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Stepping Into the Future of Behavioral Health: Opportunities, Challenges, and Possibilities

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To improve our practices of today and to overcome the problems that confront us at present, the behavioral health field must anticipate what the future is likely to bring. Such foresight is particularly important right now because of the changes and disruptions that have occurred due to the COVID-19 pandemic over the past 3 years. We begin by recounting major developments in the mental health field since the founding of the National Institute of Mental Health (NIMH) more than 70 years ago, including some firsthand experiences of the senior author. Subsequently, we review the present situation of the behavioral health field with particular attention to the effects of COVID-19 and our current workforce crisis. Likely future scenarios are then described in two principal domains: clinical developments and community developments. Clinical developments over the next decade are likely to include much more self-directed, integrated, virtual, and personalized care. Community developments are likely to include self-empowering community interventions, better population health management, new collaborations with public health, and continued efforts to address stigma. To increase the probability of the future described, several facilitators are also outlined to create the conditions under which expected future developments can be expected to flourish. These include addressing the behavioral health workforce crisis, modernizing behavioral health clinical training, fostering opportunities for cross-sector work, fostering opportunities to engage in policy issues, creating centers of excellence for innovation in behavioral health, and fostering an integrated framework that undergirds behavioral health. The future we have described holds considerable promise for the behavioral health field and for all who suffer from mental or substance use conditions. We must begin working today to turn this potential future into tomorrow's reality.

Public Policy Relevance Statement
At present time, the prevalence of mental illness and substance use conditions and the related workforce crisis in this field represent major national issues. This study provides historical background on the development of the mental health field, the current status of behavioral health, and some likely future directions. This framework is essential to understand and address this major public policy issue.

To improve our practices of today and to overcome the problems that confront us at present, the behavioral health field must anticipate what the future is likely to bring. Doing so necessitates examining first the roots of our current system so we understand how the past has led to the present. We then describe the changes and disruptions that have occurred due to the COVID-19 pandemic. Finally, we discuss probable positive and negative developments so that we can build capacity to accommodate both.

Our goal is simple: to improve behavioral health prevention, care, and rehabilitation. We seek to do this by peering into the future of this field so that we can adapt better to that future. We will describe probable positive and negative developments so that we can develop the capacity to accommodate both as we move forward. To do this, we first must examine the roots of our current system.

An important note on terminology: In this article, the term mental health refers to all the actions of the organized mental health system, including research, policy, and services. This term is used to describe historical developments up to the year 2000. After that

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time, the term behavioral health is used to reflect the growing integrated efforts of the mental health and substance use fields.

Looking Through the Lens of History

The late 1940s and the early 1950s were a time of major ferment in the mental health field. In 1946, the Congress passed, and President Truman signed, the National Mental Health Act. Shortly thereafter, Dr. Robert Felix was charged with setting up a new National Institute of Mental Health (NIMH), which came into existence in 1949. Dr. Felix's broad background in medicine and public health enabled him to establish the new Institute so that it would address all aspects of the mental health field, including community, prevention, epidemiology, treatment, care, outcomes, and rehabilitation. The Institute was designed to have three principal components to address these dimensions: research, training, and services (an overview of the major milestones in the history of NIMH can be found at https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh).

Shortly thereafter, in 1957, Dr. Felix also established the Mental Health Study Center (MHSC), which was placed in the community of Prince George's County, Maryland, near Washington, DC. The purpose of the MHSC was to examine all aspects of mental health and mental health care in a community. Its work included community demographic transitions, prevention, community epidemiology, mental health service development and assessment, as well as program innovation. The staff of the MHSC included psychiatrists, psychologists, social workers, sociologists, demographers, and community organizers.

The senior author, Ron Manderscheid, began his federal career at the NIMH in the MHSC in the late 1970s. He was very intrigued with all the ferment going on in the MHSC regarding innovative programs and services for teens in the community, new married couples' interventions, community demographic transition assessment, and biopsychosocial research. During this initial period, he had an opportunity to work as a graduate student with Dr. Julius Axelrod, a Nobel Laureate in 1970, to examine the potential role that the brain catecholamines play in response to stress. Much of the work from this period is reflected in current efforts in these different fields.

In addition, he had the opportunity to work with Dr. Milton Shore, a psychologist at the MHSC who went on to become the President of the American Orthopsychiatry Association in 1981, and his colleague, Dr. Fortune Mannino, a social worker who was the chief of the community service development program at the MHSC.

In 1963, the Congress passed, and President Kennedy signed, the Mental Retardation Facilities and Community Mental Health Centers Construction Act (Public Law 88-164, 1963). This Act further propelled the development of community mental health services and set forth a vision for the future of mental health in the United States. The ultimate goal was to develop 1,500 community mental health centers, each of which would serve communities ranging in size from 75,000 to 150,000 people and include a full range of mental health services from prevention and health promotion to care and rehabilitation. Ultimately, 804 of these centers were built by 1980, when the program was discontinued by the Reagan Administration.

