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Please see the accompanying full Prescribing Information.

Please see inside pages for Brief Summary of Prescribing Information and visit www.VykatXRHCP.com for full Prescribing Information.

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On the Cover:

Ken Whitcomb, MD, submitted this original artwork for a local Dallas art installation focused on mental health. Dr. Whitcomb created the piece himself; it is not AI-generated! The work explores the mind, spirit, and human experience through images of flowers and blooming, conveying themes of love, happiness, hope, inspiration, energy, emotion, connection, and positive mental health.

MISSION STATEMENT

The mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

—Approved by AACAP Membership
December 2014

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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MISSION OF AACAP NEWS

- 1 Communication among AACAP members, components, and leadership
- 2 Education regarding child and adolescent psychiatry
- 3 Recording the history of AACAP
- 4 Artistic and creative expression of AACAP members
- 5 Provide information regarding upcoming AACAP events
- 6 Provide a recruitment tool

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AACAP in Action: Science, Media, and Atlanta



■ John T. Walkup, MD

From advocating for science to reaching new audiences, AACAP President John T. Walkup, MD, has been busy! Here's a look at some of his latest work, recent media opportunities, and what's ahead as AACAP prepares for the 2026 Annual Meeting in Atlanta.



It Starts with Science

Scientific research is not an academic exercise. It is the foundation of evidence-based medicine. Discoveries made through federally supported research become the clinical guidance physicians rely on every day and lead to better approaches to prevention, diagnosis, and treatment.

AACAP President John T. Walkup, MD, recently submitted comments on behalf of AACAP's more than 11,000 members opposing proposed changes to federal research policy that AACAP believes could significantly affect scientific research in the United States. His comments underscored AACAP's commitment to protecting scientific integrity and ensuring that children, adolescents, and families continue to benefit from rigorous research and scientific progress.

Bringing AACAP's Expertise to a Bigger Audience

Dr. Walkup has also been bringing AACAP's expertise to broader audiences.

In August, he joined Joe Sirven, MD, on *What's Health Got to Do With It?* for a wide-ranging conversation about the youth mental health crisis. They discussed access to care, workforce challenges, screening, and opportunities for earlier intervention. At the heart of the conversation was a problem child and adolescent psychiatrists know all too well: Too many young people with mental illness still cannot get the care they need.

AACAP followed that appearance with another significant media opportunity, this time reaching the pediatric community through *Contemporary Pediatrics*. Dr. Walkup discussed how pediatricians and child and adolescent psychiatrists can work together to meet the growing demand for mental health care, including collaborative care, psychiatric access programs, behavioral health training for pediatricians, and the need to preserve and strengthen the child and adolescent psychiatry workforce.



"We need all the pediatricians and all the child psychiatrists working together to address this mental health crisis," Dr. Walkup said.

These opportunities do more than raise AACAP's visibility. They bring the expertise of child and adolescent psychiatrists directly to physicians, other health professionals, families, and the public.



And Now, Atlanta

All of this provides a fitting backdrop for the 2026 AACAP Annual Meeting, October 26–31 in Atlanta.

The Annual Meeting brings together many of the issues AACAP has focused on throughout the year: science, evidence-based care, access, workforce, innovation, and the difficult questions facing psychiatry today. It is also an opportunity to reconnect as a professional community and learn from one another.

One program in particular captures that spirit.

During a special Presidential Interview, Dr. Walkup will sit down with Awaiss Aftab, MD, for a candid discussion about some of the most challenging issues facing psychiatry. Their conversation will explore diagnostic validity, the cultural politics of mental health, and the future of mental health treatment. It promises to be a thoughtful, substantive exchange about where psychiatry stands and where it is headed.

The breadth of this year's program reflects tremendous work by **Program Committee Chair Barbara J. Coffey, MD, MS; Local Arrangements Co-Chairs Wanjikū F.M. Njoroge, MD, and Joel Stoddard, MD; Deputy Local Arrangements Co-Chairs Nicole King Cotton, MD, and Jennifer E. Holton, MD; the Program Committee; AACAP members; and staff.**

There is plenty to celebrate. AACAP is standing up for science, expanding the reach of child and adolescent psychiatry, engaging directly with the challenges facing the field, and bringing our community together in Atlanta.

10 Factors Common to Psychodynamic Psychotherapy That Will Make You a Better Therapist



■ Martin Drell, MD

In an 1857 letter to Joseph Dalton Hooker, an English botanist and explorer, Charles Darwin wrote: “It is good to have hair splitters and lumpers!” (Darwin, 1857). A 2023 column of mine, “Why Are There Five Hundred Plus Types of Psychotherapy?” investigated the “hair splitting” side: the various dynamics that are involved in “creating” a new therapy and having it accepted by the public (Drell, 2023).

I wrote in that column that perhaps the spawning of new therapies is “due to entrepreneurial, capitalistic, and/or narcissistic reasons which prefer ‘new’ products over ‘old ones.’ Few products, and don’t believe that therapy is not a product, promote themselves by saying they are ‘me too’ products just like their predecessor. This would not be good for business.”

(Upon rereading this 2023 column, I note that I neglected to mention the estimated 18,000-20,000 mental health and wellness apps available that are largely unregulated—the vast majority of which are not well researched as to their effectiveness.)

My present column “whipsaws” towards the Darwin’s “lumper” side of the dichotomy and focuses on common factors (a.k.a. propositions, principles, or perspectives, if you wish) within psychodynamic therapies (PDT) that cut across many therapies and will guide and enhance one’s skills at being with patients in a therapeutic way (Kernberg et al., 2012).

I hope this list will allow for a figure-ground shift that will allow the reader to see the commonalities in the forest rather than focusing on the many differently named trees.

The 10 Common Factors:

1 Curiosity in what makes humans tick. Mentalization, a very popular recent psychodynamically informed therapy specifically focuses on the capacity of people to understand the thoughts and feelings of others and themselves (Midgley et al., 2017). It bridges the gap between what someone does and why they do it. Mentalization (which is evidence based) provides a manualized approach to teach skills that can enhance empathy and its usefulness in emotional regulation and the management of one’s life.

2 A focus on the individual within a larger system. Models like George Engel’s Bio-Psycho-Social model (Engel, 1980) help explain how each level of the system can be the focus of specific curiosity with separate academic communities dedicated to their study. It further explains that each level is interconnected to all the others, and that an intervention at one level will reverberate throughout the entire system.

3 The importance of the unconscious. Much of what we do is unconscious and often causes problems for one’s negotiating life and its vagaries (Freud S., 1930).

4 The concept of transference. In keeping with the importance of the unconscious, transference of the patient and the therapist (or caregiver), which can be called countertransference (Marshall, 1979), is ubiquitous and therefore part of all relationships.

5 All things are overdetermined/multidetermined. Although there is a history in medicine to look for the one variable that will explain all, most things in life are not so simple. Life is complex.

6 The importance of defenses. Defenses (Freud A., 1936; Vaillant, 1994; Vaillant et al., 1986)—which may seem to be unconscious in nature—attempt to protect, reduce anxiety, and maintain the status quo even when that may diminish one’s quality of life.

The concept of acting out includes an array of defenses that provide temporary relief while causing longer-term difficulties.

7 Acting as a neutral party. It is felt that the best way to interact with patients is to take a neutral stance that attempts to be non-judgmental, respectful, empathic, and supportive.

8 Resistance is to be expected. The interplay of conscious and unconscious dynamics in all cases makes resistance inevitable.

9 Therapy is interested in the past. This interest includes early development, attachment, trauma, adverse childhood experiences, family-of-origin work, object relations theories, and ghosts in the nursery. But the major goal is to address symptoms and problems in the present.

10 The importance of formulation. The complexity mentioned in the previous factors leads PDT to prefer formulations over diagnoses. A good formulation seeks to create the best understanding of why the patient has come for one’s assistance.

These 10 factors underlie psychodynamic therapy and many other therapies (Plakun et al., 2009; Wampold, 2015). If acknowledged, internalized, and used, they will make you into a better therapist no matter what type of therapist you choose to call yourself.

