a place to go that will accept, support and stabilize them regardless of age or clinical condition. Crisis receiving and stabilization services act as a "no wrong door" mechanism for those in crisis to receive immediate behavioral health support and offer our de-facto crisis responders (i.e., law enforcement, emergency departments) a more appropriate alternative to address crisis. Minimally, crisis receiving and stabilization services accept all referrals (including walk-in and first responder drop-offs), do not require medical clearance prior to admission (but offer medical support, as needed), design services to address mental health and substance use needs, offer 24/7/265 multidisciplinary staffing capable of meeting all levels of crisis and screening for suicide and violence risk, when clinically indicated. Best practices dictate functioning for a 24 hour or less facility with a dedicated first responder drop-off area, incorporation of intensive support beds (including those within the real-time bed registry system), and coordinate connection to ongoing care.

To meet the needs of children and families in crisis, crisis receiving and stabilization services should consider the following:

- Children and adolescents should have **a separate area from adults** to be received and supported during crisis. It can be distressing and frightening to young people to witness adults in crisis, increasing the likelihood that the child's crisis will escalate rather than diminish. The climate of receiving and stabilization needs to be calming, positive, welcoming and compassionate.
- **Receiving spaces should be developmentally attuned**, with places to play and move safely, especially for younger children. For adolescents, who may be particularly concerned about the stigma of seeking help, spaces that allow privacy are optimal. The environment should be calming aesthetically and include art and signage that is appealing and friendly to youth, and not overstimulating.
- **Telehealth should be available for care provision and engagement of supportive others.** Children and adolescents in crisis may prefer to see providers via videoconferencing, also expanding the capacity for access to limited child behavioral health specialists. Telehealth technologies can be used to integrate other support important in the care process, including school personnel, family members, peers, or primary care providers.
- For all crises pertaining to child and adolescent concerns, crisis receiving and stabilization services should be staffed by individuals with **specialized training** in child and adolescent development and behavioral health (as outlined above for call responders and mobile crisis teams).
- **Medical staff must have training in child and adolescent health** to ensure developmentally appropriate, high-quality medical care, as needed. If pediatric or child psychiatric providers cannot be available on-site, telehealth may be utilized as a mechanism to ensure 24/7/265 pediatrician and child psychiatry consultation.
- Crisis receiving and stabilization services must have **spaces for family support and gathering**, both to immediately support the child in crisis and to provide a space for separation and parental/guardian support, as needed. Families should be offered comfortable places to stay with children, including places for rest for young children, access to snacks and developmentally attuned activities.

Three vignettes are provided in **Appendix A** that describe example circumstances with varied system responses during child and adolescent crisis situations. These represent a small sampling of the crisis situations that present during childhood and adolescence but are illustrative of the unique considerations that arise during each stage of crisis response, from call to stabilization.

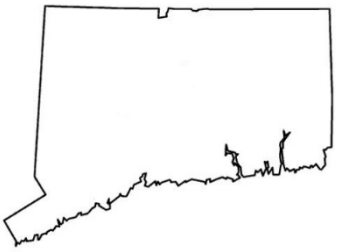
Examples and Outcomes of Child and Adolescent Crisis Response Systems



Arizona: Crisis Response Center (CRC)

In 2006, county bond funds supported the development of the Banner-University Medicine Crisis Response Center (CRC), serving adults and children in Pima County, Arizona. The CRC was initiated to provide support to those in need of urgent psychiatric care and to reduce the number of individuals with behavioral health needs in emergency departments or the criminal justice system. In addition to a 24/7 Behavioral Health Crisis Line that can dispatch GPS-tracked mobile crisis teams and manages an electronic bed placement board, the CRC offers a peer-operated warm-line staffed by trained peers who, as described on their website, "provide a friendly voice, support and help to alleviate loneliness and isolation."[76] They also offer a Tribal warm line, supported by the American Indian Support Service. The CRC serves approximately 12,000 adults and 2,200 children annually, with 45% brought directly by law enforcement via a secure gated sally-port and 10% are transported from emergency departments. Adults and children are served in distinct, separately licensed areas of the facility. The CRC is connected to a Level II trauma emergency room, a 66-bed Behavioral Health Pavilion, and the mental health court. Between 2015-2019, the CRC had an 8% increase in adult visits and a 24% increase in youth visits. Increasing numbers may reflect growing awareness of the service, including among law enforcement who now have a more sophisticated option than waiting hours in an emergency department, and may also reflect the limited options to prevent crises before they occur.

