SUPPORTING AUTISTIC YOUTH WHO ARE EXPERIENCING A MENTAL HEALTH CRISIS

By

Sadie Hill

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Name: **Sadie Hill**

Degree: **Master of Social Work**

Title: Supporting Autistic Youth who are Experiencing a Mental Health Crisis

Examining Committee:

Dr. Lisa Moy, BA, BSW, MSW, PhD, RSW
Primary Supervisor
Faculty, School of Social Work & Human Services

Dr. Evan Taylor, BSW, MSW, PhD, RSW
Second Reader
Faculty, School of Social Work & Human Services

Dr. Leah Douglas, BSW, MSW, PhD, RCSW
MSW Chair
Faculty, School of Social Work & Human Services

Approved:

Abstract

Autistic youth are at an increased risk of presenting with one or more co-occurring psychiatric disorders. In addition to this, autistic youth are at a greater risk of experiencing a mental health crisis. Emergency department utilization is four times greater for this population than neurotypical youth, and autistic youth are psychiatrically hospitalized to inpatient units at significantly higher rates (McGuire & Siegel, 2018). Despite this, emergency departments and standard psychiatric units are often not equipped with the environmental supports, staff training, and resources to effectively support autistic youth. This literature review has found that environmental adaptations and the implementation of autism specific assessment tools increase treatment outcomes of autistic youth on standard psychiatric units. Access to autism specialized psychiatric units has shown even greater patient outcomes (McGuire et al., 2015); however, a limited number of these units exist. Further research and implementation of ASD specific adaptations are warranted to address gaps that currently exist in meeting the needs of autistic youth who are experiencing a mental health crisis.

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List of Acronyms

ABA	Applied Behaviour Analysis
ADHD	Attention Deficit Hyperactivity Disorder
AIC	Autism Inpatient Collection
AMA	American Medical Association
APA	American Psychiatric Association
ASD	Autism Spectrum Disorder
ASAN	Autistic Self-Advocacy Network
ASD-CP	ASD Care Pathway
CASW	Canadian Association of Social Workers
CBT	Cognitive Behavioural Therapy
DSM- III	Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition
DSM- V	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
ED	Emergency Department
ID	Intellectual Disability
MCAS	Mental Health Crisis Assessment Scale
NASS	National Autism Spectrum Disorder Surveillance System
NASW	National Association of Social Workers

Introduction

As a society, our understanding of, and response to, mental health crises has dramatically improved over the years (Mintz, 2017). However, this knowledge has been predominantly based on an understanding of mental health crises in neurotypical individuals (Kalb et al., 2017). This ableist and unilateral approach of understanding has proved problematic for non-neurotypical populations experiencing a mental health crisis.

The term 'mental health crisis' is understood to be synonymous with a psychiatric emergency and is defined as including two key components. First, there must be the presence of an acute psychiatric event requiring immediate intervention and, second, there be a perceived lack of resources available to respond appropriately to meet that individual's needs (Vasa et al., 2020). In many circumstances, behavioural components, such as increased aggression and self-harm behaviours, are associated with such crises as well (Righi et al., 2018). In this regard, the term mental health crisis more appropriately encompasses the situations referred to throughout this paper than the term psychiatric emergency (Vasa et al., 2020). To align with the terminology used by Vasa et al. (2020), as well as many other prominent researchers on the topic, the term mental health crisis will be used throughout this paper to refer to the experience of autistic youth with acute mental health care needs.

Significance

Between the years of 2007- 2014, youth across Canada visiting hospital emergency departments for mental health concerns increased by 45% (McCabe et al., 2019). The needs of those experiencing mental health crises often surpass the resources available from community organizations, leaving individuals to predominantly rely on hospital emergency departments as

their first point of contact for care (McCabe et al., 2019). However, the primary focus of emergency departments is to assess risk and stabilize—over a broad spectrum of medical concerns—and, as a result, they are not generally equipped to respond to the specialized and complex nature of mental health concerns experiences by the youth population, even less so youth who are neurodiverse (Kalb et al., 2017; McCabe et al., 2019).

Neurodiversity is defined as the presence of varying neural and behavioural differences within individuals where certain concentrations of diverse functioning have been associated together and been diagnosed under the DSM-V (Koi, 2021). Neurodiversity is the viewpoint that brain differences are normal and that there exists a range of neural development patterns amongst people (Autistic Self Advocacy Network, 2022). Of these various neural patterns there are certain patterns with similar characteristics that are then marked and diagnosed as certain neurodiverse disorders, such as ASD (Autistic Self Advocacy Network, 2022). Overall, the neurodiversity movement and the Autistic Self Advocacy Network (2022) advocate to view these marked patterns of neural functioning as simply diverse, rather than as neural deficits.

Neurodiverse individuals with autism spectrum disorder (ASD) are at an increased risk of psychiatric comorbidity, with approximately 70-72% of individuals diagnosed with ASD having at least one co-occurring psychiatric diagnosis, and approximately 41% of individuals having two or more co-occurring psychiatric diagnoses (Kuriakose et al., 2018; Rosen et al., 2018). In addition to an increased risk of psychiatric comorbidity— meaning, the presence of a psychiatric diagnosis co-occurring along with an ASD diagnosis- individuals with ASD also are at an increased risk of experiencing a mental health crisis (Vasa et al., 2020).

Research shows that autistic youth experiencing a mental health crisis are admitted to inpatient psychiatric units at significantly higher rates than neurotypical youth in crisis, and

likely for longer admissions (McGuire & Siegel, 2018). Despite high rates of hospitalization, the environments and treatment strategies present in general inpatient units often do not meet the needs of this population (Donnelly et al., 2020; Kuriakose et al., 2018).

Such high comorbidity rates highlight the need for health professionals to be familiar with ASD and for an increase in specialized psychiatric care providers employed in emergency settings. It is important to look to the literature to answer the question, how can autistic youth be best supported while experiencing a mental health crisis? To answer this question, I will first be exploring the current healthcare and social service systems available to support autistic youth, as well as seeking to understand how these systems respond to the unique needs of neurodiverse youth experiencing a mental health crisis, and finally, where systems can go from here to ensure better outcomes in care for autistic youth.

Terminology

Before delving into the literature to explore the reasons behind an identified increased risk for this specific population, it is important to first look at the power of language and the importance of how language reflects values of dominant society. Disability language and terminology has changed over the years, reflecting societal, legislative, political, and theoretical shifts in the way disability is understood (Withers, 2012). Historically, the language surrounding disability held negative connotations and perpetuated societal values that disability was synonymous with inferiority and 'the other'– belonging outside of dominant society (Flink, 2021). As society has evolved, various social rights and disability rights movements have advocated for the need to shift language to better align with the ever-evolving societal values around equality and inclusivity (Flink, 2021).

