"EVERYBODY GOT THEIR GO THROUGHS"

Young Adults on the Frontlines of Mental Health

CLASP

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Overview and Key Findings

Young adults living in poverty face high exposure to "go throughs": lived experiences of structural disadvantage and trauma with lasting implications for educational, economic, and other life outcomes. They frequently "get through" these challenges without formal mental health supports, relying on community-based programs and peer networks to cope with their experiences.

To better understand opportunities to improve state and local policy in support of behavioral health outcomes for low-income youth and young adults, we conducted focus groups to begin to explore young people's perspectives. We spoke to 26 low-income African-American young adults, ages 18-24, across three focus groups; one focus group was conducted in an urban area and two were conducted in a rural county, all in the Southeastern United States. Focus group participants included seven young women and nineteen young men. Urban participants were recruited in partnership with a workforce development program; rural participants were students in a GED program.

Throughout our conversations, we were struck by the openness and candor of focus group participants, their willingness to engage, and their strong desire to see change for themselves and for their communities. The major findings are a call to action, underlining the importance of an assets-based approach to mental health supports for youth and young adults. Such an approach recognizes and validates strengths, resilience, and young adults' drive to fully achieve their education, employment, and life goals. Key findings included:

1. Young adults defined mental health in terms of strengths, not problems. Young adults shared an affirmative vision of wellness that includes positive attributes, behaviors, and values.
2. Although substance use is a common experience among young adults living in poverty, substance abuse leading to clinically significant impairment or distress is rare. Substance abuse rates are 1.5 to 2 times higher among White young adults living in poverty than young adults of color.[1]
3. Experiences of poverty, violence, racism, and other forms of trauma were palpable in the room, and the young people frankly spoke about the ways in which these experiences had derailed education and employment. At the same time, they expressed a powerful commitment to overcome these challenges and achieve their vision of mental health.
4. Participants had strong ideas about what kinds of mental health supports worked and didn't work. Key observations included negative experiences with medical interventions (therapists, medication), schools, and guidance counselors; a history of law enforcement as the primary responder in some communities; and the core role of community-based and peer approaches that capitalize on shared experiences.
5. A large number of these young people reported they did not have health insurance (27 percent) or were unsure as to whether or not they had coverage (15 percent). We had several reports from young men about being kicked off Medicaid at their 19th birthday. Despite the importance that they placed on addressing trauma, mental health, and substance abuse issues, none of them indicated they knew how to access help for these issues through their health insurance.

Action implications for mental health policy

The federal fight for health care

1. At the national level, it is critical to sustain the Affordable Care Act's Medicaid expansion, which is a lifeline for low-income young adults who otherwise lose coverage at age 19.
2. It is also critical for the nation to maintain the Affordable Care Act's commitment to parity for mental health services and to prevention as a core element of Medicaid and insurance benefits.
3. At the state level, all states should adopt the Medicaid expansion and should commit to full implementation of the mental health parity and prevention provisions.
4. Expanded coverage should be coupled with a widespread public education campaign about access to behavioral health benefits.

Principles for framing policy and practice

5. Low-income young adults apply an assets frame to mental health; policy and practice conversations should respect and work to adopt this framing.
6. The perspective of low-income young adults highlights the importance of a prevention lens in mental health policy.
7. In conversations about mental health, low-income young adults also emphasize the integral role of societal structures and systems of oppression.
8. Policy choices should reflect the central position of service-delivery locations and approaches that are outside of a traditional medical model.
9. Trauma-informed practices in all of the systems that serve low-income young adults should be dramatically expanded.

CLASP believes that centering the voices of youth and young adults in identifying challenges and barriers as well as generating solutions is critical to developing effective policy recommendations. Young adults living in poverty are both positioned on the frontlines of mental health in terms of challenges, and have valuable perspective to shape mental health policy conversations. As long as young people have "go throughs" to get through, policymakers have a responsibility and an opportunity to invest in moving young adults living in poverty toward their vision of mental health.

> "I don't want to be a wreck all my life. I just won't."
>
> *- Rural Focus Group Participant*

Research and perspectives from youth leaders, advocates, expert practitioners, and policymakers underline the enormous need for a focus on providing improved access to mental health and support services for low-income youth and young adults.[2] Youth program providers have articulated the obstacles that young adults with unaddressed mental health challenges face—particularly those dealing with the consequences of trauma. In addition, research has consistently shown that mental health is a major concern for low-income youth of color and can hinder their ability to stay on or reconnect to an educational and career pathway that leads to economic security.[3]

This report summarizes findings from focus groups, as well as analysis of data from the 2015 National Survey on Drug Use and Health. We center the voices of young adults by leading with their perspectives: how do they define mental health? How do they talk about behavioral and substance abuse challenges? What do they describe as the greatest threats to mental health in their communities? Which supports are effective and ineffective? What role do they see for health insurance in addressing behavioral health challenges? Based on the themes that emerged from young adults, we selected and analyzed quantitative data points to provide additional context. We conclude with emergent policy and practice implications along with next steps for this critical work.

Mental Health Defined

How do young adults define mental health?

We began with seeking to understand how young people view and talk about mental health. Our close analysis of focus group content yielded a rich depiction of the meaning of mental health to the young adults in our groups. Focus group participants from both urban and rural areas consistently used several characteristics when defining mental health, although there were also a number of characteristics that were uniquely identified by urban and rural participants.