The Act signed by President Kennedy was the culmination of numerous efforts undertaken over the previous quarter century to bring mental health services out of the psychiatric hospital and into the community. This focus on community services has persisted down to the present day. As the reader will note below, although this focus has always been highly valued in the field, it has waxed and waned during different presidential administrations and congresses.

In the interval between 1963 and 1981, work continued at the MHSC. Two of the directors of the NIMH began their careers originally as staff people at the center. The first was Dr. Stanley Yolles, who served as the NIMH director from 1964 to 1970, and the second was Dr. Bertram Brown, the NIMH director from 1970 to 1977. In this same period, Dr. Milton Shore and Dr. Fortune Mannino together produced a 50-year history of the American Orthopsychiatry Association (Shore & Mannino, 1975). This text supported the importance of continued work on community services and on the social antecedents of mental illness in communities.

Another especially important development during the early 1970s was the initial formation of national mental health and substance use consumer groups. For those with mental illness, a primary concern was forced treatment in psychiatric hospitals and poor-quality outcomes. For those with substance use conditions, a primary concern was the lack of professional services and the need to develop self-help activities. These consumer movements continued to grow through subsequent decades, and they have come to have a major impact on current activities in the mental health and substance use fields. Some of these key related developments will be noted below. For further information on the development of the consumer movement from the primary consumer point of view, please see National Empowerment Movement (1990), Van Tosh (1993), and Van Tosh et al. (2000).

Subsequently, President Carter created the first President's Commission on Mental Health in 1977. This Commission resulted in the development of the National Mental Health Systems Act, which was passed by Congress and signed by President Carter in the fall of 1980. Subsequently, it was repealed by President Ronald Reagan in 1981. The Mental Health Systems Act (1980) was intended to rectify problems that arose through deinstitutionalization, as more seriously ill clients were released from the state mental hospitals into the community. These clients were not able to find appropriate mental health services in the community because they lacked health insurance. Local community mental health centers had a mandated mission from NIMH to seek clients with insurance. The Mental Health Systems Act of 1980 would have put into place a much broader implementation of the Community Support Program began in the mid-1970s to provide a full range of services to people with serious mental illness living in the community and to extend Medicaid insurance to this group. This full range of services included mental health, health, and social services.

The year 1982 was a major turning point for mental health in the United States and the NIMH. The Institute's community mental health services program was converted to a block grant, the funds were reduced by 25%, and the block grants were awarded to the states. At the same time, the MHSC was closed. In addition, NIMH came under attack because it not only supported research but also included major training and service programs, such as innovative mental health programs for criminal justice settings and workplaces. These programs were viewed as a threat by the Reagan Administration.

Over time, the cumulative effects of these adverse events had a negative impact on mental health services in local communities,

which were starved of financial resources. Moreover, they accelerated the problem of homelessness in the United States. Overall, the homeless population grew to more than 500,000 persons each night, of which from one-third to two-thirds were mentally ill (Fischer & Breakey, 1985). Further, during this same period, incarceration of those with mental health or substance use conditions began to increase dramatically. From 1982 to the present, the problem of incarcerating persons with behavioral health conditions grew to an estimated 80%–90% of the 750,000 persons incarcerated each night in city and county jails.

Prior to 1986, NIMH did not have any appreciable program that focused on children or children's mental health services. After that date, because of political advocacy with the Congress, NIMH developed a small program focused on children with serious mental conditions. Research by the Institute in this area continues to the present day (The NIH Almanac, 2023).

By 1993, President Clinton and the Congress were able to develop legislation to address some of these problems in the Alcohol Drug Abuse and Mental Health Administration Act of 1992 (ADAMHA Reorganization Act, 1991–1992). This legislation resulted in the creation of the Substance Abuse and Mental Health Services Administration, which was to include all the major training and service programs from the Alcohol Drug Abuse and Mental Health Administration. This effort was intended to protect national training and service programs, which were under attack throughout the 1980s by the Reagan Administration. Initially, and for some period thereafter, Substance Abuse and Mental Health Services Administration struggled because it had a small staff and an equally small budget.

It also separated the three institutes, namely, NIMH, the National Institute on Drug Abuse, and the National Institute on Alcohol and Alcohol Abuse, which subsequently were to conduct only research programs. These three institutes were placed into the National Institutes of Health, where they remain today. These steps were the culmination of political actions undertaken by the Nixon Administration, which originally created the National Institute on Drug Abuse and National Institute on Alcohol and Alcohol Abuse. Advocates for the substance use field supported these actions to strengthen science and evidence-based practices for treating drug and alcohol conditions. Looking at today's perspective, it likely would have benefitted the mental health field to keep the three institutes together with the national training and service programs, particularly because of current efforts to develop and implement care that integrates these services.

