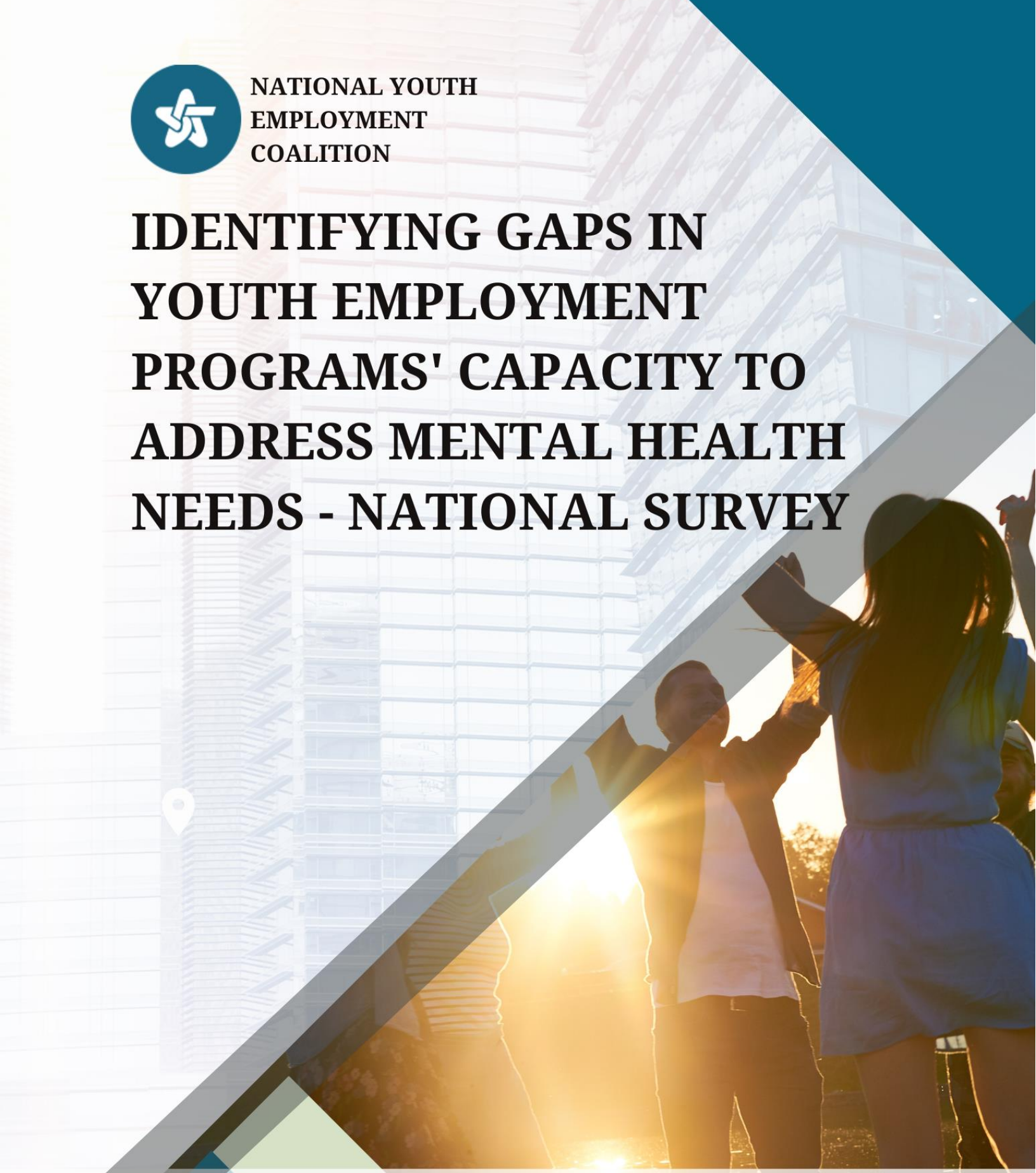
NATIONAL YOUTH EMPLOYMENT COALITION

IDENTIFYING GAPS IN YOUTH EMPLOYMENT PROGRAMS' CAPACITY TO ADDRESS MENTAL HEALTH NEEDS - NATIONAL SURVEY



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August 2022

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EXECUTIVE SUMMARY

In 2021, U.S. Surgeon General Vivek H. Murthy released the advisory "Protecting Youth Mental Health" report on the state of youth mental health and a call to action for our country. This advisory highlighted the alarming trends in youth mental health statistics prior to the COVID-19 pandemic and served as the inspiration for our organization, the National Youth Employment Coalition (NYEC), to improve our understanding of the preparedness of the youth employment field in addressing this heartbreaking crisis. In 2022, NYEC conducted a nationwide survey to hear from providers about the readiness and resources of youth programs across the US to respond to the youth mental health pandemic; the processes and systems providers have in place to fight the crisis; and what supports they need to combat this ongoing, life-threatening challenge. The survey yielded 563 responses across 49 of the states.

Key Findings

- **Most youth employment programs indicated that their youth cannot access mental health services when they need them.** 60% percent of respondents estimated that fewer than half the youth could access mental health support in their community when needed.
- **Anxiety and depression are the most observed mental health conditions among youth.** 93% of all respondents stated that they have "observed" anxiety amongst their youth, while 90% of respondents stated they "observed" depression.
- **64% of respondents did not have a process for screening and/or monitoring youth people for mental health needs.** Moreover, 60% of these respondents estimated that more than half of their youth need mental health support.
- **89% of respondents indicated they did not have sufficient resources to deliver quality mental health training to staff.** 72% of respondents do not track if youth receive needed mental services.
- **External stressors, mental health stigma, and lack of access underlie and exacerbate the youth mental health crisis.** NYEC conducted four focus groups that found that school stress, finances, employment, and isolation and other stressors contributed to a youth's negative well-being. Youth also face barriers in accessing mental health support because of cultural stigma, lack of transportation, difficulty talking to a caring adult, and lack of funds for mental health services in their community or families.

Recommendations

- Acknowledge and directly address systemic factors contributing to the mental health crisis, including but not limited to structural racism, generational trauma, affordable housing, and economic inequality.
- Encourage mental health screenings upon intake into the workforce development and other human-services systems and increase training for frontline practitioners in the workforce development and other human services fields, so they can identify mental health warning signs and make initial assessments.
- Increase the availability of mental health services with dedicated funding for in-house services among WIOA (Workforce Innovation and Opportunity Act) providers and a focus on leveraging other federal, state, and local resources to support youth connected and enrolled in employment programs.

INTRODUCTION

In December 2021, U.S. Surgeon General Vivek H. Murthy released an alarming report on the state of youth mental health. Before the COVID-19 pandemic up to 1 in 5 children ages, 3 to 17 in the U.S. had a mental, emotional, developmental, or behavioral disorder. Even before the pandemic, suicide rates were increasing by 57% between 2007 and 2018 for youth between the ages of 10-24. These sobering trends have made suicide the second leading cause of death amongst young adults in the United States. The pandemic has exacerbated these trends due to the disruption of the daily lives of young people amid the public health threat. Populations most impacted by these negative mental health outcomes include LGBTQ+, BIPOC, rural, low-income, and youth with justice involvement.

Economic turmoil, loneliness, and technological impacts have combined to create a unique mental health epidemic for today's young adults. Compounding these trends is the fact that many young adults remain disconnected from school and work, two potent connections to safeguard one's physical and mental well-being. The 2020 national youth disconnection rate is 12.6% or 4,830,700 disconnected youth, and most experts assume this number is undercounting due to COVID-19-related data challenges. Detachment from school and/or work makes it difficult to support oneself, access healthcare, and support future ambitions. Most glaringly, populations that are overrepresented when it comes to incidences of mental health issues are also overrepresented in unemployment rates and disproportionately underserved by mental health services. The pandemic has intensified the need for mental health services while also adversely impacting attachment to good-paying and career-sustaining jobs. We are still building our knowledge about the shape of this crisis, the services available, and what young people say will help them. But we do know there is a crisis.

The National Youth Employment Coalition (NYEC), in partnership with its member agencies, youth providers, federal agencies, and academic institutions, the Department of Labor, the Substance Abuse and Mental Health Administration (SAMHSA), and other partners, deployed a national survey in March 2022 to understand the readiness of youth programs across the US to respond to the youth mental health crisis; the processes and systems providers have in place to fight the crisis; and what supports they need to combat this ongoing, life-threatening challenge. Additionally, NYEC conducted a series of four focus groups comprised of the youth that these organizations served. We hope the insights in this report underscore the need for a significant infusion of mental health resources and investments in youth development programs so that all young people have a path to prosperity and well-being.

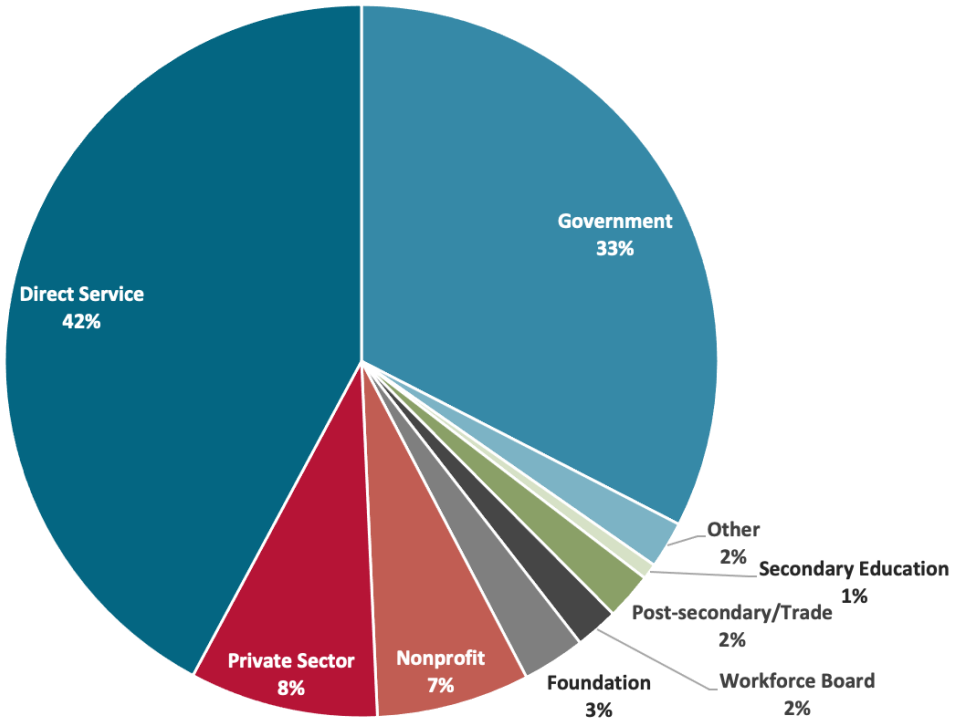
> "I have one client that has been waiting for a placement for mental and substance abuse for over 4 months. He will end up overdosing or worse before he is placed and gets the help needed." -Survey Respondent, Kentucky

SURVEY RESULTS

Background of Youth Employment Programs Responding to NYEC Survey

"Identifying Gaps in Youth Employment Programs' Capacity to Address Mental Health Needs- National Survey", received 562 responses from organizations, agencies, and programs across the nation. Most responses (73%) came from direct service organizations and government agencies. Figure 1 below provides a full summary of the program types represented among the survey responses.