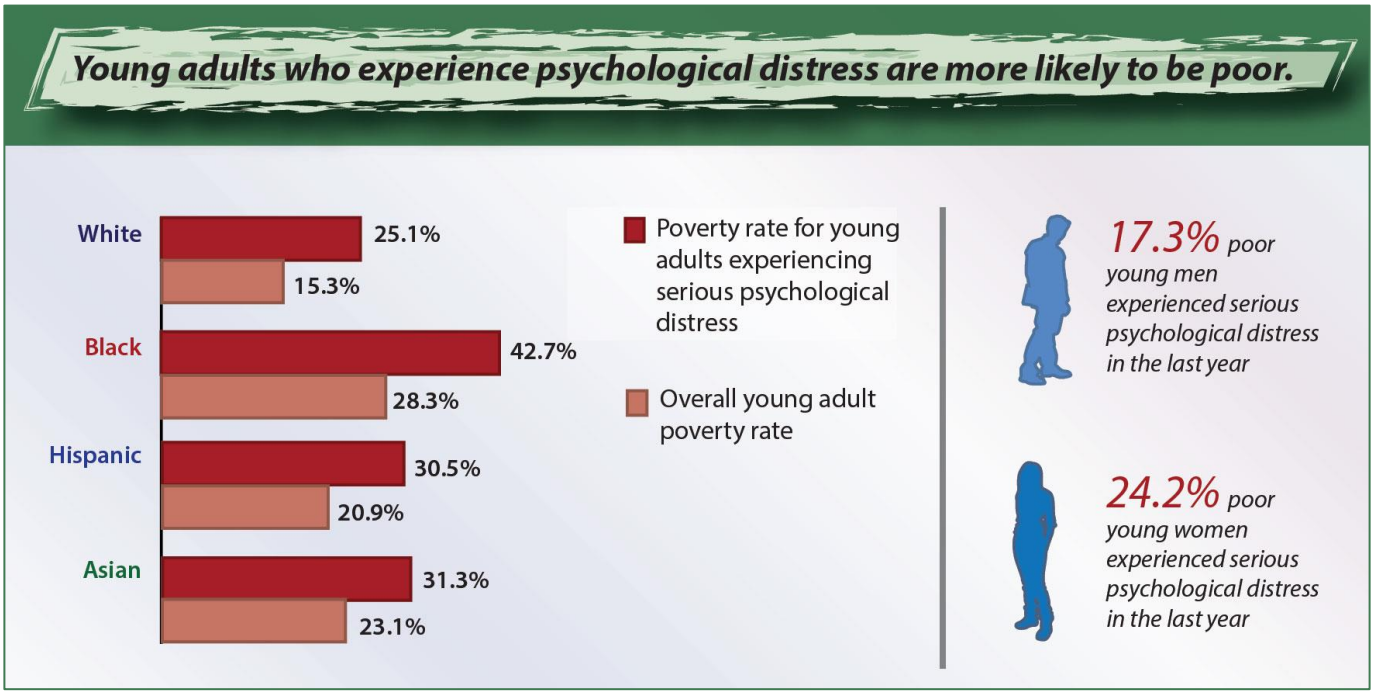
The dominant model of mental health since the 20th century has been a medical model that views mental illness as disease with physiological causes in need of diagnosis and medical treatment. This illness—or deficit—approach is the dominant framework in mental health services because psychiatry has been the dominant profession within those services.[4] As a result, much of mental health practice is focused on medication and one-on-one therapy. Competing perspectives have been less influential in shaping our cultural understanding of mental health and our public policy, with limited dollars increasingly focused on hospitalization and crisis services.[5] What is clear across both urban and rural focus group participants is that low-income young adults have a sophisticated understanding of mental health that is assets-based and does not align neatly with a traditional medical model of mental health. The perspective of young adults that we spoke to was most closely aligned with a wellness promotion framework, which is characterized by a focus on wellbeing rather than the prevention of illness and disorder.[6]

"Go-throughs"

Unfortunately, existing national data sets do not consider mental health in the framework defined by low-income young adults. National data do, however, provide useful context for understanding mental health experiences and needs as defined by practitioners and policymakers in the behavioral health field. Focus group participants described high exposure to "go throughs" in the form of structural disadvantage and trauma with implications for measurable indicators of mental health.

Serious Psychological Distress (SPD)

Adults are defined as having experienced *serious psychological distress* if they report moderate to high levels of depression, anxiety, or emotional stress during their worst month in the last year[7]. Nearly 21 percent of young adults ages 18-25 living in poverty reported experiencing SPD within the last year, with poor White young adults (26.1 percent) more likely to report psychological distress than young people of color (16-18 percent). The poverty rate for young adults who experience serious psychological distress (28.5 percent) is higher than that for young adults overall (19 percent). These poverty rates are particularly high for young people of color who experience psychological distress.



Any Mental Illness (AMI)

Adults are defined as having *any mental illness* if they have had any mental, behavioral, or emotional disorder in the past year that meets DSM-IV criteria excluding developmental disorders and substance use disorders[8]. Among young adults living in poverty, 22.3 percent report experiencing AMI within the last year. The rate for poor White young adults (26.9 percent) is higher than that of Black (14.8 percent) and Hispanic young adults (20.4 percent). Young women (26.1%) living in poverty also demonstrate higher rates of AMI than young men (18 percent). Some participants discussed having diagnosable mental illness, with multiple references to ADHD diagnoses and one reference to a diagnosis of bipolar disorder.