In 1999, the U.S. Surgeon General, Dr. David Satcher, developed the very first *Surgeon General's Report on Mental Health*, and in 2002, President Bush created the President's New Freedom Commission on Mental Health. Both these efforts continued to be directed toward remedying major deficits in the field of mental health services. The Surgeon General's Report focused on integrating primary and mental health care. The President's New Freedom Commission Report focused on recovery, the personal involvement of clients in care decisions, and the development of the peer workforce.

The senior author played a role in the creation of the President's New Freedom Commission on Mental Health. In a series of early-morning breakfast meetings the senior author held in the early 2000s with Laurie Flynn, a DC colleague from the National Alliance for the Mentally Ill, and Dr. Tim Murphy, the state mental health commissioner from Virginia, the three agreed that action was needed to increase the likelihood that President Bush would actually create a mental health commission. These actions included work with two senior Republican U.S. Senators, Orrin Hatch of Utah and Peter Dominici of New Mexico, who prepared and sent letters to the President encouraging him to create the commission, which he subsequently did. This commission fostered a new focus on the importance of recovery and the key role that peers play in care delivery.

In addition, near the turn of the century, major efforts were undertaken by Substance Abuse and Mental Health Services Administration and others to foster stronger collaboration between the mental health and substance use fields and to promote integrated care that included both types of services. It was at this time that the terms behavioral health and behavioral health care were informally adopted. They have been used since that time and are used in the section of this article on the future. Because the fields were originally combined until the Nixon Administration separated them, mental health policy has always included elements of addiction policy.

Shortly after the New Freedom Commission, the Mental Health Parity and Addiction Equity Act of 2008 (Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 2008) and the Patient Protection and Affordable Care Act of 2010 (Patient Protection and Affordable Care Act, 2010) were passed. These two pieces of legislation played a huge role in bringing mental health into the mainstream of health care. They also greatly facilitated the development of the philosophy of person-centered care and self-directed care, trends that continue to develop today.

The senior author was involved in helping to prepare the Patient Protection and Affordable Care Act of 2010. In 2009 and 2010, he had breakfast every 2–3 weeks with Catherine Dratz, a Senate staff person who was involved in drafting this legislation. She worked at the Senate Finance Committee Office of Senator Max Baucus of Montana. In this process, they had many informal discussions about the mental health content in the ultimate legislation.

The Affordable Care Act included many provisions that facilitate access to higher quality community mental health services (Manderscheid, 2014). Key provisions include the establishment of state health insurance marketplaces for individuals with low incomes, expansion of Medicaid to include more persons who live in poverty, proclamation of mental health services as an essential health benefit, and the creation of health homes that offer services that integrate mental health and primary care (see the text of this legislation at Patient Protection and Affordable Care Act, 2010).

For further detail on this history, the reader is referred to the following documents: *Care and Treatment of the Mentally Ill in the United States: Historical Developments and Reforms* (Morrissey & Goldman, 1986), *The Mad Among Us: A History of the Care of America's Mentally Ill* (Grob, 1994), and *Better but Not Well: Mental Health Policy in the United States Since 1950* (Frank & Glied, 2006).

The Situation Today

The COVID-19 pandemic has led to a rapid growth in children, teens, and adults experiencing behavioral health conditions (Household Pulse Survey; Centers for Disease Control and Prevention, 2021). In total, the number of people with behavioral health conditions has approximately doubled in the past 3 years. Before the pandemic, about 20% of the population experienced these conditions. Today, these numbers have doubled to approximately 40%. Most recently, the Centers for Disease Control also

provided findings on adolescents that showed approximately 40% of adolescents experienced hopelessness and anxiety, and approximately 29% of female adolescents have contemplated suicide (Zablotsky et al., 2022). In the past 40 years, we have never seen prevalence estimates this high.

Today, we also have a crisis in our human resource capacity to deliver behavioral health services. Although this issue has been deteriorating for many years, it has worsened considerably during the COVID-19 pandemic (Gilbert et al., 2023; Saunders et al., 2023). Because the prevalence of behavioral health conditions has doubled and our human resource capacity has remained essentially the same, we only are able to care for about one-quarter of those with these conditions today. Prior to the pandemic, we could care for approximately one-half (Kessler et al., 1994).

Very recently, we have begun to see a very unfortunate return to the past in the decisions elected officials are making regarding inpatient care. In both California and New York City, proposals have been put forward by these officials to detain homeless persons with mental illness who reside on the streets and place them into mandatory inpatient care (Dembosky et.al., 2023). Other jurisdictions are considering similar actions. Over the last half century, evidence has documented the clear preferability of providing voluntary services in the community using a full continuum of care and appropriate peer support. These political choices run counter to the 1999 Olmstead Supreme Court Decision (*Olmstead v. L.C.*), which requires that care be integrated into the community and provided in the least restrictive settings possible.

