Refocus and Renew

Moving Toward Health for Adults with Serious Mental Illness and Youth with Serious Emotional Disturbances

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Refocus and Renew: Moving Toward Health for Adults with Serious Mental Illness and Youth with Serious Emotional Disturbances

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Introduction

No American is untouched by mental illness and substance use disorders (i.e., behavioral health disorders), whether in their families, themselves, their neighbors, or their coworkers. When mental illness or substance use causes significant impairments in functioning and individuals experience serious mental illness (SMI)—including bipolar disorder, significant depression, or schizophrenia—or children experience serious emotional disturbances (SEDs), the challenges and level of strain can be insurmountable. Over time, around the world and in the United States, many phases have emerged in the care and treatment of people with mental health conditions, which eventually give way as new, more humane and scientifically informed methods come to light. This includes policies that prioritize community-based care over institutional care when people with SMI can manage safely in their communities.

Despite these innovations, too many people with SMI have no access to appropriate care, frequently experience homelessness, repeated arrests or incarcerations, and are unable to regain their footing enough to find employment, rebuild familial relationships, and achieve stability. Similarly, too many youth with SED experience disrupted schooling and are involved in multiple public systems, including child welfare, juvenile justice, and behavioral health systems.

Times of change offer an opportunity to **refocus** and **renew** commitments to solve tough problems. The "Beyond Beds" Technical Assistance Coalition (TAC) policy paper series began in 2017 as a way for the National Association of State Mental Health Program Directors (NASMHPD) to disseminate information and tackle complex matters in mental health and substance use services. The specific impetus of the series was to progress beyond solely funding psychiatric inpatient beds as a single solution to the needs of people with SMI. The goals centered around health and crisis services and aimed to catalyze a more comprehensive psychiatric care continuum. Since the initial "Beyond Beds" series, the TAC policy papers have taken on increasing importance and prominence as vehicles for providing knowledge, policy guidance, and public messaging to state mental health leaders and beyond. Now in its ninth year, this year's TAC paper series, "*Refocus and Renew: Moving Toward Health for Adults with Serious Mental Illness and Youth with Serious Emotional Disturbances,*" calls on state leaders to **refocus** on SMI and SED treatment and recovery—and to **renew** their commitment to system changes in improving whole-person health. The series focuses on providing updated information and guidance on SMI and SED and renewing efforts for systems-level changes (**Box 1**).

This leading "umbrella" paper for *Refocus and Renew* aims to provide an overview of what successful treatment and recovery look like for people with SMI and how far the United States is from reaching that reality. It focuses on two areas where state mental health leaders can have the most impact through renewing their commitment to change: first by addressing whole-person health and reducing early mortality for individuals with SMI and youth with SED, and second by reducing the high costs associated with the illnesses by reducing multisystem involvement and improving treatment access earlier in the illness course.

Box 1: FY2025 *Refocus and Renew* series

1. Umbrella: Refocus and Renew: Moving Toward Health for Adults with Serious Mental Illness and Youth with Serious Emotional Disturbances

Refocus on Children and Youth with SED

2. Serious Emotional Disturbance in Children, Youth, and Young Adults
3. Cross-System Collaboration to Support Children and Youth with Behavioral Health Needs and Their Families

Refocus on Adults with SMI:

4. The Latest on Schizophrenia Spectrum Disorders
5. Strengthening Systems to Address Eating Disorders
6. Improving Maternal Mental Health in Women with Serious Mental Illness