Within the shift of disability terminology and language, there has been great debate over whether individuals should use person-first language or identity-first language when referring to individuals that identify as having a disability (Autistic Self Advocacy Network, 2022). Person-first language, such as using *person with a disability* rather than identity-first language, a *disabled person* has been adopted across various professional and medical communities such as the American Psychological Association (APA) and the American Medical Association (AMA) over the recent years (Flink, 2021). This change in language can be seen as a linguistic tool to demonstrate recognition of an individual being seen and valued wholistically before acknowledgment of their disability, compared to that of identity-first language which is argued to put emphasis on acknowledging the disability before the person (Flink, 2021). Although the APA and the National Association of Social Workers (NASW) both endorse the use of person-first terminology, there are critiques around this terminology for not reflecting the use of identity-first language by disability advocates, as it is argued that person-first language minimizes the role of society's construction and disabling of individuals (Krcek, 2013).

Widespread debate exists regarding the popularity of using person-first language, as it is argued that one cannot simply remove their disability from who they are, making it a key piece of their identity (Withers, 2012). Furthermore, many disability groups and activists have taken back the use of identity-first language and shifted the narrative to proudly represent their identity, with their disability being a key integral part of who they are (Flink, 2021). The Deaf community is one example that has been vocal about preferring identity-first language, as well as many ASD individuals and advocates prefer identity-first language to describe themselves rather than using person-first language (Lei et al., 2021). Research has identified divergent opinions when referring to ASD; many members of the autistic community prefer identity-first language-

in other words, autistic - whereas professionals and non-ASD members prefer person-first language such as person with autism (Lei et al., 2021). Although there is not a clear answer of language to use, it is important that autistic individuals guide the conversation on terminology choice themselves. Semantic language being used should be less focused on the person vs. identity debate and instead focus on highlighting and communicating the strengths and diversity of those in the autistic community (Robertson & Larson, 2016; Withers, 2012).

Throughout this paper, I have decided to follow the recommendation of the Autistic Self-Advocacy Network (ASAN), as well as the preference of autistic individuals noted in Lei et al.'s (2021) research, which is to use identity-first language when referring to autistic individuals (Autistic Self Advocacy Network, 2022; Koi, 2021). Furthermore, I have decided to follow the APA, AMA and NASW's adoption of person-first language, and use person-first language when discussing disability in the broader sense (Krcek, 2013). These choices align more closely with the neurodiversity movement and disability rights movement, and validate that autism is not something that a person has but rather a defining feature of the individual that cannot be untangled (Koi, 2021).

Background

To better understand ASD and the implications core autistic symptomology have on an individual's ability to receive mental health care, it is important to explore background considerations. This section explores prevalence rates as well as historical perspectives that have been foundational in the evolution of understanding ASD. Due to the restraints existing on the scope and length of this paper, I will not be discussing the biological underpinnings or varying positions on the cause of ASD.

Prevalence

Autism Spectrum Disorder (ASD) is a heterogeneous neuro-developmental disorder characterized by core deficits in social communication and social interaction along with the presence of restricted, repetitive behaviours (American Psychiatric Association, 2013). ASD is a prevalent developmental disorder seen across all ages and cultural demographics, that has seen an increase in diagnoses in recent years (Stadnick et al., 2020). This increase in prevalence is best described by improved recognition of ASD characteristics and changes in diagnostic criteria specifying fewer distinct rule-out symptomology (Weir et al., 2020). Individuals with ASD often experience co-occurring medical and/or psychiatric disorders; moreover, approximately 32% of autistic individuals have a co-occurring intellectual disability (ID) (Rosen et al., 2018).

It is estimated that in Canada, one in sixty-five youth (5 to 17 years of age) have received a diagnosis of ASD (Government of Canada, 2018). Additionally, it has been found to be four times more commonly diagnosed in males than females (Centers for Disease Control and Prevention, 2020). However, there is evidence that autistic females may be underdiagnosed or diagnosed later in life due to misunderstandings of diagnosis criteria for females or symptom camouflaging—described as behavioural adaptations autistic individuals use to help hide aspects of their autism- (Weir et al., 2020). Furthermore, emerging research around gender diversity and neurodiverse youth has highlighted that autistic youth are more likely to identify as gender diverse than their neurotypical peers (Pyne, 2021). This finding highlights the need for research statistics to go beyond reporting within the constraints of the gender binary. This will be further discussed in the discussion section of the paper. In addition to gender diversity, it is important to highlight that there is a gap in the literature around prevalence rates amongst racialized groups. Specifically, there is evidence that Indigenous youth have been under-represented in dominant

research claims and that ASD appears to be under-diagnosed among Indigenous children in British Columbia, Canada (Lindblom, 2014; Di Pietro & Illes, 2014). This will also be discussed in more detail later in the paper.

Historical Perspectives

Over the past decade, the field of adolescent psychiatry has become more inclusive of neurodiversity (Stadnick et al., 2020). However, wide-spread research is still limited, and definitive evidence-based guidelines for care are not yet available (Ameis et al., 2018; Rosen et al., 2018). The heterogeneous nature of ASD and a vast range of strengths, limitations and needs of individuals along the spectrum highlights the importance of client and family centered research and considerations to be at the forefront of care planning and treatment best practice (D'Astous et al., 2016; Rosen et al., 2018).

To better understand ASD today, it is important to understand the historical context of ASD and disability. The understanding of ASD was shaped largely by the societal climate of the time toward the conceptualization of disability. The term autism was first introduced by a Swiss psychiatrist named Paul Eugen Bleuler in 1911, who defined it as a symptom of schizophrenia, and a "shutdown of reality" (Alves et al., 2016).

Although the term was first coined in 1911, it was not until 1943 that autism was first described in an individual (Grollier et al., 2016). In 1943 a psychiatrist named Leo Kanner is usually recognized as the first clinician to identify autism in children, as he first described 11 children in his research to have "autistic disturbances of affective contact" (Mintz, 2017, p. 45). He described such *autistic disturbances* to be based on behaviours of social isolation, a desire for sameness (Mintz, 2017) as well as an inability to relate to others (Alves et al., 2016). Kanner

believed autism to be a rare neurological illness separate from schizophrenia (Alves et al., 2016) that was caused by the child's reaction to cold and unloving parents (Mintz, 2017). Although initial descriptions of autism believed it to be rare and a childhood disorder, research has shown that the disorder is prevalent across the lifespan, with approximately 1% of the population in the US having ASD at the time of publication of the 5th edition of the DSM (American Psychiatric Association, 2013), while other studies suggest 1-2% of the population has ASD (Weir et al., 2020).