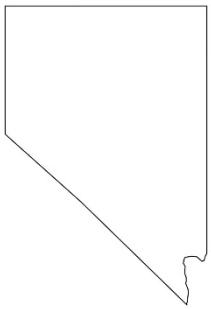
Connecticut: Mobile Crisis Intervention Services



Connecticut's Mobile Crisis Intervention Services (formerly called EMPS) is available at no cost to all youth in the state under age 18. A single statewide call center, currently accessed by dialing 2-1-1, deploys providers to the crisis location. The providers are comprised of 160 trained behavioral health professionals from 14 different sites, allowing for on-site response within 45 minutes of when a child experiencing a behavioral health need or crisis. Mobile Crisis provides ongoing care to youth and families for up to 45 days to offer stabilization and linkages to ongoing behavioral health support.

Since data collection began in 2011, the number of Mobile Crisis response episodes of care increased by 54%, with 14,585 episodes in 2018 alone. For two consecutive years, schools have provided the greatest proportion of referrals to Mobile Crisis (44.3% in 2018). Schools often use Mobile Crisis as an alternative to transporting a child to the Emergency Department or contacting law enforcement. A recent study demonstrated that over a period of 18 months, youth using Mobile Crisis had 25% lower emergency department use than a comparable group[77]. Most (88%) of parents or guardians report satisfaction with Mobile Crisis and 2018 data demonstrate significant decrease in problem severity and increase in functioning among youth who received Mobile Crisis[78]. Evaluation of Mobile Crisis has demonstrated significant cost savings, with the

average cost of an inpatient stay for Medicaid-enrolled children and youth being $13,320, while the cost of Mobile Crisis was $1,000, saving $12,320 per youth[79].



Nevada: Children's Mobile Crisis Response System Rural Team
In November 2016, the Rural Mobile Crisis Response (RMCRT) team of Nevada began taking calls. By September 2017, the RMCRT had served 243 youth and families across Rural Nevada; 86 percent of youth were successfully diverted from the hospital. Initially funded for three years through the State's Division of Child and Family Services, the Department of Public and Behavioral Health Rural Clinics received a budget enhancement during the 2019 legislative session to grant continued funding through Fund for a Healthy Nevada (allocated from tobacco settlement monies to help with services that address the health and well-being of all Nevadans). Call volume has increased in recent years, and in 2017, the RMCRT reported a Hospital Diversion Rate of 86%. The rural team intends to expand coverage using telehealth and has already equipped many of its rural schools, hospitals and Juvenile Detention Centers with the telehealth program the RMCRT uses for interventions, allowing for more efficient crisis response.

Crisis Lessons and Innovations from COVID-19

COVID-19 has disrupted the delivery of behavioral health care across the globe. Data also points to an anticipated surge in behavioral health care needs related to the pandemic, including for children and adolescents who are suffering the burdens of family financial insecurity, caregiving load, and social isolation during a time of limited access to supports [80] [81]. Past pandemics, such as the Influenza of 1918, 2009 H1N1 flu, and the 2014 Ebola virus all were associated with increases in depression, anxiety, stigma, and shaming.[82] Longitudinal negative impacts of other large-scale community crises (e.g., natural disasters) on children's behavioral health and academic functioning have also been well documented [83] [84]. These tragic events, though, also led to significant transformations in behavioral health care.[85] There are many lessons and innovations from the global response to COVID-19 that can guide us as we reconstruct our children's crisis system.