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ACADEMY & ASSOCIATION 101

What is the American **Association** of Child and Adolescent Psychiatry, and how does it differ from the **Academy**?

The American **Association** of Child and Adolescent Psychiatry was formed in 2013 **as an affiliated organization of the Academy** as a way for CAPs to increase their advocacy activities. Activities such as AACAP's Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the **Association** affect me as a dues paying Academy Member?

Your **dues remain the same** whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. **Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.**

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.

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AACAP'S HEALTHCARE ACCESS AND ECONOMICS COMMITTEE (HCAE)

Member Practice Economics 2025 Survey Results



■ Eugene Grudnikoff, MD, Andrew Lustbader, MD, and Suzie C. Nelson, MD

AACAP's Healthcare Access and Economics Committee (HCAE) conducted a survey of AACAP members in August of 2025. The goal was to assess member practice trends and sources of payment and inform AACAP's policy and advocacy priorities. Altogether, 1,717 members responded, a 16% response rate of 11,373 members—a meaningful increase from the 10% response rate in the 2017 survey. The results offer important insights into the evolving landscape of child and adolescent psychiatry.

Practice Settings and Hours Worked

The 2025 survey asked members to describe their predominant work settings and methods of practice. Respondents indicated 2.8 distinct practice settings or methods of practice. The most common setting was office-based, direct-to-patient care, reported by 74% of respondents, followed by telehealth (42%) and teaching/precepting (41%). Fewer members reported practicing in inpatient settings (20%), administration (20%), consultation or psychosomatic care, including emergency departments (15%), or collaborative care models with primary care practices or medical specialty clinics (15%).

Survey participants reported a mean of 35, and a median of 40 hours worked per week. As expected, the highest average hours were spent in direct-to-patient office-based care, at 20.6 hours per week. Notably, collaborative care models and subacute outpatient care each averaged just 1.2 hours

per week—underscoring the limited integration of child and adolescent psychiatrists into collaborative and team-based care models, despite evidence supporting their effectiveness.

Insurance Network Participation: A Troubling Decline

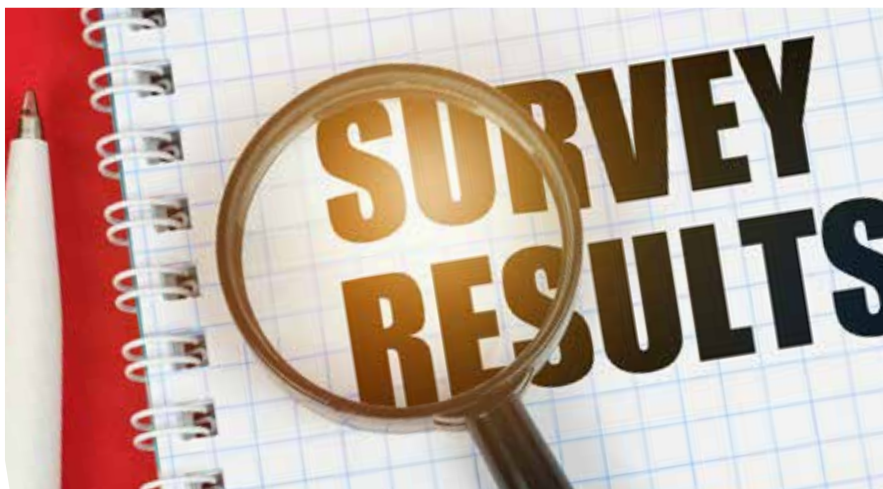
Perhaps the most striking finding of the 2025 survey is the continued low—and declining—rate of insurance network participation among AACAP members. Using a comparable 2017 survey question, participating in at least one insurance network decreased from 64% to 56% of respondents in 2025. Among those in private practice, the rate was even lower: only 44% participate in any insurance plan. These findings suggest that roughly half of child and adolescent psychiatrists are willing or able to work within insurance-based payment systems.

For context, these figures remain dramatically below national benchmarks for physicians overall. According to an analysis of 2014–2017 National Electronic Health Records Survey data from the State Health Access Data Assistance Center (SHADAC), more than 95% of physicians nationwide accepted new patients with private insurance, and 74% accepted new patients with Medicaid.

Barriers: Prior Authorization, Reimbursement, and Administrative Burden

The reasons for low participation emerge clearly from the survey data and are consistent with what AACAP has heard from members in the past survey. Among members who do participate in insurance networks, the most commonly cited complications are excessive requirements for prior authorizations, appeals, or audits, followed by limited reimbursement. These findings echo the 2017 survey, in which the same two issues—prior authorization burdens and inadequate reimbursement—topped the list of concerns, along with the sheer volume of time spent on insurance-related administrative tasks.

The persistence of these barriers over eight years is itself a finding of note. The administrative machinery of insurance participation—prior authorization



requests, appeals, audits, and claims management—continues to exact a substantial toll on child and adolescent psychiatry practices. Time spent on these non-clinical tasks is time not spent with patients, and it contributes to physician strain and burnout. For a specialty already facing severe workforce shortages relative to the scale of unmet need in child and adolescent mental health, this burden has real consequences for access to care.

For members who do not participate in insurance networks at all, limited reimbursement remains the most commonly cited barrier. In both 2017 and 2025, inadequate payment rates emerged as the primary reason members opt out of insurance networks entirely. When asked what single change would most increase their likelihood of participating, members pointed clearly to reducing excessive requirements—including prior authorization and audit burdens—as the most important lever. Better reimbursement rates were also frequently cited.

Implications for Advocacy and Clinical Practice

The 2025 survey results validate and reinforce AACAP's advocacy priorities. The HCAE views the findings as supporting continued focus on workforce development, protecting telehealth flexibility, opposing harmful cuts to Medicaid, and protecting patient access to community behavioral health services. In each of these areas, the survey data provide evidence that current policy and payment structures are failing to support adequate access to child and adolescent psychiatric care.

On the clinical practice side, AACAP members expressed interest in having our organization approach health plans directly to work toward reducing excessive administrative requirements—particularly around prior authorization requirements. Members also called for educational resources to help them better navigate the process of entering into agreements and contracts with health plans. These findings suggest that many members may consider greater insurance participation if the terms of participation were made

more reasonable and the pathways to contracting were made clearer.

The low participation in collaborative care models—averaging just 1.2 hours per week—also warrants attention. Collaborative care is a well-supported model for expanding behavioral health access in primary care settings, yet it remains a marginal part of most AACAP members' practice. Structural barriers, including reimbursement models that do not adequately support consultation and co-management roles, likely contribute to this underutilization. AACAP's advocacy for payment reforms that support collaborative and integrated care models remains as important as ever.

Currently Available Member Resources

The survey findings also point to a set of underused supports that may help mitigate some of these pressures. AACAP offers a range of practical resources to assist members in navigating the challenges highlighted here, including guidance on working with health insurers, managing prior authorization demands, and understanding coding, contracts, and regulatory requirements. Telepsychiatry toolkits and implementation resources are available and may lower barriers to expanding access across settings.

The data also highlight a missed opportunity. As noted above, collaborative care models currently occupy only a small portion of most members' time, yet they represent a scalable, team-based approach to extending the reach of child and adolescent psychiatrists. Participation in collaborative care does not require a major shift in practice structure and can be incorporated as a limited, sustainable component of clinical work. Established workflows and expanding reimbursement pathways further support broader adoption.

Looking Forward

The survey paints a clear picture: the structural challenges that have long constrained insurance participation among child and adolescent psychiatrists have not abated. The barriers that

drive non-participation—inadequate reimbursement and excessive administrative requirements—remain the same. And the gap between child and adolescent psychiatry participation rates and those of physicians broadly continues to reflect a specialty under significant economic and administrative strain. AACAP's continued advocacy around these issues, as well as members' increased awareness and usage of AACAP's resources, can hopefully help CAPs reverse some of these trends.

The HCAE Committee appreciates the engagement of members who took the time to complete the survey—your responses directly inform our work. While this was a self-selected random sample of members who received email invitations and took the time to participate, and not a true representative sample, we look forward to using these findings to guide our advocacy, our engagement with health plans, and our efforts to develop additional educational resources that support members in navigating an increasingly complex practice environment. We remain committed to working with AACAP leadership, policymakers, and payers to address the systemic barriers that limit access to child and adolescent psychiatric care for the patients and families who need it most.