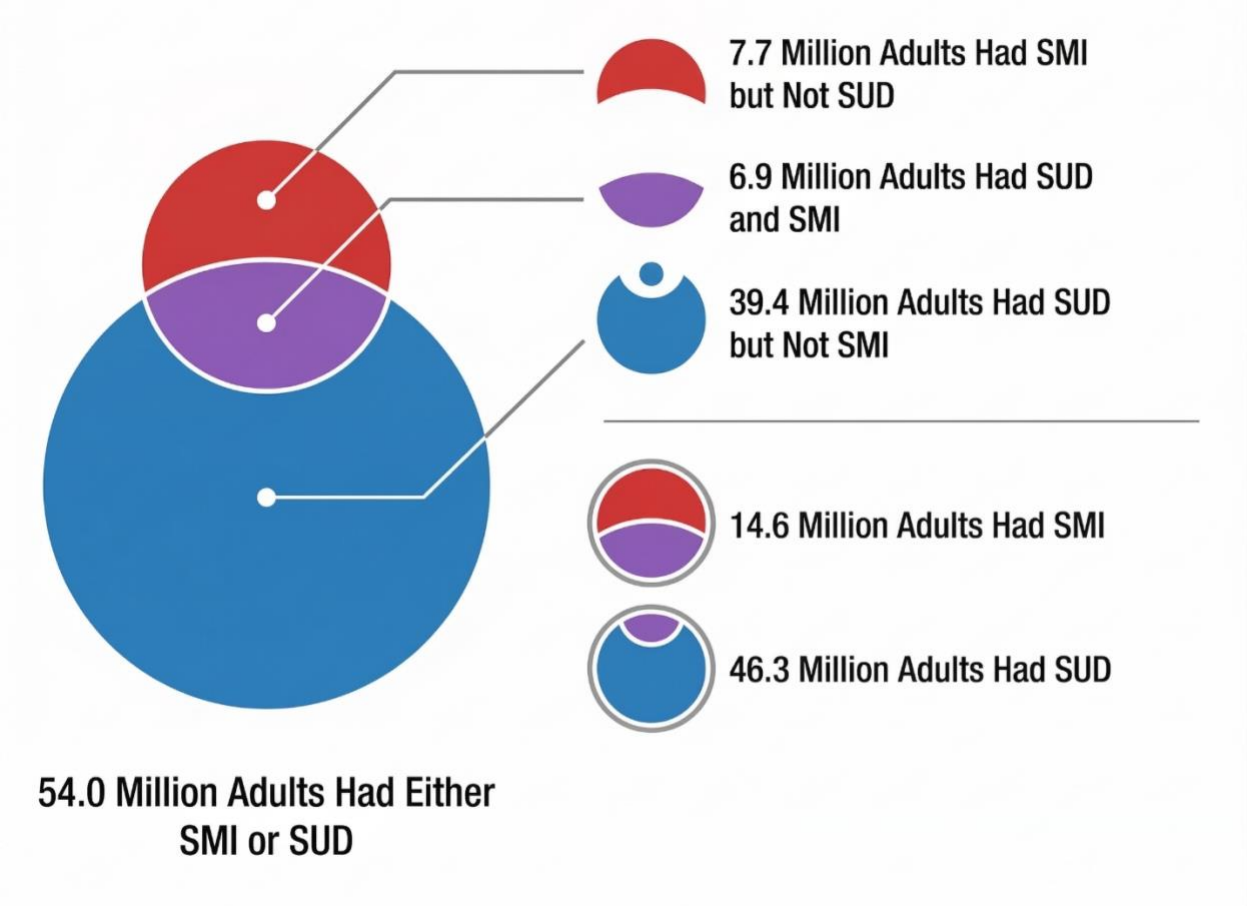
Renew Commitment to Systems-Change

7. A Systems-Based Approach to Supporting Individuals Who Have Experienced Grief and Loss
8. Legal Tools Throughout the Behavioral Health Care Continuum
9. The Evolving Landscape of State Hospitals in the Public Mental Health System
10. Forensic Issues in the State Mental Health System

Almost 15 million individuals in the United States—approximately 5.6 percent of the U.S. adult population—are living with SMI as defined by SAMHSA.[1] Approximately 6.9 million of those individuals also have a co-occurring SUD (**Figure 1**).[2] Nearly 30 percent of individuals with SMI, or more than 4 million adults, did not receive any form of treatment in 2024, despite the significant impairments associated with SMI. Children and adolescents face similar substantial mental health challenges. National estimates indicate that SED affects between 5 and 10 percent of youth in the United States, translating to approximately 5 to 7 million children and adolescents.[3] SMI and SED treatment gaps highlight the need for state and local leaders to continue their efforts and refocus on SMI and SED treatment.

Refocus on SMI and SED Treatment and Recovery

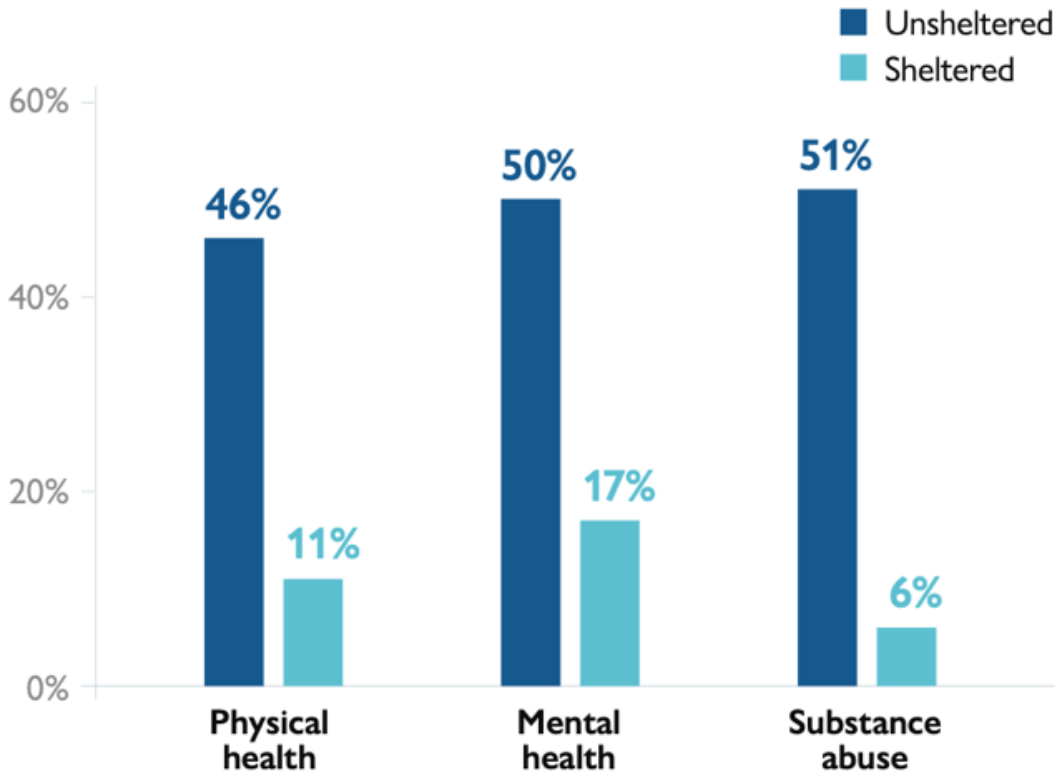
Figure 1: American Adults with SMI, SUD, or Both