Serious Mental Illness (SMI)

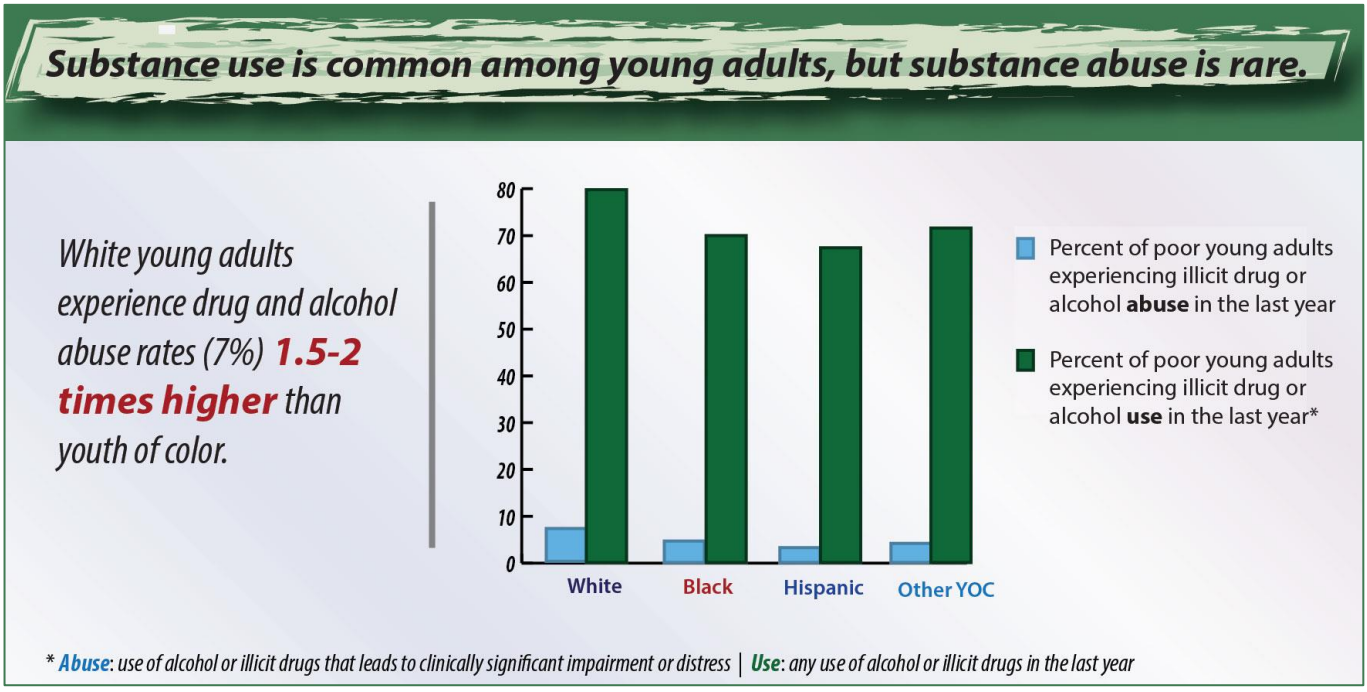
Adults are defined as having *serious mental illness* if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities[9]. Among young adults living in poverty, 4.5 percent report that they have experienced SMI within the last year. This rate is not substantially different from the rate for young people of all income levels in this age range (5 percent)[10]. The rate for poor White young adults (6.6 percent) is twice that of Black (2.7 percent), Hispanic (3.0 percent) and other young adults of color (3.3 percent). One clear instance of experience with serious mental illness was mentioned by a focus group participant, where she described being hospitalized for anxiety.

Substance Abuse

> Like, the younger people—they see older people, like, smoking so they feel that okay, it's cool keep doing it. You know, everybody smoking with him so they smoke too. If I can get the same reputation as him, right then, like that.
>
> *- Urban Focus Group Participant*

> Now, it's a fact going on with my age group that I'm hearing. They go to the club and have parties. And now you're meeting in the bathroom and they do cocaine. That's another thing … like … selling pain pills is like a form of income.
>
> *- Urban Focus Group Participant*

Mental health and substance abuse risks are often more pronounced for 18- to 25-year-olds than for other similar age groups, such as adolescents or young adults ages 26 to 34.[11] In both urban and rural settings, a majority of focus group participants identified illicit drug and alcohol use as prevalent in their communities. There were references to use and abuse of a range of illicit drugs including marijuana, cocaine, crack, molly, as well as prescribed drugs such as Xanax and pain killers. Participants noted that substance use and abuse was a salient challenge fostered by a host of environmental factors, and that it acted as a major barrier to stability and employment.



The challenge presented by substance use is supported by national data. CLASP analysis of the 2015 National Survey on Drug Use and Health found that nearly 74 percent of poor young adults ages 18-25 report having used alcohol or illicit drugs at some point within the last year. Substance abuse is defined as meeting the criteria for dependence or abuse of alcohol or illicit drugs in the past year based on criteria specified in the DSM IV.[12] The defining feature of substance abuse is clinically significant impairment or distress.[13] Although substance use is common among young adults, substance abuse is rare. The only conversation about substance abuse by young adults that emerged during the focus groups was about an incident where a couple was found dead in a park from a Xanax overdose.

In the urban setting, participants referred to drug use as a major barrier to employment. The participants described experiences where they lost jobs or had been denied jobs due to drug testing requirements. A unique conversation that emerged in the urban setting was that seeing role models such as rappers or older peers doing drugs made it seem "cool," and that is why a lot of young people used drugs. On the other hand in the rural setting drug use was blamed for causing users to be violent and was perceived as negative overall.

In both settings, selling drugs was raised as a source of income; this was especially true for youth who were involved in the justice system and could not access jobs.

Threats to Mental Health

Addressing mental health among young adults requires looking beyond the definition identified by practitioners and policymakers in the behavioral health field. We need a broader definition that includes environmental factors that disproportionately affect economically disadvantaged communities. There has been growing attention in public policy to the role of Adverse Childhood Experiences (ACEs), a list of traumatic events that in sufficient numbers have been linked to long-term health outcomes and life expectancy. [14] Focus group participants described experiencing multiple ACEs with dramatic impacts for their education pathways and employment prospects. In addition, there is a growing recognition that racism and other forms of toxic stress perpetuated systemically are forms of ongoing trauma that affect the lives of young people of color.[15] The central threats that emerged among focus group participants were the financial strain associated with poverty and disadvantage, as well as multiple forms of unresolved trauma.

