Southeast (HHS Region 4)

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Crisis Care Guide: Mental Health Equity in Underserved Populations

SAMHSA

Substance Abuse and Mental Health Services Administration

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Crisis Care in Underserved Populations Overview

MENTAL HEALTH EQUITY

All minority groups experience disparities in mental health equity and access to care. The disparities are often attributed to **systemic racism, ableism, and mental health stigma**. There are multiple strategies that can be implemented to achieve mental health equity such as increasing crisis and community-based services, mental health awareness and anti-stigma campaigns, and to increase culturally appropriate services amongst many others.[1]

CURRENT STATE OF CRISIS CARE

There are at least **five tiers of crisis response** to prevent and stabilize individuals who are at risk of harming themselves or others, or caring and functioning effectively in the community.[2-6]

Tier 1 OUTREACH & ENGAGEMENT

Tier 2 CRISIS CALL CENTERS "SOMEONE TO TALK TO"

Tier 3 MOBILE CRISIS TEAMS "SOMEONE TO RESPOND"

Tier 4 CRISIS STABILIZATION PROGRAMS "SOMEWHERE TO GO"

Tier 5 POST-CRISIS COMMUNITY-BASED SUPPORT

FUTURE OF CRISIS CARE[3, 7-8]

The future of crisis care is being transformed with the development of **988**, a nationwide, three-digit number that will assist people who experience mental health crises. The number goes into effect **July 16, 2022**. Even with the addition of a national number, there are still multiple barriers to overcome to ensure 988's effectiveness. Further, there are many organizations and initiatives in the Southeast Region that have promising practices for equitable crisis care.

> "THE FUTURE OF CRISIS CARE IS BEING TRANSFORMED."

Mental Health Equity

According to SAMHSA, health equity is when **everyone** (regardless of race, ethnicity, gender, religion, socioeconomic status, sexual orientation, and geographical location) has a fair and just opportunity to access healthy living. Factors that can prevent mental health services are employment status, unstable housing, insurance status, proximity to services, and culturally incompetent care. Mental health equity ensures these factors do not prevent people from receiving mental health care and services.[9]

STRATEGIES TO ACHIEVE MENTAL HEALTH EQUITY [1]

Adopted from "Mental Health Equity in the Twenty-First Century: Setting the Stage"

- Increase Crisis and Community Based Services
- Mental Health Awareness and Anti-stigma campaigns for community and police
- Address Social Determinants of Health (housing, food insecurity, employment, transportation)
- Increase culturally appropriate services including linguistic and cultural interpreters
- Bias Reduction Training
- Health Literacy Education
- Patient Empowerment

MENTAL HEALTH EQUITY AND HEALTHCARE DISPARITIES

Healthcare disparities are structural differences in how the healthcare needs of marginalized communities are treated differently and less than the needs of typically celebrated communities. Communities that are marginalized include non-Whites and immigrants, non-English speaking, LGBTQ+, intellectually and developmentally disabled, and members of rural communities. Healthcare disparities can be attributed to **racism, xenophobia, sexism and homophobia, and ableism**. [1]

Mental Health Equity *(cont'd)*

SYSTEMIC RACISM AND MENTAL HEALTH EQUITY [10-11]

A report by the Surgeon General found that communities of color are more likely to lack quality care, diagnosis, and treatment of mental health issues. Communities of color have **unique histories** that can impact a population's mental health struggles. These histories are the effects of systemic racism which includes discriminatory policies, actions, and beliefs that are ingrained into every aspect of society (criminal justice, employment, healthcare, education, housing, etc.). Whether these actions, beliefs, and policies are deliberate or not, they still persist and oppress marginalized communities.