Untreated SMI and SED are associated with higher rates of suicide ideation, planning, attempts, and deaths.[4,5] Though the 2024 NSDUH shows declines among adolescents for serious suicidal thoughts (from 12.9 percent in 2021 to 10.1 percent in 2024), plans (6.2 percent to 4.6 percent), and attempts (3.6 percent to 2.7 percent), the persistence of these phenomena underscores the need for timely treatment and robust prevention strategies.[6]

Individuals with SMI and SED are overrepresented in many public service settings, often as a result of falling through the cracks of the mental health service treatment system. According to an analysis of federal data, one in three jail inmates have a co-occurring mental health condition, physical health condition, or disability. [7] People with mental health needs are also largely overrepresented in the population experiencing homelessness, especially those who are unsheltered and living on the streets (**Figure 2**).[8] In the 2018 *Bolder Goals and Better Results* SAMHSA TAC paper, the needs of persons with SMI experiencing homelessness were identified as a key component of goal setting necessary for overall outcome improvements.[9]

Figure 2: Health Concerns Among Sheltered vs. Unsheltered



Renew Commitment to Whole-Person Health

In 1948, the World Health Organization (WHO) established a definition of health: "Health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity."[10] In the past 70 years, this definition has been a long-standing source of debate and discussion. In a recent analysis, Schramme argued that the controversy over the word "complete" represents a divide in how the word is interpreted. For example, it could be interpreted by its quantifiable meaning, suggesting that a person would need to achieve 100 percent of the factors and, in that sense, also achieve the elusive goal of "happiness" to be healthy. Or it could be interpreted by its qualitative meaning, suggesting that a healthy person has all the elements of health.[11] Others have argued that the WHO definition should be parsed across varying definitions, depending on the scope of practice and application, such as its application to older adults or people with chronic conditions.[12]

Mental health focuses on the aspects of health that relate to mental well-being. Galderisi and colleagues wrote about a proposed new definition of mental health, identifying that the idea of well-being centers around positive attitudes and functioning, including social integration. Yet Galderisi pointed out that mental health needs to allow space for normal emotions that are more negative, such as anger, sadness, or even unhappiness at times.[13] In this sense, the pressure to experience positive feelings at all times may, in fact, set a bar too high for what should be the

standard goal for mental health. Given this dilemma, Galderisi and colleagues suggested a different definition of mental health:

> Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium.[14]

These authors recognize the importance of the dynamic state of mental health and note how it shifts across life cycles from early developmental years through older adulthood. In addition, mental health may include the ability to manage stressors, modulate emotions, be flexible of mind, and relate empathically to others.[15] Mental health is not defined by the absence of mental health conditions, nor by the absence of general mood fluctuations, bad days, and the presence of heightened emotions.[16] Mental health reflects one's ability to thrive and experience other aspects of well-being.[17]

Mental health conditions, mental illness, and mental disorders are terms that are often used synonymously. According to SAMHSA, "mental illnesses are disorders, ranging from mild to severe, that affect a person's thinking, mood, and/or behavior."[18] SAMHSA's definition of SMI and SED are based on functional impairment, not a particular diagnosis, and have not changed since 1992. National data have cited that almost one in five adolescents and adults in the United States has some sort of mental health condition.[19,20] According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition, Text Revision,

> A mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. These syndromes or clusters of symptoms should be significant enough to cause distress or disability, rather than be expressions of normal ups and downs related to life circumstances.[21]

Individuals with a diagnosed mental health condition can still have periods of good mental health. They may also have co-occurring conditions such as substance use disorders and/or intellectual or other developmental disability disorders, as is highlighted in the work of the Link Center.