Financial strain

> "I feel like it all come down to money…because, when you struggling and stuff, you gonna do what you got to do. Like, it is going to come down to like either you want to fight or you want to flight and if you flight, you going to die. That plane gonna crash. Because you not gonna make it but so far…Money don't make happiness, but when you can't do nothing without money, you gonna snap bruh. The pressure gonna be too much and not everybody can handle that pressure."
>
> *- Rural Focus Group Participant*

Among young adults in both urban and rural contexts financial strain emerged as a common theme. The following challenges were identified by young adults across both contexts:

- Transportation
- Financial support to family
- Housing expenses
- Paying bills
- Loss of public benefits such as Medicaid and food stamps

Financial strain was particularly salient for young people with a history of contact with the criminal justice system. A couple of rural participants noted being a felon as an identity that blocked opportunities for them. A female participant talked about youth reentering society wanting to work and "better themselves" but encountering a lack of access to jobs due to their status as "felons."

In addition to the shared challenges, urban focus group participants uniquely identified drug testing as a barrier to accessing jobs and lack of housing as an exponential cause of stress. Rural focus group participants uniquely identified food insecurity as a major stressor. A young parent in the rural context shared that lack of affordable child care was a cause of hardship for her.

Trauma

Focus group participants reported a range of traumatic experiences, both recent and throughout their childhoods. Perhaps most prominent in both the urban and rural context was gun violence; however, participants also reported experiences with racism and unresolved community and family trauma at alarming levels.

Gun violence

> "Not even just this week. Past three months…I been hearing it. People dying here, people dying there. People dying this place. People dying that place. Then when I came back it got worse. It was like, 'Oh, this person just died.' Like three people died in one day. Off this gun violence."
>
> *- Urban Focus Group Participant*

> "I can say this one. Like, I was on the porch with my sister, my older sister, and her boyfriend, and somebody's family and this car just pulled up and stood beside the house that was like down the street from us and some dudes got out of the car and they was looking at us, so then they got back in the car and drove off and then when they came back down the street, they were shooting at us and my sister's boyfriend and me ended up getting shot in the leg."
>
> *- Rural Focus Group Participant*

One of the main themes that emerged as a threat to young adult mental health during the discussion in both the urban and rural contexts was gun violence. Many of the focus group participants shared that gun violence is a prevailing issue in their communities. Both urban and rural participants described frequently witnessing and experiencing shootings in their communities and the consequences of the loss of their peers' lives. A number of rural participants had themselves been shot.

The prevalence of gun violence in communities is reflected in national data from the Centers for Disease Control and Prevention. Data released by CDC show that in 2015 there were 26,755 documented non-fatal gun violence incidents in the United States among youth ages 18-25.

CDC Gun Violence Data-Nonfatal/Fatal 2015, United States, Ages 18 to 25 Both Sexes				
RACE	**NUMBER OF INJURIES**	**INJURY RATE PER 100,000**	**NUMBER OF DEATHS**	**DEATH RATE PER 100,000**
All Races	26,755	74.4	4220	11.7
White	3,964	19.7	537	2.7
Black	11,803	195.9	2832	50.7
Hispanic	1,120	15.6	751	9.8

As we can see from the CDC non-fatal gun violence incidents data, tens of thousands of young adults injured by gun violence survive. Although their physical wounds might heal, these incidents leave behind an emotional toll that can last long after. For focus group participants, experiencing gun violence in their own communities built a sense of mistrust and a need for self-protection and self-defense.

Despite the severity of the implications of gun violence, these young adults have built resilience and are aware of the gaps that exist in addressing community violence. Although many focus group participants struggled to imagine their communities free of gun violence, some offered solutions including increased investment in community programs and collective efforts to better the community driven by community members. Although short on specifics, recommendations included building communities where "everybody helps everybody," free from "pettiness," and where adults expose young people to new opportunities.

Racism

> "I stay in the white folks section. And it is like the white folks, they be like this: 'We run it now. We got a white president back in the oval.' It is like they got little nasty attitudes now."
>
> *- Rural Focus Group Participant*

Racism was another prominent form of trauma described in both urban and rural settings. Young adults affected by racism report feeling excluded and discriminated against. Racism as a theme came up more during the discussion with rural participants than urban participants. However, in both contexts, our young adult participants identified experiencing racism and discrimination in a job setting, both when applying and once they were performing their jobs. Rural focus groups also described racism in schools and school policy. For example, focus group participants talked about schools deliberately blocking Black students from graduating while supporting White students to do so. Since the rural focus group took place in March 2017, some participants described a heightened incidence of racist attitudes toward them after the presidential election.

Other adverse experiences

Participants identified many additional regular, potentially traumatic influences in their environments: gang violence, cultural and socioeconomic insensitivity, bullying, homelessness, parental incarceration, untimely loss of parents and other family members, witnessing a parent's drug addiction or domestic violence, sexual abuse, and being "kicked out" by parents. Also common in the rural focus groups were descriptions of other forms of violence including physical fights, stabbings, and assaults at school and in the community.

Effective Mental Health Supports

Young adults in both urban and rural contexts had clear ideas about which types of supports were effective in helping them address mental health challenges and which were ineffective or in some cases, harmful. Young adults living in poverty frequently "get through" their "go throughs" without formal mental health services, relying instead on community-based programs and peer networks. National data indicates that only 12 percent of young adults living in poverty received any formal mental health services in the past year, and that White young adults receive mental health treatment at 1.5 to 2 times the rate of youth of color. More than three quarters of a million young people living in poverty reported needing—but not receiving—mental health treatment in the last year.

It is therefore not surprising that the mental health supports described by focus group participants as most effective were not traditional, formal mental health treatment services. The list of effective strategies that emerged focused on three key themes: community-based programs, shared experience/background, and group/peer-to-peer approaches.