Black/African-Americans [10, 12]

- Endured a long period of chattel enslavement
- Passage of the 13th Amendment disproportionately targeting Black/African-American men
- Racism in policing
- Disenfranchisement through poll taxes, literacy tests, grandfather clauses, and other exclusionary actions
- Jim Crow laws permitted overt discrimination
- Economic exploitation that can lead to poverty
- Race-based stereotypes
- More likely to be homeless, incarcerated, or have substance use issues

Indigenous [10, 12]

- Mass genocide
- Racism in policing
- Genocide by the spread of disease
- Land dispossession
- Environmental injustices
- Erasure of Indigenous cultural practices

Latinx [10]

- War-related trauma
- Displacement/migration to the United States
- Economic hardship
- Xenophobia
- Political refugees
- Language barriers

Asian-Americans & Pacific Islanders (AAPI) [10]

- Xenophobia
- War-related trauma
- Hate crimes
- Land dispossession
- Refugee
- Language barriers

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The Current State of Mental Health Crisis Care [4, 13-14]

Mental health crisis care, like physical crisis care, is 24/7 emergency health services offered to anyone, anywhere, and anytime[4] who is at risk of harming themselves or others, or caring and functioning effectively in the community.[14] Similarly, there is a mental health crisis system that includes a **call center, mobile crisis team, and crisis care facilities**. Unfortunately, there is inadequate funding for mental health crisis services which leads to crisis interventions from law enforcement and the justice system as a whole. This approach is detrimental to those with immediate mental health needs. This approach is also seen as putting a band-aid over a foundation crack which can result in multiple hospital readmissions, unnecessary incarceration, homelessness, early death, and suicide.[4]

Crisis Response Tiers [2-6]

Tier 1

OUTREACH & ENGAGEMENT

Early outreach and engagement practices for individuals at risk of a mental health crisis.

Tier 2

CRISIS CALL CENTERS

"SOMEONE TO TALK TO"

Regional call centers should have air traffic control (ATC) capabilities to ensure their clinically trained responders are able to engage in crisis intervention and suicide risk assessments on the spot.

Tier 3

MOBILE CRISIS TEAMS

"SOMEONE TO RESPOND"

Mobile crisis teams are community-based interventions that should at least be staffed with a peer specialist and a licensed and/or credentialed clinician who are trained to de-escalate crisis situations. Law enforcement and Emergency Medical Services (EMS) should be on standby.

Tier 4

CRISIS STABILIZATION PROGRAMS

"SOMEWHERE TO GO"

Crisis stabilization programs are short-term facilities that should observe and stabilize individuals who are experiencing mental health crises. Think of these as the emergency department of mental health.

Tier 5

POST-CRISIS COMMUNITY-BASED SUPPORT

Community-based options can be as simple as supportive family and friends. Certified Peer Specialists can also serve as support since these individuals are eager to share the tools, skills, and information they have learned from their own struggles.[5-6]

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Cultural Competence and Humility in Crisis Care

Cultural competence is finite and **skills-based** awareness of another person's background, language, practices, and beliefs.[15] Cultural humility is a **process-based** approach that engages in self-reflexivity to challenge internal beliefs about another person.[16-17] Language barriers in mental health services and law enforcement involvement in crisis care are two areas where changes should occur. The infinite goal is to fix and challenge power imbalances, especially in healthcare, and aspire for partnerships and advocate for others. With these approaches at the forefront, critical changes and restructuring of the current state of mental health crisis care are possible.

LANGUAGE BARRIERS

- 8 to 9 percent (22 to 25 million people) of the U.S. population experience limited English proficiency.[18-19]
- As such, communities with higher rates of language barriers are less like to utilize mental health services.[19]
- Trained professional interpreters and bilingual health care providers have a positive impact on low English proficiency patients' satisfaction, quality of care, and outcomes.[20]
- Policies addressing language barriers in various counties across California found an increase in use of mental health services from 8.8% to 17.3% when language assistance is provided at no additional cost.[19]

