# From Prevention to Population Health

## Three Decades of MPSI Scholarship on Youth Mental Health

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**Core message:** Youth mental health depends not only on access to services, but on the everyday developmental conditions created by schools, families, communities, and public health systems.

## About this report

This report synthesizes three decades of scholarship associated with the Missouri Prevention Science Institute (MPSI; formerly the Missouri Prevention Center) and related collaborators. Its purpose is to make visible MPSI's conceptual and programmatic research connecting early developmental and school-ecology studies, prevention science, implementation science, school-community systems, universal screening, and more recent work on Nurturing Schools and population mental health.

The organizing question is simple and persistent: How do we reduce the societal prevalence and burden of youth mental health problems? Across the work reviewed here, the answer increasingly points beyond intervention efficacy alone. It points toward the creation of schools, families, communities, and public systems capable of producing mental health at population scale.

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**Central argument:** The central challenge facing youth mental health is no longer simply developing and delivering effective interventions; it is creating schools, communities, and public systems capable of producing mental health at population scale.

## Executive summary

The United States has made real scientific progress in youth mental health. We now have effective treatments and preventive interventions for many of the emotional and behavioral concerns that affect children and adolescents. Schools have become essential settings for early identification and support. Prevention science has also shown that many problems can be delayed, reduced, or prevented.

And yet the burden of youth mental health concerns remains high. That is the central paradox of the field: we know much more than we are able to deliver at scale.

MPSI scholarship helps explain this gap. Across three decades, our work has emphasized that youth mental health develops in context. Early studies examined how academic competence, attention, language, parenting, sociocultural experiences, and school conditions shape later emotional and behavioral outcomes. Later work applied prevention science to develop, test, and disseminate interventions in schools and communities. More recent projects have focused on implementation, universal screening, school-community partnerships, and usable tools such as the Early Identification System (EIS) and PULSE.

A consistent lesson runs through this body of work. Interventions do not reduce prevalence simply because they are effective in controlled studies. They must reach the right young people, fit real settings, be used well, last over time, and work equitably across communities. They also must connect with the everyday developmental settings where young people live and learn.

Schools are especially important in this regard. They are not merely places where mental health services can be delivered. They are developmental environments that shape belonging, competence, autonomy, connection, engagement, and opportunity. In this sense, youth mental health depends not only on access to services, but on the experiences young people have every day.

This report argues that the central challenge in youth mental health is no longer only to develop effective interventions. That work remains important, but it is not enough. The larger challenge is helping schools, communities, and public agencies create the conditions in which mental health can improve at population scale. Meeting that challenge requires a shift in emphasis: from programs alone to coordinated public action, from risk identification to nurturing environments, and from isolated initiatives to sustained population health impact.

**Key Idea:**
MPSI's work confronts the central paradox of school mental health:
the field knows far more than it can reliably deliver at scale.

## 1. The great mental health paradox

Over the past half century, few areas of psychology have experienced greater scientific progress than youth mental health. Researchers have developed effective interventions for depression, anxiety, conduct problems, substance use, classroom behavior, social-emotional skill development, and related concerns. Prevention science demonstrated that many emotional and behavioral problems and their antecedent risks can be delayed, reduced, or prevented (Greenberg et al., 2001; Mrazek & Haggerty, 1994; National Research Council & Institute of Medicine, 2009). Schools increasingly adopted multitiered systems of support, and public health models became more prominent in school mental health (Herman et al., 2004; Herman et al., 2021a).

Yet the societal burden of youth mental health concerns remains alarmingly high. A 2019 *American Psychologist* article describing the Missouri Prevention Center began from this problem: nearly one in five children experiences a serious mental health condition before adulthood, many never receive care, and those who do receive usual community care often benefit little (Herman et al., 2019). More recent work has documented continued concern about youth depression, sadness, suicidality, disengagement, unmet need, and the limits of service systems alone (Reinke et al., 2025).

**The paradox:** Effective interventions can improve outcomes for individual youth without necessarily reducing prevalence or burden across a population.