There have been many misunderstandings of autism over the years that created and enforced harmful stigmas and oppression of this population. A prominent misunderstanding existed about the cause of ASD throughout the 1940s-1960s, where conceptualization of autism as a form of childhood schizophrenia led society to believe that ASD was a child's response to a severe emotional disturbance stemming from having toxic, unloving, distant, and neglectful mothers, who were known as 'refrigerator mothers' (Alves et al., 2016; Mintz, 2017). The response at this time was to remove the children from the supposed '*toxic'* parental relationships and place them away in psychiatric institutions, where they were 'hidden' away without proper assessment, support, and access to therapeutic relationships (Mintz, 2017). The view toward the family was that of shame and blame and, given societal views on disability were framed within the medical model, areas of focus were on medical deficits and the removal of ASD rather than support and adaptation (Robertson & Larson, 2016).

Leading up to the publication of the Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III), theories on autism began to shift and recognize autism as a neurobiological disorder (Alves et al., 2016). It was in 1980 within the publication of the DSM-III that autism was seen as its own separate category of developmental disorder with distinct

diagnostic criteria (Mintz, 2017). This identification of autism as its own disorder was an influential point for scientific research to expand on and to shift understanding beyond 'refrigerator mothers' and conceptualization as neurodevelopmental deficit (D'Astous et al., 2016). Additionally, it was shortly after the deinstitutionalization movement in the late 1980s that alternatives to inpatient care were being created, such as behavioural health services in the communities (McGuire & Siegel, 2018). Along with the shift in care options, so did the conceptualization of the disorder and understanding of how best to support autistic individuals' core symptomologies and co-occurring disorders.

Conceptualization of Disability

Disability was first understood through the emergence of thought known as Eugenics, which put forth that certain individuals with less socially desirable traits were seen as inferior community members (Withers, 2012). The conceptualization of disability has a long history, including the development of several models theorizing various understandings (Krcek, 2013). Prominent and foundational models for understanding disability are the medical and social models of disability, which will be discussed in greater detail below.

It is important to note that there exist various discussions about ASD, which are largely shaped by one's own positioning in society, and the way in which that society conceptualizes disability (Weir et al., 2020). There is no single known cause for ASD; however, dominant research suggests it to be a highly heritable disorder with there being a 64-91% risk of genetic factor association (Weir et al., 2020). Furthermore, there is no treatment or way to 'cure' ASD, as it is understood to be a neuro-developmental disorder seen across the lifespan (D'Astous et al., 2016). The very idea of 'curing' and 'treating' ASD is seen as controversial, as many activists and autistic individuals challenge the notion of core ASD characteristics being seen as deficits

(Autistic Self Advocacy Network, 2022). Rather, they align with the ideology of the neurodiversity movement; which advocates for ASD to be recognized as a diverse and beautiful way to view the world (D'Astous et al., 2016; Koi, 2021).

Models of Disability

The medical model of disability views disability as an individual problem characterized by functional limitations of people with impairments (Withers, 2012). Impairments are defined as "any loss or abnormality of psychological, physiological, or anatomical structure or function", while disability is defined as "any restriction or lack (resulting from impairment) of ability to perform an activity in the manner within the range considered normal for a human being" (Krcek, 2013, p.5). It is important to note the difference between these two terms and their construction within society, as the definition of impairment speaks to an individual's body unable to function in a particular way, whereas it is the definition of disability that inserts meaning to this impairment by comparing it to what is seen as normal (Krcek, 2013). Whenever there is something that is considered normal, there will be something in contrast judged as deviant or atypical, and those which fall along the margins are at risk to face othering and oppression (Robertson & Larson, 2016).

Within the medical model, the environment and culture within which impaired individuals are positioned is viewed as unproblematic (Withers, 2012). It is the medical professionals that are viewed as the experts, as the voices of those with disabilities are viewed as unimportant or mistaken. This model relies predominantly on diagnosis and treatment using evidence-based scientific procedures and manuals, such as the Diagnostic and Statistical Manual of Mental Disorders (Krcek, 2013). It is the medical model of understanding that is the default in the

medical community, holding the assumption that there exists a superior developmental patterning all individuals ought to align with, so the interventions within this model are aimed toward correcting or ridding oneself of impairment through measures like surgery, drug therapy and rehabilitation therapies (Robertson & Larson, 2016).

The social model of disability was developed as an opposing perspective to the medical model, a counter way of understanding disability which highlights the critical oppression seen through the medicalization of disability (Robertson & Larson, 2016; Withers, 2012). Disability is understood within the social model as the oppression that people with impairments face (Wither, 2012). A key component of this model is recognizing the difference between impairment and disability, and the realization that people live with impairments, whether those be physical and/or psychological, however it is society that constructs disability and that the concept of disability would not exist if the values of society were to be detached (Krcek, 2013; Robertson & Larson, 2016). Additionally, the social model is celebrated as an avenue of commonality that empowers the voices of disabled people to advocate against social marginalization and oppression (Robertson & Larson, 2016; Withers, 2012). Rather than applying interventions to change the individual, the social model puts forth that changes need to be made to the oppressive and socially created barriers that exist throughout many systems in western society.

Oliver (2009) argues within Robertson and Larson's (2016) publication that it is crucial for society to reject the medicalization of disability through the medical model, as this medicalization is a "key aspect in the social control of disabled people" (p. 53). This social control has been seen in examples such as institutionalization and segregation within learning environments (Robertson & Larson, 2016). The understanding and intervention approach for ASD has shifted to be understood beyond that of the medical model, to embrace perspectives of

the social model (Mintz, 2017). The social model view understands ASD and other disabilities as an impairment of a specific area within an individual and puts forth that transformation of oppressive systems that render these populations as disabled needs to occur, to progress western society to be more inclusive of individuals with all levels of abilities.

Methodology

This section provides an overview of the methods utilized and put forth which theoretical frameworks were most evident in my understanding and conceptualization of the research. Additionally included is a section about positionality, where I situate myself in relation to the writing of this paper. Positionality is a key part of the methodology, as it is in this section that I acknowledge the various prominent influences of social location in relation to the research and how these impacted the decisions I made while writing this paper.

Methods

This review addresses the key research question: how can autistic youth be best supported while experiencing a mental health crisis? To explore this question, I utilized the University of the Fraser Valley library database. More specifically, prominent databases that were utilized were: EBSCOHost, Social Work Abstracts, PsycINFO, Taylor & Francis Online Journals and SAGE Journals Online. Keywords searched in the databases were: “autism spectrum disorder”, “developmental disability”, “mental health”, “mental health crisis”, “psychiatric crisis”, “youth”, “adolescents”, “mental health care”, “treatment interventions”, “emergency response”, “community-based treatment”, “hospital-based interventions”, “social work”.

Society's understanding of ASD and mental health is constantly evolving and, as a result, I have placed time constraints on the literature reviewed to include work that has been published in the last eight years. Eight years has been chosen as an appropriate time constraint as this is when the most recent edition of the Diagnostic Statistics Manual (DSM-V) was published. The focus is on work that follows the most recent diagnostic criteria to speak to current perspectives on how ASD is defined. Any work that is included beyond eight years has been included to add a foundational and historical perspective of ASD, and/or has been necessary in order to outline theoretical frameworks that guide my understanding of the research.

