Policy for Transformed Lives

State Opportunities for Young Adult Mental Health Policy and Systems Change

CLASP
Policy solutions that work for low-income people

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"Are we a service industry? Or a transformational industry? A service industry is kind of like McDonald's. How many burgers can we sell, as efficiently as possible, provide a quality product so people keep coming back. You know, when you have a line at the cashier, how do you move them quickly and efficiently through. And you're really measuring your success by the number of burgers you sell. Or whatever you want to sell. We do a lot of that, out of necessity. We have to bill for services, so we capture time, we bill in increments of 15 minutes. We capture services. Whether it's an individual service, or a family-based service, or a group therapy service, or in Kentucky we do collateral services which are with teachers and so forth. And then we capture all of that and we measure it ... All that's great for service industries. **But how would we have to change if we were in the business of transforming lives?** Cause that's what we really signed up for."

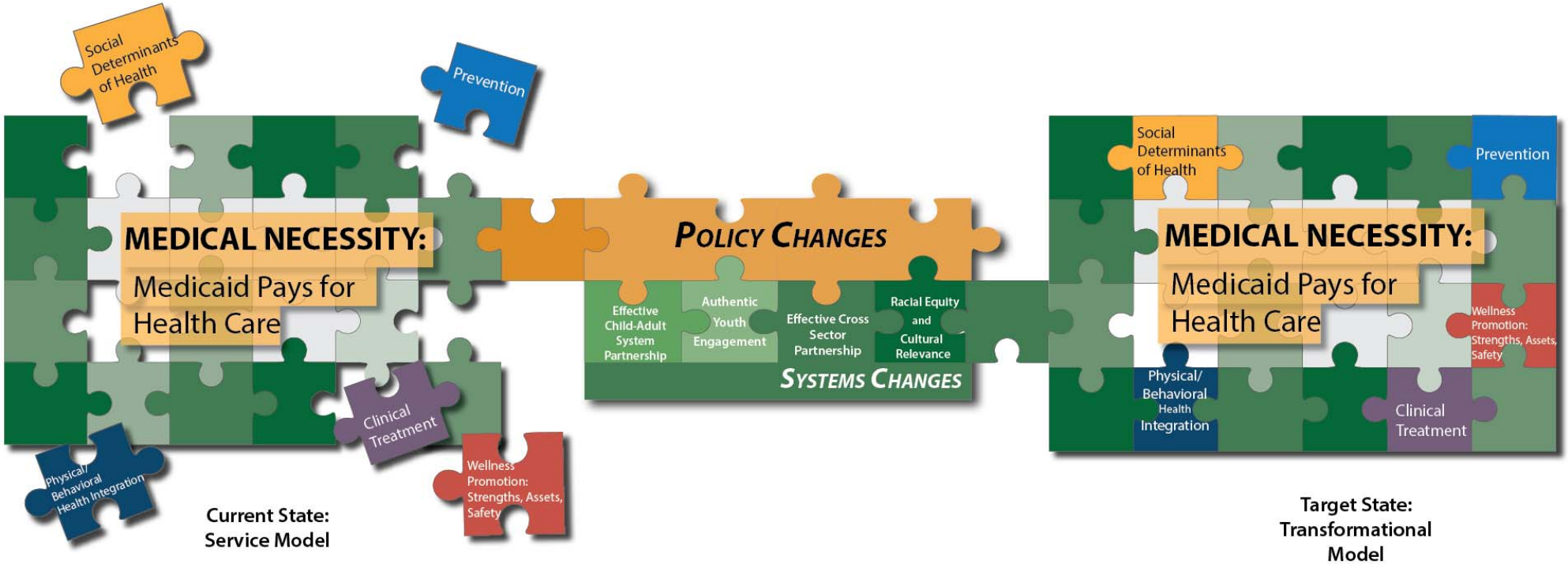
- Ron Van Treuren, Louisville

Introduction

More than one in five young adults ages 18-25 in poverty reported serious psychological distress within the past year.[1] When young adults' mental health needs are unaddressed, their economic stability, independence, and overall wellbeing can be undercut. CLASP conducted an in-depth scan and analysis[2] of how selected states (Maryland, Michigan, Oregon, and New Mexico) and localities (Los Angeles, CA, Louisville, KY, and New York, NY) are addressing young adult mental health to inform efforts to improve relevant policies. Part of our *Policy for Transformed Lives* series focused on young adult mental health, this brief describes opportunities for state action based on the promising efforts already underway.