Community-based programs

Focus group participants in both urban and rural settings saw community-based programs as the most effective mental health support they had experienced. In no case did the programs that young people described have an explicit focus on mental health; in most cases these programs were dedicated to workforce development, education, or aspects of youth development broadly. In meeting these other developmental goals, however, these programs provided critical supports that addressed the key threats to mental health described by participants. These programs addressed financial strain both by providing direct, tangible financial assistance and helping with access to needed public benefits. They addressed community violence by giving young people "something to do," teaching new skills such as conflict resolution, providing information, and teaching morals and values. In these supportive contexts, young people felt they could address experiences with racism and unresolved trauma because the program brought together young adults with shared experiences and caring adults who were relatable because of their shared background.

> We all sat around in a circle and we basically discussed some of the issues going on with all of us, and we come to find out that some of us had similar problems, some of us different…They basically took everyone's situation and found like the common denominator or source and basically that's what we worked on sitting here.
>
> *- Urban Focus Group Participant*

Vulnerable young adults who have had negative experiences with and feel betrayed by a host of systems and institutions—and despite the focus of community-based programs on a range of other goals—perceive the environment created in these programs as therapeutic.

Shared experience/background

> To be honest with you, I would rather talk to somebody that went to prison or came through here because they know the lifestyle. They know how it was. And they understand you.
>
> *- Rural Focus Group Participant*

Whether in community programs or not, focus group participants expressed a strong preference for support from adults with a shared experience or background. Young people both explicitly named a preference to speak with adults from a shared racial background, and perhaps more importantly, with shared life experience. Participants felt that shared experience would reduce the likelihood that they would be judged or treated differently when they talked about difficult experiences. Although one focus group participant described a positive experience working with a professional from a very different background, the overall preference in both the rural and urban setting was to receive support from adults with intimate knowledge of "the struggle" because of their own life experiences.

Group/peer to peer

> I feel like it is better to talk to our peers like we doing now. 'Cause the way our generation set up, we all have somewhat of a similar lifestyle. So, like yea. And I feel like this somethin' we should do, like, every now and then.
>
> *- Rural Focus Group Participant*

Participants in both the rural and urban setting also expressed a strong preference for supportive conversations with peers in a group setting. Participants indicated that group conversations were preferable because they allowed young people to find commonalities and differences in experience, and to learn from each other. They also felt that peers were more likely to relate to their experience and provide advice or guidance that was useful and applicable.

Overall, focus group participants reported relying on and a preference for informal, non-traditional, community-based mental health supports that draw on the shared life experiences of adults and peers.

Ineffective Approaches to Mental Health

Focus group participants were equally clear about mental health interventions that were not effective and in some cases, harmful. In both urban and rural settings, participants described deep and troubling problems with schools as a source of mental health support. Rural participants also described negative experiences with traditional one-on-one therapy and psychiatric medication that resulted in near universal rejection of these interventions. Perhaps of greatest concern, rural participants described a number of instances of law enforcement being used to address behavioral health challenges that actually exacerbated rather than resolved past trauma.

Schools

> Like, then you won't have nobody judging you because…there used to be, what's it called? This counselor or whatever. She used to ask me like, 'Why do you act the way you act?' And I used to feel like, yeah like, after I tell her, she make fun of it. Like she really didn't see why I was acting the way I was acting. She was making fun of me. She was laughing at me with the teachers. Yeah, so that's what makes me mad with teachers. Like, I feel like you all laughing at. If I tell you my personal life and my personal business, you shouldn't go back and talk about it to no other teachers. And that is what they were doing.
>
> *- Rural Focus Group Participant*

Although schools are often viewed as a key institution for meeting the holistic needs of students, both urban and rural participants felt that they'd been failed, and in some cases betrayed by schools and school personnel. In both the urban and rural context, participants felt there was a general lack of understanding and caring from school personnel who failed to consider the challenges that students brought with them to school. Rural participants described both outright racism in schools and school policies, and overreliance on harsh, exclusionary discipline that had pushed many participants out of school. Even those who engaged in school activities and performed well academically could be derailed by a single incident. Young women described schools that were unwilling to accommodate them because they were pregnant or parenting, an experience echoed by pregnant and parenting young women nationwide.[16]

Focus group participants in both urban and rural settings expressed particular disappointment in school counselors. In the urban focus group, participants emphasized the role of counselors as disciplinarians and graduation credit-counters rather than helpers. Rural participants shared a view of counselors as not helpful, and in some cases as a source of betrayal.

The overall assessment of focus group participants was that schools, school systems, and school personnel do not effectively support the mental health needs of youth and young adults with extensive trauma histories and multiple barriers to success.

Traditional one-on-one therapy

> Certain things, you don't want to talk to people about. Especially, I'm gonna just be honest, I ain't too kindly with, you know, I ain't fittin' to have no white man sit in front of me and ask me questions about my life. What about 'What your life about?' Like, it's stuff like that, because I feel like they really coming at you a certain type of way because people may think you got an issue, but you really don't, you feel me? I just, I don't know, it just suddenly everybody make you snap off or make you just blink off. Everybody is just different.
>
> *- Rural Focus Group Participant*

A number of rural focus group participants had first-hand experience with one-on-one therapy, and they overwhelmingly described negative experiences. As might be expected based on the importance ascribed to shared background and experience for providing effective supports, therapists—who were typically described as White and male—were met with suspicion and skepticism. Participants described their approach to questioning as frustrating, either because it did not get to the heart of the problem or was not responsive to an expressed desire to stay away from or focus on certain topics. Participants vividly described therapists as furiously scribbling on a notepad and reporting the content of conversations to parents in a way that the young people considered unfair. Many participants indicated that they did not return to therapy or complete the intended course of treatment. Participants who had undergone one-on-one therapy generally felt that these experiences were not helpful, and in some instances made problems worse.