1. **COVID-19 has further illuminated disparate inequities in our health, education and economic systems and the resulting toll on youth behavioral health.** COVID-19 has disproportionately impacted non-White racial and ethnic groups [86] [87] [88]. Social determinants of health, including systemic racism, poverty, and inequitable access and quality of healthcare and education, have historically prevented BIPOC individuals from having equal economic, physical and behavioral health. Children suffer the same disparities, which during and following crises are compounded by their limited ability to independently mobilize resources and supports to buffer the negative impacts [89]. COVID-19 is expected to worsen the inequities in health outcomes for those living in poverty and in resource-poor rural communities across the United States [90].The disparate increases in unemployment and economic burden from COVID-19 in poor regions and in communities of color alone will be detrimental to children's mental health. Golberstein and colleagues found a striking 35% to 50% increase in "clinically meaningful childhood mental-health problems" during a 5-percent-age-point increase in national unemployment

during the Great Recession (2007 to 2009) [91]. Given unemployment rates of over 11% in August 2020 compared to less than 4% in January 2020, and that the increase is in the context of a health crisis and school closures, the mental health impact on children is likely to be even more severe than past trends, particularly in communities that are harder hit. In addition to greater density of family and community members inflicted with COVID-19 in communities of color, resulting in greater behavioral health consequences, youth of color are much less likely to have access to behavioral health support and at greater odds of receiving poor quality behavioral health care [92]. Children living in rural areas are also more likely to have more negative COVID-19-related health outcomes and limited accessibility, availability and acceptability of behavioral health services [90 93].

The profound inequities highlighted during COVID-19 have implications for how we build crisis response systems for children. Namely, children's behavioral health crises must be viewed within the context of the child's family and neighborhood/community and influenced by social and environmental factors. As such, these factors must be both assessed and addressed during crisis response, rather than simply focusing on the individual child or attributing crisis behaviors to individual psychopathology that can be treated at the child level [94]. In addition to assessing for and addressing social determinants of health during crisis response with children and families, our systems must act as "health strategists," addressing the social determinants that contribute to the development of behavioral health crises in the first place [95]. Recognizing the anticipated long-lasting impacts of COVID-19 on marginalized communities, Shah and colleagues (2020) called for our public health departments to think beyond individual interventions and to foster cross-system partnerships, with public health departments in the lead, to develop broad social supports (e.g., financial assistance, microloan programs) to assist those most vulnerable [90]. So too must our children's behavioral health systems consider the broader interventions that may prevent and address crises by integrating supports for accessible and culturally responsive healthcare, food, housing and educational support.

2. **EDs are not suited for youth mental health or substance use crises, and broad community awareness campaigns and education can route children and families to more appropriate avenues for support .** Many families with children experiencing significant psychological deterioration in the context of COVID fear increased exposure risk by going to the ED. This has further highlighted the need for creating more appropriate places for children in crisis to go and has resulted in public awareness efforts to triage families to other community-based settings, including telehealth options. This type of re-routing of families from the default of the ED as the first point of entry during a crisis can be facilitated by the establishment of the 9-8-8 crisis line. However, the 9-8-8 system alone will not be sufficient to alter families' patterns of service utilization. Awareness campaigns can direct youth and families to trusted internet and social media sites as escalating events and crises do arise, providing de-escalation and help-seeking information and encouraging more appropriate pathways to support and care. During COVID-19, the Centers for Disease Control, the World Health Organization, and other health organizations regularly provide updates and guidance across multiple social media platforms, and these platforms similarly reciprocate by routing those seeking new, more specific information to the CDC and WHO sites,[96] and this similarly should be

envisioned and configured with appropriate behavioral health crises sites. In addition, public health information to address behavioral health crises (e.g, the 9-8-8 number, noticing if others are struggling, de-escalation techniques) can be added to existing user platforms, including through banners, pop-ups, and other such tools to directly message users about preferred approaches for managing behavioral health difficulties. This may include chatbots for basic psychological first aid and geotargeted sites for crisis services based on one's location.[97]