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TASK FORCE ON CHILDREN, FAMILIES, AND IMMIGRATION

Youth, Immigration, and Deportation Fears: Navigating Family Preparedness and How CAPs Can Intervene



■ **Anushree Jagtap, MD and
Linda Chokroverty, MD**

You are working in the psychiatric emergency room at your local teaching hospital, and you care for a family with the following scenario:

Sofia is a 12-year-old, bilingual girl in a regular education 7th grade public school class, residing with her parents and siblings, ages 5–14, in an apartment in the neighborhood. Her mother brought her to see you upon request of their school as she expressed suicidal ideation to one of her teachers. Sofia has no formal medical or psychiatric history but does have a pediatrician. Further assessment reveals that Sofia has been feeling worried and sad for about a year over a variety of concerns, including grades, friendships, and bullying. When asked, she admits to being worried that her parents would be taken away from her and sent back to their country of origin. These feelings have worsened after viewing social media with images of ICE agents dragging people away and sending them to unknown places. Collateral history from her mother indicates that her parents are undocumented immigrants from Mexico; they have not returned to their country since Sofia and her siblings were born in the United States. She reveals that she was unaware of her daughter's distress, and that she and her husband have not

talked about their status because they did not want to upset the children. Her mother is not sure if they even know that their parents are undocumented. She also indicates that neither she, nor her husband, have made arrangements in the event that she or her spouse were deported, though she spends many sleepless nights worrying about this possibility herself.

In addition to assessing Sofia's safety for discharge with an outpatient mental health referral, there are several important issues raised here for which CAPs may be able to provide guidance.

Issue 1: Fear of separation from parents and family due to the unknown

For children who are aware that they have undocumented family members, uncertainty is not an abstract concept. It means wondering if a parent will return home tomorrow, if a family member will suddenly disappear, or if the family will remain together. This daily reality is a source of tremendous stress.

Constant shifts in the landscape of immigration policy directly fuel this environment of chronic stress. Rapid changes in enforcement priorities and legal protections create a climate where security can vanish overnight. The impact ripples far beyond individuals to mixed status households, broader migrant families, and the interconnected communities they enrich. When families live in fear, children can experience chronic anticipatory anxiety, emotional distress, and disruptions in school engagement. At the core of this distress is acute unpredictability, including fear of sudden workplace enforcement, abrupt family separation, prolonged detention, or deportation.¹ These persistent threats undermine the core foundation of safety that every developing child requires.

While navigating these volatile socio-political realities can feel overwhelming, CAPs are uniquely positioned to offer meaningful stability and support with access to guidance and resources. Specifically, the AACAP Resource Library on Children, Families & Immigration offers vital materials covering a host of topics starting with psychoeducation on immigration related child traumatic stress, traumatic grief, and traumatic separation.²

Issue 2: The need for open communication between caregivers and children among immigrant families about concerns and emergency plans.

In the recent **JAACAP** article entitled, "Navigating Uncertainty: Facilitating Parent–Child Conversations About Immigration Enforcement–Related Family Separation", Vega Potler et. al review step-by-step methods for mental health professionals to help parents have difficult conversations around deportation and family separation with their children³. In the case of Sofia above, avoiding the "elephant in the room" of possible parental detention and deportation likely contributes to her distress and despair. Her mental health, as well as her mother's, could improve considerably through much-needed communication between children and caregivers.

AACAP's Resource Library includes resources on talking with children through a specialized curriculum and resource guide developed by Cultures Connecting entitled, "Guiding Youth in Polarizing Times," which offers age specific examples of how to discuss difficult topics around immigration and deportation.²

Issue 3: The need to have a Child Care Plan and a Family Emergency Plan

The Immigration Legal Resource Center offers a step-by-step guide to family emergency preparedness.² As with many of the immigrant families we encounter in our work, Sofia's parents have discussed informal arrangements amongst themselves; however, they lack a *written* plan for the care of their minor children. It is quite important for the safety and well-being of children and youth for parents to have a written plan in place not only for basic childcare but also for decisions around education and medical care. Obtaining a formal legal document for guardianship through family or probate court is an option, but this could be a practical hardship for many parents, and also a source of fear of further exposure and risk (real or imagined) for detention/deportation. Legal documents for caregiving that could be prepared by a family without involving a court vary by state. Some examples of these self-generated documents include a "caregiver's authorization affidavit" or "designation of a person in parental relationship." These forms name the adult caregiver and specific child(ren) requiring care in the event of parental separation. Additionally, some states require the forms to be notarized. By having the correct form(s) on hand specific to their community, CAPs can provide an invaluable resource to their patient families.²

Finally, a family emergency plan, like disaster preparedness family emergency plans, is needed. Items in this plan include copies of all important documents such as birth certificates, passports, immigration documents, medical information, contact phone numbers and addresses of family and other caregivers, meeting place for family to convene in event of separation, etc. A complete list is available in the Immigration Legal Resource Center's Family Preparedness Plan named above.²



Summary

Even when clinicians don't have all the answers to the challenges faced by immigrant families, connecting these families and interested individuals to vetted, educational tools and other resources offers tangible relief. As described by Martín *et al.*, moral injury can occur when clinicians are unable to provide care aligned with their ethical values and may be mitigated through individual action and institutional support.⁴ CAPs can create trauma-informed clinical spaces that normalize immigration-related fears without pathologizing valid safety concerns. Beyond psychoeducation and direct care, the AACAP Resource Library on Children, Families & Immigration shows us how we can drive broader systemic support by engaging in local and state advocacy through drafting resolutions, endorsing protective public policies, and amplifying community resilience.² While no single intervention eliminates the systemic burden, collective action fosters genuine safety and solidarity across our healthcare networks.

With intention and the right resources, CAPs can help manage uncertainty faced by immigrant families. Concrete steps taken today can help them prepare for the unknown tomorrow.

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COLLABORATIVE & INTEGRATED CARE

A Workforce Multiplier: Expanding Access to Child and Adolescent Psychiatry Through Collaborative & Integrative Care

Stories of Collaborative Care: An interview with Dr. Alison Manning and Dr. Nathan Copeland



■ **Chennai Alexandra Marcus and King Fok, MD**

Introduction

As the demand for child and adolescent mental health services continues to rise, integrated models, such as Collaborative Care Management (CoCM), offer an alternative approach—one that extends psychiatric expertise beyond the clinic and to the broader healthcare system.¹

In this conversation, **Dr. Alison Manning** and **Dr. Nathan Copeland** share their experiences as child and adolescent psychiatrists working within integrated frameworks. Their work highlights a growing shift in the field: specialty-specific psychiatric care is moving toward team-based, systems-oriented models that engender patient trust, strengthen interdisciplinary care, and expand access to patients who might otherwise never receive mental health services.

Choosing Collaborative Care Management

Both Dr. Manning and Dr. Copeland describe entering integrated care through an interest in systems-level impact and interdisciplinary teamwork. Rather than focusing exclusively on direct patient encounters, their roles allow them to engage with the patients of providers outside of their own reach.

Dr. Manning, a triple-board trained child psychiatrist, integrates psychiatric care directly into a pediatric primary care clinic. In this setting, she evaluates pediatric patients, provides recommendations, and teaches residents and pediatricians in real time. This embedded model allows for immediate collaboration and continuity of care within a familiar environment for patients and families.

Dr. Copeland's work spans multiple integrated care models, including participation in the North Carolina Psychiatry Access Line (NC-PAL), a statewide child and perinatal psychiatry access line, and leading multiple CoCM teams at Duke Health and across North Carolina. Additionally, through NC-PAL, he routinely teaches pediatric primary care providers best pediatric mental health practices in the primary care setting through the REACH Patient-Centered Mental Health in Pediatric Primary Care curriculum. Through these roles, he provides consultation to pediatricians and family medicine physicians managing various mental health conditions in their clinics, as well as training providers in best practices for pediatric mental health care. CoCM teams at Duke Health and across North Carolina. Additionally, through NC-PAL, he routinely teaches pediatric primary care providers best pediatric mental health practices in the primary care setting through the REACH Patient-Centered Mental Health in Pediatric Primary Care curriculum. Through these roles, he provides consultation to pediatricians and family medicine physicians managing various mental health conditions in their clinics, as well as training providers in best practices for pediatric mental health care.