This is the great mental health paradox. It does not mean that prevention science failed. Nor does it mean that treatment, screening, or school mental health initiatives are unimportant. Rather, it means that the existence of effective practices does not guarantee population-level change. A vaccine does not reduce disease burden unless it reaches large populations, is taken up, is implemented well, is trusted, is sustained, and is embedded in an system capable of monitoring and responding to changing conditions. Youth mental health is similar. Effective interventions can improve outcomes for participating youth while having little effect on prevalence if they do not reach enough students, are implemented inconsistently, or leave unchanged the developmental contexts that contribute to risk in the first place.

Much of MPSI scholarship can be read as an extended effort to understand and respond to this paradox. Early work asked why youth develop depression, antisocial behavior, academic disengagement, and co-occurring problems. Prevention science studies asked how these developmental pathways might be interrupted. Implementation science studies asked why effective practices so often fail to take root. Community systems work asked how schools, families, service providers, and local policies might be aligned. A Nurturing Schools lens now asks how the everyday work of education can be understood, designed, and monitored as mental health promotion.

## 2. A population health perspective on youth mental health

A population health perspective shifts the unit of analysis. Instead of asking only whether an intervention works for an individual child, it asks whether schools, communities, and public systems are organized in ways that reduce risk, promote wellbeing, and improve outcomes across populations. This perspective is compatible with clinical care, but it is not reducible to treatment access. Treatment is essential for youth with significant needs. *However, no treatment system alone can absorb the full burden of youth mental health concerns if the environments producing risk remain unchanged*.

The distinction is important. A service-delivery perspective tends to focus on identifying students with problems and connecting them to support. A population health perspective includes that work but adds several additional questions: What developmental experiences are common across students? Which school and community

conditions are increasing risk or promoting wellbeing? Are supports reaching enough youth to matter at the population level? Are systems monitoring changes over time? Are practices feasible and sustainable in the settings where they are intended to operate? Are benefits equitably distributed?

MPSI work has repeatedly emphasized these questions. The 2019 *American Psychologist* article organized the MPSI portfolio around four principles essential for reducing population prevalence and burden: specifying malleable antecedents, developing surveillance systems, implementing multitiered preventive interventions, and using ongoing feedback to improve quality (Herman et al., 2019). A 2021 *School Psychology Review* special issue extended this logic to a countywide public health approach that combined universal screening and supports, mentoring, psychiatry, FACE, and broader school-community partnerships (Herman et al., 2021a).

From this perspective, mental health is not merely the absence of disorder. It is a developmental outcome shaped by patterns of belonging, competence, connection, autonomy, safety, predictability, engagement, and opportunity. This conceptualization aligns with public health and positive mental health frameworks that emphasize flourishing, supportive environments, and the conditions that make healthy development more likely (Biglan et al., 2012; Keyes, 2007; World Health Organization, 2004).

## 3. How our thinking evolved

The history of MPSI scholarship is not a simple movement from individual treatment to broader systems. Ecological, developmental, preventive, and systems-oriented thinking were present from the beginning. What evolved was the depth, precision, and practical application of those ideas.

The progression was logical and cumulative. Early work clarified developmental pathways linking academic competence, attention, language, parenting, sociocultural experiences, and school contexts to later emotional and behavioral outcomes. That work led naturally to prevention and intervention studies designed to alter those pathways. Over time, the central question became larger: how can effective supports reach more young people, earlier, more equitably, and with enough consistency to improve mental health at population scale?

In this sense, MPSI scholarship moved from understanding developmental risk and protection to building practical approaches for identifying, preventing, monitoring, and promoting youth mental health. The guiding idea is the same: young people's mental health is shaped by the everyday conditions in which they learn, relate, struggle, and grow.

**Figure 1.** **Evolution of MPSI's scholarship. The progression reflects an expanding operationalization of an ecological, preventive, and population-oriented commitment.**


### Understanding developmental pathways

Our early work sought to understand why some youth develop depression, antisocial behavior, disengagement, and co-occurring academic and behavioral problems while others do not. This work was grounded in developmental psychopathology and social ecological thinking, but it repeatedly returned to school-relevant mechanisms. Academic competence, language development, teacher-student relationships, engagement, parenting, peer experiences, and sociocultural context were not treated as peripheral to mental health. They were understood as possible developmental pathways through which mental health risk or protection accumulates.