When considering the health of Americans, the overlap of and interplay between physical health and mental health are important considerations. The Centers for Disease Control and Prevention (CDC) emphasize that mental and physical health have equal importance when considering overall health. Because public health looks at overall strategies for preventing the development of illness, among other things, much work needs to be done to foster opportunities that integrate approaches to prevent illness and foster health, including mental health and physical health. Moreover, the CDC notes that during rising demand for mental health services,

using a public health approach to promote positive mental health is a major goal. Working to build integrated systems that holistically approach the need for mental health care will enhance protections that minimize the complex risks associated with poor physical and mental health. [22]

Now is the time to focus even more on health across America, and drill down to define what it means to develop programs and services around whole-person health. The current federal initiatives toward health, as highlighted in the Make America Healthy Again Report issued through the White House in February 2025, only make this clearer.[23]

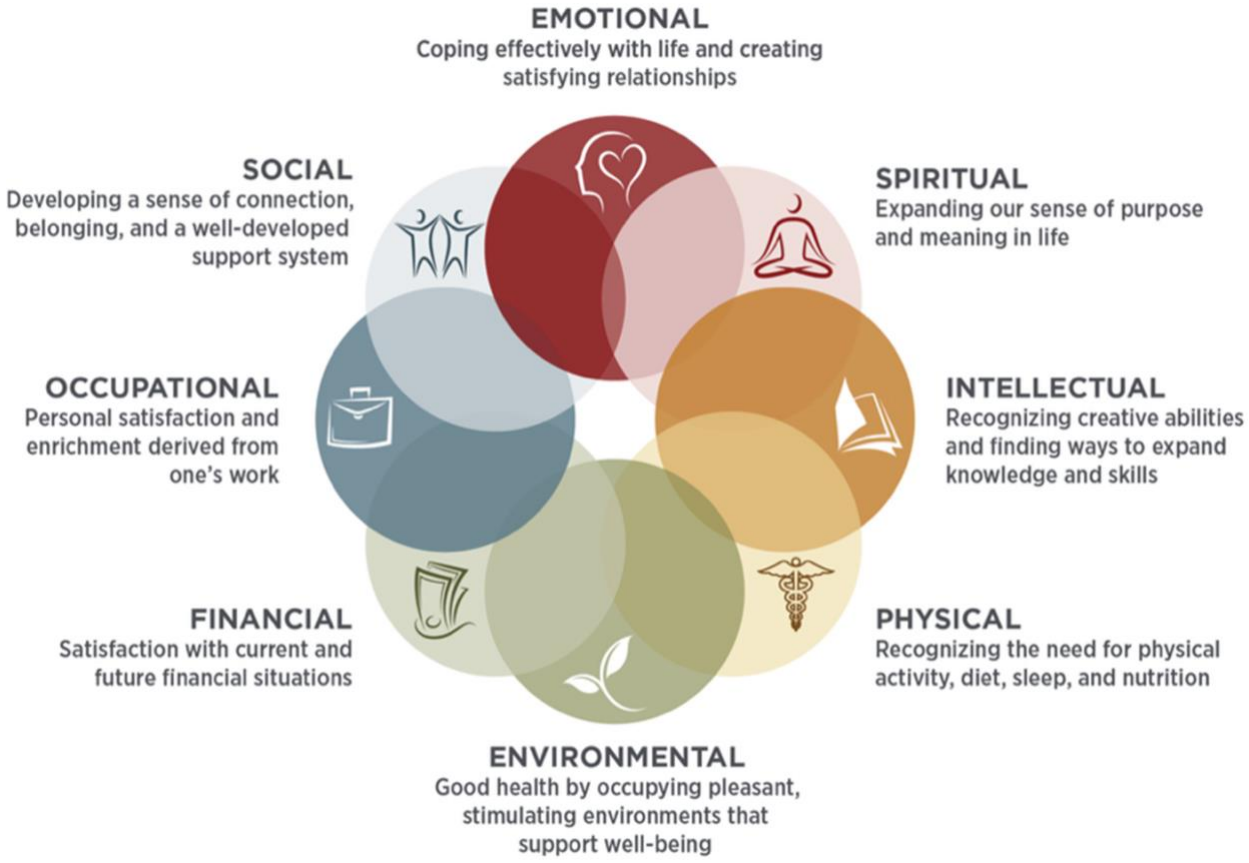
REDUCED LIFE EXPECTANCY OF PEOPLE WITH SMI AS ANOTHER FACTOR IN PRIORITIZING WHOLE-PERSON HEALTH

The life expectancy of people with SMI is 25 years shorter than that of the general population, a difference that has persisted for decades despite waves of attention and initiatives to address it over the years.[24] This continued gap in early mortality reflects profound system failures that require a renewed commitment by all leaders, state behavioral health, public health, mental and physical health service providers, policymakers, and others, to address whole-person health in people with SMI.