For both physicians, the appeal of integrated care lies in variety, collaboration, and the ability to influence psychiatric care at a population level. As Dr. Copeland reflects, integrated care and CoCM offers the opportunity to “exist in different spaces,” interact with diverse providers, and remain connected to the realities faced by communities in underserved or rural areas in underserved or rural areas.

A Workforce Multiplier in Action: True Stories in Clinical Practice

A central concept that emerged from the discussion is the idea of the psychiatrist as a “workforce multiplier.” In integrated care, psychiatrists not only directly treat every patient who walks into their clinic, but they also empower other clinicians outside of their own clinic to deliver effective mental health care for children with significant barriers to mental health access.

Dr. Copeland describes a case he was supporting in CoCM of a child with major depressive disorder being treated in a rural primary care setting without access to a child psychiatrist. While the primary care provider had done an excellent job engaging the patient and initiating treatment with an SSRI, the prescribed dose was too low. Dr. Copeland recommended increasing the child's dose beyond what the provider had previously tried. He notes that while the primary care provider had great knowledge of evidence-based treatments, the nuance of titrating psychiatric medications to therapeutic dosages is best managed by a child psychiatrist in integrated care models. Concurrently, the CoCM team's behavioral health care manager

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(BHCM) worked with the patient to set physical activity goals and engage in meaningful daily activities. The patient improved not through direct psychiatric care, but through a coordinated team effort involving Dr. Copeland, the primary care provider, and the BHCM. Importantly, the impact extended beyond a single patient. The primary care provider also gained confidence in titrating antidepressant medications to therapeutic dosages, a skill that was applied across their broader patient caseload. In this way, CoCM and integrated care functioned as a “workforce multiplier,” extending the expertise of the child psychiatrists and the building capacity of primary care providers to deliver effective mental health treatment within their communities.

Similarly, Dr. Manning shared the story of a 9-year-old with complex psychiatric needs, including PTSD, depression, ADHD, and a history of multiple hospitalizations. Despite significant barriers to accessing psychiatric care, integrated care within the primary care setting allowed for timely intervention, including psychopharmacologic

management and supportive services. Over time, the patient stabilized and was able to transition back to primary care, avoiding further hospitalization. Reflecting on this model, Dr. Manning emphasized that primary care providers are often “so grateful to have somebody to bounce these cases off of.” Integrated care not only improves patient outcomes but also supports and empowers clinicians to manage complex cases.

Shared Responsibility with Primary Care Providers

A defining feature of integrated care is the partnership between psychiatry and primary care. Pediatricians are increasingly on the frontlines of mental health care, often managing conditions such as anxiety, depression, and ADHD in their clinics.

Both physicians emphasized the importance of supporting primary care providers, who may not have received extensive training in mental health but are nonetheless deeply committed to caring for their patients.

Dr. Manning highlighted how pediatricians often face challenging situations such as families who are hesitant about psychiatric medications and/or psychotherapy and may feel uncertain about how to proceed. In these moments, a child psychiatrist operating in an integrated care model plays a key role in offering expert guidance, reframing conversations, and tailoring strategies that help meet patients and families where they are. The team can then leverage the pediatrician’s long-term relationship with the family to provide comprehensive psychiatric care in a familiar and trusted setting, which can reduce social and logistical barriers to accessing care.

Dr. Copeland noted that this work involves acknowledging the emotional burden borne by primary care providers. Many pediatricians manage complex psychosocial cases without formal structures for supervision or reflection. Integrated care creates a space not only for clinical consultation, but also for validation, shared decision-making, and emotional support for these clinicians.



The **NextGen CAPs: Excellence Through Mentorship Video Series**, sponsored by the AACAP Diversity and Culture Committee and supported by the Abramson Fund, highlights the diverse career pathways in child and adolescent psychiatry. Featuring psychiatrists at various career stages, the series explores their roles and diversity, aiming to inspire and engage the next generation of child and adolescent psychiatrists.

Watch video:

<https://www.aacap.org/NextGenCaps>

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Ultimately, integrated care fosters a sense of shared responsibility, where mental health care is not isolated within psychiatry, but integrated within the frontlines of primary care.

Building Your Career: Advice for future Child Psychiatrists

For trainees interested in integrated care and CoCM, both physicians emphasized that this is a rapidly growing and evolving field with expanding opportunities.

Dr. Copeland encouraged trainees to recognize that integrated care is likely to become an increasingly standard part of psychiatric practice. As healthcare systems continue to specialize, psychiatrists will play a critical role in bridging gaps between disciplines and improving communication across care settings.

Dr. Copeland advised seeking early exposure through electives, access programs, or integrated care clinics, as well as networking and building relationships with clinicians working in integrated and CoCM settings. Most importantly, he notes to “explore broadly,” recognizing that interests may evolve over time, and acknowledge that integrated care is, indeed, evolving with the expansion of healthcare systems.

Dr. Manning also highlighted the importance of national and local resources, including child psychiatry access programs and professional organizations, as entry points into this work.

Notably, both emphasized that expressing interest early in training can open doors, as institutions increasingly look for clinicians willing to engage in systems-based care.

Conclusion

Integrated care represents a transformative shift in child and adolescent psychiatry, one that prioritizes accessibility, teamwork, and systems-level impact. By extending psychiatric expertise into primary care and community settings, these models allow clinicians to reach children and families who might otherwise go unseen.

As demonstrated by Dr. Manning and Dr. Copeland, this work is not only clinically impactful, but also deeply meaningful. It reflects a broader vision of psychiatry: one that empowers providers, strengthens systems, and ultimately improves the mental health of youth in entire communities.

In an era marked by increasing demand and persistent disparities in care, integrative care offers a compelling path forward, one where psychiatrists serve not only as clinicians, but as partners, educators, and catalysts for change.

Further Reading/Citations

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Dr. Alison Manning is an assistant professor in the Department of Psychiatry and Behavioral Sciences at Brown University. Dr. Manning obtained her medical degree from Drexel College of Medicine and completed Triple Board combined training in pediatrics, adult psychiatry, and child and adolescent psychiatry at Brown University. Dr. Manning established and oversees integrated psychiatry services in Hasbro's pediatric primary care clinic and serves as the clinical director for Rhode Island's Child Psychiatry Access Line (PediPRN), a program that supports pediatric primary care providers in managing pediatric mental health in primary care.

Dr. J. Nathan Copeland is an Assistant Professor in the Duke Department of Psychiatry and Behavioral Sciences and an attending child and adolescent psychiatrist at the Duke Center for Autism and Brain Development. He completed medical school at the University of Tennessee and both his general adult psychiatry residency and child and adolescent psychiatry fellowship at the University of North Carolina.

Dr. King Fok is a psychiatry resident at Brigham and Women's Hospital in Boston, Massachusetts. Dr. Fok attended the University of Notre Dame on the prestigious Evans Scholarship where he attained a Bachelor of Arts with honors in Sociology and Pre-health with a minor in International Development Studies. Subsequently, he obtained a Master of Science in Global Health and Policy with honors from Queen Mary University of London. He completed his medical education at Harvard Medical School where he was awarded the Dean's REACH Scholarship and Klingenstein Medical Student Fellowship for child psychiatry. He is an active AACAP member with plans to pursue a fellowship in child and adolescent psychiatry.

Chennai Alexandra Marcus is a 4th year medical student at the Oakland University William Beaumont School of Medicine and active member of AACAP. She is interested in how team-based approaches can expand access to psychiatric treatment. She plans to pursue psychiatry residency with a focus on child and adolescent psychiatry and integrated care for underserved populations.