Research included in this paper focuses on peer-reviewed articles from a range of academic journals such as: Journal of Autism & Developmental Disorders; Journal of Child Psychology and Psychiatry; International Review of Psychiatry; Canadian Journal of Community Mental Health; Research in Developmental Disability; and Autism: The International Journal of Research & Practice. In addition to academic journals, government reports and publications have been included to reference population statistics. My search for journal articles began by being primarily situated in social work journals, to explore the implications for practice and identify the role social workers have in providing care for autistic youth experiencing a mental health crisis. However, it was important to go outside of social work journals as well to broaden the lens in which ASD is understood. Given neurodiversity is understood predominantly through a medical model, it was important to include articles from journals of psychiatry and child development.

The literature review focuses on content from Canada and the United States of America (USA) because the dominant conceptualization of disability is similar in each country; additionally, both countries rely on practice guidelines from the DSM-V. Most of the research

around the topic of psychiatric care for autistic youth has been completed in the USA and there is a lack of data originating from or focused on Canadian populations. Generally, this research can be applied to the Canadian system due to defining diagnostic criteria and care guidelines to which professionals must adhere to originating from American institutions and organizations such as the American Psychiatric Association.

Although medical approaches seem to align between the United States and Canada, there are a number of differences to be mindful of when applying American literature to the Canadian context. The model of health care differs between the two countries with Canada having universal health care, and the USA having a pay for service model (Siegel et al., 2012). Regarding research analysis, this is an important consideration as a pay for service model creates further barriers for individuals to access care. As the age of adulthood and therefore adolescence differs interprovincially within Canada and internationally between Canada and USA, inclusion criteria for this literature review focused on youth twenty-five years of age and under. This age has been chosen due to include the prominent age ranges seen in the literature when referring to youth and adolescence.

My intention was to include literature that prioritized the voices of autistic individuals first-hand experience with mental health crises and navigating systems of care. However, a review of the literature proved this intention difficult, as voices of autistic youth with lived experience facing co-occurring mental health challenges is seemingly scarce in the academic community. Much of the research is focused on the voices of families, professionals working with the ASD community, and researcher analysis. Therefore, a conclusion was made to include research from the various perspectives of those roles supporting autistic youth, to develop a foundational

perspective around supports. This is an area that will be further discussed in the gaps in the literature section.

Theoretical Framework

The conceptual framework which underpins my literature review was formed from a combination of anti-oppressive theory and critical disability theory. This section provides an overview below.

Anti-Oppressive Theory

Anti-oppressive theory serves to examine the harmful effects of social inequalities based on socio-political context, and the ways that these power differentials disadvantage certain members of society (Robertson & Larson, 2016; Strier & Binyamin, 2014). Through an anti-oppressive framework, disability is understood as the result of social and economic systems in society that create exclusion, discrimination and oppression for any person or groups of persons that differ from society's cultural norm (Robertson & Larson, 2016).

Young (2013) puts forth that oppression is structural in nature and more than just the result of a few people or policies. It is caused by unquestioned norms, habits, and those unwritten rules that members of society follow and deem to be the default status quo (Young, 2013). Young (2013) categorizes oppression into five common 'faces': exploitation, marginalization, powerlessness, cultural imperialism, and violence (Young, 2013). These faces can be applied to the literature to further understand the social oppression of autistic youth within mainstream societies. Marginalization and cultural imperialism can be critically applied to the common experiences of neurodiverse individuals being marginalized within society. Additionally, cultural imperialism in the very roots of diagnostic criteria by assessing the presence of a disability based on the deviation of an individual's behaviour from a socially agreed upon and constructed norm.

It is those who have power within society that establish what is valued and renders deviancy from that set of values as wrong and pathologized (Milton, 2016).

It is through a foundation formulated upon Young's five faces of oppression and anti-oppressive theory that a critical reflection of the literature can take place to question disparities in service. Why is it that crisis supports for autistic youth are not included as part of the norm? Why are the voices of autistic youth not included in, and prioritized amongst dominant discussions of health needs? And finally, why is it that there exists a safe environment and thought-out policy to support neuro-typical individuals experiencing a mental health crisis, yet neurodiverse individuals were not afforded that same *luxury?*

Critical Disability Theory

Critical disability theory acted as an additional framework to help guide my understanding and interpretation of the literature. Central themes within critical disability theory are that disability is a social construction, and although individuals have varying degrees of impairment, it is society and structural organizations that oppress and disable individuals with impairments (Robertson & Larson, 2016). The emphasis is on changing environments and perspectives rather than changing people or abilities (Milton, 2016; Robertson & Larson, 2016). Through this theory of understanding, the gaps in effective supports for autistic youth can be understood to be because of the longstanding marginalization of this population and their needs, rather than being because the population's needs are too complex or deviant. Furthermore, gaps in effective supports exist due to the needs of neurodiverse individuals being ignored during the creation of standard psychiatric models of care. The structural environment and oppressive

polices thus remain the focus of intervention and change rather than core ASD symptomology and neurodiverse identity.

Positionality

It is challenging to write about a topic on which I do not have lived experience. It is important for me as the author of this paper to acknowledge that I do not have a diagnosis of autism spectrum disorder or any other diagnosis that labels me as neurodiverse. I identify as an able-bodied, neurotypical, white female who benefits greatly from being a member of dominant Canadian society. I am cognizant that while I benefit in this society, many are oppressed and do not receive access to the same opportunities that I do. As a professional who works with many autistic youth, I am motivated to explore the literature to learn about best practices that I, as a social work professional can incorporate as part of my allyship and role. My role as a practitioner in community-based supports, as well as a practitioner in adolescent psychiatric units within hospital settings has inspired me to critically analyze the supports available to autistic youth experiencing psychiatric distress. During my time working within standard adolescent psychiatric units, I have had the pleasure of working with many amazing colleagues, who bring with them a wealth of passion and experience. Within these environments I have also noticed that despite working with amazing colleagues, there exist a number of systemic gaps when supporting autistic youth. My paper in no way is intended to disparage the inspiring and great work colleagues in these positions are doing, but rather to highlight the gaps that exist, and encourage critical reflection on how the current system of psychiatric care can become more inclusive to better meet the needs of neurodiverse individuals.

Literature Review: Thematic Findings

The objective of this literature review is to critically analyze the existing research regarding autistic youth with a co-occurring psychiatric disorder(s), particularly the supports available to autistic youth experiencing a mental health crisis. There are a number of themes throughout the research; however, due to the limited scope of this paper, I focus on co-occurring psychiatric disorders, community-based supports, emergency department utilization, acute psychiatric hospitalization, and, finally, specialized inpatient psychiatric units.