Much of the early national spotlight on this issue in the United States came from work initiated by NASMHPD in the landmark 2006 report, *Morbidity and Mortality in People with Serious Mental Illness*.[25] The report shows that at the time, the mortality gap for individuals with SMI compared with the general population was widening, largely due to modifiable risk factors like smoking, obesity, substance use, and inadequate access to medical care. The report authors called for state mental health authorities to embrace two guiding principles to address this gap: (1) overall health is essential to mental health, and (2) recovery includes wellness.

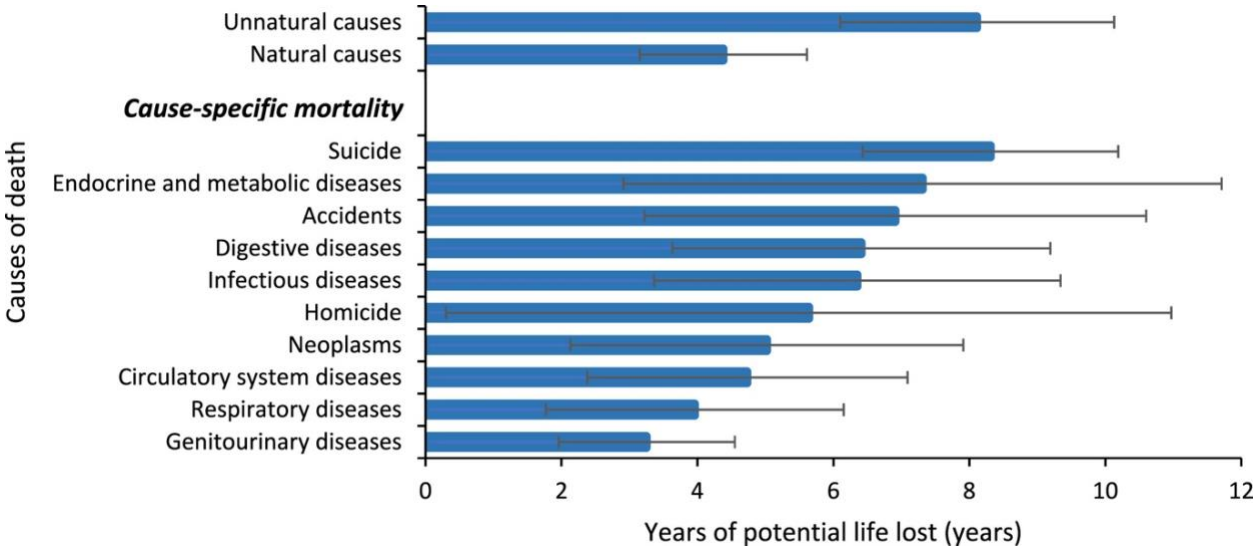
One of the most prominent national responses to these findings was SAMHSA's 10x10 Wellness Campaign, launched in 2009. The campaign's goal was to increase the life expectancy of people with SMI by 10 years over a 10-year period; it emphasized integrating mental and physical health care and promoting wellness and prevention. The campaign promoted eight dimensions of wellness (**Figure 3**), adapted from an article in *Psychiatric Rehabilitation Journal* published in 2006 about the need for public mental health systems to shift their paradigm to a wellness approach.[26] The campaign succeeded in mobilizing public attention and initiating wellness programs across states, sparking multiple state and local-level pledges to the 10x10 promise. An evaluation of the Minnesota 10x10 campaign showed that some progress was made in reducing the early mortality gap among people with SMI, but that multiple types of interventions—specific to the different populations—are needed to really shift the needle on this problem, such as addressing unintentional injuries during manic episodes in individuals with bipolar disorder and addressing chronic medical conditions in people with schizophrenia.[27] In a recent paper, Thomas and colleagues reported that people with HIV and schizophrenia had better access to care when initiatives to reduce Medicaid fragmentation were in place.[28]

Figure 3: Eight Dimensions of Wellness



Globally, and more recently, countries such as Australia and the United Kingdom have also acknowledged the premature mortality crisis in their mental health populations and implemented national frameworks to respond. For example, Australia's National Mental Health Commission's Equally Well initiative, which began in 2017, was developed to improve quality of life for people living with mental illness. It seeks to champion physical health care for people with mental illness as a priority to reduce the life expectancy gap. Access to physical health care is also a pillar in Australia's national strategy for suicide prevention.[29] A six-year progress report published in 2024 suggests significant progress has been made, including 55 new physical health programs for people with mental illness in primary care settings and $5 million in new research funds to address physical health care in those with mental illness. Strategic areas of focus for the future include a three-year data linkage project to develop a first-of-its-kind comprehensive picture of progress on life expectancy gaps in people living with mental health conditions, and a robust communication strategy to maintain momentum and increase awareness of the impact to influence policy and guidelines. Similarly, the UK's National Health Service has committed to providing annual physical health checks for individuals with SMI through their NHS Health Check program. The annual visit through primary care includes checking blood pressure, height and weight, blood glucose, blood lipids, and smoking and/or alcohol use. These health checks can be done at home or transportation to a facility can be provided.