ETHICS COMMITTEE

Blurred Boundaries: When Physicians Prescribe for Family Members



■ Rina Bhalodi, MD, Khalid Elzamzamy, MD, and Gabrielle Blackman, MD

Professional and personal boundaries may become blurred and difficult to navigate when physicians treat their loved ones. Although it is discouraged by medical ethics boards, physicians, at times, choose to treat their own family members for a variety of conditions.¹ Prescribing psychotropic or controlled medications or managing more clinically complex situations within one's own family, however, raises more serious ethical and clinical concerns. Psychiatric treatment is particularly vulnerable to unconscious bias because a parent's emotional distress about their child's condition may influence diagnostic judgment, risk assessment, and treatment decisions. What, if anything, should a clinician do if presented with such a situation? On the surface, the decision for a parent to treat their child may seem understandable if the parent has expertise in treating similar conditions, the symptoms are clinically concerning, access to child and adolescent psychiatric care is limited, and the parent is actively seeking additional support. However, the dual role of parent-clinician creates an ethically complex situation, especially when psychotropic or controlled medications are involved, even when the parent's intentions are well-meaning.

Parents are generally motivated to ease their child's suffering. For those with medical training, that motivation may be accompanied by a heightened sense of

responsibility and/or perceived ability to intervene, especially in emergencies or when significant barriers to care exist. Yet, even when well-intended, a parent's decision to prescribe medication for their own child raises ethical concerns. These ethical concerns emerge from the convergence of parental and professional roles, potentially compromising the typical objectivity, structure, and safeguards in clinical care.

Professional codes of ethics have long addressed the issue of treating oneself or family members. Although legally not barred from doing so, per the AMA Code of Medical Ethics (Opinions 1.2.1 and 8.19), physicians generally should not treat themselves or immediate family members, especially in cases involving controlled substances, except in emergencies or isolated settings where no other qualified physician is available. Core concerns are that personal relationships may compromise clinical objectivity, limit full evaluation, and undermine patient autonomy and informed consent. Even when treatment of relatives may be reasonable, physicians remain responsible for documenting the care provided and communicating relevant information to the patient's treatment team.²⁻³ These concerns are not merely theoretical. State medical boards have investigated and sanctioned physicians for prescribing controlled substances to themselves or immediate family members.⁴⁻⁷

Maintaining objectivity is a key tenet of medical practice. Parents' desire to relieve a child's distress may impact the professional distance expected in a physician-patient relationship. This in turn may influence clinical processes, including history taking, examination, treatment decisions, and monitoring of side effects, while also increasing the risk of inadequate documentation and limited clinical oversight. The difficulty of maintaining adequate boundaries may also become evident in how the parent engages with the treatment team. For example, if when asked what brought the child to the hospital, the parent responds with a clinical framing of the situation rather than answering solely from the perspective of a parent describing concern for their child, the boundary between parental and professional roles has become blurred.

Child psychiatrists may understandably bring psychological knowledge and supportive coping strategies into their parenting. Yet there is an important boundary between psychologically informed parenting and formal psychiatric evaluation and treatment. The ethical concern arises when the boundary is crossed, particularly through use of structured therapeutic interventions or the prescribing of medications, especially controlled substances.

In the case of a parent and minor child, the child may feel unable to question or decline a parent's treatment decisions because of the dependent nature of their relationship, therefore undermining meaningful assent. Under Principle IV on "Assent and Consent" in the AACAP Code of Ethics, children and adolescents should participate in treatment decisions to the extent of their capacity, and, whenever reasonably possible, both the minor's assent and the legal guardian's consent should be obtained before initiating treatment. This assumes the involvement of a neutral clinician who

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can assess the child's developmental capacity and explain the rationale for treatment. When the prescribing parent is also the legal guardian, those roles overlap, weakening the safeguards that the AACAP Code of Ethics seeks to preserve.

Professional guidance advises physicians to seek independent care for family members.^{2,3} Ethical codes are not intended to obstruct care, but rather to support safe, objective, and developmentally appropriate care. A clinician encountering a parent-clinician treating their own child with a complex

condition can assist by helping identify the barriers to a more traditional model of care, reminding the parent-clinician of relevant ethical and regulatory guidance, ethical conflicts of interest, and potential liability associated with treating family members. Clinicians may also need to consider whether the situation triggers institutional, child protection, or state medical board reporting obligations. For further guidance, please refer to the AACAP Code of Ethics, APA Code of Ethics, AMA Code of Medical Ethics, and State medical board regulations.

Acknowledgement: *The authors thank the AACAP Ethics Committee members and leadership for their thoughtful feedback and input on this article.*

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Bipolar Disorder:
Parents' Medication Guide

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NECCAP ZOOM PROGRAM

What Every Child and Adolescent Psychiatrist Needs to Know About Opioids, Marijuana, and Substance Use Disorder Treatment



■ **Top row L to R: Sharon Weinstein, MD; Abita Raj, MD; Miriam Schizer, MD, MPH; Shannon Mountain-Ray, MSW, LICSW. Bottom row L to R: Kayley Siemiatkoski, MD; Aaron Quiggle, MD, MS; Timothy Wilens, MD; Amy Yule, MD. Co-chairs: Sharon Weinstein, MD and Abita Raj, MD**

Overview:

The 2026 NECCAP Update on Substance Use Disorders in Children and Adolescents brought together clinicians for a comprehensive review of current evidence, emerging practices, and practical approaches to caring for youth with substance use disorders. The program highlighted advances in assessment, treatment, and access to care while addressing the evolving challenges faced by providers supporting adolescents and families affected by substance use. As the United States continues to address the opioid epidemic, the need for child and adolescent psychiatrists and pediatric providers with expertise in substance use disorders remains critical.

Presenters provided an overview of the opioid crisis and reviewed evidence-based strategies for evaluating and treating opioid use disorder in youth, including screening, toxicology testing, medications for opioid use disorder, psychotherapy, family-based interventions, and approaches to improving engagement with care. The program also explored practical

strategies for partnering with parents and caregivers and reviewed treatment approaches across levels of care. In addition, presenters discussed cannabis use among adolescents in the era of legalization in Massachusetts, including the neurobiology of cannabis exposure in the developing brain, evolving clinical considerations, and multimodal treatment approaches for cannabis use disorders.

Together, these presentations emphasized the importance of integrated, developmentally informed, and family-centered care. By equipping clinicians with current knowledge and practical tools, the program aimed to strengthen the capacity of providers to improve outcomes for children, adolescents, and families impacted by substance use disorders.

Presentations

Tim Wilens, MD—Marijuana in Young People

Cannabis use and cannabis use disorders frequently begin during adolescence. This presentation addressed important knowledge gaps among practitioners caring for youth. The session provided a comprehensive review of cannabis

use in adolescents and young adults, including current epidemiological trends, the impact of legalization, neurobiological effects on the developing brain, evolving cannabis products and their associated potencies, toxicology testing, pharmacokinetic drug interactions, and the current evidence supporting medicinal uses of cannabis. The presentation also examined the neuropsychiatric risks associated with early-onset cannabis use and reviewed evidence-based, multimodal treatment strategies for adolescents with cannabis use disorder. Emphasis was placed on understanding the unique vulnerabilities of the developing brain, distinguishing medical from non-medical cannabis use, and applying current evidence to clinical decision-making.

The session addressed key practice gaps by equipping clinicians with practical knowledge of cannabis neurobiology, the current evidence regarding therapeutic indications in youth, and recommended treatment approaches for cannabis use disorder. Particular emphasis was placed on the importance of routine screening for cannabis use, utilizing motivational interviewing to reduce heavy cannabis use, engaging families in treatment, and incorporating developmentally appropriate, evidence-based interventions into clinical practice. Overall, this presentation provided practitioners working with children, adolescents, and young adults with an up-to-date, evidence-based framework for understanding cannabis use and its associated risks. Participants gained practical strategies to educate patients and families, identify problematic use early, and deliver effective, compassionate care to improve outcomes for youth affected by cannabis use disorder.

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Aaron Quiggle, MD, MS— Medication for Opioid Use Disorders (MOUD): Where do Adolescents Stand?