The consensus in our stakeholder conversations was that despite good coverage through Medicaid for traditional mental health treatment services, challenges such as low reimbursement rates and an insufficient mental health workforce to meet the needs of youth and young adults remain. While addressing these challenges is valuable and will likely produce incremental change, systemic change that centers youth and young adults requires bold action. Based on our findings, we have developed a guiding framework and identified several opportunities for states to transform their approach to youth and young adult mental health.

Guiding Framework: Youth/Young Adult Mental Health



Current State: Service Model

Target State: Transformational Model

Transformational Goal: Push the boundaries of how healthcare is defined to include innovative frameworks that are critical to supporting youth/young adults with low incomes.

Policy Change that Expands the Boundaries of "Health care"

States should identify and pursue opportunities to expand the definition of "health care" to include approaches with significant potential to improve mental health outcomes for youth and young adults. Despite the challenges posed by the boundaries of health care as traditionally defined in Medicaid, states and localities are engaging in and recognizing innovative strategies that support the mental health of this population. Central to meeting the mental health needs of this population are integrated physical and behavioral health, addressing the social determinants of health, increased investment in prevention, and wellness promotion focused on strengths, assets, and safety. However, these core components of mental health are covered in varying degrees by Medicaid. Policy efforts can draw from states and localities that have used existing decision-making authority in Medicaid to incorporate these strategies into the definition of health care.

Integrated Physical and Behavioral Health

Stakeholders indicated that integrated physical and behavioral health was best supported by Medicaid. States and localities take different approaches to integration, including through co-located services and close partnerships between primary care providers and behavioral health providers.

In New York City, Mt. Sinai Health System's Adolescent Health Clinic is an example of youth-focused, integrated services. Beyond clinical mental and physical health services, they provide other wraparound supports like mediation, sexual education classes, and family therapy. The clinic promotes a holistic approach to health by co-locating mental health providers (including social workers and psychologists) with primary care providers and allowing individuals to be reimbursed for those services simultaneously. Those reimbursements are possible because the New York Department of Public Health issued statewide guidance in 2016 that clarified billing processes for co-located physical and mental health providers.[3]

Stakeholders said that integrated health care is the innovative approach best supported by Medicaid outside of clinical treatment and would make a meaningful difference for young people. Most also indicated, however, that their states and localities were not engaged in large-scale efforts to provide such care to youth and young adults. Even in places with solid examples of integrated physical and behavioral health services, Medicaid did not fully cover the costs of comprehensively meeting the needs of youth and young adults in a youth-friendly environment. States have a low-barrier opportunity to expand support for integrated physical and behavioral health services targeting youth and young adults and to improve how these services are reimbursed to increase their efficacy and availability.

Social Determinants of Health

Social determinants of health (SDOH) is a public health framework that describes a set of environmental factors linked to both physical and mental health outcomes, including economic stability, education, social and community context, health and health care, neighborhood, and built environment. The framework is nearly universally recognized by a broad spectrum of stakeholders, and the concept is viewed as having intuitive value. In certain sectors, particularly education and youth development, stakeholders indicated that the concept of SDOH is useful, but some question the utility of that specific language outside of the health sector. For example, stakeholders from education, youth development, and youth workforce development described a focus on Adverse

Childhood Experiences (ACEs) and trauma-informed practice as their system's nod to SDOH but indicated a need to translate the framework into language viewed as more resonant and relevant in their sector.

One particularly strong example of this translation came from Louisville. The Center for Health Equity was deeply invested in a SDOH framework but used "Root Causes" to describe the SDOH. Using the analogy of a tree, with health outcomes represented by the leaves, "root causes" are the social determinants of health. The roots shaping the leaves are neighborhood development, housing, transportation, criminal justice, early childhood development, education, health and human services, environmental quality, built environment, food systems, and employment and income. The Center for Health Equity expands the framework by describing how the soil feeds the roots through its "systems of power," such as racism and sexism, which define how different people experience root causes. Root cause analysis has provided a useful guiding framework for cross-agency and cross-sector collaboration in Louisville's support of youth and young adults.

Beyond using SDOH as a framework for guiding cross-sector collaboration, states have used Medicaid to fund efforts that address the SDOH directly. Oregon has used Coordinated Care Organizations (CCOs) as the main vehicle for transforming Medicaid service delivery. Oregon's approved 1115 Waiver currently allows CCOs to bill for "health-related services" that address social determinants of health such as food, housing, or employment support. For example, some CCOs provide members with a "prescription" for food that can be filled at a local food bank. The Oregon Health Authority is developing additional CCO guidance about how to best implement these programs with the goal of ultimately reducing costs and supporting better health outcomes. Oregon is also exploring opportunities for CCOs to fund community-level improvements, such as the addition of green space, that benefit the entire community, not just CCO members. Using Medicaid dollars to address community-level challenges can broadly benefit low-income communities and improve community-level mental health outcomes.