Medication

> Yeah, how you going to put somebody on medication and then that really messed them up. Because they don't need the medication. Anybody talked about putting me on some, I'm like, 'I'm not taking no medication. You can prescribe it to me, but I ain't taking it.' Because I know…I don't need it.
>
> *- Rural Focus Group Participant*

Several rural focus group participants also had experience being prescribed psychiatric medication—typically for a diagnosis of ADHD. Use of medication to address behavioral challenges was universally viewed negatively, both by young adults, and reportedly by their families. Those who had been on medication themselves or had seen it used by close friends or siblings indicated that the medication was "effective" in the sense that it

"calmed me down." The medication's side effects, however, were perceived as intolerable, with multiple participants describing feeling like a "zombie" while on medication. Focus group participants also described medication being incorrectly dispensed by school personnel. One participant shared a story of a sibling who was given someone else's medication dose at school with dangerous results. There was also a strong sense reported both by young people and in some cases their parents that they didn't "need" medication and that they were not interested in taking it. As a result, most participants indicated that they discontinued their prescribed medication, despite the consequences for their behavior. Overall there seemed to be a strong cultural norm against the use of medication to address mental health challenges, with participants preferring to experience behavioral problems rather than the side effects of medication.

Law enforcement

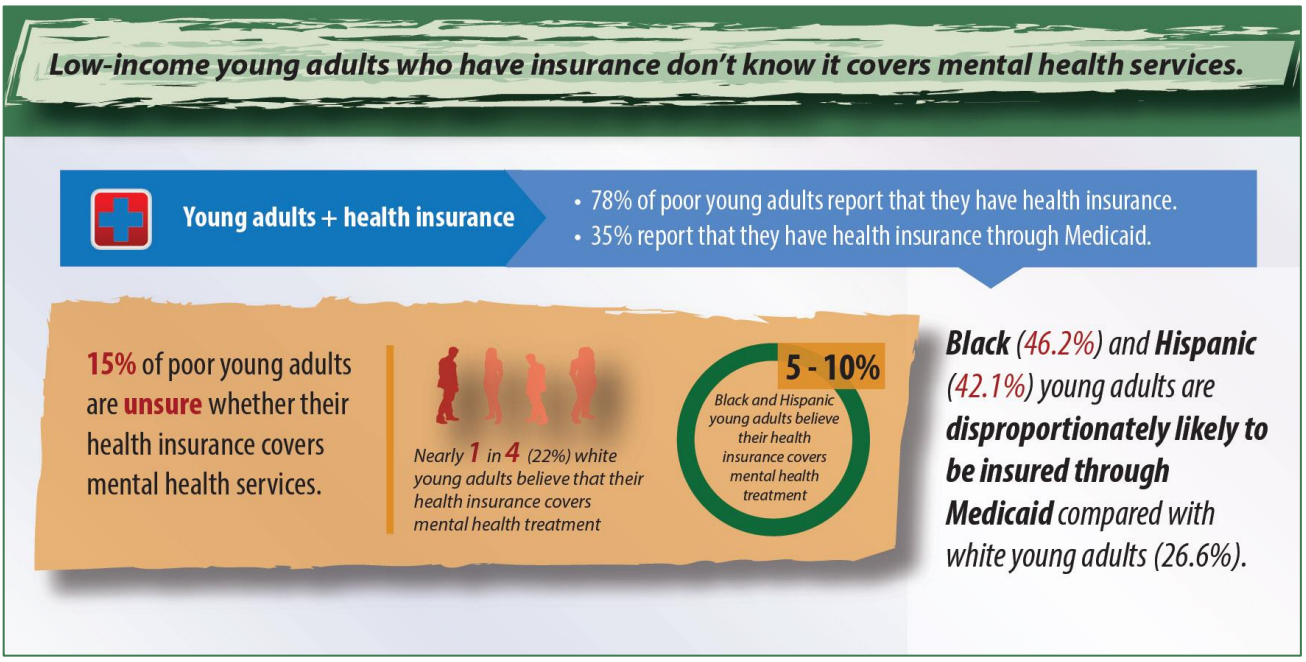
> "But then my mama—she called the cops on me like four times and they told me, they was like, 'We come back down here, you not coming back.' So, they left. She kicked my ass out."
>
> *- Rural Focus Group Participant*

Among rural focus group participants, there was strong evidence that law enforcement were frequently the primary responders to mental health problems, particularly those that manifest as acting-out behaviors. Focus group participants described police interventions at school, in the community, and in the home. These interventions were universally ineffective, with law enforcement officers threatening arrest, or in some instances, failing to act to protect victims of violence. One participant even described an instance where a police officer had been building a relationship with a troubled young person in the community, playing basketball with him, and ultimately ended up shooting this young person to death. Low-income communities, especially those of color, already have a complicated history and set of contemporary experiences with law-enforcement. Reliance on law enforcement to address mental health issues was an ineffective strategy that typically failed to address the behavioral crisis and only served to criminalize young adults experiencing behavioral health challenges.

Health Insurance

Expanded health coverage under the Affordable Care Act (ACA) and accompanying laws supporting coverage parity for mental health services represent a key opportunity to achieve better health outcomes for low-income young adults. Across the urban and rural context, 58 percent of focus group participants reported that they had health insurance, with 27 percent reporting that they did not have health insurance, and a full 15 percent of whom were unsure as to whether they had coverage or not. Coverage rates were higher among urban focus group participants (66 percent) than rural focus group participants (56 percent).