Figure 1: Types of Organizations Responding to NYEC 2022 Survey on Identifying Youth Employment Programs' Capacity to Address Mental Health Needs



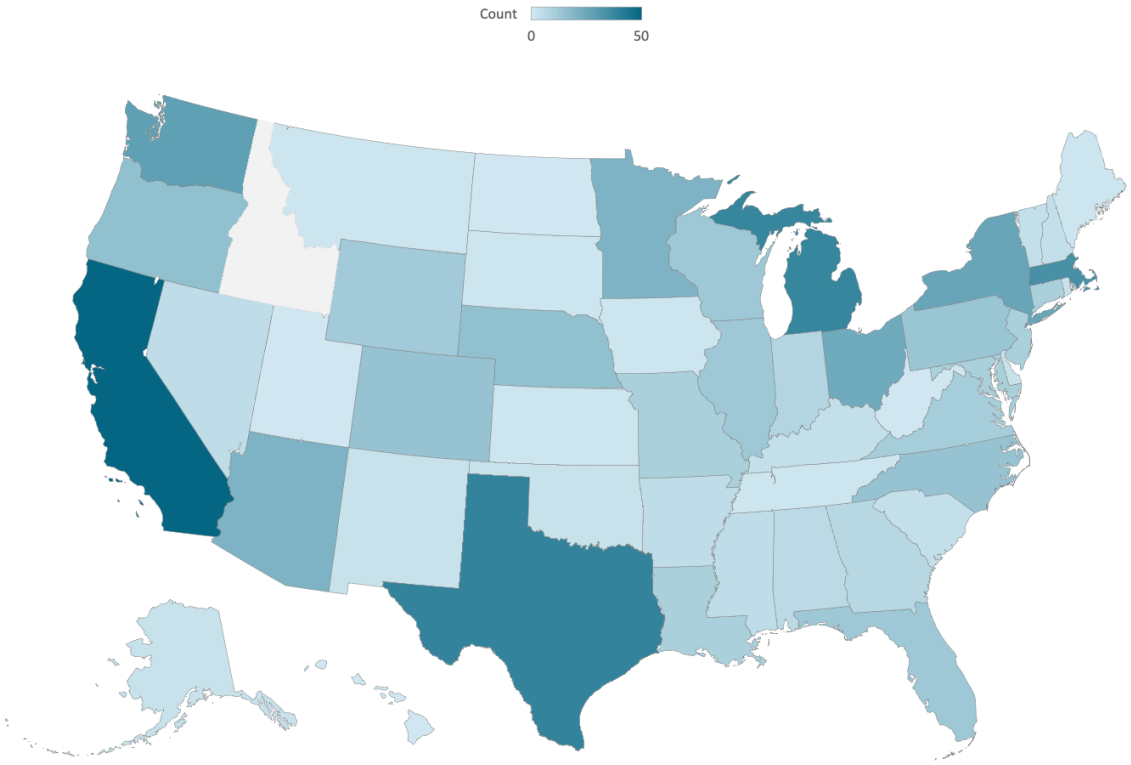
Program Size

Regarding the funding level of the participating programs, 26% fell in the under $500k category of program size, 17% in the $1.01 million to $10 million category, 5% in the $10+ million category, and 31% were uncertain of their program's budget size.

Locations

Forty-nine of the fifty US states were represented at least once among respondents. No program from Idaho responded to the survey. The five states with the most survey responses came from California (50), Texas (39), Michigan (38), Massachusetts (34), and Washington (28). Some responses came from local workforce development boards, which each fund multiple programs. Thus, the state location data may underrepresent the total member programs represented in the responses.

Figure 2: Locations of Survey Respondents' Organizations



Demographics of Youth Served by Programs

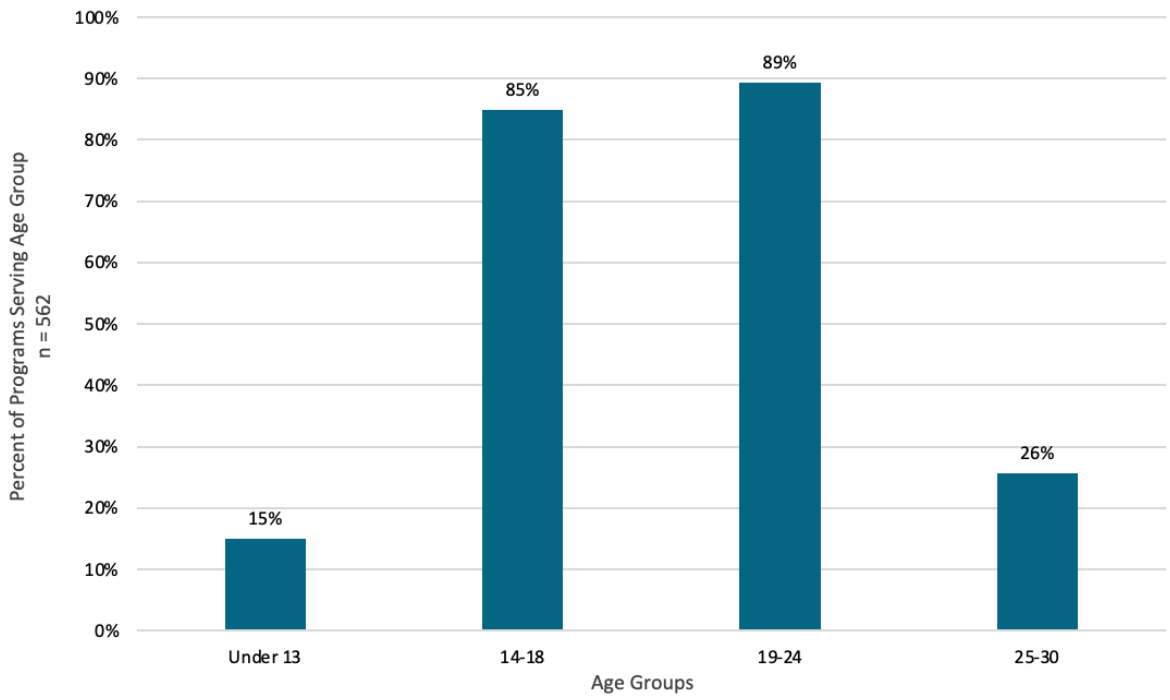
Regarding the demographics of the populations served, the survey asked respondents which of the following groups their programs served: urban, suburban, rural, and tribal. Of the 562 programs responding, 7% (42) serve all population types, 36% (202) serve urban, suburban, and rural, 37% (206) serve urban and suburban but not rural, 27% (150) serve rural areas but not urban or suburban, and 14% (78) serve tribal populations in both urban and rural areas. For understanding the differences in service challenges between urban and rural populations, the remainder of this report will discuss these population types in terms of "non-rural" serving programs and "rural" serving programs, with "rural" meaning rural only, and "non-rural" combining both urban and suburban-serving programs. Since there were only 4 programs that served tribal-only populations, there was not enough data to adequately identify challenges unique to these populations, though there is some discussion of these responses in later sections. Of all 78 tribal-serving programs, 56 also served urban populations, 8 served suburban but not urban or rural, and 10 served rural populations but not urban or tribal.

Table 1: Population Types Served by Responding Programs*	
Programs serving non-rural only (urban and suburban)	206 (37%)
Programs serving both urban and rural	202 (36%)
Programs serving rural only	150 (27%)
Programs serving tribal populations	78 (14%)
Programs serving all population types (urban, suburban, rural + tribal)	42 (7%)

**Percentages will not equal to 100 as programs serving tribal populations are counted in both "tribal" and geographic (rural, urban-rural, and non-rural) categories.*

Together the responding programs serve a total of over 343,000 youth, with ages 14-18 and 19-24 being the most common age groups served. 89% of responses stated they serve the 19-24 age group, 85% serve ages 14-18, 26% serve ages 25-30, and 15% also serve ages 13 and under.

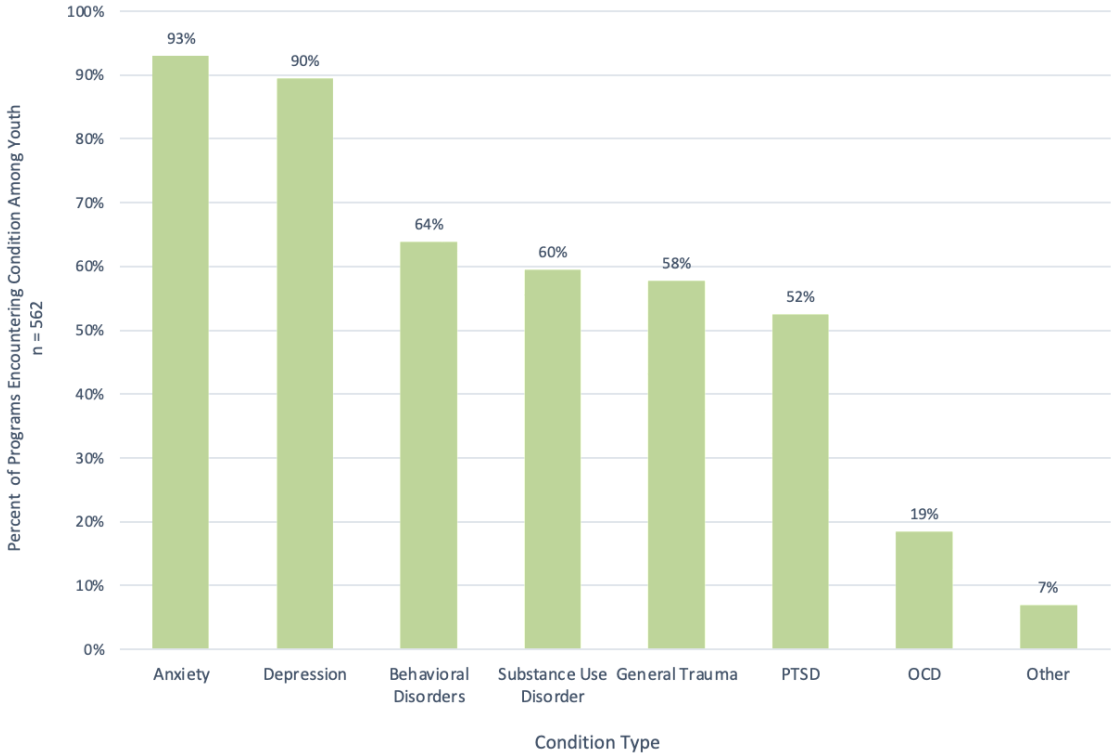
Figure 3: Age Groups Served by Respondent Organizations



Mental Health Screening Capacity

Youth seeking attachment to the workforce will oftentimes participate in job training programs that are comparable to the respondents of the survey. Many workforce providers and educational institutions are often on the frontline for observing and addressing a youth client's mental health. As the nation faces a mental health crisis among young people, youth employment programs frequently observe mental health conditions that negatively impact their youth's ability to obtain and retain employment. Of the 562 programs responding, 98% reported observing at least one mental health condition among the youth in their programs. The two most common mental health conditions seen among youth by responding programs are anxiety and depression, followed by general behavioral and substance use disorders. Figure 4 below provides a full visual of the types of disorders observed by the responding programs.