In contrast with these current difficulties, much progress also has been made in the behavioral health field over the last half century. Today, we recognize trauma's critical role in the onset of mental and substance use conditions for both adolescents and adults. We have come to know that at least 85% of mental health problems are due to the trauma that people have experienced (Felitti et al., 1998; Substance Abuse and Mental Health Services Administration, 2023). We also appreciate the importance of person-centered care and consumer participation in decision-making. And we know that recovery and well-being are essential components of our mission.

Moreover, we now understand the critical role of the social and physical life determinants as causal factors in trauma and subsequent mental health and substance use conditions. As a result, we are beginning to undertake community interventions, population health management, and social care to address these determinants. Social care links efforts to address housing, employment, and social support with more traditional behavioral health interventions. Although this work is still very new, it shows considerable promise. At present, federal legislation is being considered by the U.S. Congress to expand the capacity of the behavioral health field to address these issues. This legislation, the Community Mental Wellness and Resilience Act of 2023 (Community Mental Wellness and Resilience Act, 2023), is especially important to help the field move upstream to address disease prevention and health promotion and improvement in personal and community well-being (see the text of this legislation at H.R.3073–118th Congress [2023–2024]: Community Mental Wellness and Resilience Act of 2023, 2023).

Another important development has been the rapid growth of peer support for all types and levels of care. An excellent overview of the development of peer- and consumer-operated services is provided by Phyllis Vine in *Fighting for Recovery* (Vine, 2022). Peer support makes it much easier for people to enter and receive care. It offers important support and guidance to help consumers confront the vicissitudes of care and to engage in the process of recovery. Some peer support is voluntary, such as in Alcoholics Anonymous, and some is paid work. Despite this importance, many peer supporters are still underpaid today, and many more are needed because of our human resource crisis.

Since all these negative and positive factors are occurring together, the behavioral health field seems to be at a major turning point today. Thus, we now turn to an examination of the future and how we may improve this situation. We have subdivided the discussion of the future into likely clinical developments and likely community developments, together with an analysis of facilitators that could increase the likelihood of the future actions described.

Likely Developments in Clinical Services

The landmark passage of the Patient Protection and Affordable Care Act of 2010 provided a philosophical foundation for person-centered care (Centers for Medicare & Medicaid Services, n.d.-a). in the behavioral health field in subsequent years. Person-centered care means that the whole person should be considered as care is delivered, not simply a specific diagnosis. This philosophy has permeated the behavioral health field. This concept comes mainly from the efforts of the consumer movement in mental health and the new initiatives undertaken as a result of this legislation. Key examples include the expansion of integrated care (combining of mental health, substance use, and primary care); the addition of social care, specifically work on the social and physical life determinants negatively impacting upon a client; and the rapid expansion of self-directed care, in which consumers play a much more pivotal role in designing and implementing the care they receive. All these changes are dramatic, and we expect even more changes in the future.

Self-Directed Care

The concept of self-directed care (Centers for Medicare & Medicaid Services, n.d.-b), has developed more rapidly in the intellectual and developmental disability field and in the substance use field than it has in mental health. This has allowed some of the lessons learned from these fields to be taken over into mental health. The Human Services Research Institute in Cambridge, Massachusetts, has been a leader in promoting research and development in self-directed care in the mental health field (Human Services Research Institute, 2019).

The national consumer movement has taught us that the essence of recovery is regaining one's voice and self-direction of one's own life. Thus, we expect self-directed care to proliferate in the mental health field over the next decade. The development of self-directed care and its expansion will have implications for the types of training that providers receive in the future, the exact nature of the care that is delivered, and the settings in which such care is provided. Currently, behavioral health providers are trained to lead the care process. With self-directed care, they will need to be trained to share the leadership of that process. The care itself will involve negotiations between the provider and consumer regarding care goals and processes. Finally, as self-directed care becomes more prevalent, we expect more consumer-directed care programs to evolve so that peers can work with consumers in delivering that care.

Several corollaries to this development are worth mentioning. First, clear outcomes will need to be negotiated between provider and

consumer at the outset of care and updated as care progresses. The currently available system for goal attainment scaling is a valuable tool for this purpose (Shankar et.al., 2020). Another corollary of this type of care will be the requirement for providers to have a much more in-depth understanding of the recovery process for each particular consumer, where that consumer currently is in the process, and what some of the barriers are to future progress.

Integrated Care

The philosophy of person-centered care also implies that integrated care is delivered when required. This means that the person's physical health needs are considered at the same time as their behavioral health needs (Manderscheid & Kathol, 2014). Because of the exceptionally large number of persons with mental health and substance use conditions who also have chronic physical health conditions (Ohrnberger et al., 2017), we would expect integrated care to grow rapidly over the next decade (UnitedHealthcare, 2024).