Youth and young adults living in poverty identify social determinants of health, such as financial strain, housing instability, food insecurity, and exposure to violence as key issues affecting their mental health. They also clearly call for investment in addressing root causes and community-level change. States interested in effectively and equitably addressing the mental health needs of this population can take advantage of the SDOH framework and maximize Medicaid dollars to align their approach with the needs of youth and young adults.

Prevention

Despite challenges identified by many stakeholders, several states have made progress in building a preventative approach to young adult mental health through SAMHSA-sponsored Now is the Time Healthy Transitions Initiative (NITTHTI) grants, or youth drop-in centers more broadly. Both New Mexico and Kentucky have established youth drop-in centers through NITTHT grants, and Los Angeles has established drop-in centers as part of its system of care. In partnership with Oregon's Youth Move chapter—Youth Era—CCOs have established a network of seven youth drop-in centers across the state that support youth and young adults who have experienced trauma or other difficulties but do not meet the criteria for the state's early psychosis intervention program. Staffed by certified youth peer specialists whose services are Medicaid billable, these centers are critical to effectively meeting the needs of transition age youth. In Maryland, population-specific drop-in centers, such as Youth Empowerment Society (YES)—Baltimore's only drop-in center for homeless youth—was created by

and is currently staffed by formerly homeless youth. It provides urgent direct services to youth experiencing homelessness, develops leaders, and engages in system-level reform.

A major gap in supports for low-income youth and young adults is prevention efforts funded by Medicaid. States can leverage Medicaid's mental health parity provisions, reimbursable peer support, and closer cross-sector collaborations to maximize preventative services. By generating energy around increased funding for preventative approaches, states can expect significant improvements in outcomes and substantial cost savings.

Wellness Promotion: Focus on Strengths, Assets, and Safety

Wellness promotion recognizes that health extends beyond preventing problems or illness to promoting an affirmative set of positive outcomes focused on strengths, assets, and safety. Centered in ideas from the fields of positive and community psychology, mental health promotion includes enhancing individuals' ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, wellbeing, and social inclusion to strengthen their ability to cope with adversity.[4] Youth and young adults typically define mental health in terms of strengths, and their vision of wellness includes a range of positive attitudes, behaviors, and values that they seek to develop.[5]

We did not find examples of wellness promotion funded through Medicaid, despite wellness being strongly aligned with the needs of youth and young adults. Wellness promotion efforts were typically grant funded and housed in the youth development sector and cultural organizations. For example, in Los Angeles, the Gang Reduction Youth Development (GRYD) office is housed within the Mayor's office and supported by city funds. GRYD funds a network of partners that intervene with youth and young adults at risk for gang involvement or with a history of gang involvement. In addition to providing referrals for traditional behavioral health services, GRYD supports positive activities that build leadership skills and community pride. For example, young people fundraise, manage, and plan an annual youth festival along with engaging in service projects focused on improving the community. Ensuring young people's safety and connecting them to positive activities is viewed as a central component of GRYD's work.

Youth and young adults need a full continuum of supports from wellness promotion, to prevention, to intervention, to treatment. Nearly all interviewees felt this continuum was out of balance, with disproportionate focus on treatment, limited focus on prevention, and no focus on wellness promotion. The challenge of Medicaid neglecting wellness is not unique to mental health, but in the physical health realm, Medicaid has made some progress in funding supports that build strengths. For example, health education is Medicaid billable at Federally Qualified Health Centers (FQHC), and breast pumps are covered for nursing mothers.

Medicaid has a troubling history of requiring participation in "wellness initiatives" (i.e. smoking cessation programs) with punitive consequences for those who fail to participate. Though perhaps well-intentioned, these and other punitive policy choices that limit access to health coverage are detrimental to meeting the needs of young people. States have an opportunity with youth and young adult mental health to reimagine wellness initiatives to align with a focus on strengths, assets, and safety. Increased access through Medicaid to these types of wellness promotion activities would be truly transformative.