Co-occurring Psychiatric Disorders

Across the literature it is a widespread finding that autistic youth experience higher rates of psychiatric symptomatology when compared to neurotypical youth with psychiatric disorders and psychiatric rates noted within the general public (Kuriakose et al., 2018; Rosen et al., 2018). The presence of co-occurring psychiatric symptomatology within this population is associated with additional complications around assessment, diagnosis, and care planning (Ameis et al.,2018; McGuire & Siegel, 2018; Rosen et al., 2018). A contributing factor to the complexity of care planning for autistic youth with co-occurring psychiatric disorders is that research is limited on co-occurrence, and direct evidence-based guidelines are not yet available (McGuire & Siegel, 2018; Righi et al., 2018; Rosen et al., 2018).

Additionally, symptom overlap, diagnostic overshadowing, and ambiguous symptom presentation in ASD—factors which will be further explained in this section—make assessment and diagnosis challenging (Rosen et al., 2018). Distinction between the core symptoms of ASD from the core symptoms of other disorders must take place to determine which diagnostic label is warranted to best describe presentation (Matson & Cervantes, 2014). Diagnostic challenges exist as it is often unclear if the psychiatric symptomatology will present the same in neurodiverse

populations as it does in neurotypical individuals, if the symptomatology presents similarly but is better explained by core symptomatology seen in ASD, or unclear if psychiatric presentation will present as entirely atypical from what is seen in neurotypical populations (McGuire & Siegel, 2018; Rosen et al., 2018). Individual difference such as intellectual functioning, adaptive functioning, and age also add to ways in which presentation may vary (Ameis et al.,2018).

Diagnostic overshadowing is common, which is "the attribution of ASD-related symptoms to a co-occurring disorder, or, conversely considering emotional and behavioural symptoms as part of ASD" (Rosen et al., 2018, p.41). For example, many autistic youth receive diagnoses of a behavioural and/or emotional disorder before receiving an ASD diagnosis, despite an ASD diagnosis better accounting for such symptomology. As Rosen and colleagues (2018) go on to explain, a commonly seen disorder where this takes place within this population is in relation to the presence of symptoms of inattention, hyperactivity, and impulsivity where an initial ADHD diagnosis is given, delaying an ASD diagnosis, or alternatively prescribing such symptoms to be part of the ASD and overlooking a diagnosis of ADHD. ADHD is just one example of a co-occurring disorder; however, there exist several additional commonly seen psychiatric disorders in autistic youth.

The co-occurrence of psychiatric disorders is prominently noted across the literature, with approximately 70-72% of autistic youth having been diagnosed with at least one co-occurring psychiatric disorder, (Rosen et al., 2018) and 41% of this population reporting a diagnosis of two or more (Kuriakose et al., 2018). Common psychiatric disorders seen within this population are anxiety and mood disorders, obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), Tourette Syndrome (Government of Canada, 2018) and oppositional defiant disorder (ODD) (Rosen et al., 2018). Existing research has focused

predominantly on anxiety and ADHD co-occurrences; however, there has been a growing amount of research done that looks at other disorders such as mood disorders, ODD, conduct disorder, and psychotic disorders (Rosen et al., 2018). Irritability/agitation, sleep disruption, complex behavioural challenges, and suicidal ideation are also commonly experienced by this population (Ameis et al., 2018; Kalb et al., 2018).

Youth with ASD are four times more likely to experience clinical depression symptomatology than their neurotypical peers (Greenlee et al., 2020). While reported rates vary slightly, Fung et al., (2015) notes that depression prevalence rates for autistic youth is 4-58%, compared to the prevalence rate of neurotypical youth being approximately 12%. Explanation for the difference in prevalence reporting is due to variance in community-based reports, inpatient clinical reports, and the usage of differing assessment methods. The literature suggests that depression is a commonly seen disorder that has increased risk factors for symptomatology associated with increased age and higher IQ (Fung et al., 2015). However, increased social-communication abilities have been found to help mitigate the risk of depression symptomology (Greenlee et al., 2020).

Despite an increase in research and the development of more adaptive practices to support autistic youth experiencing mental health challenges, little is currently known about suicidality in this population (McDonnell et al., 2020). This is especially problematic due to youth suicide rates having increased in the North American population and given that autistic youth may be at an increased risk for suicidality due to the nature of core characteristics of ASD (Greenlee et al., 2020). McDonnell and colleagues note that decreased social interactions, deficits with communication, and common isolated activities, have been found to increase risk factors for depression (Greenlee et al., 2020) and suicidality (McDonnell et al., 2020). They

conclude that the presence of suicidality can increase risk factors for youth experiencing a mental health crisis and requiring support from emergency services.

Community-Based Supports

Many autistic youth are involved with community-based organizations for vocational and behavioural supports as well as mental health supports (D'Astous et al., 2016). While community-based interventions benefit individuals due to the client-centered and de-institutionalized nature, there exists a lack of community-based supports designed to respond to individuals experiencing a mental health crisis (Liu et al., 2017; Vasa et al., 2020). To date, research on treatment modalities for autistic youth with co-occurring psychiatric challenges has been limited, however the most widely supported modality in which many mental health supports are based around is cognitive behavioural therapy (CBT) (Rosen et al., 2018). The research around CBT as a primary treatment modality for autistic youth has been predominantly based on autistic youth with co-occurring anxiety and depression (Donnelly et al., 2021; Rosen et al., 2018). Additionally, this research has focused on autistic youth without an intellectual disability (Rosen et al., 2018). In order to respond to the varying needs of individuals across the autism spectrum, there needs to be further research into best treatment modalities across a wider range of co-occurring psychiatric disorders, including a focus on individuals with an intellectual disability.

Overall, the literature has found that the majority of community-based services do not meet the requirements to effectively respond to a mental health crisis with this population. This is often because environments are not set up to accommodate many externalized behaviours, programs are voluntary in nature, crisis supports do not fit under the organization's mandate, and there existing a widespread shortage of psychiatrists specialized in co-occurring psychiatric

disorders in the system as a whole (Kuriakose et al., 2018; Vasa et al., 2020). The lack of wrap-around out-patient mental health services available leaves families with few options of support when there is a crisis and leads them to rely on emergency department systems, not because of being offered superior care, but because it is the only option (Kalb et al., 2017).

Emergency Department Utilization

Autistic youth access emergency department services at an increased rate of 4 times that of neurotypical youth and are 3.7 times more likely to be admitted to hospital following an emergency department (ED) presentation (Iannuzzi et al., 2021; Liu et al., 2017). Although this population presents to the ED more than their neurotypical peers, not all presentations to the ED need the acute level of care provided at the ED (Righi et al., 2018). Research suggests that of the total number of presentations, it is a minority of ED visits that warrant the need of acute emergency response (Liu et al., 2017). The literature suggests that the high number of ED visits seen amongst this population of youth results from a lack of community resources designed to respond to mental health crises, and an inability to access key psychiatric evaluation tools through outpatient services (Liu et al., 2017; McGuire & Siegel, 2018).