Figure 4: Years of Potential Life Lost Among Individuals with Mental Illness by Cause of Mortality



Multiple factors contribute to the gap in life expectancy among people with SMI compared with the general population. A systematic review and meta-analysis published in a *Lancet* journal examined years of potential life lost by cause of mortality among those with mental illness (**Figure 4**), and reported that death by suicide, endocrine and metabolic diseases, and accidents were the three leading causes of death among this population.[30] The life expectancy gap is especially pronounced in younger individuals with SMI.[31] The significantly higher risk of death from lung cancer in individuals with SMI is in part due to much higher rates of tobacco use in that population. Although smoking rates have decreased in the general population over the last 30 years due to public health messaging and tobacco industry regulations, smoking rates have not decreased in those experiencing SMI; consequently, smoking rates among individuals experiencing SMI are higher than those of the general population.[32]

Social determinants of health, like social isolation, housing, and employment also contribute to higher premature mortality rates among individuals with mental illness. According to a study from Australia, individuals with mental illness who were not employed had a significantly higher risk of premature death compared with those who were employed.[33]

Another important well-being indicator that captures the overall health of an individual are disability-adjusted life years (DALYs), which indicate overall disease burden expressed as total number of years lost due to illness, disability, or early death using combined measures of premature mortality and years of healthy life lost due to disability. The landmark 2019 Global Burden of Disease study examined the overall burden of mental illness in 204 countries and territories across the world from 1990 to 2019.[34] Depressive disorders and SMI showed the highest DALYs across the globe.

Addressing the premature mortality gap in individuals with SMI requires a renewed commitment and coordinated response among policymakers, state leaders, and health care providers. Integrating physical and behavioral health care can be a foundational step through models such as Certified Community Behavioral Health Clinics.[35] Additionally, implementation of evidenced-based interventions for individuals with SMI, such as smoking cessation programs,[36] weight management and physical activity promotion,[37] and increasing efficacy of self-management for chronic conditions such as diabetes,[38] can be integrated into health and mental health practices to address whole-person health. By building systems that treat the body and mind together through a renewed commitment to whole-person health, we can begin reducing the life expectancy gap in this population.

SAMHSA supports the Center of Excellence for Integrated Health Solutions that works to advance the implementation of high-quality treatment for individuals with co-occurring physical and mental health conditions, including substance use disorders.

Renew Commitment to Improving Quality and Reducing Costs

Access to care is critical, but the national commitment must strive for access to quality care most of all. Many are trending toward developing a quality improvement framework to identify health concerns and improving how to address them. Typically, this approach involves screening broadly for a condition and then following positive screens with further diagnostic assessments and treatment if needed. From a quality improvement lens, there could then be analyses of how many screenings are done and how many people are referred and then treated for the identified condition, with an examination of outcomes at each step in the process. For example, breast cancer cure rates were substantially increased by improving knowledge about breast self-exams and mammograms. Similarly, for mental illness in youth and adults, screening is a first step toward identifying and addressing any needs that are identified.

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program funds preventive health care for Medicaid beneficiary youth under age 21. The EPSDT benefit is mandatory for all states and stems from section 1905(r) of the Social Security Act.[39] The federal guidelines on this benefit are specific. For example, the program requires a comprehensive health and developmental history and periodic screenings for conditions among youth. In 2022, CMS issued an information bulletin to remind state Medicaid agencies that the requirements for EPSDT include addressing behavioral health needs for children and youth, and to inform the agencies robust guidance and technical assistance availability to ensure that children and youth receive high-quality behavioral health services.[40]

In 2001, a class action lawsuit was filed on behalf of "Rosie D" and eight other Medicaid-eligible children, alleging that they were hospitalized or at risk of being hospitalized because the Commonwealth of Massachusetts failed to honor its EPSDT requirements. This class action lawsuit involved tens of thousands of youth on Medicaid in Massachusetts who had emotional, behavioral, or other psychiatric disabilities.[41] The Honorable Judge Michael A. Ponsor in the Western Division of the U.S. District Court ruled in favor of the plaintiffs in 2006. Now, after

almost 20 years, the state has been able to exit the lawsuit, but only after an entire reform of the children's behavioral health system that involved implementing quality improvements in the identification of needs and service delivery that emphasize home-based care. The state was finally found in compliance in 2021, though many advocates note that work is still needed for ongoing improvements.[42] This type of litigation has now taken place in numerous states, leading to reform in screenings and increased home-based services, including mobile crisis and stabilization services. Though the work needs to continue in earnest, this is a time to **renew** a commitment to deliver quality behavioral health services to youth. Two papers in this TAC series, one that focuses on the definition of SED and clinical descriptors[43] and one that focuses on the needs of multisystem involved youth,[44] provide more detailed guidance to help inform leaders about improving youth services.