3. **The rise in risk coupled by a decrease in reporting of child abuse and neglect during COVID-19 highlighted the need for accessible mechanisms for youth and families to directly access crisis support.** Many children during COVID-19 are at increased risk of abuse, neglect and exposure to family violence.[98] Calls to protective services have decreased during stay-at-home orders, likely due to schools being closed and traditional monitoring systems not being intact [99]. By providing children and families with an accessible way to get help when they are in distress (e.g., by educating them about 9-8-8 and supports that are youth- and family-centered), exposure to adverse childhood experiences may be reduced or prevented. Further, youth and families will benefit from behavioral health literacy efforts that educate them about how to obtain and sustain positive mental health, recognize and seek help for mental health problems, and identify and support others experiencing mental distress. Recognizing the tremendous burden on families during COVID and the increased risk of child abuse and neglect, many organizations have mobilized to provide education and support to families to reduce risk. For example, the Child Mind Institute (https://childmind.org/coping-during-covid-19-resources-for-parents/), a national nonprofit, offers online learning, outreach, and resource support to families including tips for parent self-care, strategies for remote learning and discipline, skills for responding to children's mental health needs. Even prior to COVID-19, behavioral health literacy efforts for children and adolescents were increasingly implemented via school curricula, with several states (e.g., Florida, New York, Virginia) recently mandating the inclusion of mental health literacy in schools. For example, New York schools are required to integrate four key mental health literacy components into students' education [100]: 1) Understanding how to obtain and maintain good mental health; 2) Decreasing stigma related to mental health; 3) Enhancing help-seeking efficacy (knowing when, where, and how to obtain good health with skills to promote self-care); and 4) Understanding mental disorders (*i.e.,* anxiety and depression) and treatments.

4. **Telehealth services are needed, feasible, and often preferred by youth and families.** The paradigm shift in children's behavioral health crisis systems calls for significant expansion of telehealth technology. During COVID-19, behavioral health systems witnessed a dramatic increase in the utilization of telehealth to support the behavioral health needs of children and families. This occurred with federal, state and local infrastructure support, policy adjustments to ease use, and technical assistance and training to providers and consumers [101] [102]. A transformation of our children's crisis system toward robust telehealth capacity will require continued infrastructure improvements (e.g., enhanced broadband systems, up-to-date telehealth delivery equipment, internet connectivity services for providers and consumers); policy expansion

(e.g., reimbursement parity for telehealth, expanded access of Medicaid and Children's Health Insurance telehealth programs); and ongoing guidance and support to providers and families to increase adoption and facility of telehealth services [80] [103]. Policy must move toward parity such that state parity laws guarantee comparable payment for telehealth at the same rate as in-person services (i.e., reimbursement parity). Prior to COVID-19, only five states had implemented telehealth parity laws, and while 21 states expanded telehealth services during COVID-19, only 13 required parity. We must continue to evolve in this area and consider how to best integrate telehealth at all levels of the crisis system. As demonstrated during rapid adoption of telemental health during COVID-19, funding must be dedicated to both clinician and user training and to improving the infrastructure (e.g., hardware, software, internet access) necessary for successful telemental health practices [103].

During COVID-19 and beyond, child and adolescent mental health services traditionally provided in-person, including crisis services, may be shifted to telehealth, allowing youth and families to access support while minimizing health risks and other burdens of in-person care. As illustrated in Box 3, telehealth has already improved crisis response efficiency and outcomes for children and youth [104]. It is important to recognize that rapid shifts to telehealth may inadvertently increase health disparities, as people with less income may not have consistent access to the internet or devices. Increasing access to the internet, ensuring that resources are accessible to individuals with disabilities, and providing free or low-cost devices may help to address this problem. Further, given that so many children and families access behavioral health services through schools, it will be essential for school-based behavioral health providers to become facile with and be supported to use telehealth services

Box 3. To address the absence of child and adolescent behavioral health specialists in EDs, the Children's Hospital of Colorado used telepsychiatry to link the specialists at its central academic medical center to pediatric EDs and urgent care centers in the Denver area. The goal was to improve care and decrease patient transfers to the main campus. Children and youth who received the telehealth consultations, when compared with those receiving usual care, had ED lengths of stay that were 2.8 hours shorter, patient charges for care that were more than 40% lower, and higher satisfaction with services among ED providers and the patients' caregivers.