Sample Policy Changes

The states and localities featured in this report are evidence of both the need and the opportunity to make policy improvements. For example, states might consider:

- Reviewing and updating their definitions of "medical necessity" and providing guidance around the interpretation of these definitions to reduce barriers to effective implementation
- Improving reimbursement rates for mental health care, particularly for community-based and non-traditional providers
- Expanding credentialing and Medicaid reimbursement for peer recovery specialists, community health workers, and other non-traditional providers without requiring traditional billing schemes (i.e. 15-minute increments)
- Identifying and building up career pathways for peer recovery specialists so they are not stagnant in their personal growth and have a voice at the table
- Fostering cross-sector and adult-child system partnerships through data sharing and referral tracking across the human services systems
- Exploring the role of value-based payments (flat payments per member based on key outcomes, rather than fees per service provided) in addressing wellness, prevention, or the SDOH
- Adopting a community health assessment model that considers the role of Medicaid dollars in supporting community-level health
- Addressing reimbursement for cultural interviewing and indigenous/culturally derived healing practices
- Building a crisis response system that diverts young people from the justice system and towards intervention and wrap-around supports

This list is by no means comprehensive or prescriptive; each state will need to identify the specific policy changes with the greatest impact based on the current system and careful diagnosis of the level and source of policy barriers. To be effective, this process must be informed, supported, and centered in systems change.

Essential Systems Change Strategies

As states identify policy changes that will expand the boundaries of "health care" within Medicaid to better meet the needs of low-income youth and young adults, the selection process must be informed by guiding principles and practices that generate systems change. Stakeholders identified authentic youth engagement, effective adult-child system partnerships, effective cross-sector partnerships, and incorporation of a racial equity lens as essential to effectively meeting the needs of youth and young adults. When guided by these four practices, states are more likely to create meaningful, lasting system changes.

Authentic Youth Engagement

State and local stakeholders widely recognized that authentic youth engagement strengthens behavioral health systems at both the practice and policy level. Interviewees reported variability in levels of youth engagement, how deeply it had penetrated different sectors, and whether youth were only engaged around programs and practices or also engaged in policy advocacy. We also found variability in the extent to which young people and their allies encountered resistance to their authentic participation. In states and localities that demonstrated broad-based buy-in to youth engagement, the system of services and supports available was typically more robust and youth friendly.

New Mexico is a leader in state-level youth engagement and has taken several steps to ensure that behavioral health services and supports for youth and young adults are youth guided and youth driven. A state-level youth coordinator is housed in the Behavioral Health Division of the Children, Youth and Families Division (CYFD), which is responsible for advising the division, planning and coordinating trainings, and leading the New Mexico Youth Move chapter. The state is also implementing youth-developed and youth-led training for agency staff in youth engagement principles and practice. New Mexico stakeholders report a notable culture shift in the state towards flexibility, hope, and effective support for transition age youth because of these innovative, authentic, youth-adult partnerships.

In Louisville, stakeholders described several youth advisory councils that had a role in developing the city's policies and agenda. For example, Louisville boasts a Racial Equity Youth Council that recently explored the impact of School Resource Officers on the mental health of young people of color. The city also has a youth council focused on young women's experiences with violence, and the Healing the Future Fellowship Program where young people spend the summer developing policy recommendations to achieve equity in issues like environmental quality, injury and violence prevention, and racial healing. These youth advisory councils provide a model for meaningful, on-going youth engagement around key city-level policy decisions.

Young adult mental health policy is unique for its high levels of buy-in to youth engagement and leadership. Local affiliates of Youth Move National and SAMSHA grants like NITTHTI and Systems of Care (SOC) have helped to embed youth engagement strategies into both practice and policy that supports youth and young adult mental health. As states engage in systems transformation to support young adult mental health, the voices and leadership of youth and young adults must drive the identification and vetting of policy change proposals.

Effective Cross-Sector Partnerships

Stakeholders in each state and locality added meaningful perspective to our conversations, suggesting that a broad cross-section of sectors serving youth and young adults are interested in and impacted by mental health. We spoke with people spanning Medicaid, mental health, primary care, youth development, youth workforce development, homelessness, child welfare, juvenile justice, education, health equity, public health, county organizations, tribal communities, human services, Youth Move chapters, and other sectors. States and localities varied in whether these different sectors were partnering effectively and which subsets of stakeholders were partnering closely. Stronger partnerships were a key element of building a system that youth and young adults experienced as relatively seamless.