LAW ENFORCEMENT

- It takes law enforcement 30 minutes to book someone in jail versus 3 hours to connect someone to a community crisis program.[2]
- One in four fatal police shootings between 2015 and 2020 involved a person with a mental illness.[3]
- 44 percent of incarcerated persons in jail and 37 percent in prison have a mental health condition.[3]

These figures suggest that law enforcement officials are not adequately trained to properly handle and de-escalate mental health crises. Also, data from the National Suicide Prevention Lifeline found that **98 percent** of calls to their number do not require an emergency response from EMS and law enforcement.[8]

Crisis Care in LGBTQ+ Community [21]

Mental well-being needs in LGBTQ+ populations differ from cisgender and heterosexual populations. Roughly **39 percent** of the 4.5 percent of the U.S. LGB population reported having a mental illness in the past year. Further, LGBTQ+ people are more than twice as likely to report a mental health disorder in their lifetime than heterosexual people. Considering these experiences, LGBTQ+ individuals use mental health services more than their heterosexual counterparts.[22] Current crisis responses for the LGBTQ+ community occur on different levels. Regarding tier two of crisis response, there are multiple organizations and hotlines that dedicate themselves to 7 days a week, 365 days/year support for queer people in crisis.

Examples Include:

- The Trevor Project (24/7, 365) [23]
- National Suicide Prevention Lifeline [24]
- LGBT National Hotline [25]
- Crisis Text Line [26]

Crisis Care in Rural Communities [4]

Rural communities have limited resources for mental health care due to geographical challenges and insufficient financial and staffing resources. There are current innovations for rural communities that have been successful.[27] Some strategies include:[28]

Advancements in Technology

- Remote crisis care staff
- Mobile applications
- Telehealth services
- Dedicated phone lines

Reform

- Crisis response programs
- Pre-arrest diversion programs

Peer Support

- Remote crisis care staff
- Mobile applications
- Telehealth services
- Dedicated phone lines

Crisis Care for Individuals with Intellectual and Developmental Disabilities (IDD) [14]

One in 54 children in the United States is diagnosed with Autism Spectrum Disorder (ASD). It is estimated that 54 to 70 percent of individuals with an IDD such as ASD have co-morbidity with a mental illness. The most common comorbidities are ADHD, anxiety disorders, depression, schizophrenia, and bipolar disorder. [29-31] Literature shows that access to specialized mental health clinicians is very limited despite the growing number of IDD diagnoses. [32] Crisis care in the IDD community is inadequate because instead of IDD patients being transported to stabilization facilities, they are taken to the Emergency Department where they are isolated and restrained for hours on end.

IDD Crisis Care Models [14]

Model 1

SPECIALIZED INPATIENT PSYCHIATRIC UNITS

Multidisciplinary care units

Model 2

CRISIS RESPONSE CENTER

Provides walk-in, immediate treatment of behavioral conditions

Model 3

ACCESS CENTERS

Provides walk-in, immediate treatment and is physically connected to multiple levels of behavioral health care.

Model 4

SYSTEMATIC, THERAPEUTIC, ASSESSMENT, RESOURCE, AND TREATMENT (START)

Individualized, community-based intervention that is specifically dedicated to optimizing independence, treatment, and community living for patients with IDD.

Model 5

COMMUNITY-BASED ACUTE TREATMENT (CBAT)

Short-term crisis stabilization

Model 6

LONG-TERM STABILIZATION UNIT

Lengthened treatment for lasting and impactful changes

Crisis Care in Latinx and Asian Immigrant Communities[33]

Specialized crisis care in Latinx and Asian immigrant communities is a growing discipline, much of which is a response to the ever-present mental health disparities. A way to combat these disparities is through **Cultural Brokering**. Coined in 1990 by Jezewski, Cultural Brokering is the act of "bridging, linking, and mediating between groups or persons of different cultural backgrounds for the purpose of reducing conflict or producing change".