5. **COVID-19 has illuminated the need for flexibility and innovation to provide effective care amidst different public health parameters.** Across all tiers of support, from universal mental health promotion to treatment for mental illness, behavioral health supports have been adapted to meeting the changing landscape of mental health needs resulting from the pandemic and its sequalae and to conform to the necessary adjustments in service delivery. The innovations in behavioral healthcare during COVID-19 point to the importance of a nimble system during community crises, and to the importance of crisis systems being similarly equipped to adjust as needed to changing public health parameters. For example, at the universal (Tier 1) level, addressing prolonged loneliness

experienced during COVID-19, a risk factor for multiple behavioral health conditions, requires that not only everyone retain some contact virtually with others (e.g., school, peer activity networks), but also that teachers, coaches, mentors, and other supportive adults directly reach out to young people weekly, as employers are now being encouraged to do with each worker. [105] Video and voice interactions will be needed, particularly for children often too young to shift to a more written or texting type intervention. At the selective intervention (Tier 2) level, the lack of direct contact and access will require modifications in screening and responding to early signs of distress. Nontraditional groups (e.g., parenting groups, teachers/school staff, community organization members) may be provided familiarity with a simplified version of psychological first aid and specific questions or approaches to check in with children, which historically may have been done with a more standardized program designed for more highly trained clinicians (but now insufficient or inaccessible) At the intensive intervention (Tier 3) level, different counseling models will be better suited to evolving public health circumstances; for example, written counseling has been described as effective to address needs for those who may not have access to telehealth equipment or resources[106]. Novel approaches mindful of new public health constraints (e.g., changes in shaking hands/greetings, going to an office) should be monitored for applicability to crisis management as well.

6. Finally, even with brick and mortar schools closed, **schools remain a hub for a full continuum of behavioral health supports for students and their families**. Of children in the United States who receive any behavioral health care, over half receive care at school, and this is even greater for youth of color or living in poverty. [107] During COVID-19, schools mobilized to continue supporting students' nutritional, educational and behavioral health needs. While rates of community behavioral health access dipped during COVID-19, school support personnel and school-based mental health clinicians continued to provide needed behavioral health support, often via telemental health. Our children's behavioral health system should leverage schools as a place to support social emotional health, and to practice early identification and intervention, including crisis response. Parallels from Hurricane Katrina to COVID-19 also illuminate the need to ensure that beyond the supports for students and families, our behavioral health and education systems must attend to the ongoing needs of educators and other school staff as they work to support students' behavioral health.[108] Guidance from the Centers for Medicare and Medicaid Services and SAMHSA offers states ideas and examples for how state Medicaid programs can increase and improve school mental health service delivery and several states and local communities have leveraged school-community partnerships to improve children's behavioral health systems. [109] [41]

Conclusion

The stage is set to reimagine the child and youth crisis prevention and response system given the limitations of the existing system, burgeoning innovations in youth mental health, and lessons learned amidst the current global pandemic and increased attention to longstanding social injustices. As community behavioral health crisis policies and practices are established, the unique needs of children and families must be considered across the developmental spectrum and across communities and cultures, always addressing issues of equity and racism. The vision must include promotion, prevention, early identification and intervention available through natural

supports like schools, primary care, and other community partners (e.g., afterschool programming, faith organizations) and through expanded technologies, including telehealth. The opportunity to shift the paradigm for how we build and implement children's crisis response systems is within our reach and will require thoughtful leadership and advocacy, significant policy and financing support, and active engagement of youth and families to shape the supports they will receive.

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

Appendix A: Vignettes

The roles of the (a) Call Responder, (b) Mobile Crisis Team, and (c) Receiving and Stabilization Services are described below, and then applied to each vignette:

Call Responder: (1) **clarify safety**: is this new/unusual (possible poison ingestion), or abuse/trauma reaction; (2) **identify impacts** across multiple spheres of life: does the child do this everywhere, or only at home, around certain people (3) **seek to understand this unique family and youth's perspectives and their goals** to manage this event; and (4) **offer parent support/appropriate de-escalation strategies** (see Box 2); clarify if parent receptive to speaking with a behavioral health provider, if telehealth visit acceptable.