Several studies highlighted academic competence as a developmental pathway to mental health. Low academic competence in first grade predicted later depressive cognitions and symptoms, suggesting that academic struggles can shape self-perceptions and emotional development over time (Herman et al., 2008). Related work examined attention problems, academic pathways, and depression, showing that difficulties in one domain can cascade into others (Herman et al., 2007; Herman & Ostrander, 2007). More recent work extended this competency model by showing that teacher-rated likeability mediated the link between low academic competence and later depressive symptoms in elementary school (Herman et al., 2020).

Other studies emphasized family and early developmental experiences. Language delays and low home learning stimulation predicted later depressive symptoms, and first-grade language skills mediated the effect of early home stimulation on later depression risk (Herman et al., 2016). Parent and teacher training studies showed that interventions designed primarily to support behavior and parenting could also reduce internalizing symptoms (Herman et al., 2011; Webster-Stratton & Herman, 2008).

A third line of work examined sociocultural and motivational influences. Early engagement studies emphasized the roles of teacher context, perceived competence, autonomy, and involvement in predicting academic engagement among marginalized students (Herman & Tucker, 2000; Tucker et al., 2002). A sociocultural perspective on depression prevention argued for universal and targeted approaches that address both individuals and their social and cultural surroundings (Parks & Herman, 2003). Together, these studies made clear that mental health problems do not emerge suddenly or in isolation. They develop through cumulative experiences across families, schools, peers, community, and cultural contexts.

### Schools as developmental contexts

The next major strand of work focused more explicitly on schools as developmental contexts. A 2002 paper on antisocial behavior argued that schools can intensify or deter risk through climate, teacher interactions, monitoring, structure, and academic practices (Reinke & Herman, 2002). A 2004 made a parallel argument for internalizing problems, describing schools as strategic public health settings and urging school psychologists to engage in prevention and wellness activities rather than remaining confined to sorter and repairer roles (Herman et al., 2004). A subsequent paper in 2009 paper on childhood depression further argued that schools are not merely service-delivery sites; they are environments that can contribute to or protect against depression (Herman et al., 2009).

This work anticipated the emergence of the Nurturing Schools framework. The central point was already visible: schools shape mental health through ordinary educational processes. Students experience success or failure, connection or rejection, autonomy or control, safety or threat, predictability or chaos. These experiences are not mental health add-ons. They are part of the developmental experiences of schooling.

### Prevention science

The founding of the Missouri Prevention Center in 2007 formalized these commitments within a prevention science framework. A 2010 *Counseling Psychologist* article described prevention science as an interdisciplinary field designed to integrate research on etiology, intervention development, efficacy testing, effectiveness, dissemination, implementation, and policy (Herman et al., 2010). It also positioned the Missouri Prevention Center as an example of prevention science in action, with research, service, training, and policy work organized around promoting children's mental health.

Prevention science contributed several enduring ideas. First, problems can be prevented before they meet diagnostic thresholds. Second, risk and protective factors should guide intervention targets. Third, universal, selective, and indicated supports are complementary rather than competing strategies. Fourth, population benefit depends not only on potent treatments but also on reach. Small effects delivered to large populations can produce meaningful public health gains, whereas large effects delivered to a small and unrepresentative group may have limited population impact (National Research Council & Institute of Medicine, 2009).

### Implementation science and innovation design

As prevention efforts moved into real-world schools and communities, implementation challenges came to the forefront. Effective programs often fail to scale because schools lack time, staffing, leadership support, coaching resources, usable data systems, and alignment with existing routines. MPSI work recognized that implementation is not a final consideration after interventions are developed. It is part of the intervention itself.

A recent implementation science paper on school mental health makes this point directly: implementation failure is often not merely a dissemination problem; it is an innovation design problem (Herman, Reinke, & Selders, 2026). Using universal screening as a case example, the paper argues that sustainable school mental health reform depends on designing innovations that are intrinsically aligned with the contexts in which they are delivered (Herman et al., under review). The Early Identification System (EIS) embodies this logic. It was designed not only to identify risk but to be feasible, usable, linked to action, and capable of supporting repeated cycles of decision making in schools (Herman et al., 2023; Reinke et al., 2025).