These findings are aligned with national data, where 78 percent of low-income young adults report that they have health insurance, but there are significant disparities by race and gender. Black (65.9 percent) and Hispanic (59.7 percent) young men living in poverty are insured at lower rates than White young men (81.3 percent) and young women of all races (82.3 percent). Black (46.2 percent) and Hispanic (42.1 percent) young adults are disproportionately likely to be insured through Medicaid when compared with White young adults. The lower coverage rates reported by the young people in our focus groups may be attributable to the fact that neither of the states where the focus groups were conducted participated in Medicaid expansion under the ACA. In non-expansion states, Medicaid eligibility ends at age 19. One of the ACA's most popular provisions allowed young adults to be covered by their parents' health insurance until age 26. In the absence of Medicaid expansion, there is no parallel protection for young adults whose parents don't have health insurance coverage through their employer. Several male rural participants described being summarily "kicked off" Medicaid on their 19th birthday, with the main predictor of not having coverage being older than 18.



When asked about health insurance coverage, both urban and rural participants immediately thought of physical health. Participants indicated that they used their health insurance for annual physicals, dental procedures, minor and serious injuries, prenatal care/labor and delivery, and to address chronic conditions including sickle cell disease and acne. Young people perceived disparities in access to and quality of treatment based on having insurance or not. In the rural context, they also perceived discrimination based on having Medicaid versus other types of insurance, with reports of having to travel substantial distances or make multiple rounds of calls to locate providers that would accept Medicaid.

> "Anyplace you be trying to go to, you try to get like health services and you don't got insurance, they don't give you no attention."
>
> *- Urban Focus Group Participant*

> "I probably could have a stab wound and he could have a little cut on his eye—because he got insurance, they going to look at him first."
>
> *- Urban Focus Group Participant*

> "And I feel like it is discrimination because one dentist I went to on Sunset, they was like, they don't accept Medicaid patients. But I went to the same exact dentist in Oakwood and they accepted it. So, I didn't really get that part."
>
> *- Rural Focus Group Participant*

Overall, rural focus group participants were more knowledgeable about different insurance rules, and many had devastating first-hand experiences with hospital bills that came during gaps in coverage or because of a delay in recertification. A surprising number of both rural and urban focus group participants were uncertain about whether they had health insurance coverage, what that insurance covered, and how to get coverage if they didn't have it.

> To get it back, I think I have to go back and try to apply for it or something like that. I'm not really sure.
>
> *- Urban Focus Group Participant*

This focus on physical health and uncertainty about covered services is supported by CLASP analysis of national data. Only 22 percent of White young adults living in poverty believe that their health insurance covers mental health treatment (whether or not it actually does), a number that falls to between 5 percent and 10 percent for Black and Hispanic young adults. Less than 10 percent of low-income young adults across racial groups believe that their health insurance covers drug and alcohol treatment. It is perhaps not surprising that, according to national data, 15 percent of young adults living in poverty report being "unsure" as to whether or not their health insurance covers behavioral health services.[17]

Despite the promise of the ACA, a substantial number of vulnerable young adults remain without coverage, particularly in states that did not expand Medicaid and poor young adults of color. Even those with coverage have varying degrees of understanding of which services are covered, and very few recognize that their insurance can help them access behavioral health services.

"About to Go Hectic": The Federal Fight for Health Care

> "This world is really about to go hectic real live because Medicaid 'bout to get tooken…" - *Rural Focus Group Participant*

Protecting Medicaid from draconian cuts and restructuring that would throw millions of people off of their insurance is a racial and economic justice issue. Medicaid is the primary source of coverage for low-income young adults of color; in an administration that has demonstrated open hostility toward people of color in its policy proposals, we must consider the possibility that proposed changes are part of a racist agenda that actively seeks to undermine the collective health of black and brown communities.[18] In this context, advocates ought to act with urgency to ensure that the needs of low-income young adults are a part of the national policy conversation. Specifically:

At the national level, it is critical to sustain the Affordable Care Act's Medicaid expansion, which is a lifeline for low-income young adults who otherwise lose coverage at age 19. Thirty-two states, including DC, have taken advantage of federal dollars available through the ACA to expand Medicaid. The Medicaid expansion has been particularly helpful for low-income young adults—between 2013 and 2014, the share of low-income young adults who had public coverage increased from 30 to 41 percent, and the share of young adults who were uninsured fell from 35 to 24 percent.[19] Cutting state Medicaid budgets by more than $800 billion, as in the Republicans' American Health Care Act, risks further exacerbating the disparities in health coverage experienced by young adults living in poverty by swelling the number of young adults who lose coverage at age 19.

It is also critical for the nation to maintain the Affordable Care Act's commitment to parity for mental health services and to prevention as a core element of Medicaid and insurance benefits. Without this framework, states and communities will lack the federal financial resources and the commitment to respond to the needs and the vision articulated by these young people. For example, schools across the country currently receive $4 billion in Medicaid annually to provide essential health services to students, including mental health services. School leaders view proposals to cut Medicaid funding as a substantial threat to their ability to deliver critical mental health services for students.[20] The current level of investment does not provide sufficient resources for school-based mental health supports to reach all of the students who could benefit. Draining federal resources out of states and forcing states to ration care and cut benefits would be short-sighted and costly in terms of lost productivity.

All states should adopt the Medicaid expansion and commit to full implementation of the mental health parity and prevention provisions. Given the critical role that Medicaid plays in opening the door to physical and behavioral health care for low-income young adults, particularly young adults of color, states that have failed to expand Medicaid coverage are doing a disservice to vulnerable young adults. By rejecting the AHCA and choosing instead to expand Medicaid, states have the opportunity to make choices that will have an immediate meaningful difference in the lives of low-income young adults in their state.

Expanded coverage should be coupled with a widespread public education campaign about access to behavioral health benefits. Expanded health insurance coverage alone does not guarantee that young people can and will access services. Although Medicaid recipients are much more likely to get behavioral health services than the uninsured, they have high rates of perceived unmet need and moderate rates of receiving active treatment, indicating that coverage expansion without addressing supply or public education policy may be insufficient.[21] If young people do not know their insurance covers behavioral health services—and the vast majority do not—they will miss out on opportunities to take advantage of needed services.