This presentation provided a comprehensive review of opioid use disorder (OUD) among adolescents and young adults, with a particular focus on epidemiology, co-occurring psychiatric conditions, disparities in access to evidence-based treatment, and current approaches to pharmacologic management. OUD in youth is associated with significant morbidity and mortality; yet, substantial disparities remain in the availability and implementation of evidence-based care, particularly medications for opioid use disorder (MOUD). The presentation highlighted persistent gaps in treatment initiation and engagement, emphasizing that many clinicians remain unfamiliar with the evidence supporting MOUD in adolescents, current regulatory considerations, and the age-related barriers that limit access to care. These knowledge gaps contribute to the underutilization of pharmacotherapy and ongoing disparities in treatment outcomes for young people with OUD. The session reviewed the current evidence supporting pharmacologic treatment for adolescents and young adults with OUD and examined barriers to the delivery of MOUD across healthcare settings. Participants learned to recognize disparities in access to evidence-based treatment, understand the epidemiology of OUD in youth, and apply current evidence and best practices when incorporating MOUD into treatment planning or referring patients to appropriate evidence-based programs.

Overall, this presentation strengthened clinicians' knowledge and confidence in identifying, evaluating, and treating adolescents and young adults with opioid use disorders. By increasing provider awareness of evidence-based practices and the existing treatment gaps, the session aimed to improve access to MOUD, enhance treatment engagement, and ultimately improve clinical outcomes for this vulnerable population.

Abita Raj, MD—Accessing Care and Resources for Adolescents with Substance Use Disorders

Adolescents and young adults with substance use disorders continue to face significant barriers to accessing evidence-based treatment, despite a growing need for specialized services. This presentation highlighted the widening gap between the increasing prevalence of substance use disorders among youth and the limited availability of developmentally appropriate treatment programs. Beyond workforce and program shortages, additional barriers to care were explored, including stigma and social isolation, fear of legal or social repercussions, difficulty navigating treatment systems, geographic disparities in access, and the complexity of co-occurring psychiatric disorders. The presentation provided a practical overview of the continuum of substance use treatment for adolescents, including developmentally appropriate levels of care, recovery-oriented programming, and innovative, nontraditional resources available throughout Massachusetts.

Using clinical case vignettes and real-world examples, participants examined how to match adolescents to the most appropriate level of care, while addressing the unique challenges associated with co-occurring psychiatric and substance use disorders. Participants gained an enhanced understanding of the continuum of substance use treatment available to adolescents across Massachusetts, increased confidence in identifying pathways to evidence-based care for youth with co-occurring mental health and substance use disorders and achieved greater familiarity with community-based recovery supports that promote long-term recovery and improved clinical outcomes.

Shannon Mountain-Ray, MSW, LICSW—Psychotherapeutic Approaches for Addressing Adolescent Use

A practical review of current evidence-based approaches to the assessment and treatment of adolescent substance use disorders is essential to providing effective, developmentally appropriate care. This presentation highlighted

the critical role of language in clinical practice, emphasizing person-first, recovery-oriented terminology, and the impact of reducing stigma on patient engagement and treatment outcomes. The presentation addressed ongoing gaps in provider education related to the identification, assessment, and management of substance use disorders among adolescents and young adults, with a focus on integrating evidence-based practices into pediatric and behavioral health settings. The session reviewed developmentally appropriate outpatient treatment models, universal substance use screening approaches, validated screening tools, and brief interventions tailored to the severity of identified substance use. Participants gained practical guidance on determining the appropriate level of care based on clinical presentation, functional impact, safety concerns, and recovery needs. Evidence-based psychosocial interventions—including motivational interviewing, family-based therapies, cognitive behavioral therapy, and contingency management—were discussed with attention to adapting treatment strategies to the developmental and psychosocial needs of youth.

The presentation emphasized that adolescent substance use disorders emerge within a complex interplay of individual, family, peer, community, and societal factors, requiring comprehensive, trauma-informed, and patient-centered approaches. Participants gained practical strategies to enhance screening, assessment, treatment planning, and evidence-based intervention, with the goal of improving access to care, engagement, and outcomes for adolescents and young adults with substance use disorders.

Miriam Schizer, MD, MPH— Drug Testing in Adolescents with Substance Use Disorders

A practical review of drug testing principles in adolescents with active substance use was presented, emphasizing the appropriate use of toxicology testing to support the diagnosis and treatment of substance

use disorders. The session reviewed indications for urine drug testing, best practices for specimen collection, limitations of available testing methods, and the mechanisms contributing to false positive and false negative results. Given the frequency with which psychiatrists and pediatric clinicians evaluate adolescents with substance use, proficiency in toxicology screening is essential for accurate assessment, informed clinical decision-making, and effective treatment planning. The presentation provided an overview of currently available drug testing modalities, highlighting their advantages, limitations, and appropriate clinical applications to support individualized care. Through interactive case vignettes, participants explored real-world scenarios addressing when testing is indicated, how to select appropriate testing methods, and strategies for interpreting complex toxicology findings. The discussion emphasized the importance of confirmatory testing and clinical correlation when unexpected results raise concern for inaccurate findings.

Participants gained a stronger understanding of standard urine drug testing components, evidence-based specimen collection practices, interpretation of toxicology results, and the limitations of commonly used testing approaches. The presentation reinforced that toxicology testing should be integrated into a comprehensive clinical assessment rather than used in isolation. These principles support clinicians in more effectively evaluating and treating adolescents with substance use disorders, improving diagnostic accuracy, guiding treatment decisions, enhancing patient engagement, and promoting better clinical outcomes.

Amy Yule, MD—Co-occurring Substance Use Disorders and Psychiatric Disorders in Adolescents

This presentation reviewed the key clinical principles involved in assessing co-occurring psychiatric disorders in adolescents with substance use disorders (SUDs). Significant gaps remain

in clinician knowledge regarding the identification and treatment of youth with co-occurring psychiatric and substance use conditions. This session provided practical, evidence-based guidance to support effective assessment and treatment of this population. Untreated psychiatric disorders can create barriers to substance use treatment, making accurate diagnosis and integrated care essential. The presentation presented an overview of research on the prevalence and clinical significance of psychiatric and substance use disorders in adolescents. It then examined approaches to evaluating psychiatric symptoms during active substance use, intoxication, withdrawal, and recovery to distinguish primary psychiatric disorders from substance-induced symptoms.

The session highlighted the importance of understanding the relationship between substance use patterns and symptom development, including psychiatric manifestations of cannabis, opioid, alcohol, and nicotine withdrawal. Evidence-based treatment recommendations were reviewed, with an emphasis on integrated, patient-centered approaches that address both psychiatric and substance use disorders concurrently. Individualized treatment planning, developmental considerations, and coordinated interventions were discussed to improve outcomes for adolescents with co-occurring conditions. Participants gained skills in assessing co-occurring psychiatric disorders, identifying withdrawal-related symptoms, differentiating underlying psychiatric illness from substance-induced symptoms, and applying evidence-based treatment strategies.

Summary

All child clinicians can work to reduce preventable harm associated with the ongoing opioid epidemic and broader substance use challenges. The complexity of adolescent development across biological, psychological, social, and environmental domains requires a holistic, interdisciplinary approach. Developmentally appropriate engagement strategies and

evidence-based interventions improve outcomes for youth with co-occurring psychiatric and substance use disorders. Harm reduction approaches mitigate overdose risk and ensure that youth and families have the knowledge, resources, and support needed to make informed decisions. Reducing stigma, strengthening prevention efforts, expanding awareness of diverse treatment pathways, implementing evidence-based interventions with patients and families, optimizing medication management, and utilizing effective drug testing strategies can all improve engagement, enhance motivation for change, and support long-term recovery.

The speakers highlighted the profound impact of substance use disorders on youth, families, and communities while emphasizing opportunities for meaningful intervention and hope. Through collaborative, evidence-based care, advocacy, and continued innovation, clinicians can improve outcomes and help create a healthier future for young people and their families.