The availability of virtually delivered care has accelerated the implementation of integrated care, particularly since the beginning of the COVID-19 pandemic. We also would expect this trend to continue over the next decade because it has the capacity to democratize the relationship between provider and consumer, as noted below.

A new dimension of integrated care currently developing in the field is called integrated social care. This simply means that, in addition to behavioral health and physical health care, the person's social health needs are also addressed (Arndt-Couch, 2023). These social health needs may include housing, employment, and appropriate social support in the community. Because social care will address the negative social and physical life determinants that lead to trauma, the implementation of social care will be critical in advancing a prevention and promotion agenda in conjunction with integrated care. Clearly, the expansion of integrated care also will have considerable implications for the training that behavioral health providers will need to deliver this care. Facets of care such as working in teams and working cross-sector will be especially important in this training.

Virtual Care

How care is delivered is also changing rapidly. The recent COVID-19 pandemic has greatly accelerated virtual care done at a distance using tools such as Zoom. Simultaneously, similar work is being done to test and implement information technology-based treatment applications (apps), which now can be approved by the Food and Drug Administration for prescription by care providers. At the same time, we are in the earliest phases of the introduction of artificial intelligence (AI) and the role that it can play in delivering care and supporting consumers (Ward & Manderscheid, 2023a).

When virtual care was introduced instantly in April 2020 (Ward & Manderscheid, 2023a), in response to the COVID-19 pandemic, it included not only video-based care but also telephonic care. Both were paid for by changes in Federal regulations for the Medicaid and Medicare programs. Since that time, these changes also have been quickly adopted by private-sector insurance programs. Subsequently, virtual care has grown rapidly over the succeeding 3 years. The payment mechanisms introduced at the beginning of COVID-19 medical emergency also have been extended into the future.

Some of the original challenges with virtual care, such as state licensing requirements, are now beginning to be confronted. For example, efforts are underway to create interstate compacts between subsets of states so that service providers can provide services in all states included in a particular compact even if only licensed in one of the states.

Through discussions with a broad range of providers and service consumers in the field, we have learned important lessons from the introduction of virtual care (SBMA, n.d.). One of the most important is that virtual care democratizes the relationship between the consumer and the provider. The consumer is not going into a space controlled by the provider but is operating in a virtual space where the two are equal. Thus, for many consumers, the introduction of virtual care has improved their engagement in care as well as the outcomes they are achieving.

Although many clinical apps currently are available in the market, most have not been tested for efficacy or safety. Thus, it is particularly important to pay close attention to those apps that have been approved by the Food and Drug Administration for prescription and to be wary of other apps that are on the market. Better federal leadership and research are essential to improve our knowledge of apps and how they may best be used for mental health care.

AI began to become available in fall of 2022. Extraordinarily little is known at present regarding how AI will be used for behavioral health care. It seems clear, however, that such systems have exciting potential. Thus, it will be particularly important for the behavioral health field to work closely with AI developers in exploiting this technology for mental health care.

We expect virtually delivered care to grow and change over the next decade. What we do not know today is how this will occur. Will apps and AI systems support interpersonal care? Will such systems conflict with interpersonal care? How well we can work with the information technology industry, particularly that component developing AI systems, will determine which of these paths will be followed.

Personalized Care

Today, we are rapidly moving into the third generation of psychotropic medications. The first-generation medicines caused a side effect of tardive dyskinesia or involuntary movement (Abou-Setta et al., 2017; Ayano, 2016). The second generation of psychotropic medication caused metabolic effects, in which a person could gain considerable weight over 6 months to a year, once the person was on the medication (Gautam & Meena, 2011). The third generation of psychotropic medications currently being developed is being designed to remedy both side effects. What is becoming clear regarding these medications is the importance of how the medication is calibrated to personal biometrics and genetics. As these medications become progressively personalized to individuals and their specific responses, we would expect some of the controversies around the earlier generation medications to become mitigated over time. Anecdotal information from service users in the field suggests that it also has become clear that many people with behavioral health conditions can recover through personal and interpersonal activities without the need for such medications.

The field of biometric devices such as smartwatches that monitor a person's level of stress, physical activity, and heart rate can also be expected to develop over the next decade (Cermak, 2021; Frackiewicz, 2023). Especially important in this work will be field-based research to help understand how biometric feedback loops can be deployed to manage behavioral health conditions or even prevent

the expression of symptoms. The progress of this work will depend on developing a much better understanding of the relationship between external biometric responses and internal neural and emotional states (Patel et al., 2018). To date, progress has been relatively slow in this field because it has not received sufficient attention from researchers and practitioners in the behavioral health field.

An even more complex undertaking in the next decade will be charting the interactions between all these components. For example, how do physical exercise and meditation influence the course of behavioral health conditions? How do biometric devices and the feedback loops that are possible either prevent or control behavioral health conditions? And how does psychotropic medication interact with the human genome? To understand these questions, progress needs to be made in developing both a theoretical framework for linkages and practical fieldwork showing how they, in fact, interact. Until such breakthroughs are made, only modest progress can be expected.