Next Steps and Emergent Implications for Policy and Practice

> "Just everything bro. It's like everything. It's like every time something go negative I just think like if that shit had never happened, I wouldn't have been here now. I could have been somewhere else doing better, probably going to college right now."
>
> *- Rural Focus Group Participant*

Our focus group conversations are a powerful call to action. In rooms where experiences of trauma were at times raw and palpable, there was both a frank acknowledgement of the ways in which these experiences had derailed education and employment, and a commitment to overcome these challenges and achieve the assets-based vision of mental health that focus group participants articulated.

Although we have learned a great deal through this work thus far, there are gaps and limitations that are critical to address. We recognize that it is essential to learn from young people who belong to other ethnic groups and live in other regions to understand how disparate identities and experiences are similar to and different from those of African-American young adults. We also recognize that there are examples of effective practices across the country, and we want to learn from practitioners, providers, and policymakers about the factors that support their success. Despite these limitations, we feel that these findings have a set of emergent policy implications that include larger principles for shaping ongoing policy discussion.

Principles for framing policy and practice

Low-income young adults apply an assets frame to mental health; policy and practice conversations should respect and work to adopt this framing. The best evidence from the fields of youth development, education,[22] and communications[23] suggests that young people are best served when they are viewed, approached, and treated as assets rather than problems. Yet all too often, our public policy and policy discourse employs deficit framing that reinforces negative stereotypes and re-inscribes trauma. Mental health advocates have long struggled to reduce the stigma associated with mental health and reframe the conversation.[24] We have a unique opportunity to draw on the powerful example of the assets framing of mental health articulated by young adults as we work to shape mental health policy to more effectively meet their needs.

The perspective of low-income young adults highlights the importance of a prevention lens in mental health policy. The young adults we spoke to were not focused on increasing or improving the availability of mental health services; they very clearly called for their experiences and communities to be different and for an end to the types of trauma that they had experienced. This perspective aligns with a prevention framework, which articulates that it is less costly to individuals and society to prevent behavioral health challenges than to

treat them once they have developed.[25] A prevention lens would underscore the role of violence prevention and reduction strategies, policy efforts to address gun violence, and anti-incarceration strategies in addressing mental health.

Low-income young adults also emphasize the integral role of societal structures and systems of oppression in conversations about mental health. Young people engaged in complex structural analysis, describing the role of poverty and disadvantage in mental health challenges. This structural analysis considers the role of larger societal structures in creating the inequities, barriers, and challenges experienced by young people. For example, *law enforcement should not be primary responders to mental health crises experienced by low-income young adults.* One of the features of a "law and order" framework is the criminalization of vulnerability and normative adolescent behavior, which places low-income youth of color at disproportionate risk for contact with the juvenile and criminal justice system.[26] With deinstitutionalization and the influx into the community of persons with severe mental illness, the police have become frontline professionals who manage these persons when they are in crisis.[27] The reliance on law enforcement to intervene in behavioral health crises is likely evidence of both the under resourcing of behavioral health systems in low-income communities and racist perceptions of young adults of color that treat symptoms of trauma exposure as inherent violence and criminality. Law enforcement officers have no role in responding to a mental health crisis, and at a minimum should be trained to recognize such crises and connect families to more appropriate resources.[28] In addition, the recent decision by U.S. Attorney General Jeff Sessions to require prosecutors to seek the harshest punishments available for drug offenses will have predictably devastating consequences for young adults in communities where upwards of three quarters of young people report having used illicit drugs or alcohol in the past year. Efforts to reduce and eliminate poverty and other structural barriers should be central to mental health policy development.

Policy choices should reflect the central role of locations and approaches that are outside of a traditional medical model. Communities of color have a difficult history with systems built on a medical model and are justifiably skeptical of an approach that has a history of disbelieving their pain[29], medicating without consent, withholding treatment, experimenting on their bodies, and subjecting them to additional trauma by acting upon racist assumptions.[30] The low-income youth we spoke to overwhelming rejected much of the arsenal of traditional behavioral health professionals: one-on-one therapy and medication. They expressed that the most effective support was provided by community-based programs that typically cannot and do not bill Medicaid for behavioral health services. Our policies must move from a framework in which refusing to take medication or come to therapy is seen as "non-compliance" to one that values culturally derived healing practices. To effectively meet the needs of vulnerable young adults, our policies must be flexible enough to work in non-traditional locations and through non-traditional approaches that can more effectively respond to cultural nuance and that value people's lived experiences.

Trauma-informed practices in all of the systems that serve low-income young adults should be dramatically expanded. Evidence shows that the introduction of trauma-informed practices in youth-serving systems promotes healing in the face of trauma and adversity[31]. Insurance systems, including Medicaid, have the ability to pay for trauma informed care in these systems.[32] Efforts to expand trauma-informed practices should apply a racial equity lens that not only considers community and family-based experiences, but also understands racism as a form of ongoing trauma. Our policies and practices must also set an expectation of

cultural humility from practitioners. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the provider-client dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities.[33] It is different from cultural competence in that it is focused on self-humility rather than a state of knowledge or awareness. To the extent that practitioners and providers incorporate trauma-informed approaches and cultural humility into their interactions with youth and young adults, the chance that young people will be re-traumatized by the systems they encounter will be reduced.

Conclusion

One of CLASP's core principles for realizing youth justice is centering youth voices. [34] Investing in the mental health of youth and young adults is also critical to realizing youth justice.[35] Low-income young people are faced with a cascade of "go throughs" that position them on the frontlines of mental health and have implications we cannot afford to ignore. Their perspective on those frontlines must shape mental health policy conversations. As long as young people have "go throughs" to get through, policymakers have a responsibility and an opportunity to invest in moving young adults living in poverty toward their vision of mental health.

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