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Caring for Others While Living with Uncertainty: Reflections from Immigrant Psychiatrists



■ **Afifa Adiba, MD, Abishek Bala, MD, MPH and Josh Feder, MD**

Immigrant physicians often speak about sacrifice—years of training, separation from loved ones, and the determination required to build a life in a new country. Less often discussed are the moments that leave a lasting mark: the quiet encounters that challenge our sense of belonging, our security, and even our professional identity. The stories that follow are not simply about immigration or medicine. They are about what it means to care for others while carrying uncertainty yourself, and about the resilience required to continue showing up with compassion, dignity, and purpose in the face of it.

Afifa Adiba, MD

I was asked to write about the experience of being an immigrant physician, yet each time I tried to begin, I hesitated. As a psychiatrist, I am trained to examine my own thoughts. What I found was not one clear emotion, but many—fear, sadness, and a quiet unease—layered together.

Part of that hesitation comes from knowing this story is not mine alone. It belongs to my family. I can carry my own uncertainty, but the idea of them facing it is far more difficult. Still, I feel a responsibility to give voice to experiences that often remain unspoken.

Becoming a physician in the United States is demanding. For immigrant physicians, the path carries an added

weight. Beyond years of study, missed milestones, and distance from loved ones, there is constant, quiet pressure to prove your place.

That feeling stayed with me during my first trip home in nine years. I went to see my grandmother, who had been like a second mother to me. Even though that decision was not simple.

When we returned, we were sent to a secondary inspection without explanation. We sat in a silent room, surrounded by unfamiliar faces carrying the same worry. My four-year-old asked why we were there, and I did not have an answer that felt safe or complete.

We waited, thinking of everything we had built over the past 15 years. When we were finally allowed to leave, nothing outwardly had changed—but something within me had.

Since then, I have come to understand that this experience is not defined by a single moment, but by the quiet persistence that follows it. We continue to show up—for our patients, for our families, for the lives we are building. And perhaps that is where our strength lies: not in the absence of fear, but in choosing, every day, to move forward despite it.

Abishek Bala, MD, MPH

During a recent H1-B visa renewal process, I encountered something that caught me off guard, not in the form of procedural delays or paperwork issues, but in the line of questions posed about my medical specialty.

At the border, the first officer, upon learning I was a physician, asked what I specialized in. When I said I was a child and adolescent psychiatrist, his demeanor changed. “Oh, so you prescribe psychotropics?” he asked. “Do you just use meds, or do you use therapy too?” He added that many mass shooters are reportedly on psychotropics, an implication that felt unsettling. I took the time like I do with many of my patients and families to explain that psychiatric care is nuanced. Medication is not always first-line, and that therapy or a combination of modalities is more appropriate, depending on the individual and the context. Later, in the immigration office, a second agent asked me a similar question, “Do you do medications and talk?” Two different agents, both raising questions about my practice as a psychiatrist. The repetition was unnerving personally and professionally.

The narrative that psychiatric medications are dangerous or linked to violence fuels stigma, creates public mistrust, and undermines the credibility of psychiatric professionals who are trained to use evidence-based care to reduce suffering and save lives. The above situation reveals a broader concern about how misperceptions about psychiatric care are filtered into institutional processes.

For international medical graduates working in the U.S. on visas, this is more than just an uncomfortable exchange. It's a glimpse into how our professional roles are viewed under the microscope of immigration scrutiny. Those of us on visas, often referred to in administrative paperwork as "Alien Physicians," are used to being questioned about our training, our contracts, our intentions. But now, we're also being asked to defend the nature of our clinical practice itself. This adds a new and concerning layer of vulnerability for psychiatrists on visas. We are already navigating workforce shortages, high clinical demand, and the emotional toll of treating mental illness especially in underserved communities. But to now, our standard of care and duty

to our patients questioned during visa interviews introduces a new social challenge.

It is imperative that we address not only public misconceptions about psychiatric care but also the systemic contexts in which these misperceptions arise. Federal offices should not become platforms where psychiatry is passively discredited or simplistically linked to societal violence. Doing so contributes to the very stigma we work so hard to dismantle in our clinics, communities, and classrooms. We need informed discourse, thoughtful policy, and above all, a collective commitment to viewing mental healthcare not with suspicion, but with the respect and understanding it deserves.

We, the Task Force on Children, Families, and Immigration share Drs. Bala and Adiba's alarm at the injection of clinically oriented inquiry into administrative processes involving non-citizen colleagues. Child and adolescent psychiatrists commit to ethical principles to help children and families and avoid harm, and this recent approach by U.S. officials challenges that commitment on the part of some of our colleagues, reminiscent of the last century, where, as Pastor Martin Niemöller wrote: *"First they came for the socialists, but I did not speak out...Then they came for me."* And so, we speak out.

Joshua D. Feder, MD



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Dr. Sarin by Day, Aashima “Sister” by Night: Reflecting on Teaching English to Kids in India



■ **Aashima Sarin, MD and
Richard Ha, DO**



Every Wednesday at 7:00 pm EST, psychiatry resident and AACAP member Dr. Aashima Sarin has been volunteering to teach English to children attending class in Sujata Academy, a school located in Dungeshwari, India. Despite her busy training schedule at Boston Medical Center, she has been developing lesson plans and conducting hour-long online English classes to her students since April 2025.

Sujata Academy was established by Join Together Society in 1994 to provide free preschool, elementary, and technical education to youth in Dungeshwari. Dungeshwari is in the Indian state of Bihar. This state historically has a reputation of being one of the most impoverished regions of the world and a land of lawlessness. This article is an interview with Dr. Aashima Sarin about her volunteer work with the children in this region.

What are your duties as a volunteer English teacher at Sujata Academy?

As a volunteer English teacher at Sujata Academy, I create lesson plans and design a curriculum to teach 6th grade students conversational English. I meet with them virtually on Wednesday evenings, utilizing Google Meet to see and teach them. I create PowerPoints using Hindi and English to convey relevant topics, vocabulary, and grammar. My goal is for them to feel more comfortable speaking English. They already understand the grammar,

but they have limited opportunities to speak and practice. My hope is that they pick up skills so that if they ever have the opportunity to travel to bigger cities in India or even leave the country, they know enough English to communicate effectively. Aside from this, I also hope to positively increase their confidence with speaking a different language, especially because in many Eastern countries, English can be very intimidating.

What are the skills required for your teaching role?

Though I am by no means trained as an English teacher, I think the most important skills are being fluent in Hindi and having the comfort to go back and forth between the two languages. I am able to identify nuances in the translation and oftentimes, I avoid complicated language that can be found in our vernacular that would not be helpful for the kids. Most importantly, though, I think creativity is important because I am constantly thinking of ways to teach content through a virtual platform. I am unable to be present with them in real life, work with a child individually, answer questions in real

time, that a teacher would normally be able to do better when teaching face-to-face. We often have technical difficulties and issues with Wi-Fi, so I try to have different check points to assess their progress and proficiency.

How did you find out about this volunteer experience?

Since joining AACAP in my third year of medical school, I have come across a variety of opportunities. I was recently connected to the AACAP Asian Caucus and put into a WhatsApp group chat called “Chai and Chaat,” which I just think is so clever. It is a lovely community where many South Asian child and adolescent psychiatrists gather to support each other and share ideas.

Dr. Richard Ha actually posted this opportunity in this group chat, which I saw the weekend of my wedding. I was so distracted with the festivities, but this opportunity caught my eye. They were looking for a Hindi-speaking individual who was willing to offer their time to teach English to a group of middle school children. I was thrilled to come across such an opportunity where I could work with children of my home





country, use my Hindi skills, and teach! I waited to reach out because I wanted to make sure I could dedicate time to this and when I did, Dr. Ha immediately connected me to the Sujata Academy team, and I have been working with them since.

What compelled you to volunteer for this project?

I am an American-born Indian and have had the immense privilege to be so deeply connected to my culture. When I was kid, my parents made it a priority to teach both me and my brother how to not only speak Hindi, but to also read and write Hindi. I remember putting up a fight as a young child, but I was still drawn to the language. It got to a point where, at just 7 years old, I picked up the language so quickly, I could skip many of my classes! For context, my parents enrolled us in a Hindi language class at The Hindu Temple of Birmingham in Birmingham, Alabama. My parents wanted us to be connected to our culture, but to most importantly be able to communicate clearly with our grandparents and other relatives in India. My brother and I love to blend in in India when we are visiting. Being able to speak like a local, read, and write has really helped to shape our identities as children of immigrants.