With regard to adult services, screening for mental illness and substance use is critical within primary care settings,[45] emergency rooms, and carceral settings, and is becoming more recognized for school health and other locations (**Figure 5**).

Figure 5: Typical Screening Tools

Screening in Primary Care:

- PHQ-2[46] or PHQ-9[47] for depression
- DAST-10[48] or AUDIT-C[49] for drug and alcohol use
- GAD-2[50] for anxiety
- BMH-7[51] that incorporates anxiety, depression and alcohol use screening
- C-SSRS—Columbia Suicide severity Rating Scale for suicide risk[52]

Screenings in Justice Settings:

- MAYSI[53]
- Brief Jail Mental Health Screen[54]
- K-6[55]
- C-SSRS[56]

Although screening seems relatively straightforward, it becomes more complex when it takes too much time and when a positive screen identifies a problem for which there are no treatment providers available. Screening, Brief Intervention and Referral to Treatment (SBIRT) and Youth SBIRT (YSBIRT) models address at least some aspects of these challenges.[57] The models' applicability to alcohol and tobacco use disorders has been studied, but the models have broader applications.[58,59] From 2021 to 2023, SAMHSA issued discretionary grants to increase the implementation of SBIRT. Grantees served more than 450,000 people; an evaluation found that the percentage of individuals who reported no alcohol or drug use within the six months after the initial screening and brief intervention increased by 128 percent.[60] In the SBIRT model, practitioners are taught to not just ask the routine screening questions, but to use the screening as an opportunity to provide a small "dose" of treatment or intervention that could help motivate individuals toward more formal treatment.

Beyond screening, quality of care in behavioral health services has been increasingly scrutinized. In part, this is because payers want to ensure the best outcomes at the most reasonable costs, but there is also increased demand for higher quality care in all aspects of medicine. The Agency for Healthcare Research and Quality (AHRQ) has noted a long dearth of reliable quality measures in mental health and behavioral health services.[61] The Experience of Care and Health Outcomes Survey is conducted to assess the experience of consumers of mental health and substance use services by gathering feedback from consumers, providers, and managed care organizations. Measures for youth mental health services include the following:

- Getting treatment and counseling quickly
- Communications with clinicians
- Information provided by clinicians on medication side effects
- Family involvement in care
- Information about self-help groups and treatment options
- Cultural competency of providers of care
- Treatment effectiveness
- Health plan administrative and office staff services

Similarly, the AHRQ-supported Consumer Assessment of Healthcare Providers and Systems outpatient mental health survey focuses on outpatient service quality of care received by adult individuals who present with mental health and substance use disorders. This survey asks patients about their experiences receiving care and about how they could access help in between appointments. It also asks about barriers to accessing care.[62]

These quality measures are becoming increasingly relevant to delivering and paying for services. Medicaid managed care companies and other insurers are examining quality and service delivery to help pursue funding that actually pays for better outcomes. Although this has been a goal of general health care, it is time to focus on the behavioral health quality measures to drive down cost and deliver better outcomes.

Another important aspect of psychiatric care and behavioral health services is measured in the ability to retain people in services.[63] Both for medication adherence and participation in outpatient interventions, keeping people in care can be a challenge for providers. High staff turnover is one factor, because it affects maintaining relationships between providers and individuals in care. However, many studies have investigated both intrinsic and extrinsic variables related to persons served that are important to consider. One study, for example, showed that only 32.7 percent of individuals engaged in mental health treatment had sufficient visits to achieve maximum benefit.[64] A study examining adherence to treatment among individuals with co-occurring substance use and psychiatric illness found that factors correlating with lower adherence included lower support by friends for drug/alcohol sobriety, lower satisfaction with the medications, lower self-efficacy for how to avoid returning to drug use, lower social supports relevant to recovery, and medication side effects.[65]

Individuals moving across systems, such as those with SMI who are justice involved or experiencing homelessness, have high rates of treatment retention challenges. Sometimes providers shift the treatments individuals receive, which increases the risk of symptom

exacerbation. Studies examining dropout rates of people on antipsychotic medications found that second generation medications had better retention, although that may have been related in part to study design.[66] The advent and promotion of long acting injectables as a remedy for treatment retention is a positive step, but not all medications are available in an injectable form and not all people are willing to receive injections.[67] Using court leverage has been one approach, such as with assisted outpatient treatment increasingly designed to help catalyze treatment adherence for those who meet the criteria for this type of court oversight.[68] When courts are involved, it is important to understand proper procedure and implementation of legal requirements. Improving treatment adherence and retention for people with SMI and SED must continue to be a major goal of system leaders and partners.