Along with psychiatric co-occurrences within this population, there is an increased risk of mental health crises. Vasa et al. (2020) conducted a study looking at the prevalence of mental health crises, and they found that approximately 32% of participants in their study had experienced a mental health crisis in the past three months. When experiencing a mental health crisis, many autistic youth and families present to emergency departments (ED) for care, with visits to the ED occurring at a rate of four times greater than their neurotypical peers (Liu et al., 2017). The rate of presenting to EDs has increased over recent years and is usually due to an individual exhibiting externalizing behaviours (Righi et al., 2018). Prominent externalizing

behaviours have been described as increased aggression and self-injurious behaviours (Righi et al., 2018). Furthermore, the leading cause of ED visits for autistic youth results from psychiatric concerns when that individual is older than five, as children under five often require medical support for physical health in the ED (Righi et al., 2018). Of those being seen in the ED for mental health crises, the top three leading causes were noted as anxiety, physical aggression, and suicidal behaviour (Kalb, 2018).

Age is an important consideration when looking at utilization of ED services. Research shows that autistic youth school age and older access ED services more frequently than their neurotypical peers, with 12–15-year-old autistic youth accessing emergency department services most often (Iannuzzi et al., 2021). In addition to age, risk factors that have been associated with an increase in ED utilization are a history of physical aggression towards others, residing in a rural community, and lack of structured daytime routine (Liu et al., 2017).

Once autistic youth present to the ED with a psychiatric concern, they are likely to be kept for observation and assessment for extended periods of time and admitted to inpatient units at a higher rate than their neurotypical peers (Mannenbach et al., 2021; McGuire & Siegel, 2018). A study that looked at ED boarding times, which is the length of time an individual spends waiting in the ED before being admitted to a psychiatric unit, found that the presence of an ASD diagnosis was the number one predictor of lengthy boarding times with the number two predictor being the presence of an intellectual disability (McGuire & Siegel, 2018). Lengthy waiting times in the ED are problematic as often the environments of emergency departments are not suited to meet the needs of this population and can in part exacerbate the psychiatric symptoms that individual is experiencing and result in an increase in self-injurious and/or unsafe behaviours (Iannuzzi et al., 2021).

In order to better serve the specialized needs of this population, as well as decrease the number of ED visits that did not require acute ED level of care, there needs to be an increase in outpatient services specialized in de-escalation training for autistic youth experiencing psychiatric concerns, as well as resources focusing on early identification and intervention available to youth and their families (D'Alli & Valcante, 2017). Clinical pathways have been identified as helpful tools ED staff can use with complex populations in order to promote continuity of care for outpatient services as well as decrease likelihood of individuals re-admission to the ED (McCabe, 2019). Clinical pathway utilization with autistic youth experiencing co-occurring psychiatric disorders will be further discussed in later sections of this paper.

Acute Psychiatric Hospitalization

Admission to a psychiatric unit for psychiatric concerns occurs six times more often for autistic youth than neurotypical youth presenting to the ED with psychiatric distress (Pedersen et al., 2017; Taylor et al., 2019). It has been found that before reaching the age of 21, approximately 10% of autistic youth will be hospitalized due to a mental health crisis (Liu et al., 2017; Taylor et al., 2019). On average, youth with ASD face longer admissions to in-patient units and experience the use of crisis interventions such as restraint, seclusion rooms, and emergency medication administration more often than that of their neurotypical peers (Kuriakose et al., 2018). Additionally, many hospital staff often lack the adequate training and clinical experience needed to implement the necessary adaptations for effective treatment, which will be discussed further in this section. A lack of adequate training increases the level of risk of harm for both patients and staff (Kuriakose et al., 2018).

Although autistic youth as a whole face hospitalization at a higher frequency than their neurotypical peers (McGuire & Siegel, 2018), not all individuals will experience psychiatric challenges in the first place, or if so, not at a level requiring acute psychiatric hospitalization (Righi et al., 2018). Several risk factors increasing the likelihood of psychiatric hospitalization have been identified in the literature. The most prominent risk factors of psychiatric hospitalization have been found to be lower adaptive functioning, greater ASD core symptom severity, self-injurious and aggressive behaviours, the diagnosis of a mood disorder or OCD diagnosis, and coming from a single parent household (Kuriakose et al., 2018; McGuire & Siegel, 2018; Righi et al., 2018). Additionally, Kuriakose et al. (2018) reported that receiving an ASD diagnosis later in life and being prescribed psychotropic medications act as risk factors for psychiatric hospitalization. Consistent throughout the literature, risk for hospitalization increases with age (McGuire & Siegel, 2018; Righi et al., 2018).

Providing care to autistic youth in standard psychiatric units presents its set of own unique challenges. Inpatient psychiatric units have been generally designed to care for neuro-typical individuals with typical adaptive functioning and communication abilities (Donnelly et al., 2020). The environment and treatment interventions within these units are centered around process-oriented group therapies and are not suitable to meet the needs of the ASD population, leading to poor patient outcomes for this population (McGuire & Siegel, 2018). For example, many standard psychiatric units commonly use verbal-based interventions such as talk therapies and implement programming that has high social interaction components (Pedersen et al., 2018). These common practices present problematic to autistic youth due to core symptomologies of ASD being linked to challenges with social interaction and social-emotional communication (Pedersen et al., 2018).

Although not designed with this population in mind, these standard psychiatric units can offer effective treatment to autistic youth, given that appropriate accommodations are put into place (Kuriakose et al., 2018; McGuire et al., 2015). Appropriate accommodations that have been identified are environmental supports such as visual schedules, low stimulus quiet areas, individualized behaviour plans, therapeutic and educational activities specific to the interests of each individual, sensory interventions, and staff with training specific to ASD (Kuriakose et al., 2018).

Inclusive Adaptive Strategies

In addition to the adaptation of environment and treatment interventions, the development and utilization of effective psychiatric evaluation tools during times of psychiatric distress has shown to be critical in helping to both recognize and intervene at an earlier point of mental health crises (Kalb et al., 2018). Few measures existed that look at assessing a mental health crisis, and furthermore, none of the prominently used scaling tools were designed for youth, or neurodiverse individuals (Kalb et al., 2018; Vasa et al., 2020). The creation of a mental health crisis assessment scale, a measurement scale designed with autistic youth in mind has been hugely beneficial as it takes into account ASD symptomology and unique experience of psychiatric disorders which can be more accurately applied to ASD youth in crisis (Kalb et al., 2018). Additionally, the tool is publicly available which expands the ability for various outpatient professionals to be able to accurately assess and respond to level of crisis risk, diverting the need of lower-level risk needs from presenting to an ED (Kalb et al., 2018).