Figure 4: Types of Mental Health Conditions Reported by Responding Organizations

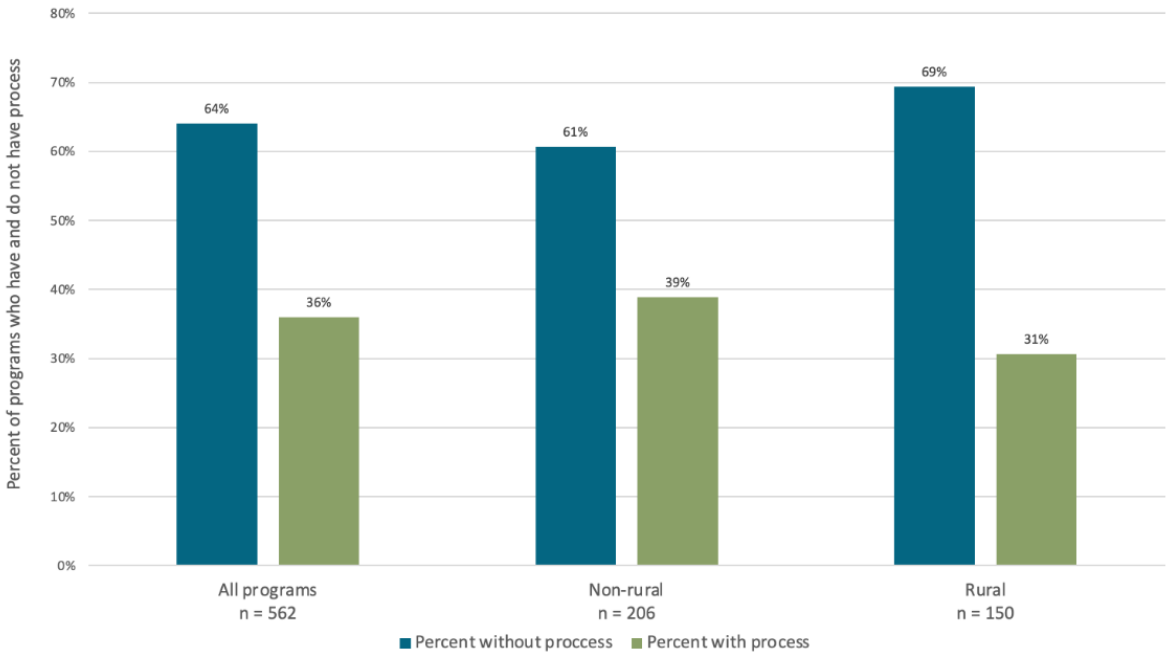


Screening for mental health needs: 64% of respondents have no process in place

Overall, only 36% of the 562 responding programs have a process for screening and/or monitoring youth with mental health needs. Once broken down by population areas served, the use of screening was lowest for the programs serving rural-only populations. While 39% of programs (80 non-rural programs) serving non-rural populations have a screening or monitoring process, only 31% of programs (46 rural programs) serving rural-only populations have a screening process. 4 programs serve tribal-only populations, none of which currently have a screening or monitoring process for youth with mental health needs.

The use of mental health screening can vary given the populations served, the type of programs and the resources a program can provide once mental health concerns are identified. For employment programs serving homelessness or foster care youth, screening typically happens immediately within a week. Whereas programs such as those connected to a community college may have a longer application process and/or waitlist which delay the time in which a screening is conducted, for instance a month after a client's contact with the community college. Another reason for this variation includes the partnerships and resources that a program must address a client's needs. For instance, many job training programs do not have connections to counselors that can assist in the event of a domestic violence incident and therefore do not screen specifically around issues around domestic violence.

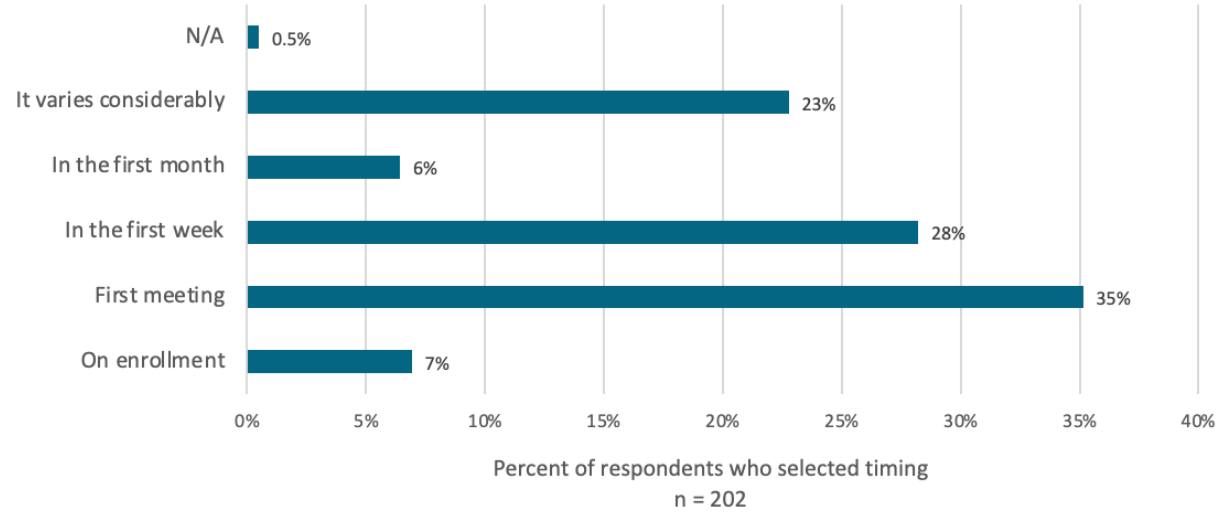
Figure 5: Percent of Survey Respondents Whose Programs Have a Process for Screening or Monitoring Young People for Mental Health Needs



Among programs with mental health screening capacity, 30% take up to a month to conduct a screening

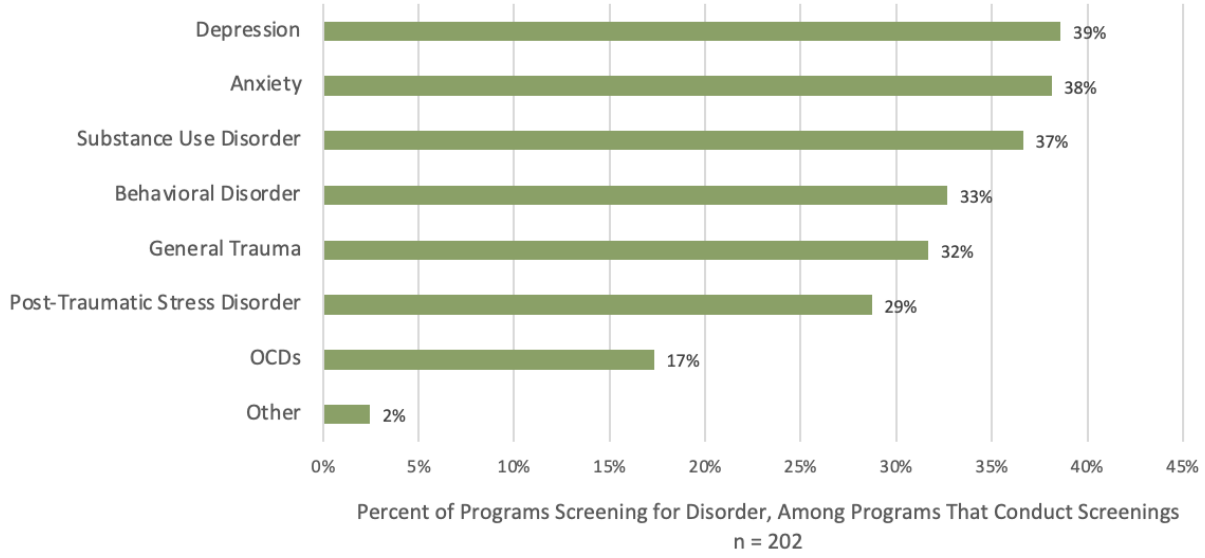
Among the programs with a mental health screening process (36% of all respondents), 70% conducted the initial screening within the first week of a young person's enrollment. The remaining 30% took up to a month or varied considerably.

Figure 6: Timing of Initial Screening for Mental Health Needs



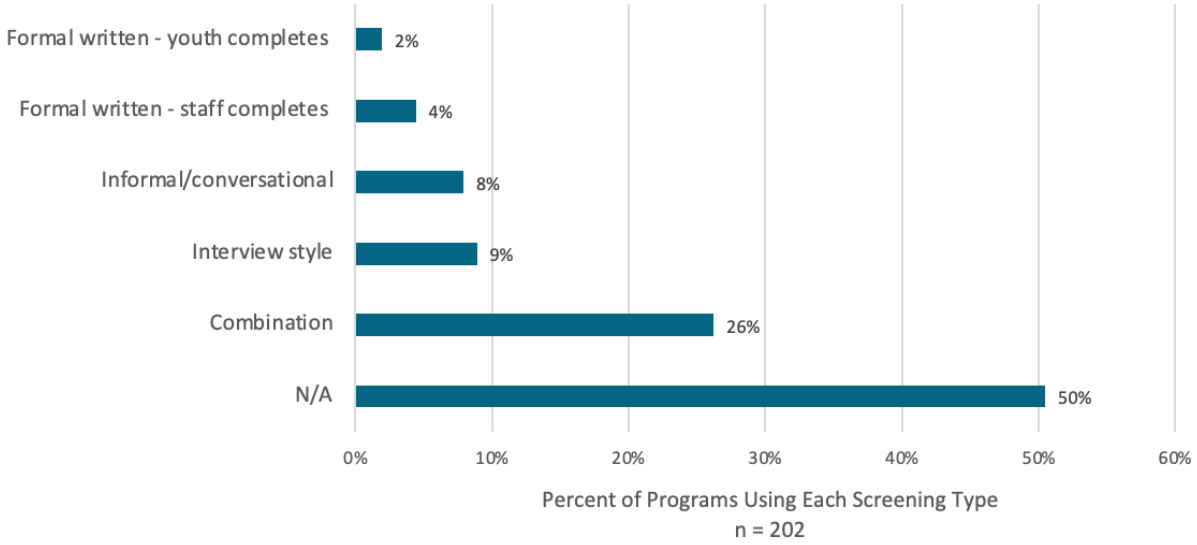
45% (90) of the 202 programs that conduct mental health screenings check for at least one disorder, and 42% (84) check for two or more disorders. The disorders screened for most were depression, anxiety, and substance use disorder. Behavioral disorders and general trauma followed closely as the next most screened disorders.

Figure 7: Mental Health Disorders Most Frequently Screened for by Survey Respondents



The programs with a screening process used a variety of tools to assess mental health needs. However, many programs that stated they do conduct a screening or monitoring process did not or could not provide details about the types of screening tools used. This resulted in 102 “N/A” responses out of a total of 202 programs conducting screening processes.

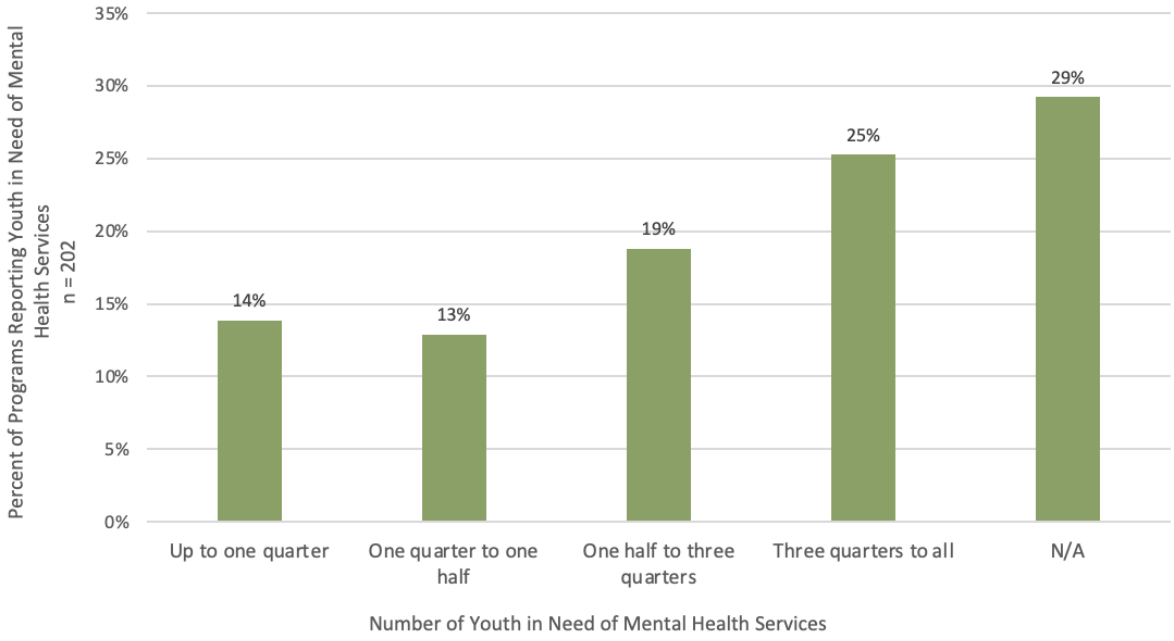
Figure 8: Types of Screening Tools Used by Responding Organizations



Among programs that conduct mental health screenings, one-third are still uncertain how many of their youth need mental health services

Among the 202 programs that conduct screening or monitoring processes to assess the need for mental health services among youth, 29% of programs did not respond to the prompt asking for the number of youth in need of mental health services. 25% of respondents stated between three-quarters to all of their youth need mental health services. Another 19% said between half and three-quarters of their youth need mental health services. Combined this means nearly 55% of the 202 programs that conduct screenings find that well over half of their youth need mental health services. The data suggests that for a third of the programs that indicated "N/A" for knowing how many youth need services that there may be a limited transparency of how that data given to program staff after it has been collected, the screening tools are ineffective for estimating how many youth need services and/or possible discomfort revealing that information on the survey.