Likely Developments in Community Building

Just recently, the current U.S. Surgeon General, Dr. Vivek Murthy, issued an advisory on the deleterious effects of loneliness and social isolation (Murthy, 2023). This report shows that more than half of adult Americans experience loneliness, a finding made prior to the COVID-19 pandemic. As a result of increased social isolation during the pandemic, we would expect this number to be much higher today. Social isolation and loneliness, two social life determinants, can lead to behavioral health conditions, such as depression and anxiety, and physical health conditions, such as heart disease or even premature death. One can speak of the effects of loneliness being equivalent to smoking almost a pack of cigarettes a day (Dyal & Valente, 2015). Clearly, addressing this loneliness and social isolation epidemic will require us to engage in significant community development activities. The antidote to social isolation is to build relationships and communities. The Surgeon General has outlined six key strategies for doing this (Manderscheid, 2023): (a) strengthen social infrastructure, (b) enact proconnection public policies, (c) mobilize the health sector, (d) reform digital environments, (e) deepen our knowledge, and (f) cultivate a culture of connection.

The Surgeon General's advisory points to the importance of community life for both personal and community well-being. As a field, we are coming late to this understanding of the significant role that community plays. Consequently, most work in this area has developed since 2010 (Hogg Foundation, n.d.). This work points to the ways in which we can work with communities and how we can foster self-empowered communities. Fundamental principles of this work include listening carefully to the community, engaging groups historically excluded by the community, promoting Indigenous leadership, and celebrating communities' successes. As noted above, the proposed legislation on community development in the Community Mental Wellness and Resilience Act of 2023 would greatly facilitate this work.

We need self-empowered communities to counter the negative social and physical life determinants that lead to trauma and behavioral health conditions. Progress is being made in several key areas related to community building, as described below.

Community Interventions

Community interventions seek to build community life and infrastructure. This can be accomplished by empowering communities to take actions to enhance interpersonal relationships and support for members and to address the life determinants that affect community members adversely. Empowered communities provide better informal support to members who suffer from mental health or substance use conditions than do those communities that have not experienced such interventions. Excellent examples of community interventions can be found in the work of the Hogg Foundation (Hogg Foundation, n.d.). Further, a commentary on global health developed by board members from the Global Alliance for Behavioral Health and Social Justice (Gil-Rivas et al., 2019) argues for community interventions.

The surgeon general's advisory on loneliness and social isolation has strong implications for actions that need to be taken in the behavioral health field. Current work in the United States and other English-speaking countries points to the significant role that community self-empowerment plays in informal outreach and engagement of those with behavioral health conditions. Project Thrive is a community-wide initiative in Allen County Kansas to reinvigorate both the economic and interpersonal lives of that community. In such communities, behavioral health chat groups, drop-in centers, and home visitation have become more common. Such interventions can play a key role in improving the behavioral health of community members who have these conditions and can create pathways toward recovery. The importance of this work is now beginning to be appreciated by behavioral health providers in the United States. We expect such efforts to grow dramatically in the next decade. Simultaneously, the Global Leadership Network is undertaking work in this area through its Rural Behavioral Health Collaborative (Global Leadership Exchange, n.d.).

Population Health Management

Population health management is an important strategy to identify and address the needs of subsets of persons in a population who are affected by similar life determinants and who suffer from similar health and behavioral health conditions. Through this approach, specific prevention and treatment interventions can be directed more effectively to those who need them most. A key example that clarifies the definition of population health management is available in the *American Journal of Public Health* (Hacker & Walker, 2013).

When a capacity does not exist to control adverse social and physical life determinants, it becomes exceptionally important to understand who is impacted by particular determinants and what the consequences are likely to be. This strategy permits populations to be disaggregated into subgroups based upon the determinants that are affecting members of these subgroups, for example, persons who are homeless. Then, it will be possible to target specific interventions to the members of these subgroups. This approach can permit intervention before the determinants have caused trauma and behavioral health conditions (Manderscheid, 2021).

Because of the importance of population health management in controlling the effects of negative life determinants, it will be essential to encourage further development in the use of this strategy. This will require that graduate training for behavioral health includes an understanding of this strategy, as well as how to

apply it to different populations of concern in the field. For example, the use of this strategy with a population of adults who already have serious mental illness potentially has vastly different implications than would be the case if the strategy were applied to a population of people in the community who have no behavioral health conditions. A related important feature will be the likely development of interventions for people with a propensity for particular behavioral health conditions. For example, if someone is exposed to a determinant that has the potential to lead to major depression and even a suicide attempt, specific protocols will need to be developed to intervene with that person before these adverse events occur. Because of its importance, we expect population health management will grow rapidly over the next decade.