### Community systems

A prevention and implementation perspective naturally led to community systems. A 2006 paper on *Positive Behavior Interventions and Supports* (PBIS) argued that moving from single prevention trials to reductions in prevalence requires sustainable community change and systems capable of supporting nurturing environments (Reinke et al., 2006). The 2019 *American Psychologist* article later described two large-scale community projects funded by a local sales tax: a countywide screening and school support system and a single point of entry for family access to mental health evaluation and referral (Herman et al., 2019).

The Family Access Center of Excellence (FACE) illustrates this community systems orientation. FACE was designed to reduce barriers to access by providing no-cost evaluation, referral, linkage, and case management for families referred from schools. In a quasi-experimental study, youth who engaged with FACE showed improvements in social-emotional, behavioral, and educational outcomes relative to youth who were referred but did not engage (Thompson et al., 2021). FACE did not replace schools or clinical services; it connected them through a more coherent access pathway.

### Nurturing Schools

The Nurturing Schools framework represents a culmination of these lines of work. It argues that mental health is both a foundation for and outcome of academic and behavioral success. Rather than treating mental health as a peripheral service layered onto education, Nurturing Schools positions instruction, relationships, discipline, classroom structure, school climate, educator wellbeing, and equity as mental health-producing practices (Herman & Reinke, under review).

This is not a departure from earlier ecological and prevention commitments. It is their operationalization within the ordinary work of schooling. The novelty is not that schools should coordinate mental health services better, although they should. The stronger claim is that the central practices of schooling should be understood, designed, and monitored as mental health interventions.

## 4. The prevention-to-prevalence gap

Prevention science helped establish that many youth mental health problems can be prevented. But the existence of effective preventive interventions did not, by itself, reduce the societal prevalence and burden of youth mental health concerns. The field increasingly confronted what might be called the prevention-to-prevalence gap: the distance between demonstrating that an intervention can work and creating systems that improve outcomes for entire populations.

This gap was visible early. The 2004 depression paper noted that technologies to prevent depression existed in clinical trials, but it remained unclear whether they could be implemented in ways that reduced societal prevalence (Herman et al., 2004). The 2006 PBIS paper sharpened the issue by arguing that the leap from preventing disorders in single trials to reducing prevalence and incidence in society is formidable because effective practices must be translated into sustainable behavior change in communities (Reinke et al., 2006).

The prevention-to-prevalence gap has several components. First is reach: interventions must contact enough youth and settings to matter. Second is fit: practices must align with the routines, resources, values, and constraints of schools and communities. Third is fidelity with adaptation: systems must preserve core functions while allowing local tailoring. Fourth is sustainability: practices must survive leadership turnover, funding changes, staff fatigue, and competing initiatives. Fifth is equity: population improvement is insufficient if benefits are unevenly distributed or if systems reproduce existing disparities. Sixth is surveillance: systems must know whether risks, protective factors, implementation quality, and outcomes are changing over time.

MPSI scholarship increasingly focused on this gap. The EIS addressed surveillance and data-based decision making. FACE attends to access barriers and cross-sector coordination. School-community coalitions expanded local capacity to support youth and families. Implementation work enhanced usability, training, coaching, and sustainability. Nurturing Schools highlights the environmental production of mental health. Together these efforts suggest that reducing prevalence requires more than effective programs. It requires coordinated systems, supportive environments, and practical ways to bring what works to the young people who need it.

## 5. Lessons learned from three decades of MPSI scholarship

**Lesson 1: Mental health is produced through developmental experiences.**

A consistent lesson across MPSI scholarship is that mental health is shaped by cumulative developmental experiences. Academic competence, language development, parenting, teacher-student relationships, school climate, peer relationships, cultural experiences, and community conditions all influence risk and protection. Mental health problems rarely emerge in isolation; they develop through patterns of success, failure, support, exclusion, stress, and opportunity. If mental health is produced through developmental experiences, then efforts to improve population mental health must focus not only on services but also on the environments that create those experiences.