Figure 9: Estimated Number of Youth Needing Mental Health Support by Responding Programs Who Conduct Screenings



Example Interpretations:

- *29% of all respondents whose programs conduct mental health screenings were uncertain about how many young people in their program need mental health support.*
- *25% of all respondents whose programs conduct mental health screenings reported that over three-quarters of the youth they serve need mental health support.*

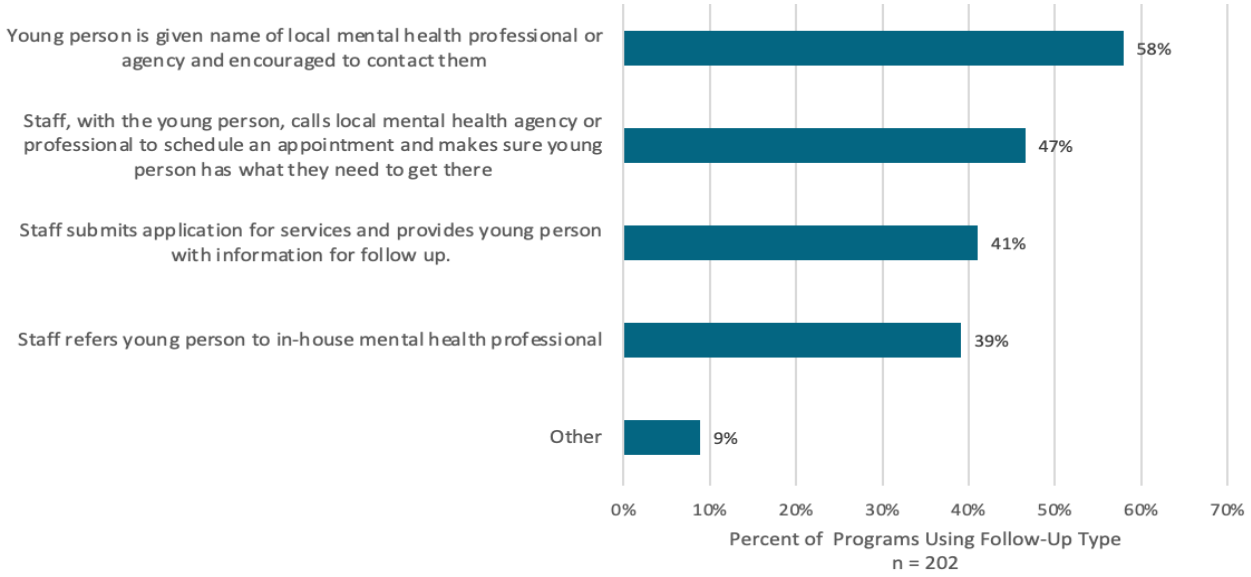
Follow-ups for youth identified in need of mental health services

After completing a mental health screening, 201 of the 202 programs that conduct screenings engage in some form of follow-up to connect their youth to mental health services. 53% of these programs engaged in two or more types of follow-ups to ensure youth connect with the services they need.

Figure 10 demonstrates that most follow-ups involve an external caretaker such as a local mental health professional or separate program. Job training programs operate with a limited and budget and staff and thus typically rely on external partnerships to meet the holistic needs of youth beyond career readiness. The fewest percentage of follow-ups for non-emergencies involved referrals to an in-house mental health professional, which in the past years has emerged as a best practice because it potentially reduces transportation barriers, decreases feelings around unfamiliarity amongst program participants and reduces stigma to mental health treatment.

For the 9% of programs that selected “Other” in response to types of follow-ups used, 6 of the 18 responses given engaged in only one type of follow up and most were unable to provide any detail on what their strategy included. Of the remaining strategies typed “Other,” responses included comments on parental involvement in a young person’s condition, case workers’ ongoing assistance in getting a young person in need of mental health services, and more funding for young people who have inadequate insurance to utilize mental health services.

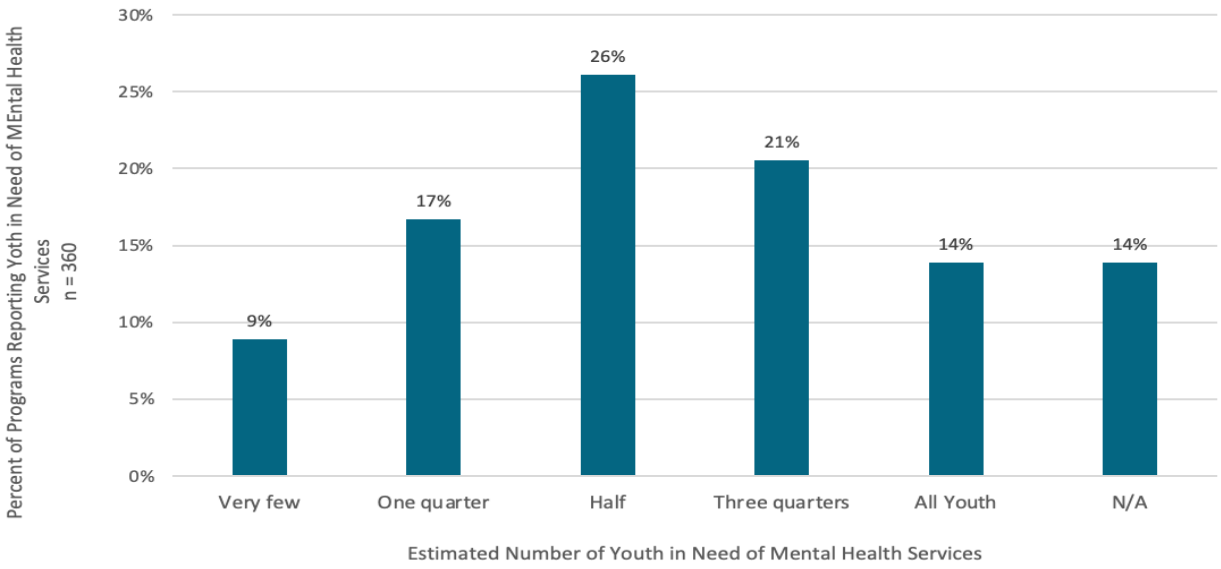
Figure 10: After Screenings, Types of Follow-ups Used for Non-Emergencies



Among programs that do not conduct mental health screenings, 20% estimate more than three-quarters of the youth they serve need mental health supports

Three hundred and sixty programs (64%) responding to the survey said they had no mental health screening process in place for youth entering their programs. Among the 360 programs that did not have a screening process to identify youth in need of mental health services, 14% (50) were not able to provide an estimate when asked how many of their youth may need mental health services or supports. 60% of the 360 programs believe that more than half of the youth they serve need mental health services.

Figure 11: Estimated Number of Youth in Need of Mental Health Services as Reported by Survey Respondents That Do Not Conduct Mental Health Screening



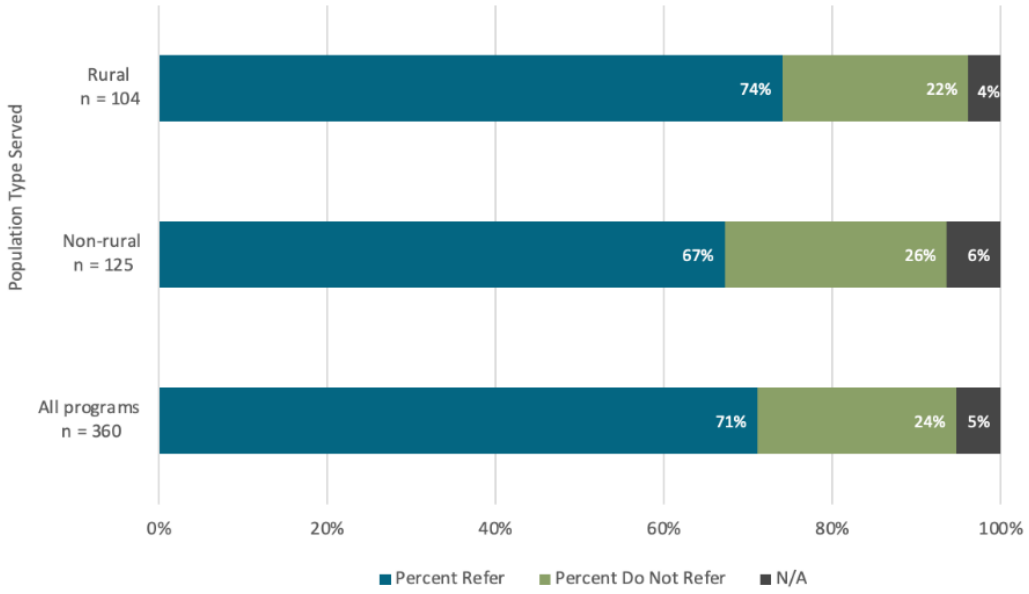
Example interpretation:

- *20% of the 360 programs that do not screen youth for mental health needs estimate that three-quarters of the youth they serve need mental health supports.*

Nearly one-third of programs that do not have a screening process for mental health needs also do not have a referral process to connect youth with external mental health professionals

Of the 360 programs that do not have a screening or monitoring process for mental health needs among young people, 256 (71%) refer youth to a local mental health provider for assessment. The percentage of programs serving non-rural populations who referred youth to local mental health providers was seven percentage points lower than programs serving rural youth only. Additionally, the percentage of N/A responses among non-rural programs was three points higher than in rural programs. This indicates a lower likelihood of mental health referrals among programs responding to the survey that serve non-rural populations but have no screening process for mental health assessments.

Figure 12: Percentage of Survey Respondents Reporting That Their Program Refers Youth to Local Mental Health Providers, Among Programs That Have No Screening Process

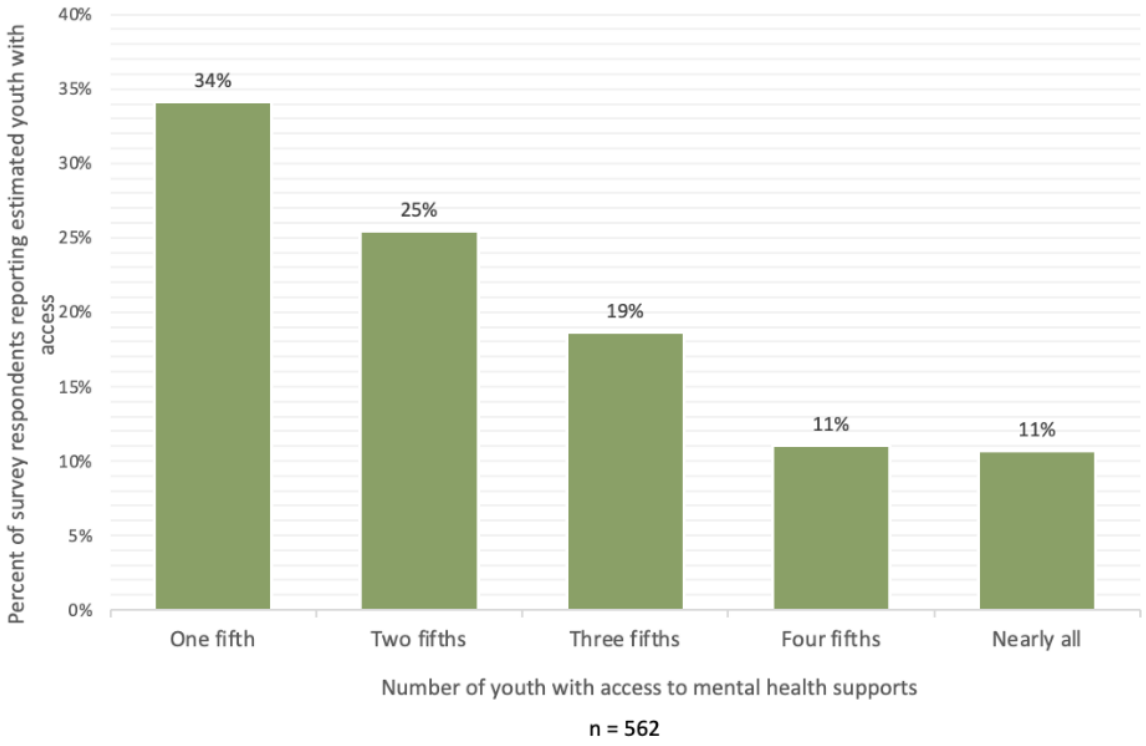


Challenges to Accessing Mental Health Services

More than thirty percent of all programs estimate less than one-fifth of youth can access mental health services when needed

When it comes to access, both rural and non-rural serving programs identified significant gaps in access to mental health supports for youth in need. Among the 562 responses, over 33% estimated that less than one-fifth of youth in their community could access mental health supports when needed, and nearly 60% estimated that fewer than half the of youth could access mental health supports in their community when needed.