Collaboration With Public Health

Collaboration between public health and behavioral health is exceptionally important. The principal skill sets of these fields are complementary and essential to address behavioral health conditions effectively. Public health brings important population intervention skills, and behavioral health brings important clinical skills. Working together, these fields can address not only population prevention and promotion but also personal treatment and rehabilitation. Recently, the Bipartisan Policy Center has provided an assessment of how we can modernize the public health system in the post-COVID-19 era (Armooh et al., 2021), and Healthy People 2020 has offered a model that shows key action interfaces between these two fields (Simon & Hurvitz, 2014).

Historically, extraordinarily little collaboration has occurred between the public and behavioral health sectors, particularly with respect to adult care. This is due in large part to the fact that the behavioral health field has been separated from the rest of health since its inception. The consequence is that behavioral health does not work closely with public health on adult care at the present time. If we are to develop community-level interventions to modify the social and physical life determinants, rather than just to mitigate effects on particular individuals, it will be essential for behavioral health to collaborate much more closely with public health (Manderscheid, 2021).

Precedence does exist for such joint efforts, however. A connection has existed between public health and behavioral health over time related to substance use programs and to early childhood programs funded by Title V of the Social Security Act. Many state health departments have led addiction efforts for many years, and most prevention efforts related to the mental health of children and youth have been conducted in public health programs.

Public health employs evidence-based interventions and a strong policy focus to improve population health, particularly on a geographical basis. In these efforts, it follows an equity-based and social determinants of health framework. Each of these elements is needed by behavioral health.

Every single state has a public health department, and every single state has an affiliate of the American Public Health Association. Further, more than 1,700 counties in the United States have organized public health departments (Institute of Medicine, 1988). With the advent of COVID-19 and much higher rates of behavioral health conditions, including opioid overdose deaths and suicides, the public health field has become progressively more engaged in addressing behavioral health problems in communities.

Going forward, our local, county, city, and state behavioral health programs need to reach out to their public health counterparts to begin and expand a dialogue and ultimately develop joint programs. Steps going forward could include actions such as the following. First, we must come to appreciate that virtually all community public health programs address populations that include a subset of persons with behavioral health conditions. Second, we must recognize that the social and physical life determinants that are root causes for behavioral health conditions are also root causes for other health conditions already being addressed by public health programs. Next, we must be willing to interact with our public health counterparts as trusted partners. Last, we must be willing to share responsibility with our public health counterparts for those in the community population who are at risk or who actually have a behavioral health condition (Manderscheid, 2023). Further, more people who enter the behavioral health field need to receive joint training in public health. Currently, there is increased interest in this, but relatively few colleges and universities offer joint programs. Such programs will become essential as we go further into the future.

Addressing Stigma

Stigma is a critically important life determinant for many people with behavioral health conditions. This is because it can limit life opportunities. For example, it can affect the work that one does, the friends that one has, and the care that one receives. Stigma has been examined by the Centers for Disease Control and Prevention (Kobau et al., 2012), and Surgeon General David Satcher made stigma reduction one of his main priorities (National Institute of Health, n.d.).

Although stigma toward persons with mental health and substance use conditions has decreased appreciably over the last quarter century (Health Partners, 2020), significant stigma still remains in many contexts. Progress in reducing stigma is due largely to the efforts of former First Lady Rosalynn Carter and federal anti-stigma initiatives. Just as we need to address the social and physical life determinants by deploying community and federal-level interventions, we also will need to address stigma through such interventions. The same public health tools and strategies described above can be used for this purpose. For example, efforts to address stigma can include major community and national social media and communication campaigns. There is an urgent need for this work over the next decade, particularly since COVID-19 has greatly increased the awareness of mental health and substance use conditions and increased the prevalence of these conditions.

Key Future Action Facilitators

For the future just described to actually unfold, key actions will be required by the behavioral health field. These key actions can be viewed as facilitators that can create the conditions for many of the future developments we have described to become reality.

Address the Current Workforce Crisis

Although workforce issues have been growing in the field for several decades, the COVID-19 pandemic has dramatically highlighted the workforce problems. Many senior clinicians are retiring, many midlevel clinicians actually left the field during the pandemic, and an insufficient number of new clinicians are entering

the field. Altogether, this has resulted in a significant reduction in the proportion of people with behavioral health conditions who are currently able to receive care—a decline from approximately 50% to approximately 25%, as noted above. Key actions will need to be taken to expand the number of new people entering professional and paraprofessional clinical training. In both the Fiscal Year 2023 and Fiscal Year 2024 federal budgets proposed by the president, significant funds were recommended for such training. As of this writing, most of those funds have not been appropriated (Gilbert et al., 2023; Saunders et al., 2023).

Another key direction to expand workforce capacity is to investigate our local communities. These communities include many people who already have training as behavioral health clinicians but currently are not practicing, for example, seniors or other people who have left the field. In addition, communities include many people who would be willing to volunteer to support behavioral health clinics, and they include peers who would be delighted to work in the behavioral health field. All these opportunities should be explored and actuated.