Mobile Crisis Team: (1) **elicit description** from the parent—is this mostly a problem for the child, the parent, both (a conflict between them), and/or other (e.g., school staff, peers); (2) **observe/speak** with the child to clarify potential behavioral health conditions that best explain behaviors; (3) **seek to understand this unique family and youth's perspectives and their goals** to manage this event; and (4) **clarify intervention now needed** to improve/resolve this crisis (e.g., parent guidance, further evaluation (medical or behavioral health))

Receiving and Stabilization Services: (1) **seek to understand this unique family and youth's perspectives and their goals** to manage this event; (2) Clarify if **ongoing parent/child/family support services** are needed (e.g., speech therapy for social pragmatics, autism program at school); and (3) **identify where these services might best be provided** (considering feasibility and accessibility for family).

Angel is a 4yo, whose parent calls 9-8-8 reporting "my child refused to eat dinner tonight and started screaming uncontrollably. My child isn't like other kids and I'm scared; doesn't talk to anyone, just sits in a corner, no facial expression, and freaks out if touched or asked to eat anything other than uncooked macaroni. I think something is really wrong and I don't know what to do."

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by distinguishing whether this circumstance is a new-onset, sudden deterioration (suggestive of poison intoxication, traumatic events, or an underlying medical condition) vs. an ongoing, worsening pattern (suggestive of autism spectrum or chronic trauma). The **CR** might further (2) **clarify impacts**, such as if these behaviors occur everywhere, all the time, with peers, family, and at preschool (suggestive of autism spectrum or general developmental or social skill delays) vs. only in certain settings and times, such as when visiting particular relatives (suggestive of trauma). The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, which might be that the child is being treated differently than other children, that relatives have expressed concerns, or that the parent may be doing something to contribute to these behaviors; inquiry about the child may reveal whether the child is distressed by any of these behaviors, or instead preferring to be apart from others to do preferred activities. The **CR** may (4) **provide some immediate de-escalation** to this event by reviewing the history of these behaviors ("these are not new, but are now more concerning, so it seems you want someone more familiar with this to

partner with as you decide your next steps") and inquiring whether the family would like to speak with someone immediately about the behaviors Angel is displaying, including offering videoconferencing as an option for communication.

In Angel's crisis, the **Mobile Crisis Team (MCT)** uses telehealth technology to connect via videoconference (which the family preferred over an in-person visit) to (1) **elicit descriptions** from the parent about the evolution of these behaviors, who in the family seems most distressed or impacted by them; (2) **observe/speak** with the child to clarify potential behavioral health conditions (e.g., trauma, autism spectrum, anxiety and selective mutism) that best explain this child's unique constellation of behaviors; (3) **understand this unique family's perspectives and their goals** (parents might ask " Is this because we did something wrong?" "We don't know who can evaluate these symptoms to help us figure out what to do at home," or "Does Angel need a special school?" "What should we do right now about Angel only eating macaroni?") and (4) **clarify interventions needed now** to improve/resolve this crisis (e.g., parent support and guidance about trying some different types of food, engaging around activities/play to see if that increases interaction and communication, and partnering around the process to obtain further evaluation, medical or behavioral health, including potential fears (parents might ask "Will I get turned in to Child Protective Services or will Angel be taken away if we talk with someone?") or perceived obstacles ("I don't know what to do, or if I can do it; I don't have insurance to do any further evaluations, and they'll just blame me for all this…like they did before")). In this case, the **MCT** used videoconferencing to engage a pediatric specialist who could discuss some of the family's concerns and better assess Angel's behaviors. Angel and her family were routed by the **MCT** to a community-based assessment and intervention program with a pediatrician to clarify the diagnosis, to partner with the school to provide evaluation for additional needs (such as speech, occupational therapy, etc.) and to create a plan to be delivered through the preschool to address behaviors.

If Angel's behaviors continued to escalate or the family requested respite and immediate in-person support, the **MCT** may have referred them to **Crisis Receiving and Stabilization Services (CRSS)**. In this case, **CRSS** providers, including specialists in child development, might (1) **seek to understand this unique family and youth's perspectives and their goals** (parents might describe fears that Angel will escalate to doing harm to self or others, or that others in the family are frustrated and likely to lash out aggressively toward Angel, such that safety becomes an issue; e.g., "My other children, and I, are freaking out—we're afraid Angel may try to hurt herself while we're sleeping"); (2) clarify if **ongoing parent/child/family support services** are needed (e.g., family education and respite, parent peer support, child diagnosis and intervention), and (3) **identify where these services might best be provided** (e.g., other family members to stay with if the family is currently overwhelmed or concerns of traumatic conditions are present, local family support chapter for autism, pediatrician specializing in autism and developmental disorders).