Figure 13: Perceived Number of Youth with Access to Mental Health Services



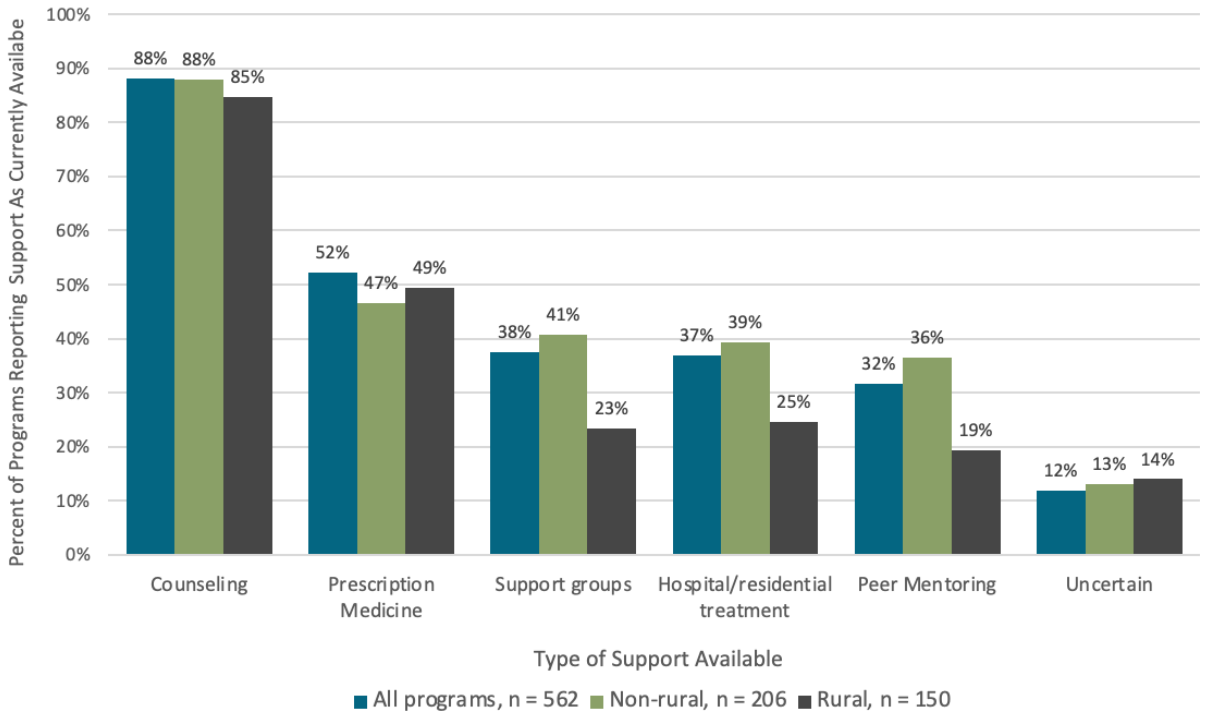
Example Interpretations:

- *34% of all 562 respondents stated that one-fifth of the total youth served can access mental health services*
- *11% of all 562 respondents stated that all their youth can access mental health services*

Common supports available in communities

Regarding community mental health resources currently available, the most common type of resource identified across all communities was counseling, followed by prescription medications, support groups, hospital or residential treatment programs, and peer mentoring. 12% of programs serving all communities were uncertain of the resources available to the community. Controlling for the rurality of the population served, 13% of non-rural programs expressed uncertainty in available supports, and 14% of rural-only programs expressed the same.

Figure 14: Types of Mental Health Supports Currently Available in Communities According to Survey Respondents



Only 28% of programs have the capacity to track if youth receive needed mental health services

Of the 562 programs responding to the national survey, 28% confirmed they can track who among their youth receives mental health services. Once controlling for rurality, 31% of programs serving non-rural populations could track who receives services, compared to 23% of programs serving rural-only populations.

Over one-third of programs are uncertain how quickly youth can obtain appointments with mental health professionals

When comparing responses about how quickly youth can access mental health supports when needed, there was little difference between non-rural and rural populations. However, when comparing responses between programs that have a screening or monitoring process or not, and those that can track who receives services and who are not able to, there was a sharp increase in responses stating they were uncertain among those without a screening/monitoring process and those unable to track. Also of concern, is the number of respondents stating they were uncertain even among those who do have a screening process and among those who can track who receives services. Nearly one-quarter of responses from programs able to track who receives services stated they were uncertain how quickly youth in need are accessing services.

Figure 15: Estimates on How Quickly a Young Person in Need of Mental Health Supports Can Obtain an Appointment with a Mental Health Professional (Either In-House or External), All Respondents

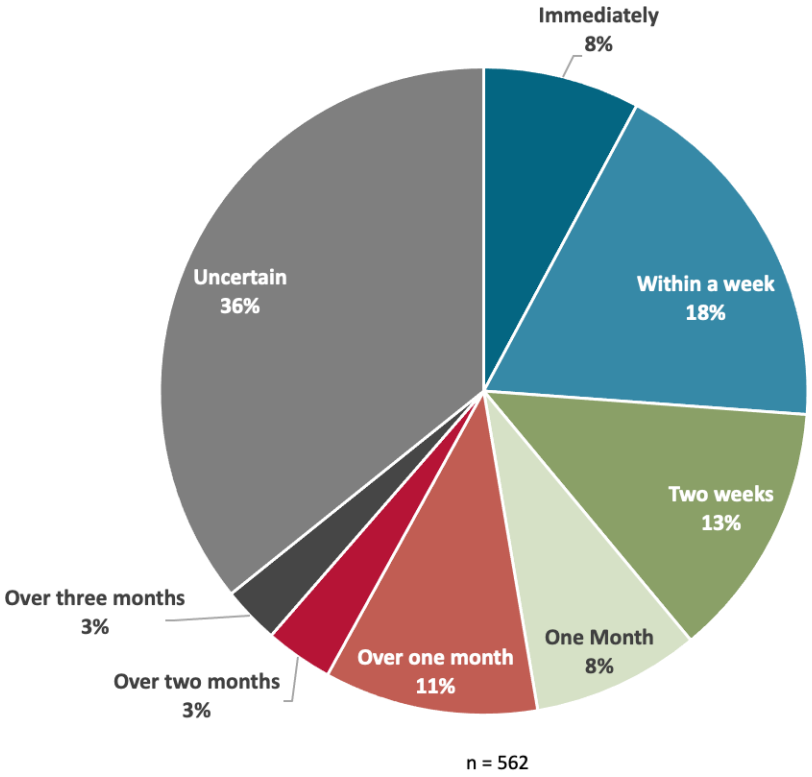
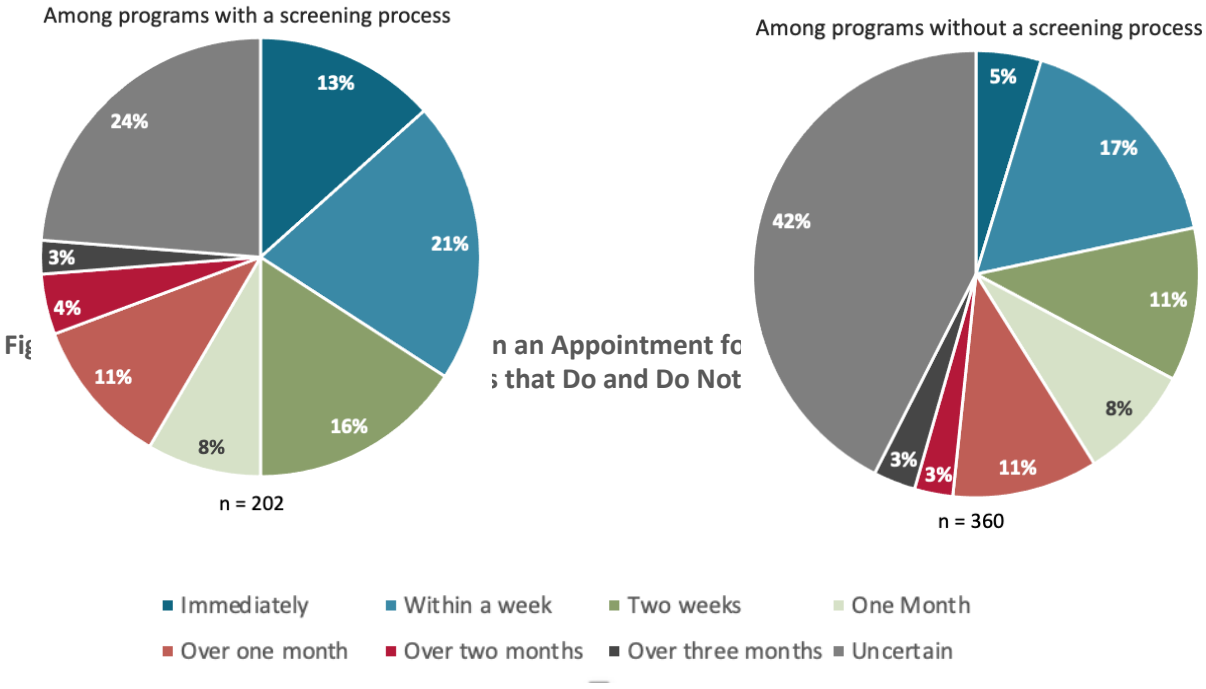
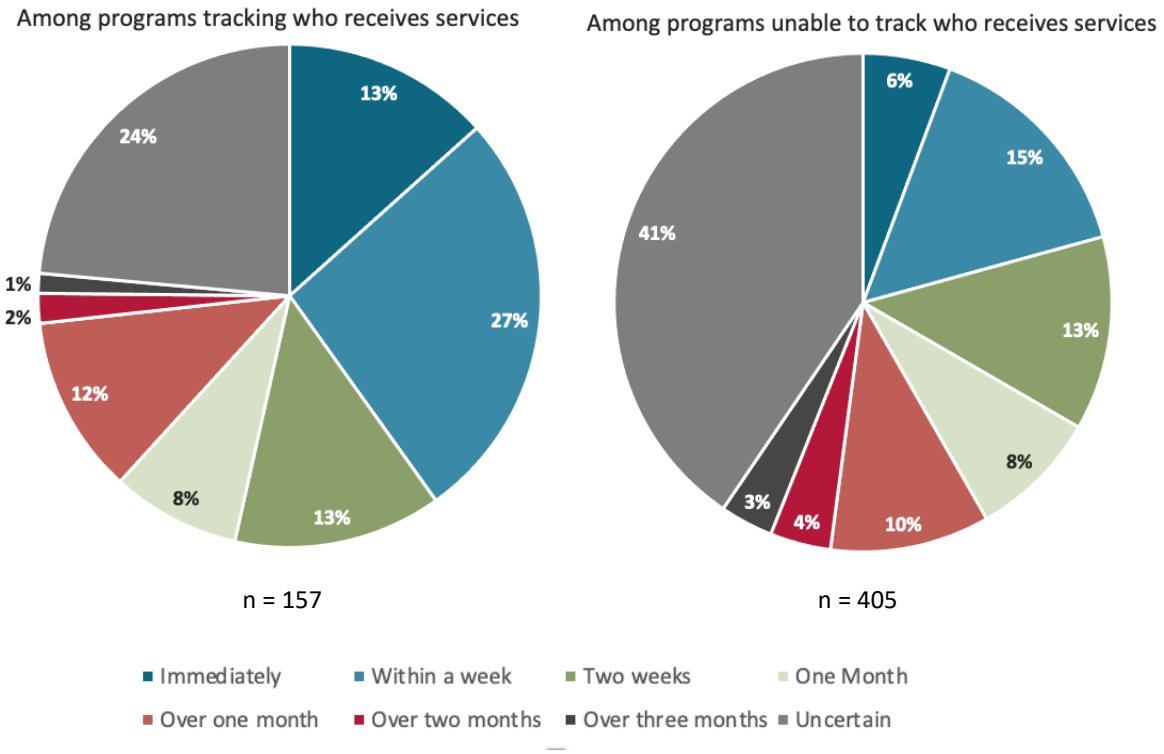