**Lesson 2: Schools are among society's most powerful mental health institutions.**

Schools are not simply places where mental health problems appear. They are developmental systems that shape identity, belonging, competence, relationships, safety, autonomy, and future opportunity. MPSI work repeatedly identified schools as strategic settings for prevention, early identification, intervention, and health promotion (Herman et al., 2004; Herman et al., 2009; Reinke & Herman, 2002). The Nurturing Schools framework extends this lesson by arguing that everyday educational practices are already influencing mental health, whether or not they are labeled as such.

**Lesson 3: Prevention is necessary but not sufficient.**

Prevention science remains foundational. It showed that problems can be delayed, reduced, and prevented. However, prevention programs do not automatically reduce prevalence simply because they are effective in trials. Population impact depends on reach, feasibility, implementation quality, sustainability, and the extent to which interventions alter the conditions that produce risk. Prevention science must therefore be paired with implementation science, school improvement, and community integration.

**Lesson 4: Implementation determines impact.**

Effective practices are only as powerful as the systems that implement them. In schools, implementation is shaped by leadership, staff capacity, coaching, data systems, time, priorities, funding, and perceived burden. EIS work demonstrates the importance of designing systems for use from the beginning, not retrofitting them for dissemination after development (Herman et al., 2023; Reinke et al., 2025). Implementation should be treated as a primary mechanism of impact rather than a secondary technical concern.

**Lesson 5: Communities, not programs alone, reduce prevalence.**

Programs can improve outcomes for participating youth, but communities shape prevalence. Reducing population burden requires systems that connect schools, families, healthcare providers, mental health agencies, social services, youth organizations, and public funding mechanisms. The Boone County school-community initiatives, FACE, and coalition models suggest that communities can build systems to identify needs, coordinate supports, reduce access barriers, and monitor outcomes over time (Herman et al., 2019; Reinke et al., 2018; Thompson et al., 2021).

**Lesson 6: Mental health and education are inseparable.**

A final lesson is that mental health and education cannot be meaningfully separated. Academic competence, engagement, relationships, behavior, belonging, and wellbeing are mutually reinforcing. Schools influence mental health through the same practices that influence learning. A population health perspective therefore positions mental health not as an additional school initiative but as central to the purpose and practice of education itself.

## 6. The evolution of our understanding of mental health

The most important evolution across this body of work may not be a movement from individuals to systems. Systems thinking was present early. The deeper evolution concerns what mental health itself was understood to be.

**Mental health as disorder prevention**

Early work focused heavily on preventing depression, antisocial behavior, conduct problems, and related concerns. This focus was appropriate and important. Depression and conduct problems impose enormous individual, family, educational, and societal costs. Prevention science demonstrated that intervention before full disorder onset was possible and necessary (Greenberg et al., 2001; Mrazek & Haggerty, 1994).

**Mental health as healthy development**

Over time, the work expanded beyond reducing symptoms to promoting competence, engagement, self-regulation, positive relationships, and school success. This shift aligns with positive mental health frameworks emphasizing flourishing and with developmental work showing that academic, behavioral, social, and emotional functioning are interdependent (Keyes, 2007; National Research Council & Institute of Medicine, 2009). PULSE and strengths-oriented extensions of the EIS reflect this broader understanding by positioning screening and surveillance not only as risk identification but also as monitoring of wellbeing and school functioning (Missouri Prevention Science Institute, 2025).

**Mental health as person-environment fit**

A further shift involved recognizing that mental health reflects fit between young people and their environments. Students vary in needs, strengths, histories, and vulnerabilities, but environments also vary in structure, support, predictability, cultural responsiveness, relational warmth, and opportunity. This perspective avoids locating mental health exclusively inside youth and instead asks whether schools and communities are organized to support healthy adaptation.