PURPOSE OF CULTURAL BROKERING

- Emphasizes cultural competence in healthcare organizations
- Promotes behavioral health equity
- Recognizes indigenous and traditional healing practices among cultural groups
- Improves service delivery of mental healthcare provider/system

Community Members

Peer Supporter/Mentor

Interpreter

Therapist/Social Worker

Lay Health Worker

Provider/Clinical Staff

MENTAL HEALTH FIRST AID[34]

Public education program that trains people to identify and properly respond to signs and symptoms of mental health and substance abuse crises. Topics covered include:

Recovery and Resiliency

5-Step Action Plan

Intervention Application

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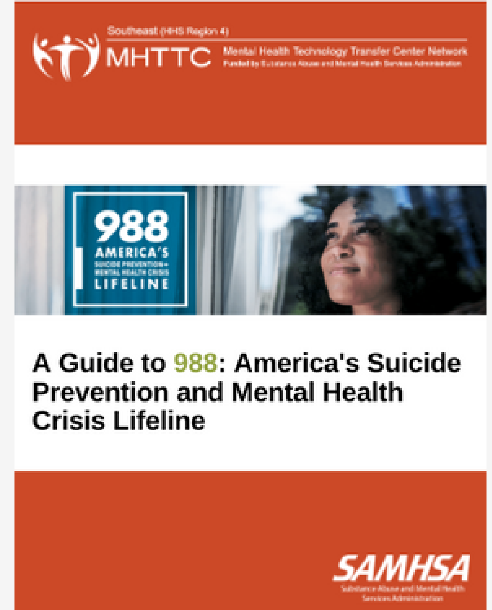
The Future of Crisis Care

988: RE-IMAGINING CRISIS RESPONSE [3, 7-8]

988, which will go into effect July 16th, 2022, is a nationwide, three-digit number that will assist people who experience mental health crises. Enacted from The National Suicide Hotline Designation Act (PL 116-172), this number will be a game-changer in the way mental health crisis care and suicide prevention are viewed and experienced. Aspects of 988 legislation that will **ensure crisis care efficacy** include:

- Requirements for high-quality, consistent 988 crisis call centers and response services statewide
- Consistent funding for 988 and crisis services
- 988 operations collaboration with all stakeholders

However, this implementation will be met with barriers that need to be addressed before successful and continuous practice.



(Click here to access 988 Guide)

How to Overcome Barriers to 988

Increase collaboration between 911 and 988 by transferring mental health crisis calls

Ensure staff are culturally competent and actively engage in cultural humility

Adequate funding for 988 number, individual crisis call centers, and the crisis continuum of care

Stakeholders should include 988 and the crisis care system as a part of their network

Before 988 is fully implemented, people should continue contacting the National Suicide Prevention Lifeline phone number **1-800-273-8255** and online chat.

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Equity and Crisis Care in the Southeast

Southeast Region Barriers to Providing Crisis Care

- In the SE region, as the percentage of counties with Black and Hispanic residents **increases**, mental health facility access **decreases**. Black and Hispanic residents have to travel farther in order to receive care. [36-37]
- **Seven** of the eight Southeast MHTTC states rank 43 or below in access to mental health care.[38]
- Of the 8 states in the Southeast MHTTC, Medicaid only covers crisis services in **5** of them.[39]

Southeast Region Promising Practices for Equitable Crisis Care

- Each of the 8 states in the Southeast Region has designated contact numbers for crisis care by county and/or self-designated regions.
- In 2019, The Mental Health Cooperative opened as a government-funded behavioral care center in Nashville, Tennessee.[40] Their crisis services are available 24 hours, seven days a week. There are **11** locations across Tennessee.[41] There are no fees for crisis services.
- The government of Alabama funds five community mental health centers across the state. In 2021, the goal was specifically to **increase** rural and mobile crisis care services. [42]
- North Carolina Crisis Solutions Coalition was comprised to **implement** effective strategies for reducing law enforcement involvement and unnecessary emergency department visits regarding crises. [43]

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