Figure 16: Estimated Wait Time to Obtain an Appointment for a Young Person in Need of Mental Health Supports Among Programs that Do and Do Not Have a Screening Process





Trainings for Direct Service Staff

Resources are insufficient to provide quality mental health training for direct service staff

Of the 235 direct service organizations that responded to the survey, only 11.5% believed they had sufficient resources to provide quality mental health training for direct service staff development. Of the 11.5% responding positively, 16 served non-rural populations and 6 served rural only areas.

Regarding funding level, 10 of 27 organizations who stated they have resources for trainings were in the $1.01 million to $10 million category of financial size, while 9 of 27 stated their funding level was uncertain. After accounting for population type served, non-rural programs made up 16 of the 27 organizations, with 7 stating their funding level was unknown, and 6 placing their programs in the $1.01-$10 million category. Rural-only organizations made up 6 of the 27 organizations with sufficient resources for staff training, with 3 being in the under $500k funding category, and 1 each in unknown, $500k-$1 million, and $1.01-$10 million categories.

Types of training offered, frequency, and type

The 27 organizations who stated they had sufficient resources to provide trainings named a variety of training types when prompted, with most being conducted on an annual basis. The most frequently named training was mental health first aid (8), followed by trauma-informed care (6), suicide prevention (4), and crisis prevention (3). Other trainings named included addiction and substance abuse training, self-care and mindfulness, and motivational interviewing. Several organizations did not provide specific types of training but stated they offered various continued education trainings for staff annually.

Finally, four industry-recognized trainings were noted in the feedback: Advanced Childhood Experience (ACE), Child and Adolescent Needs and Strengths (CANS), NAMI Smarts for Advocacy, and Question Persuade Refer suicide prevention (QPR).

Mental Health Supports, Barriers & Needed Improvements

Programs face significant barriers in getting youth the mental health support they need

Across all programs, the most often identified barrier by all respondents was a general feeling of discomfort among youth toward mental health services. Over 60% of programs identified this feeling of discomfort among youth as a barrier, and this percentage remained largely the same when controlling for rural and non-rural. Lack of transportation was the second most often named barrier by all programs; once controlling for rurality, the issue of access to transportation was more frequently identified among programs serving rural-only populations. Availability of mental health services for youth was another frequently identified barrier for all programs, again with little difference between rural and non-rural programs. Long wait times for mental health services tied with the availability of mental health services as the third most often identified barrier by all programs. However, once controlling for rurality, wait times appear to be a more common challenge for programs serving non-rural populations. See Figure 18 below for a full count of all programs identifying each barrier, and Table 1 for percentages of programs identifying barriers separated by rurality of populations served.

Figure 18: Common Barriers to Getting Young People Necessary Mental Health Supports as Reported by Respondents

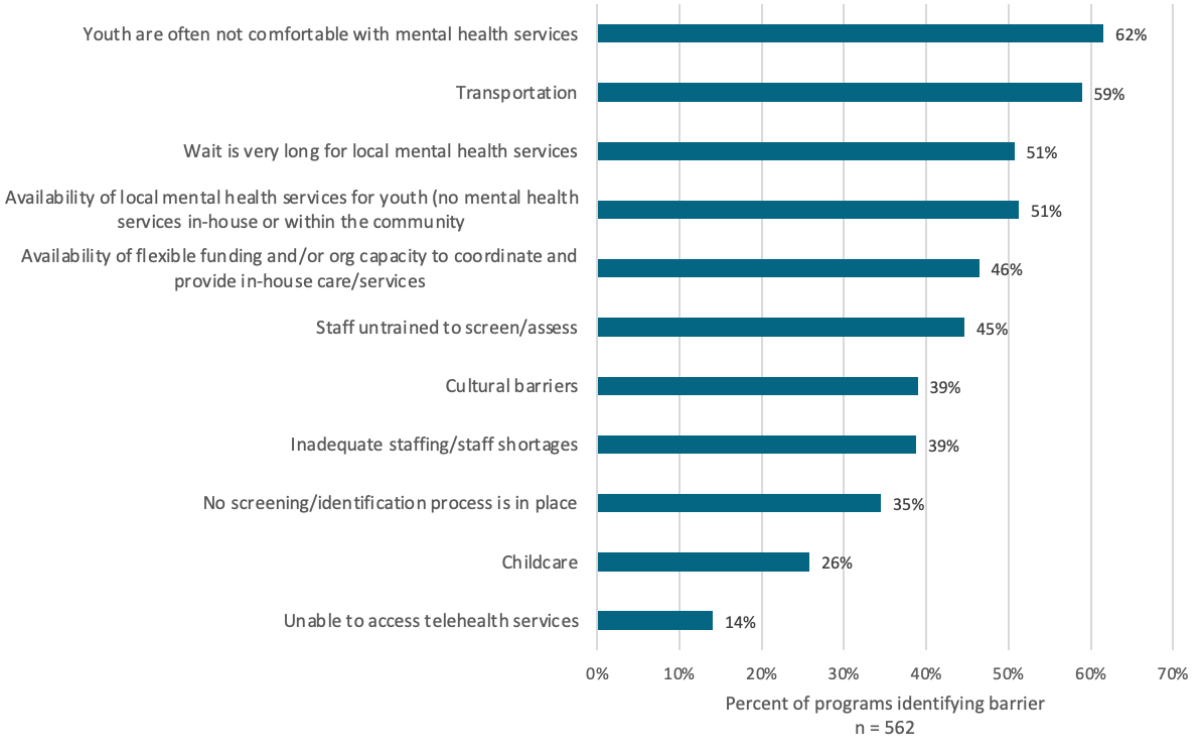


Table 2: Percent of Organizations Identifying Barriers to Getting Youth Mental Health Supports

Barrier	All	Non-rural	Rural
Availability of local mental health services for youth (no mental health services in-house or within the community	51%	49%	50%
Availability of flexible funding and/or org capacity to coordinate and provide in-house care/services	46%	54%	36%
Transportation	59%	52%	67%
Wait is very long for local mental health services	51%	57%	40%
Unable to access telehealth services	14%	10%	15%
Youth are often not comfortable with mental health services	62%	63%	61%
Staff untrained to screen/assess	45%	40%	49%
Cultural barriers	39%	45%	26%
Childcare	26%	25%	21%
Inadequate staffing/staff shortages	39%	41%	30%
No screening/identification process is in place	35%	32%	39%

*Red outlines represent a more frequently identified barrier once controlling for rurality.

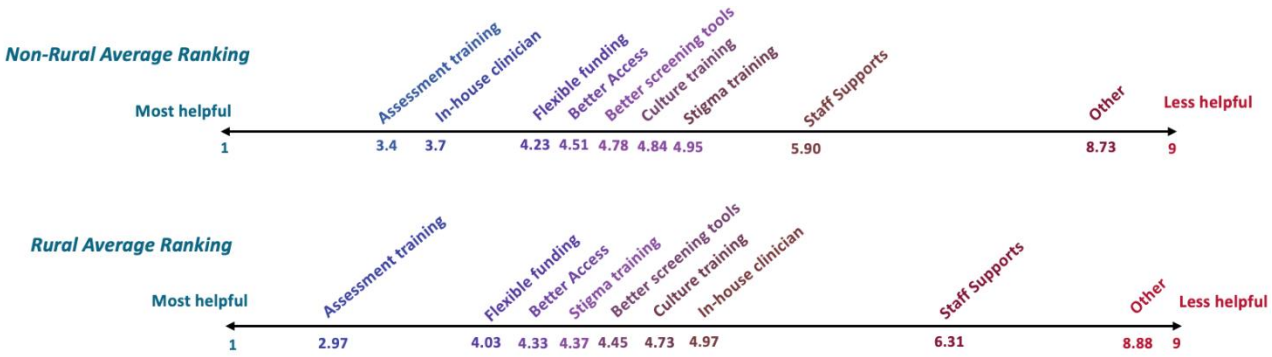
Regarding which resources would be most helpful to staff, survey respondents provided a rank ordering of nine important resources (including one "Other" category), with "1" being the most helpful and "9" being the least helpful. All responses were averaged and are shown ranked below, with staff training for screening and assessments being ranked the most helpful on average overall.

Table 3: Ranking of Needed Mental Health Supports by Helpfulness

Average Rank	Type of Support
3.23	Staff training for screening/assessments
4.24	In-house clinician
4.25	Flexible funding for transportation or other basic needs
4.29	Better access to local mental health services
4.71	Staff training for understanding/working with cultural barriers
4.73	Better screening tools
4.84	Staff training on overcoming stigma/fear of mental health services
6.03	Support for staff who experience vicarious trauma working with youth
8.71	Other

When separating responses by rurality, there were some differences in the average ranking of support helpfulness. While both non-rural and rural-only programs identified staff training for screening and assessments as the most helpful support, the average ranking for staff training rated it as more helpful overall than non-rural respondents. Respondents from programs serving non-rural populations found in-house clinicians as the second most helpful support, while those serving rural-only populations on average ranked in-house clinicians as seventh overall. Flexible funding was identified as the second most helpful support by respondents from programs serving rural-only programs.

Figure 19: Survey Respondents' Ranking of Mental Health Resources in Order of Helpfulness



While "Other" was overall ranked as the least helpful support, some programs provided specific suggestions for the "Other" category and ranked this suggestion as more helpful. Of the twenty-four responses who ranked "Other" above 9 (the lowest ranking), ten again pointed to the need for funding, either to support youth without health insurance or to improve funding stability for staff so that programs could dedicate more time to providing services and less time to fundraising. Four responses identified the need for support in eliminating the stigma surrounding mental health diagnoses among youth, particularly among family members. Additional responses named the need for increased diversity among staff working with youth, improved partnerships and collaboration between programs and agencies serving youth with mental health needs, and various social-emotional or crisis trainings for staff.