Michigan's juvenile justice system launched a mental health and justice screening initiative in May 2017 that bridges the human services, mental health, and justice sectors. That initiative selected 7 mental health sites that will screen children in 11 counties who are either at risk of entering or have already entered the juvenile justice system. Each of the seven sites has its own goals under the umbrella of screening this population, and some are partnering with systems including family courts, school districts, and child welfare. The initiative's funds do not have a set end date and its sites have already produced numerous referrals. If those pilots generate positive results, the state will replicate them statewide.

Identifying policy changes that will effectively support the entire spectrum of low-income youth in need of mental health services will require the participation of a broad range of stakeholders that are youth focused, health focused, or both. Youth-focused stakeholders will be particularly critical for efforts focused on the social determinants of health, prevention, and wellness promotion, as these sectors already have deep expertise in issues such as housing, workforce development, and building strengths and assets. The broader the coalition of stakeholders engaged, the greater the likelihood of achieving collective impact that brings benefits to all these sectors.

Effective Adult-Child System Partnerships

Although several states and localities demonstrated strengths in cross-sector partnerships, examples of strong partnerships between adult and child-serving systems were far less common. Stakeholders described the transition from the child-serving system to the adult-serving system as a major barrier to effectively meeting the needs of youth and young adults. When eligibility criteria are misaligned, youth who are eligible for services as children lose eligibility when they enter adulthood, only to land in a deep-end system in their mid-twenties because of a gap in services. Sharp segregation in funding streams, staffing, and training frequently prevents the child system and adult system from working together effectively across the transition. Adult systems often do not incorporate youth-friendly approaches and components, and young adults disengage from services they perceive as focused on older adults. Although smaller grant-funded initiatives and specific programs have addressed the challenge successfully, states and localities described limited success linking these sectors at a systemic level.

Growing evidence shows that young adulthood is a unique developmental period with specific developmental tasks and challenges.[6] Most existing policy fails to recognize young adulthood as a distinct developmental period. Addressing this challenge will require deep engagement across child and adult mental health sectors to problem solve and remove barriers that interfere with providing effective care.

Racial Equity Lens

Stakeholders in all of the states and cities that we examined readily acknowledged inequities in access to needed supports and outcomes. Very few stakeholders indicated that their state or locality had fully and effectively applied a racial equity lens to the issue of young adult mental health. In many places, health equity offices found themselves marginalized within larger health agencies, and stakeholders from other sectors often found it difficult to articulate a clear vision of their agency's approach to racial equity.

Louisville home to the oldest municipal-level health equity agency in the country, was the notable exception. Its shared vision for racial equity across city agencies was viewed as central to the work of

all the city's agencies. Because of this citywide racial equity agenda, all city employees are required to take part in racial equity training. A broad cross-section of leaders described working groups within and across agencies that focused on racial equity. For example, Jefferson County Public schools has a Diversity, Equity, and Poverty working group that includes school-based mental health professionals, and a Summer Works Program initially funded a Racial Equity Youth Council that advises the city on racial equity issues impacting youth.

Policymaking must acknowledge and address the historical trauma caused by medical systems/models. The long history of criminalization of both the mental health needs and the healing practices of communities of color partially explains why the entry point for mental health services for young people of color is so often the justice system. This history also helps to explain the discomfort of many people of color with traditional mental health services, providers, and settings—the very services most likely to be covered by Medicaid.

New Mexico has made progress in recognizing the role of historical trauma, particularly in Native communities, and has taken some steps to improve policy to respond to this history. New Mexico requires all Medicaid providers to document that they have provided cultural competency training to staff and are providing culturally competent services. Some traditional healing practices of New Mexico Native communities are reimbursable in a range of settings, and the state contracts with providers focused on specific populations including Latino and LGBTQ youth.

To disrupt long-standing patterns of inequity and make policy changes that have meaningful impact for marginalized youth and young adults, states will need to ensure that proposed policy changes are carefully vetted with a racial equity lens. States must consider the role of structural inequities as root causes in differential outcomes, along with the role of systems of power including racism and sexism in shaping how different communities experience structural inequities and their consequences.

Conclusion

The question posed in Louisville, "How would we have to change if we were in the business of transforming lives?" is essential to guide efforts to better align Medicaid policy with the needs of low-income youth and young adults. We believe that states have an exciting opportunity to identify and pursue policy changes that push the boundaries of the definition of health care to be more responsive and inclusive. In the same way that providers "signed up" for transforming lives, state and local policymakers can take the bold step of signing up for transformational policymaking to better support the mental health of low-income youth and young adults with systemic, consequential, inspiring results.

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Endnotes

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