Lin is a 7yo, whose parent texts 9-8-8, distraught that the child would not get out of the car to go into the school since the beginning of this school year; usually the child will scream and cry when approaching the school; when brought to the school other times, the child will describe physical symptoms so that the parent will be called and come get the child; today the child was cursing and biting at the teacher who was trying to walk the child into the school; the school

threatened to report the child as habitually truant if the parent cannot get the child to come and stay at school.

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by addressing whether Lin is actually trying to harm others (e.g., the teacher(s)), describes plans or obtains "weapons" to harm anyone, has specific people at home, at school, or elsewhere that frighten Lin such that Lin seeks the protection of family and to avoid a perhaps past traumatic situation (suggestive of posttraumatic stress), or if there are consistent physical symptoms that may suggest an underlying, perhaps new, medical condition, or if Lin has consistently each year avoided separating from family to attend school or other seemingly safe, desirable places (suggestive of separation anxiety), The **CR** might further (2) **identify impacts** across multiple spheres of life, such as how often these events occur, whether parents are able to transition Lin to school most days or to separate to be with others, and which people (e.g., parents, caregivers, certain school staff) are most engaged in this situation, and how long these episodes involve these other people, and how Lin is progressing academically and socially at school. The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, such as threats that the police or child services may be called if Lin does not transition into school, that the parent doesn't know what else to do and thus seeks help and support, the family fears school reporting may result in all children being removed and thus want Lin out of the home now, etc. The **CR** might (4) **offer parent support/appropriate de-escalation strategies** by helping the family preview separations to go to school, provide distracting options for Lin such as listening to music while driving to school, etc.), and to offer consultation or teleconferencing with a **Mobile Crisis Team (MCT)** to help devise alternative strategies (e.g., helping Lin transition to familiar others (staff and possibly peers) when Lin arrives at school to make these transitions less stressful) as well support the family as they address their fears about school reporting them.

In Lin's crisis, the **MCT** might initially have a phone call to demonstrate support for parent and address fears of reporting to the police/child services, and then as trust is created engage in a videoconference to (1) **elicit descriptions** from the parent about what Lin seems to "gain" by these episodes (e.g., get to go back home to be with a parent, avoid some person or activity disliked at school), how these episodes impact the parent(s) (Parent may say "yes, I have to stay home now to care for Lin, which isn't so bad since I hated my job anyway," or "I've had many problems with the school staff there---they have reported me multiple times with multiple of my children over the years, so this is just another way they try to get us to move."): (2) **observe/speak** with the child to discern if this sounds new and acute to suggest a traumatic origin, or if this seems more like ongoing separation anxiety (even if a repetition of what has occurred at the beginning of new school years), or some other behavioral circumstance (Lin might say "I need to be home with my Mother as she's sick" ("or needs my help taking care of my Grampa," etc.): (3) **understand this unique family's perspectives and their goals** (parents), which might include parental fears of being turned in, the police arriving and scaring other family members, fears of betrayal and distrust given past experiences with the school, and parental aspirations to get the school to be more understanding and partnered with the parents around these events or alternatively to compel the school to place Lin in a different school); and (4) **clarify interventions now needed** to improve/resolve this crisis, such as collaboration with the school to understand the school's experiences or concerns so that a different, more collaborative plan between home and school can be initiated to ease transitions, school options

for gradually getting Lin to transition fully (all day) into school (which might include some interval of virtual school so that Lin becomes more comfortable with new teachers and peers)..

If Lin continues to be threatening to others at school or at home, or the parents fear that others in the family may get angry or aggressive toward Lin, then **Crisis Receiving and Stabilization Services (CRSS)** may be needed to (1) **better understand this unique family and youth's perspectives and their goals** to manage Lin's behaviors and eliminate aggression during school transitions, which might include family interviewing and then supportive or focused counseling (e.g., parent previewing, calm management of Lin's escalations, problem-solving techniques and practice with family to prepare for transitions, and anxiety reduction techniques for Lin) at the CRSS site; (2) clarify if **ongoing parent/child/family support services** are needed (e.g., school-based behavioral health services to target the source of transition behaviors via skill development and/or trauma treatment); and (3) **identify where these services might best be provided** (e.g., feasible practices for the family to do differently, the possibility of implementing promptly a school program with preferred school staff or peers to improve the magnetism of school for Lin and to simultaneously make home more "boring," so that Lin is more motivated to transition to school).