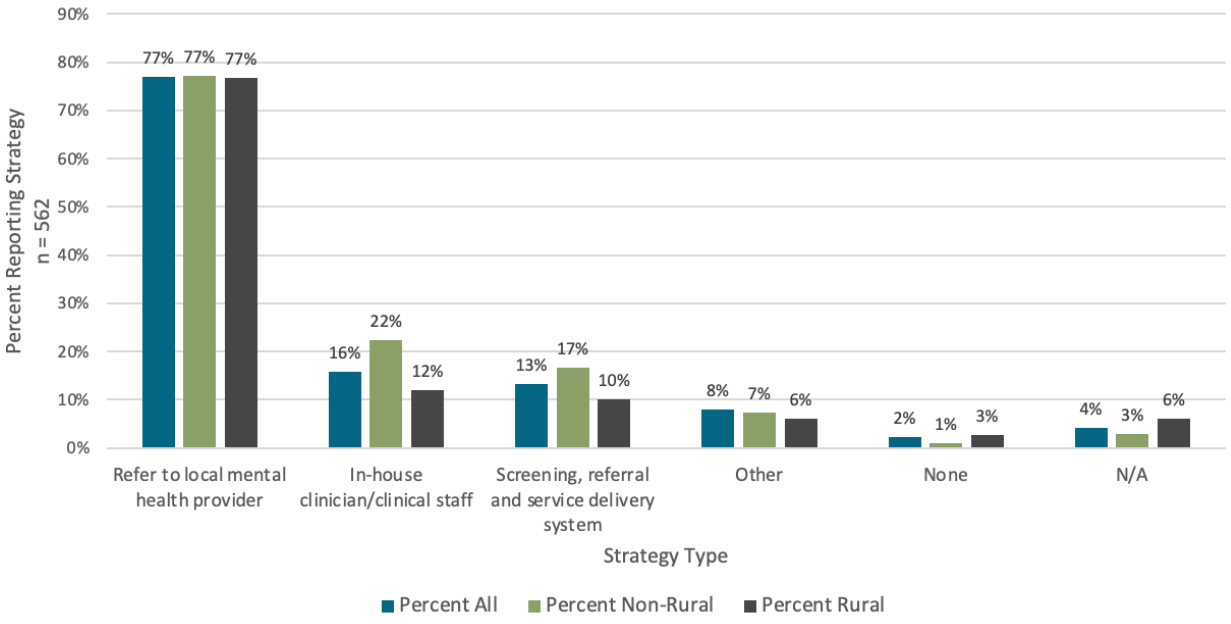
Successful strategies used to get supports to youth

Regarding strategies programs already have in place, 77% of the 562 respondents shared that one successful strategy they already implement is a referral system to get youth to a mental health provider. Another 16% said they utilize an in-house clinician, and 13% have a screening, referral, and service delivery system. Respondents could select more than one strategy thus some had multiple strategies in place. Notably, the programs serving rural only populations utilize in-house clinicians and a screening to service delivery system less than non-rural programs by 7-10 percentage points.

As seen in Figure 20 below, some programs also selected "Other" to name additional strategies they had in place. Some of these strategies included having an employee assistance program that members could use for support, referrals to state agencies such as the Department of Vocational Rehabilitation in the case of Minnesota-based programs, for example, and peer support trainings.

Finally, a small number of programs either had no strategies in place to get mental health supports to youth, or responded "N/A." Those responding "N/A" could be understood to have no support strategies in place, or to believe strategies to get support to youth do not apply to their program's mission.

Figure 20: Percent of Respondents Identifying Strategy(s) Currently Used to Connect Youth with Mental Health Supports



Community Resource Improvements

Programs perceive local mental health support quality to be somewhat adequate

Most programs participating in the NYEC survey ranked local community health supports at a 3 out of 5, with a ranking of 1 being "extremely inadequate" and a ranking of 5 being "extremely adequate." There was only a small difference in the average ranking between non-rural programs and rural-only programs, with the overall average ranking being 2.65, the non-rural average being 2.71, and the rural

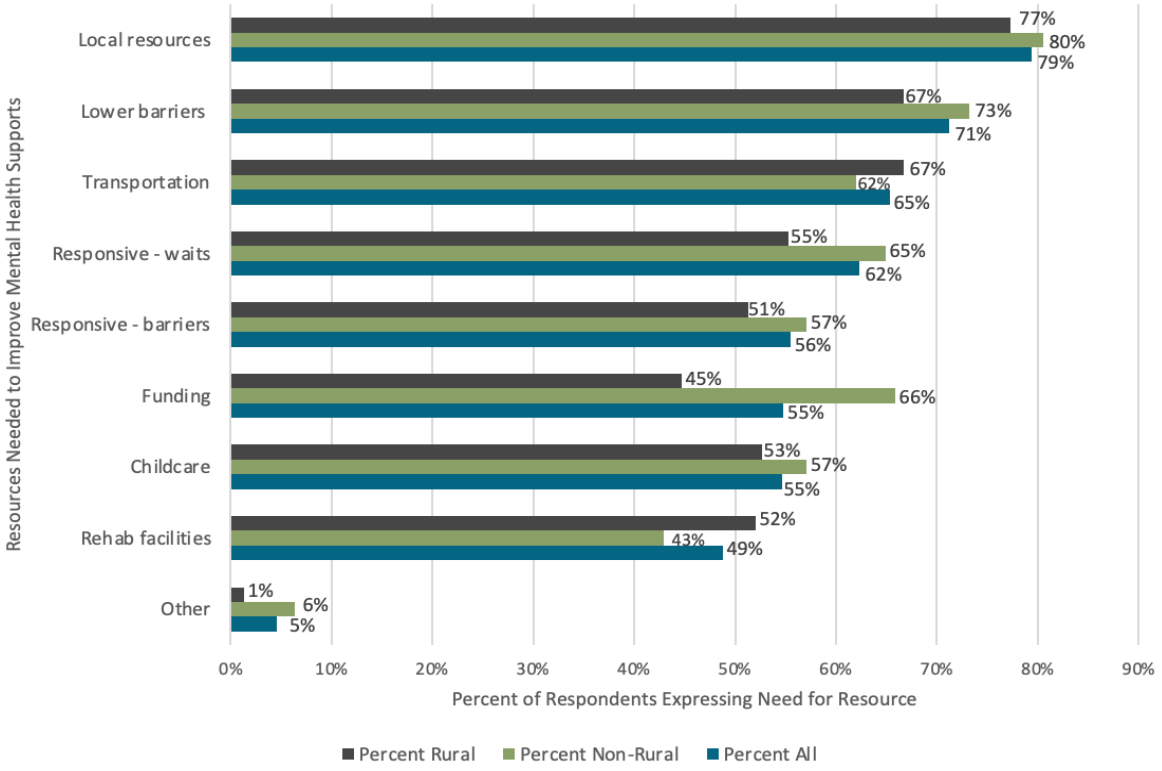
only being 2.51. Thus, the general impression across all programs is that local mental health supports are somewhat adequate, indicating there is still significant room for improvement.

Types of improvements youth employment programs would like to see in their community

As for types of resources that could prove most helpful to community mental health supports, the responding programs named a variety of useful resources. Across all programs, respondents identified the need to decrease wait times often experienced by youth in need of support. Strategies to reduce wait times overall are simply to increase the number of resources available in the local community. Beyond general increases in local resources, increasing funds to support in-house staff and lowering barriers to accessing mental health were the two most often identified improvements needed for non-rural programs, while lowering barriers and improving transportation options were the two most frequently identified improvements needed by programs serving only rural populations.

Figure 21 below provides a more extensive list of the types of resources most frequently identified as needed community improvements. A key is available below the chart to fully explain the needed resources.

Figure 21: Percentage of Survey Respondents Reporting Need for Improved Resources



Key:

More local resources so youth will not have to wait to access mental health support	"Local resources"
Lower barriers for accessing mental health services	"Lower barriers"
Transportation available to attend appointments	"Transportation"
More responsive local mental health services, waits are too long	"Responsive - waits"
More responsive local mental health services, barriers to accessing services too difficult	"Responsive - barriers"
Funding strategies or funds to have an in-house clinician/clinical staff	"Funding"
Childcare services for parenting youth who need to attend mental health appointments	"Childcare"
More substance use disorder/rehab facilities	"Rehab facilities"

Other improvements needed beyond those identified in Figure 21 included a variety of suggestions, summarized in the following list:

- Additional funding to support youth lacking insurance to pay for mental health services and improved insurance for mental health insurance in general
- Accessible professional level services (services requiring certified training) and mental health services in general in schools
- Peer mentorship programs to help youth navigate the mental health system
- More substance use and other mental health rehabilitation and in-patient facilities particularly for youth under the age of 18
- Increased diversity among mental health services staff and professionals
- Stable funding for direct service programs to ensure staff can focus more on their primary roles serving youth and less time on fundraising
- Policy and legislation reforms to improve access and eliminate red tape in accessing services
- Rehab facilities away from urban settings open to youth from cities as well as rural areas
- Better follow-up from mental health facilities and clinicians
- Elimination of stigma around mental health needs
- General consistency in availability and quality of services across regions and communities

Key Take Aways

Stress Factors

- The pandemic / general isolation
- School stress
- Finances
- Family trouble
- Employment
- Relationships
- Health

Barriers To Help

- Cultural barriers
- Stigma around mental health
- Availability of professional help
- Transportation to services
- Lack of financial ability to pay for services

Focus Groups

In addition to the national survey, NYEC conducted four focus groups between April 18th – 25th 2022, with participants in youth employment programs from across the nation. These youth ranged in age from 16-26, and their time spent with their respective programs ranging from a few months to six years. The participating youth were asked questions about their experiences with youth employment programs and general observations on their own and their peers' mental health.

Most participants stated they felt like they were under a constant state of stress, and believed their peers were as well. The stress factors named in addition to the pandemic and general isolation included school stress, finances, family trouble, employment, challenges of being a young/single parent, relationships, health, and more. All participants expressed having experiences with anxiety, depression, trauma, PTSD (Post Traumatic Stress Disorder), ADHD, or some combination of all these.

The majority of participants expressed a desire to talk about their mental health with a caring adult, professional, or peers, but some stated they had experienced trouble finding someone to talk to and felt uncomfortable speaking about their mental health due to cultural or generational stigma around mental health topics, a general distrust with sharing personal experience due to previous negative experiences doing so, and internal barriers such feelings that sharing would make them a burden to others. Others

stated they felt comfortable informally discussing their mental health with some staff at their employment program, due to the staff establishing trust with the young person and showing they cared about the participant's wellbeing beyond employment.

Cultural barriers and stigma around mental health discussions came up frequently among participants in the focus groups. Access challenges including the availability of professional help, transportation to services, and lack of financial ability to pay for services also came up as a frequent challenge. The lack of access to services may be a contributing factor to the cultural and general stigma around mental wellbeing.

Quotes from Young Adult Focus Group Session

Long Wait Times in Accessing Mental Health Services

"It's like, you never really get seen when you really needed. And over that time period of waiting for you to go to your appointment, that effect just kind of wears off from you at that, that time being, because you just end up handling the situation yourself. So I feel like, I wish there was more of a better way for people to get seen that have, situations like this."

-23-year-old, Black/African American, suburban city, Georgia, she/her/hers

Sources of Stressors Amongst Youth

"I feel like stress has probably increased, especially during the pandemic when we were all at home and these kids didn't get to be with their friends, they didn't get to do sports, they didn't get to graduate like in a traditional graduation. Um, and then now they have to readjust to going back to in person and all the different changes that are happening with that"

-26-year-old, Hispanic, suburban city, California, she/her/hers

"Growing up, my, my mom was one of those people who was like, why are you stressed? You're like 10 years old. What's wrong with you? Um, and then finally, when I was 16, I looked at her and I said, I don't wanna be alive anymore. And she was like, oh, okay, we need to work on this"

-26-year-old, Hispanic, suburban city, California, she/her/hers

Grappling with Loneliness and Suicide

"I just wish more people like me who have a hard time making friends and keeping friends and, you know, putting myself out there had a program or some sort of network to be able to talk with someone or simply just have a companion. Um, I can only imagine how many people who feel different or you know, are different from other people, bullied - how they, they may feel alone and things do happen like suicide."

-23-year-old, Black/African American, suburban city, Georgia, she/her/hers

Research Conclusions

With the majority of the 562 programs reporting that more than 60% of the youth they serve need mental health services yet for most programs fewer than half of those youth can access services, the data from the youth employment field supports what has been a growing concern in public health: the status of our workforce development system is inadequate to address and connect youth to mental health supports in the United States. More than 50% of all organizations expressed a need for improved access to mental health services for their youth, from increasing the number of clinicians available and thereby diminishing wait times, to improving funding to ensure all youth can afford to access mental health services when in need. And more than 60% expressed concern over youth being unwilling to discuss mental health challenges, which is a probable result of the existing cultural stigma around mental health but also indicates the need to provide more training for staff to understand ways to reduce this stigma and gain trust from youth.