The ASD Care Pathway (ASD-CP) was created as an approach to help improve the care of autistic youth in standard psychiatric units, through the further training of staff and implementation of ASD-specific intervention strategies (Donnelly et al., 2020; Kuriakose et al.,

2018). The implementation of the ASD-CP on general psychiatric units caring for this population resulted in the average length of stay of hospitalization reducing by 40%, and the use of crisis interventions decreased by 77% (Kuriakose et al., 2018). Evaluations identified that there were consistent reductions in crisis interventions such as the use of intramuscular chemical restraint, seclusion rooms and physical restraints (Donnelly et al., 2020). The decrease in use of crisis interventions such as those listed above, shows significant success as it decreases the risk of harm to both staff and patients alike (Cervantes et al., 2019). Furthermore, limiting the use of crisis interventions allows patients the opportunity to learn and practice adaptive replacement strategies while in a safe environment (Kuriakose et al., 2018). This will benefit autistic youth and improve care outcomes as a whole, by allowing youth the opportunity to develop various coping skill behaviours that will serve as protective factors and decrease risk of re-admission post discharge (Cervantes et al., 2019; Kuriakose et al., 2018).

Specialized Inpatient Psychiatric Units

In the United States, there are approximately ten specialized inpatient psychiatric units designed for autistic youth and youth with other developmental disabilities (Taylor et al., 2019). Unfortunately, Taylor and colleagues (2019) notes that these units exist predominantly in the Northeast region and have high barrier admission criteria. In comparison, the United Kingdom has a number of specialized units for individuals with developmental disabilities, however, these focus predominantly on the adult population (Siegal et al., 2012). While completing this literature review, I was unable to find data on the existence of specialized psychiatric units for autistic youth and youth with other developmental disabilities within Canada. This is a notable gap in the literature that will be discussed further in the sections to come. As a result of this notable gap regarding Canadian resources, the data reviewed here focuses on the US system. An

exploration of the US system provides a foundational understanding of common adaptive strategies being used at this time in order to help improve admission outcomes for autistic youth.

Specialized psychiatric units follow a bio-behavioural approach that includes both psychopharmacology and applied behavioural analysis (ABA) that guide their practice frameworks and interventions (Pedersen et al., 2018). Assessments completed on specialized units go beyond the predominantly psychiatric focused assessments on standard units, as they often include in addition behavioural assessments, communication, and adaptive functioning assessments, as well as personalized admission interviews to learn about individual-specific interests and abilities (Taylor et al., 2019). The multidisciplinary teams on these units are robust, with ASD-specific expertise from child psychiatrists, psychology, ABA interventionists, speech-language pathologists, occupational therapists, nurses, and social workers (Taylor et al., 2019). Youth often face longer admissions to these units, with the average stay being noted as approximately 25.6 days; however, this longer duration of admission allows for more clinical assessment and intervention, as well as provides more time for youth and their family to practice adapted strategies and plan with the treatment team for outpatient continuity of care (McGuire et al., 2015; Pedersen et al., 2018). It is important to note that length of stay is impacted by third party health insurance policies and how many days these insurance companies deem are needed for the youth to be hospitalized before they seize payment. This is problematic, as many of the assessments that insurance companies use to determine length of stay needs are based on neurotypical populations which on average are admitted for less time than autistic youth (Taylor et al., 2019). Unfortunately, this leads to many youth being discharged earlier than planned due to financial barriers for families, not based on a lack of service need (Pedersen et al., 2018).

The research on specialized units have shown improvement in the behavioral outcomes of children with ASD or ID, as well as decrease in readmission rates (McGuire et al., 2015). A study by Pedersen et al. (2018) found that problematic externalizing behaviours were decreased from time of admission to discharge, as well as sustained at a two-month follow-up point. This study found that at the two-month follow-up, acting out behaviours towards others had increased slightly but that self-injurious behaviours remained decreased (Pedersen et al., 2018). As specialized units have not been present for a long period of time, there is limited research about them. Taylor et al. (2019) completed a study comparing treatment of behavioural problems in ASD youth from a general inpatient unit compared to a specialized inpatient unit. Taylor and colleagues' (2019) findings were that treatment outcomes were more favourable for specialized inpatient units. These findings align with those of Pedersen et al. (2018), which state that problem behaviours like aggression, self-injurious behaviours and tantrums saw a greater decrease in specialized units. Additionally, individuals that went to a general inpatient unit were more likely to require access to emergency services within two months of discharge, compared to those that had received treatment from the specialized unit (Pedersen et al., 2018; Taylor et al., 2019).

Review of the research provides evidence for improved admission outcomes for those autistic youth who received support in specialized psychiatric units. Improved admission outcomes are evidenced by engagement in more inclusive mental health interventions, reduction of crisis behaviours and the opportunity to practice coping skills on the unit (McGuire et al., 2015; Pedersen et al., 2018; Taylor et al., 2019). Unfortunately, due to the limited number of specialized units that exist at this time, most autistic youth facing a mental health crisis will not have access to specialized unit resources and will have to rely on standard ED and inpatient

psychiatric units (Cervantes et al., 2019). Development of ASD care pathways and the inclusion of many core elements from specialized psychiatric units within standard psychiatric units, has the potential to improve the level of care autistic youth experience while experiencing a mental health crisis but also when accessing hospital services as system (Pedersen et al., 2018; Taylor et al., 2019).

Discussion and Implications

Gaps in the Literature

Several gaps and limitations arose throughout review of the literature. Although there have been many valuable research contributions within recent years, the scope of research remains narrow and does not represent the experience of the vast array of autistic youth. More specifically, the research has focused on autistic youth who are white, verbal, do not identify as having an intellectual disability, have higher adaptive functioning abilities, and come from families that have the socioeconomic means to seek out specialized psychiatric hospitalization (Donnelly et al., 2021; Rosen et al., 2018). This is particularly problematic, due to the nature of ASD being a spectrum disorder, with individuals having varying degrees of core symptomology, yet the research only capturing one end of the spectrum (Taylor et al., 2019). The findings from narrow samples of the population make it is difficult to generalize the research findings to represent a wider scope of experience for autistic youth with co-occurring psychiatric challenges.

As noted earlier, there is a gap in understanding and representation within the literature of the experience of racialized autistic youth. Due to the restraints of the scope of this paper, I cannot do justice to discuss this topic in detail. However, I want to acknowledge that research which excludes racialized voices, as well as voices marginalized by gender, further perpetuates oppression. It is essential for dominant research to include an expanded research base which

recognizes the mental health experiences of racialized autistic youth and gender diverse autistic youth more readily.