Another potential pool consists of current high school students who may have an interest in entering the behavioral health field, but for whom opportunities do not exist for them to attend local colleges. While in high school, these students should be offered courses in mental health and mental health first aid. As more schools confront behavioral health problems in their student population, we can expect such courses to become more common. Scholarships could be developed for these students to undertake junior college and bachelor's level training in mental and addictive health. Moreover, this represents an opportunity to bring minority clinicians and paraprofessionals into the field.

Modernize Behavioral Health Clinical Training

Particularly important in this training will be the development of skills to work in integrated service delivery settings. For example, such skills include learning to work in teams and learning to work across sectors. Another especially important feature of future training includes the need to develop skills in working with communities to address the social and physical life determinants and to participate in social care. For some, such training may include specialized training in public health so that work can be done directly on community development. Finally, behavioral health trainees currently receive extraordinarily little training in information technology. Going forward, such training will become much more important, particularly with the advent of AI systems (Ward & Manderscheid, 2023b).

Foster Opportunities for Cross-Sector Work

Mental health and substance use problems, by their very nature, are intersectoral. For example, they may include issues with social and physical life determinants, physical health conditions, and complex behavioral health interventions. Cross-sector work would be particularly helpful for those who address upstream social determinants of health, such as food security, housing, and employment. Thus, it is especially important that we foster opportunities, particularly for those just entering the field, to engage in cross-sector work. A new entrant could be given an opportunity to serve a detail in a public health or social service agency, or they might be given an opportunity to work in a primary care clinic or an integrated care clinic. There are many examples of cross-sector work that the field needs to explore (Manderscheid, 2021).

Foster Opportunities to Engage in Policy Issues

Excellent efforts exist at the national level and at the state level to address key behavioral health policy issues. Examples include the work of the National Association of State Mental Health Program Directors and that of the National Association of State Alcohol and Drug Abuse Directors. However, rarely do local mental health or substance use providers participate in the policy process through advocacy. This may include giving expert advice on an issue or giving testimony to a county board, a state legislative committee, or even a congressional committee. As a result, behavioral health policy issues frequently do not receive the broad support they deserve in these venues. Neither do most behavioral health training programs offer courses in mobilizing policy and advocacy. Therefore, opportunities need to be created to train mental health and substance use providers in how to engage in these processes and actually to do so. A number of training programs in the behavioral health field offer at least some minimal training in these areas. Much more needs to be done (Manderscheid & Ward, 2022).

Create Centers of Excellence for Innovation in Behavioral Health

One fundamental problem in the behavioral health field is the fact that new innovations in behavioral health services take 17 years from the time of the original research to actual implementation (Morris et al., 2011). Without a doubt, this period must be shortened. At the same time, a mechanism needs to be developed to bring new practices from field-based evidence to the awareness of providers. Thus, the field should develop centers for excellence for innovation in behavioral health. Some work has already been done on this issue by the federal government, but much more work needs to be undertaken. Such centers could be standalone entities, but they also could be embedded in other programs, for example, centers of innovation in county behavioral health programs. Such centers have the potential to improve the quality of mental health and substance use care and to help contain the cost of such care.

Foster an Integrated Framework That Undergirds Behavioral Health

More than 50 years ago, a biopsychosocial model was being developed by researchers and practitioners in the mental health field (Gale, 2022). This model showed considerable promise in moving the field forward. However, work did not continue on this model in subsequent decades, and its effects are difficult to find today. At the same time, the field has come to recognize that personal and community well-being are exceptionally important to good behavioral health. To realize the potential of personal and community well-being, it will be important to have an explanatory model that undergirds the field. This model should include biological, psychological, social, and spiritual elements as key to personal and community well-being.

Cross-sector work employing a public health approach can help the field deploy the biopsychosocial model already available from past work. Excellent models already are available. These include the Action Model to Achieve Healthy People 2020 (Simon & Hurvitz, 2014) and the Model of Health and Wellbeing from the Alliance for Healthier Communities (Alliance for Healthier Communities, n.d.).

Conclusion

It has been an honor to have the opportunity to prepare this article for the Special 100th Anniversary Issue of the *American Journal of Orthopsychiatry*. Clearly, the behavioral health field has made tremendous strides in this 100-year period, and we have had the privilege to participate in some of those developments. We hope that the coming future will be just as exciting as the past and that we will be able to greatly increase the availability, accessibility, and acceptability of behavioral health care in an environment based upon the principles of equity and inclusion.

One can only understand the future by first looking at the past and examining how that past has led to present activities. The kernels of future activities are already contained in the present. The future we have presented here will be both exciting and challenging. We do hope that the positive side of this future will far outweigh the negative. We challenge every reader of this article to find their own role in implementing this exciting future.

Keywords: futures, clinical developments, community developments, facilitators

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