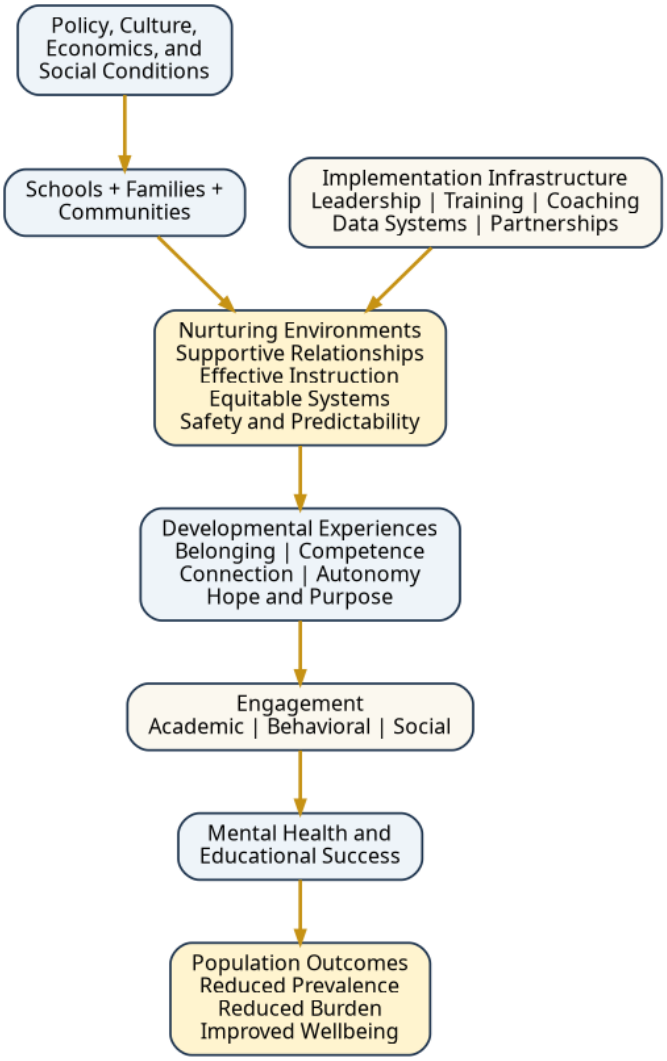
### Mental health as a product of nurturing systems

The most recent work moves toward viewing mental health as a product of nurturing systems. Nurturing systems reduce toxic stress, provide safety and predictability, teach skills, promote belonging and competence, ensure supportive relationships, and create opportunities for meaningful participation (Biglan et al., 2012; Herman & Reinke, under review). In this view, mental health is not merely treated after problems emerge. It is continuously produced through everyday interactions and organizational routines.

## 7. A population mental health theory of change

A population mental health theory of change begins with the assumption that youth mental health is shaped by nested developmental systems. Schools, families, and communities operate within broader policy, cultural, economic, and social conditions. Implementation systems support the creation of nurturing environments. Nurturing environments foster developmental experiences such as belonging, competence, connection, autonomy, hope, and purpose. These experiences promote academic, behavioral, and social engagement. Engagement contributes to mental health and educational success, which in turn influence population outcomes such as reduced prevalence, reduced burden, and improved wellbeing.

**Figure 2.** Population mental health theory of change.



The model highlights two important points. First, mental health is produced upstream of clinical service delivery. Services remain essential, but they operate within broader systems that either generate risk or promote wellbeing. Second, population health requires feedback loops. Schools and communities need continuous data on risk, strengths, implementation, and outcomes so they can learn, adapt, and improve. EIS and PULSE are important because they make these feedback loops more feasible in ordinary school practice.

## 8. Implications for research, practice, and policy

**Research: From intervention science to population science**

Future research should retain the strengths of intervention science while expanding toward population science. This means studying not only whether programs work, but how systems produce reach, uptake, fidelity, sustainability, equity, and population impact. It also means studying mechanisms at multiple levels: student, classroom, school, district, community, and policy. Population mental health research should include surveillance data, implementation metrics, cost and benefit analyses, equity indicators, and measures of developmental experiences such as belonging, competence, connection, autonomy, safety, and engagement.