The emergence of research on gender diversity and neurodiverse youth has been instrumental at challenging the notion of dichotomies of neurotypical versus neurodiverse and the gender binary, further challenging the idea that these dichotomies must exist exclusively (Pyne, 2021). Furthermore, research by Pyne (2021) highlights the highly medicalized states of being in regard to gender and neurodiversity and puts forth the importance of narratives that go beyond the medicalized schemas. The inclusion of mental health experiences of gender diverse autistic individuals is an important area for follow up to ensure that the research informing crisis response best practice is representative of all youth, including those that have been historically placed on society's margins.

The most prominent research methods utilized throughout the existing literature are the use of surveys or questionnaires geared towards the youth's caregiver(s). Participants are recruited through online databases and autism support groups and these projects aim to collect data regarding types of mental health challenges experienced, the behaviours seen, frequency of mental health crises and experience with navigating the mental health system (Ameis et al., 2018; Kalb, 2018; Vasa et al., 2020;). With this method of research, there are a number of notable critiques. First, there are a number of barriers for autistic individuals to access the study and have their stories heard, due to recruitment efforts that target the caregiver rather than the youth themselves. This is problematic as it shifts the narrative to an outsider perspective based on caregiver perceptions rather than from the perspective of an autistic individual experiencing the mental health crisis themselves. Additionally, the question types are standardized, which

limits the narrative further as caregivers must choose the best answer from what is presented rather than allowing authentic answers without impediments.

Presence and scope of practice for outpatient community supports is another identified gap in the literature. Various articles have spoken to the high reliance of autistic youth presenting to the ED being a critique on the current mental health system. Researchers argue that adequate outpatient mental health services do not exist to meet the complex needs of autistic youth experiencing a mental health crisis (Iannuzzi et al., 2021; Liu et al., 2017; McCabe et al., 2019). As many community services do not include crisis response within their mandates, further research on different bridging models from hospital to community is needed to better understand best service delivery method. Additionally, research on early identification and intervention available to youth and their families is also warranted to better understand what supports are found to be successful and where systemic barriers exist for families that hinder access to services (D'Alli & Valcante, 2017). Although a number of gaps exist in the literature, the emergence of critical discussions around supports for autistic youth are taking place in hopes to improve care outcomes and supports.

Additionally, a finding within risk factors of psychiatric hospitalization requires highlighting and further note. While many of the risk factors are associated with individual presentations of autism, such as lower adaptive functioning, greater ASD core symptom severity, self-injurious and aggressive behaviours, and the co-occurrence of a mood disorder or OCD diagnosis, coming from a single parent household is not (Kuriakose et al., 2018; McGuire & Siegel, 2018; Righi et al., 2018). Coming from a single parent household was noted as a risk factor in multiple articles, however it stands out from the others due to being a structural or systemic consideration. Despite being noted in the literature, there lacks further analysis in the

literature to critically explore why single parent households are considered a prominent risk factor. Further research into the internal family system and structure would be beneficial in order to have a better understanding of risk factors for psychiatric hospitalization.

Implications for the Social Work Profession

The findings from this literature review provide many implications for the social work profession. Social workers in Canada are upheld to the Canadian Association of Social Workers' (CASW) Code of Ethics which states that a social worker must acknowledge the inherent dignity of all people, protect human rights, and to work to promote and advocate for social justice (CASW, 2005). As people with disabilities are the world's largest minority group (Robertson & Larson, 2016), it is essential that social workers reject the various systems of service as status quo, and rather advocate for a more equitable mental health system.

A key principle of the disability rights movement is the concept of "nothing about us, without us" (Withers 2012), which honours and amplifies the voices and lived experiences of those with firsthand encounters of the research phenomenon in question. Due to the oppressive nature of many systemic practices silencing and omitting the voices of people with disabilities from dominant discourse, it is crucial that research focused on autistic individuals includes the voices of autistic people.

Implications from this review extend to clinical practice, policy formation and further education. Due to this being an area of relatively limited research, and no clear practice guidelines existing on best practice for autistic youth with co-occurring diagnoses (Ameis et al., 2018; Rosen et al., 2018), the development of ASD-specific policy and practice guidelines would be greatly beneficial. In addition to the development of practice guidelines, a prominent theme emerged from the literature highlighting the need for environmental changes to occur in the ED

and standard psychiatric units that take into consideration neurodiversity, and offer a more inclusive milieu (Kuriakose et al., 2018).

The current gaps and limitations have practice implications for social workers who are part of a multi-disciplinary team across various systems. As social work professionals work in anti-oppressive ways to help alleviate barriers to accessing care, the social work role could advocate for and implement more inclusive strategies such as the ASD-CP within non-specialized settings (Donnelly et al., 2020; Kuriakose et al., 2018). In addition to the implementation of ASD-CP adaptations for staff and service environments, the inclusion of family-centered approaches is highlighted as a key approach to help ensure the needs of autistic youth are being met.

This review clearly identifies the gap in appropriate supports available for autistic youth experiencing a mental health crisis and calls to action the need for systemic change in how the medical and psychiatric needs of autistic youth are prioritized. It is my hope that as the literature base expands on this respective topic, and that the dominant medicalization of disability and barriers to accessing inclusive mental health services can be further addressed. Expanding the research base is an important implication for social work researchers.

As the research evolves, it is essential that post-secondary institutions include these literature themes and progressing ways of understanding mental health care as core education for social work students. It is through the education of future practitioners that momentum for change can be carried on and the inadequate ableist systems that exist can be dismantled to lay formation for more equitable mental health care.

Conclusion

This paper aims to explore how autistic youth can be best supported while experiencing a mental health crisis. A review of the existing literature reveals a number of prominent themes. These themes are identified as: understanding co-occurring mental health diagnoses, community-based supports, emergency department utilization, admission to standard psychiatric units, adaptive strategies, and specialized psychiatric units for autistic youth. From these themes, several implications arose for social work professionals, from micro and mezzo level adaptive strategies and practice guidelines to macro level advocacy efforts and systems level change.

Youth with ASD have an increased risk of developing comorbid psychiatric diagnoses and being hospitalized due to experiencing mental health crises (Kalb et al., 2017; Kuriakose et al., 2018; Vasa et al., 2020). At this point in time, emergency departments and general psychiatric units do not have the adequate resources and training to effectively support autistic youth while experiencing a mental health crisis (Donnelly et al., 2020). With the proper training and specific adaptations, these environments can be more inclusive and effectively serve the needs of autistic youth with co-occurring psychiatric distress. It is important to apply an anti-oppressive lens and approach one's understanding built on foundations of critical disability theory to analyze the mental health services presently available. Further research and advocacy efforts by social work professionals is needed to implement necessary changes so that all individuals experiencing a mental health crisis can have equitable access and adequate care regardless of their neurological diversity.

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