Maximizing treatment adherence for adults with SMI and youth with SED is not a new concern. A focus for the National Alliance on Mental Illness and others has been engaging persons in care so that they want to remain in the services being offered.[69] In a meta-analysis of published studies of retention interventions for mental health services, researchers found that interventions that focused on mental health knowledge, attitudes, and barriers to treatment had greater impact.[70] Another systemic review found that a combination of behavioral (e.g., motivational interviewing, text alarms and reminders, meetings and family involvement, pill counts, medication event monitoring systems, questionnaires on medication adherence, blood drug levels, etc.) and educational approaches might improve treatment adherence for individuals with SMI such as schizophrenia or bipolar disorder.[71] To make behavioral health services not only accessible but desirable and helpful to those who receive them, more research is needed to identify factors that can drive behavior either toward adherence and away from it. Given the increasing rates of homelessness, high suicide rates, high concentrations of people with SEDs in juvenile justice and with SMI in the adult justice system, increasing high-level opioid exposure events, and other substance use trends, it is critical that behavioral health service leaders, providers, and peers focus on research findings and known factors to improve treatment retention.

PREVENTING MENTAL HEALTH CONDITIONS AND CRISIS IN YOUTH AND YOUNG ADULTS

Preventing the onset and escalation of mental illness in youth and young adults is one of the most impactful strategies for improving population health, reducing long-term disability, and averting costly multisystem involvement.[72] Most mental health conditions emerge before the age of 24, with half beginning by age 14.[73] Co-occurring substance use disorders are also prevalent in youth and young adults with mental health conditions, which can exacerbate symptoms and make treatment decisions more complex.[74,75] Early identification and intervention are critical to altering these trajectories, particularly for youth at risk of developing SMI.

One of the most promising strategies for preventing the progression of SMI, specifically psychotic disorders, is the implementation of early intervention services for early serious mental illness, especially through coordinated specialty care (CSC) programs. CSC is a team-based, recovery-oriented approach for young people experiencing first episode psychosis,[76] which typically occurs between ages 15 and 30. Core components include psychiatric assessment and medication, cognitive and behavioral psychotherapy, family education and support, supported employment and education, and assertive case management, all delivered in an integrated

fashion with a focus on recovery and hopefulness for the future.[77] Studies show that CSC produces substantial clinical improvements across a range of outcomes, including quality of life, symptom improvement, and involvement in work or school.[78] CSC has also been shown to be more cost-effective than traditional early schizophrenia care typically available in communities.[79] Through a variety of efforts, both in research, implementation, and regulations, CSC programs are available in all 50 states, though more work is needed to ensure every young person has access to this gold-standard approach.

For more on CSC programs, see another paper in the FY2025 Refocus and Renew series, "Back to Basics: The Latest on Schizophrenia Spectrum Disorders"

Preventing the progression to multisystem involvement for youth with SMI, such as involvement with the juvenile justice system, emergency department overuse, child welfare involvement, or out-of-home placements, requires early detection, collaboration among youth-serving systems, and strategic intervention within settings where youth are present. A system of care that employs a "no wrong door" approach, so that all youth can access appropriate support for SEDs, is another strategy increasingly noted across systems.[80] Alternative education settings, in particular, are a critical site for upstream prevention as they often serve as a gateway where behavior and functional challenges can be identified and referred for care, rather than serving as a pipeline into the juvenile justice system. Youth in alternative schools, which typically serve students with academic or behavioral challenges, are more likely to have experienced significant trauma, live in unstable housing, and have unmet behavioral health needs.[81] As part of a SAMHSA Transforming Transitions Initiative FY2024 award, South Carolina embedded a mental health clinician in an alternative school to provide trauma-informed mental health supports to identify and address behavioral health needs among students and families. The initiative has shown promise in helping to prevent deeper system penetration among these at-risk youth.

Ultimately, preventing mental health issues in youth and young adults requires a renewed commitment to building collaborative, proactive systems. Early intervention for serious mental illness, prevention of multisystem involvement, and school-based suicide prevention programs are examples that offer proven pathways for changing the trajectory of young lives and, in doing so, reducing the human and economic costs associated with their mental health conditions.

Conclusion

The path toward improving America's health when it comes to working with individuals with SMI, substance use disorders, and youth with SED is a challenging one. There have been fits and starts of success, with treatments that work for depression, trauma, psychosis, anxiety, and opioid use disorder, to name a few. Therapeutic interventions using a variety of talking techniques have great outcomes. Peer support is increasingly a part of the menu of available and funded options to assist. Expanding technologies offer promises to help drive people toward the right care at the right time, monitor how people in care are doing, and enhance the ability to analyze outcomes through meaningful data. Behavioral health crisis services expanded during the height of the COVID-19 pandemic and with advances of 988, mobile crisis, and crisis stabilization type interventions.

Still, an improved infrastructure is needed to prevent crises, address them, and move away from "the crisis comes first to get help" mentality. Sustained supports are needed for people of all ages who live with chronic mental health conditions and those who are at risk for developing them. By refocusing attention on whole health, SMI, and SED, further progress can be made to enhance the entire continuum of mental health, substance use, and physical health care that is coordinated and meets people's needs.

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