Research should also account for context more explicitly. Historical events, policy changes, community stressors, and cultural conditions can influence both implementation and outcomes. Work on traumatic historical events in randomized trials demonstrates that interventions do not operate in a vacuum and that contextual events may alter both dosage and effects (Herman et al., 2024). Population health science must therefore treat context as part of the causal system rather than as statistical noise (Herman et al., 2025).

**Practice: From service delivery to nurturing environments**

Practice should move from a narrow service-delivery model toward a nurturing environments model. Schools should continue to identify and support students with mental health needs, but they should also examine how everyday practices influence wellbeing. Instruction, classroom management, discipline, relationships, family engagement, cultural responsiveness, educator wellbeing, and school climate should be treated as mental health levers (Herman & Reinke, under review). This shift does not ask schools to become clinics. It asks schools to recognize the mental health implications of what they already do.

**Policy: From treatment to prevention infrastructure**

Policy should support prevention infrastructure, not only treatment access. Needed investments include universal screening and surveillance systems, implementation coaching, school-community referral pathways, data systems, workforce development, prevention funding, and incentives for cross-sector collaboration. Funding streams should support the conditions that make mental health promotion possible, including educator wellbeing, family access, culturally responsive practices, and sustainable school mental health systems.

## 9. The next generation of MPSI work

The next generation of MPSI work is well positioned to advance population mental health in at least five ways. First, MPSI can continue developing pragmatic surveillance systems that monitor both risk and strengths. EIS demonstrated the feasibility and value of multidimensional screening, and PULSE extends this work by reducing administration burden while preserving key dimensions of student functioning and school surveillance (Missouri Prevention Science Institute, 2025; Reinke et al., 2025).

Second, MPSI can strengthen the science of nurturing schools. This includes identifying which instructional, relational, disciplinary, and organizational practices most strongly influence belonging, competence, connection, autonomy, safety, engagement, and wellbeing. It also includes building practical tools that help schools monitor and improve these conditions (Herman, Reinke, Sebastian, Yang, 2026).

Third, MPSI can deepen work on implementation and innovation design. Schools need systems that are feasible, useful, and sustainable. The most promising innovations will be those designed with end users from the outset, embedded in school routines, linked to decision making, and supported by coaching and continuous improvement processes (Herman, Reinke, & Selders, 2026).

Fourth, MPSI can continue building community-level models. FACE, coalition work, school-based psychiatry, mentoring, and EIS demonstrate the value of coordinated systems (Herman et al., 2019). Future work can examine how communities sustain such systems, how benefits are distributed, and how policy and funding can support broader adoption.

Fifth, MPSI can help define the next frontier of population mental health measurement. If the goal is to produce mental health at population scale, the field needs indicators of risk, strengths, implementation, environmental quality, engagement, equity, and burden (Herman, Bradshaw, et al., in press). Measurement should not only classify students. It should help systems learn and improve.

## Conclusion

Across three decades, one concern has remained consistent in MPSI scholarship: how to reduce the societal prevalence and burden of youth mental health problems. Early work examined depression, antisocial behavior, academic competence, engagement, parenting, and sociocultural influences. Later work extended into prevention science, implementation, school mental health, and Nurturing Schools. These were not disconnected ventures. They reflected a shared assumption that youth mental health develops in context and that prevention is both possible and necessary.

Looking back, the most important evolution was not the discovery that context, prevention, or coordinated public action matter. Those commitments were present from the beginning. What changed was our understanding of mental health itself, and our ability to translate that understanding into practical approaches that schools and communities could use. Mental health came to be understood not simply as the absence of disorder, but as a developmental outcome shaped over time through the daily interactions young people have with adults, peers, families, schools, communities, and public systems. Some of those interactions create risk. Others build protection. Together, they form developmental pathways that lead toward health, wellbeing, and opportunity—or toward distress and impairment.

The future of youth mental health will depend on better treatments, but not on treatments alone. It will depend on whether schools, families, communities, and public agencies can create the everyday conditions that support belonging, competence, connection, autonomy, safety, engagement, and wellbeing. That is the larger task. When the next generation of work succeeds, it will not only improve outcomes for individual young people. It will reduce the broader burden of youth mental health problems and make healthy development a more ordinary expectation of childhood and adolescence.

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