Achieving and maintaining stable employment is particularly challenging when under mental distress. To better assist youth in their journey to employment, many youth employment programs have seen the urgent need to expand the scope of their programs to ensure their clients get connected with the necessary resources to improve their mental wellbeing. But with unstable funding and a general lack of availability of mental health resources, youth employment programs will continue to struggle to meet the needs of their young people without further investment. And as the focus group data corroborated, youth may feel more comfortable discussing their wellbeing if met with appropriate levels of discretion from staff and given a variety of avenues to discuss including group and one-on-one settings, with a strong preference for informal mental health check-ins to build trust.

> "We need more of the excellent therapy services that exist. All clinics are overwhelmed by the current need which is a fallout from the pandemic."

Yet not all programs have the same resource needs. As the data made evident, programs serving rural and non-rural populations might need different resources. Among programs serving young people in non-rural settings, we see a greater need for in-house clinicians, removing cultural barriers to mental health discussions and service access, and increasing staff numbers compared to programs serving only rural youth. Meanwhile, among programs serving young people in rural areas, we see a greater preference for improved transportation, screening processes, and staff training to use these systems, and better access to telehealth services compared to programs serving non-rural youth.

Lastly, we cannot understand what we do not track. An added concern of the mental health service capabilities of youth employment programs is the lack of tracking and monitoring in general, as well as the lack of follow-up among those who have some data tracking in place. For example, comparing Figures 4 and 7, we can see that anxiety and depression are the most frequently seen mental health disorders reported by survey respondents, but these also are the most often screened for mental health disorders, as seen in Figure 7. If we are screening for these disorders more frequently than others, we may be missing the extent to which youth are experiencing other mental health disorders. Furthermore, as seen in Figures 9, 16, and 17, even among programs that conduct screenings or track and monitor who receives mental health services, there is still a high percentage of uncertainty about how many young people need mental health services, and whether they are being connected with the mental health services they need. Finally, additional research is needed to better understand the specific needs

of programs serving tribal populations, as well as to better discern the needs of programs serving different racial demographics.

EXAMPLES FROM THE FIELD

While evidence shows that many organizations are struggling to identify and address their youth's mental health needs, some organizations are exemplars for their strategies to effectively assist youth. Strategies range from having intake forms to on-sight counselors. Practices that are integral to addressing the youth mental health crisis include:

Intake Forms

In-house Counseling

Trauma-Informed Care Models

Strategies for Systems Integration

Example From the Field: The Workforce Solutions of Central Texas Intake Forms

Intake forms serve as a preliminary way to identify the needs of those served and reduce the time it takes to address these needs. The Workforce Solutions of Central Texas (WSCT) implemented a cross-functional service delivery model in February of 2019 in an attempt to comprehensively serve clients. Utilizing internal funding and external community resources, WSCT staff assess a client's barriers and challenges to employment and education using a one-page intake information form in their Workforce Center Career Center (American Job Center). This one-page tool is the focal point to identify a client's needs and services beyond trying to obtain employment. There are three cross-functional service delivery teams in the Temple Santa Fe Business Center. This leads to increased awareness and knowledge of other program services, program eligibility, and additional cross-functional service referrals which lead to co-enrollments.

Section D of this intake form includes barriers or work limitations but can also identify basic needs that impact mental health struggles.

Section D: Work Limitations/Barriers *(select all that apply)*

☐ **Behind in Child Support**	☐ No occupational certification or license
☐ **Foster Youth**	☐ Homeless
☐ **Disability that creates a barrier to employment**	☐ Victim of abuse or domestic violence
☐ **Currently receiving SNAP (Food Stamps)**	☐ Background (record of arrest or conviction)
☐ **Currently receiving TANF**	☐ Language barrier; limited English
☐ **No child care**	☐ Other _____

Cross-functional service referrals are made:

1. From the career center
2. Unemployment insurance
3. Referrals within cross-functional teams

Example From the Field: In-House Counseling

As a way of ensuring access to quality mental health and substance use services, The Work Group, located in Pennsauken Township, New Jersey, became licensed as a mental health facility. The Work Group used behavioral health and substance use services to improve the process of young adults transitioning to adulthood. The inclusion of mental health supports increased the young adults' program completion, educational gains, and work-related outcomes.

The Work Group brought clinical mental health and substance use services in-house for youth to gain comfortability with the clinicians, reduce the social stigma of mental health services, and ensure that each clinician was a good fit for their clients. Mental health services are fully integrated into the daily life of The Work Group's education and workforce programming.

After becoming licensed, The Work Group became an approved Medicaid provider. In addition, The Work Group accessed state funds for uninsured or underinsured individuals. Those two funding streams cover virtually all the youth served by The Work Group. Aside from the youth served by The Work Group's educational program, the counseling center is open to the general community. This self-sustaining program eliminates barriers to mental health services such as transportation, long wait times, and social barriers. This business model was able to begin through private and foundation funds. After three years, it is not only fully self-supporting but also generates profit which is used to support The Work Group's education and training service.

Example From the Field: Trauma-informed Care

Trauma Informed Care Model

Trauma-Informed care can be implemented in youth employment programs to meet the social and emotional needs of their youth. HopeWorks Camden, an organization serving the urban area of Camden, NJ, is dedicated to prioritizing the mental health of all young professionals, staff, and internal teams. Their model considers that individuals likely have a history of traumatic experiences in their home and personal life and provides training for staff to implement a trauma-informed culture. Their focus extends beyond education, technology, and professional development, but making sure everyone feels safe and embraced.

Youth Healing Team

Hopeworks Trauma Informed Training is developed and delivered by the Youth Healing Team, a specially trained group of young professionals coming from Camden, Philadelphia, and other underserved communities. This team understands and implements best practices around trauma-informed care. The Youth Healing Team's unique voice provides a valuable perspective.

Example From the Field: A Workforce Board Strategy for Advancing Mental Health Services Through the Youth Employment System

EmployIndy is the workforce development board for the Greater Indianapolis region. They have leveraged their influence and technical expertise to advance mental health services for opportunity youth, through their "Youth Employment System" network of service providers. In 2020, EmployIndy expanded its trauma-informed care approach through NYEC's "The Translating Adolescent Brain Science (TABS)" project. EmployIndy provides both trauma-informed training for career navigators and self-care training for career navigators. This ensures that the workforce providers can recognize and address trauma-related issues in youth as well as prevent burnout and turnover from staff. Their trauma-informed approach focuses on realizing trauma, recognizing trauma, and responding to trauma. In some locations, EmployIndy utilizes counseling sessions with specialized counselors and life skills coaches to augment staff time dedicated to this work.

EmployIndy has also integrated social and emotional supports within its programs by ensuring that re-engagement facilitators are trained, job readiness training includes attention to positive youth development and the lived realities of youth, industry trainings are responsive to the mental needs of youth, and work experiences include emotional supports including Moral Reconation Therapy (MRT). Lastly, EmployIndy has providers detail in their request-for-proposals (RFPs) how they will offer mental health services and who they will partner with to offer mental health services. Selected sites will have twice yearly desktop monitoring and an annual full monitoring of providing these supports.

In Focus: Rural Communities and Telehealth

A rural community's demographics include a wide variation in education level, race, and income which requires unique approaches to meeting the community's mental health needs. Despite 20% of the US population living in rural areas only 11% of doctors practice in rural areas. Without a sufficient behavioral health workforce, many mental health issues go unaddressed and untreated in these communities. Rural communities face higher rates of suicides and depression and due to a dearth of mental health services individuals are less likely to seek or receive treatment compared to those living in urban communities (Carpenter-Song & Snell-Rood, 2016).

Telehealth, a method for providing healthcare via electronic communication, has emerged as a potent tool to address the lack of physical mental health resources in rural communities. Telehealth helps

overcome limitations such as accessibility, availability, and acceptability. A telemedicine study found that visits grew 45.1% annually. When centered around access, affordability and equity telehealth can allow mental health professionals located in cities to meet virtually with rural patients, which can alleviate the issue of lack of mental health resources.

In Focus: Systems of Oppression and Mental Health

The sources of many mental health challenges facing young adults stem from systems of oppression that are connected to but not limited to racism, sexism, poverty, homophobia, ableism, and more. Low-income and BIPOC youth are among the hardest hit by structural racism, economic inequality, and the aftermath of the COVID-19 global pandemic. The legacy of slavery and its effects on the mental health in BIPOC communities has led to deep distrust of the healthcare system and stigmatization of mental illness. Unjust immigration and legal systems have led to fear amongst communities discussing mental health issues or seeking contact with the healthcare system. Furthermore, the inability to pay, take off work, arrange childcare, and obtain adequate transportation among other barriers prevents millions of low-income youth from ever seeking care and obtaining a formal diagnosis.

Increase the Diversity of the Behavioral Health Workforce

In 2020, Black and African Americans made up a mere 4% of U.S psychologists. Youth are more likely to positively respond to mental health services when it is culturally competent, meet them where they are, and have low barriers to entry. More work needs to be done to ensure our next generation of mental health providers and professionals come from diverse backgrounds and reflect the lived realities of the clients that they serve. Many institutional reforms are being done including changing educational entry requirements to holistic reviews, combatting collateral consequences, and increasing wraparound supports for BIPOC individuals while they are in school.

Dismantle Systems of Oppression

The impact of white supremacy and racism pervades almost every institution of life and contributes to negative health, environmental, economic, social, and most relatedly, youth mental health outcomes. While no single panacea exists for a complete dismantling of systems of oppression, many efforts to complete this work exist both historically and currently. These efforts include:

- Recognizing the existence and effects of white supremacy both historically and currently
- Training leadership and staff on antiracism and bias
- Supporting legislation that provides redress of past injustices
- Amplify, hire and support BIPOC youth and people with other lived experiences

POLICY RECOMMENDATIONS

NYEC's survey and focus groups uncovered a workforce-development field mindful of the mental health needs of young people but struggling to step up. Federal policymakers can take steps to immediately address the lack of local resources and high barriers perceived by practitioners and young people:

- Encourage mental health screenings upon intake into the workforce development and other human-services systems.
- Increase training for frontline practitioners in the workforce development and other human-services fields, so they can identify mental health warning signs and make initial assessments.
- Increase the availability of mental health services with dedicated funding for in-house services among WIOA (Workforce Innovation and Opportunity Act) providers.
- Lower barriers to accessing services and provide last-dollar funding for mental health services, through a Program Access Fund.
- Increase Medicaid reimbursement rates for mental health services, and pressure private insurers to do the same.

Read more about NYEC's federal policy recommendations here.

At the local and state level, the American Rescue Plan Act (ARPA) provides flexible federal funding for mobile response units, community violence intervention, and other mental health services. Practitioners can shape the planning and deployment of ARPA-funded programming as it is implemented in the coming years.

RESOURCES

Adolescent Brain Science and Trauma Informed-Care

- NYEC Survey on Mental Health Needs of Youth Employment Programs
- Protecting Youth Mental Health- The U.S. Surgeon General's Advisory
- The Translating Adolescent Brain Science Project: Applying Executive Skills, Positive Youth Development, and Trauma-Informed Care to Workforce-Development
- The Future of Healing: Shifting from Trauma-Informed Care to Healing-Centered Engagement
- Understanding Depression in Young Adults
- The Brain Architecture Game (Online Training for Early Brain Development)

Racial Equity and Systems of Oppression

- Racism And Mental Health (Mental Health America)
- The Color of Justice The Landscape of Traumatic Justice: Youth of Color in Conflict with the Law Racism And Mental Health (Mental Health America)
- Youth Mobile Response Services: An Investment to Decriminalize Mental Health (CLASP)
- National Minority Mental Health Awareness Month
- Trevor Project 2022 Report: Resilience and Mental Health Among LGBTQ Youth

Mental Health Treatment

- Findtreatment.gov
- Youth.gov
- 988 Suicide & Crisis Lifeline