Devon is a 14yo, whose parent contacts 9-8-8 after finding a bag of "weed" in Devon's room and confronting Devon; Devon became livid, asked why the parent was "in my stuff," and ran out the door, breaking a lamp on the way out, saying "I don't want to live like this anymore."

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by asking family if this is a new/unusual explosive event, or recurrent ("has Devon had other episodes or signs of substance use, has Devon made threats, tried to harm self/others before" and directly address Devon's comment by exploring "what did "I don't want to live like this anymore" seems to suggest today?" to parents, or others present or who may have heard similar comments from Devon before, and which may have included descriptions of self-harm plans/acts, or preparations to gather weapons, write suicide notes, etc.). The **CR** might (2) **identify impacts** across multiple spheres of life: the CR might inquire about whether Devon explodes or "takes off" everywhere, or only today at home? and how Devon's functioning with school, peers, and parents has changed in recent months). The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, such as parental fears that Devon's substance abuse is now problematic, fears that others involved with substances may come to their home, and fears that any discussion of this with others may lead to police searching their home. The **CR** may (4) **offer parent support/appropriate de-escalation strategies**, such as ensuring that Devon is now in a safe place with trusted others, and plans by parents for addressing this situation (parents may say "we want him to return but he has to get rid of the weed and not bring it into our home again," or "we want Devon to go away now for treatment---this has been going on for too long—he cannot come back right now"), and clarify if parents are receptive to speaking with a behavioral health provider, including by teleconference, to identify next steps to locate/find Devon, and determine appropriate next steps.

In Devon's crisis, the **Mobile Crisis Team (MCT)** might speak with family to: (1) **elicit description** from the parent—is this mostly a problem for the child, the parent, or both (a

conflict between them), The **MCT** might then text or phone Devon to (2) **observe/speak** with Devon to clarify potential behavioral health conditions that best explain the episode at home (from depression to substance use ("I don't want to live like this anymore" could refer to some ongoing situation or stressor, from bullying to gender or sexual identity concerns, to ongoing substance or legal problems, etc.). From both family/others and Devon, the **MCT** may be able to (3) **understand this unique family's perspectives and their goals**, which might include parental fears of Devon harming/stealing from parents, police involvement and fear of arrests, family fears of Devon being unable to control substance use and significant deteriorations observed, as well as Devon's fears of being misunderstood, overreactions to rare marijuana use that has not been associated with deteriorations in functioning, etc. Based on information from both family and Devon, the **MCT** would speak with parents and/or Devon to (4) **clarify intervention now needed** to improve/resolve this crisis (e.g., parent guidance to reach and deescalate conflict with Devon, steps to address Devon's substance use vs. Devon's underlying distress recently leading to substance use).

If this crisis results in Devon or parents unable to work out this situation so that he can return home safely, then **Crisis Receiving and Stabilization Services (CRSS)** may be required to: (1) **better understand this unique family and youth's perspectives and their goals**, which might include discussing options with parents and Devon together to navigate an acceptable resolution, identifying underlying fears family members have regarding Devon, as well as stressors that may be influencing Devon's recent behaviors, and both the family and Devon's perceptions of law enforcement as well as social support agencies in partnering with families like them; (2) **clarify if ongoing parent/child/family support services are needed** (e.g., crisis team members clarify whether Devon will be able to safely return home by the next day or whether other options for Devon may need to be explored now, are Devon and family able to work with a provider to agree to terms of returning, is the home environment likely to work or does it remain too volatile between child and parent such that immediate return may put Devon or family members at jeopardy for harm, etc.); and (3) **identify where these services might best be provided** (e.g., does Devon require further evaluation to clarify underlying substance use disorders/withdrawal/intoxication symptoms, specialized referral for other issues, substance abuse treatment, depression, etc.).

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