When I went to college at the University of Michigan-Ann Arbor, the expectation was that we took four semesters of a language as part of the liberal arts

college. I thought, let me see how much I remember my Hindi and take the test. Surprisingly, I was able to test out of Hindi, and I felt so proud of this accomplishment. I always wanted to do something more with this skill but did not have many opportunities aside from surprisingly being able to communicate with immigrant and refugee patients at Boston Medical Center who are from Afghanistan or Nepal but can speak Hindi.

When I came across this opportunity, I felt that this was something that spoke to my personal passions. As a future CAP fellow, I love working with children and I care deeply about their whole health. What better opportunity than to do this for underserved children in India. Furthermore, my now late grandfather loved languages in India so much and always encouraged me to keep learning. In a way, I feel as though I am honoring his memory when I work with children.

What is it like for children to be interacting with a doctor from America?

Honestly, I never bring up the fact that I am a physician with kids. I try to be as relatable as possible because I know that often people in India see people from Western countries as different. The kids call me “sister” and we have a lot of fun together.

I try to share snippets of life like showing them my dog and sometimes my brother will make a cameo in our sessions. It is fun and I am so grateful for my teachers

growing up that I make sure to foster an environment that is safe, playful, yet educational.

I heard you spoke perfect Hindi, which made it easy for the other teachers to relate with you. What is it like working with the teachers at Sujata Academy?

The teachers at Sujata Academy are so wonderful. They are kind, flexible, and, most importantly, truly dedicated to the children. We communicate via WhatsApp if anything urgent comes up, but otherwise they give me a lot of freedom to be creative. I take this support very seriously and am always looking to get feedback from them because I want to meet them where they are and be part of their team.

How are you finding the time to volunteer like this?

I have been very lucky because my Thursdays typically don't start until 9:00 or 10:00 am with didactics, which gives me the flexibility to stay up and teach on Wednesday evening. I also utilize any downtime I have between patients to create my lesson plans. It is nice to utilize my brain in different ways and think like a teacher. We do a lot of teaching in medicine, but it is so nice to go back to my basics and think about, ok, how do I teach a child who speaks Hindi how to ask for the important things (e.g., where is the bathroom?, can I have some water?, Is it lunchtime yet?).



When you first started, I remember that you had concerns about how this line of volunteer work could be related to mental health. Now that you have some experience working with the youth in Bihar, what sort of potential projects related to mental health could be attempted in that region?

When I was about to start this project, I reached out to Dr. Ha curious to know what the kids' mental health was like. He said to me that surprisingly the kids are actually very happy. I also asked the teachers when I started how the kids were, and they also told me that the kids are very happy in their lives. I was curious to know because school can be a very competitive and stressful setting for kids in India, but here, I was told and learned for myself that the kids really were just grateful for what they have. I see every time I work with them that they have a genuine curiosity to learn but also derive joy from the little things in life. This experience of mine raises the notion that child mental health is so heavily dependent on prevention and that child psychiatrists can play more of a role than in reaction to evident pathology. We should be more involved in the domains of a child's life to ensure they are adequately cared for.



More information on Sujata Academy and the non-profit operating the school, Join Together Society, can be found at <https://jtsamerica.org/>.

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Dr. Richard Ha is the AACAP Asian American Caucus Co-Chair 2025–2027. He is the Youth and Family Lead Psychiatrist at Ventura County Behavioral Health. He is a core faculty member for the psychiatry residency program at Community Memorial Hospital in Ventura, California. He is a graduate of Virginia Tech Carilion Clinic Child and Adolescent Residency and Fellowship. He also helps operate Stanford CHIPAO in Southern California. He can be reached at: richard.ha@med.lecom.edu

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The Antidote to the Search Bar

What the Columbia Medical Journalism Workshop taught me about writing—and why child and adolescent psychiatrists belong on the page.



■ Jonathan Slater, MD

I have been a child and adolescent psychiatrist for 35 years. I have written for most of them. For decades the writing went mainly to other doctors—an article in *Pediatric Annals*, book chapters, a contribution to a DSM-5 text—and, once, to parents: a 2002 book, *Tell Me Where It Hurts*, on the line between physical symptoms and psychological distress. Nothing major. The work was useful. It was missing something I could not name.

I found the name in June 2020. Three months into the pandemic, children I treated were locked out of their schools and locked into screens. I wanted to say so somewhere other than a chart.

That month, Stephen Fried opened a workshop on Zoom: the Columbia Medical Journalism Workshop, built with Rita Charon, MD. Fried is a reporter and magazine writer of the old school, a teacher of narrative journalism at Columbia and Penn for decades. Charon founded the field of Narrative Medicine. I have known Rita for 40 years. She trained me to listen for the story underneath the symptom. She had not yet trained me to write that story for people who were not doctors. Stephen did.

I was in the first cohort—a grid of squares on a screen, in the strangest summer most of us could remember. The course was meant to run for six months. None of us had anywhere else to be. It ran 12.

Fried's premise was simple. The patient is not the case. The reader is not your colleague. The job is to find the human being on the page and let the medicine arrive in a sentence that human beings can read.

That is one cost of writing. It costs the chart-voice, the safety of the third person, the protection of jargon. What you trade those for is a reader who finishes the piece—who calls a doctor she had been putting off calling.

I had to learn that trade. I am still learning it.

Within six months of the workshop, the New York Daily News ran my first piece for a lay audience—the first of several there. A year later, *The New York Times* ran “Our Children Are Suffering. We Must Help Them.” Others followed in the *Washington Post*, *STAT News*, *Columbia Magazine*, and, repeatedly, *MedPage Today*—most of them on child mental health and public health. The rest are collected on my website. I am writing a second book now, a narrative account of 35 years following children into adulthood. It would not exist without what Stephen and Rita built. Neither would the Substack I started three years ago, nor *Walking the Fine Line*, the memoir I finished in 1986, in my last year of medical school, and left in a drawer for nearly forty years—now serialized there, chapter by chapter.

This is the part that matters for us.

We already know what advocacy can do when it reaches the public. In 2021, the American Academy of Pediatrics, AACAP, and the Children's Hospital Association declared a national emergency in child and adolescent mental health. That declaration did not stay in a journal. It moved through hundreds of television and radio stations, reached the Surgeon General's desk, and helped shape federal legislation. The message carried because clinicians translated it for people outside medicine.

Child and adolescent psychiatrists hold knowledge almost no one else has. We sit with the families. We see the screens, the waitlists, the empty inpatient beds, the policies that fail a child before they reach one. We also carry a professional obligation to advocate—at the bedside, and well beyond it. The page is where that obligation scales.

In a year when more medical information reaches more Americans than ever, and much of it is wrong, the case for clinicians writing for the public is a public-health argument. The evidence is real. A national survey cited in the NEJM Shattuck Lecture found that 58 percent of American adults reported changing their behavior because of a health story in the media. A panel study during COVID found that consumption of mainstream news was associated with fewer misperceptions about the virus and with higher compliance with preventive measures, while certain social platforms moved the numbers in the other direction. None of this surprises any clinician who has watched a patient walk in with an article and the right question to ask, finally, out loud.

The frame matters. The source matters more. A meta-analysis of more than a hundred studies of physician communication found that good clinician communication was associated with a 19 percent reduction in patients' non-adherence to treatment, and that training physicians in communication skills raised the odds of adherence by 62 percent. Bring those skills to the page—to a piece a stranger can read in a doctor's waiting room—and the leverage multiplies. The clinician-writer is the antidote to the search bar.

You do not need a byline in the *Times* to begin. Pick the one issue that keeps surfacing in your practice and that the public misunderstands. Read op-eds by clinicians and study how they open. Write small first: a letter to the editor,

a social-media thread, a Substack post. Find an editor. Nearly every published piece I know of, mine included, reached print through structured editing and coaching.

The Workshop exists for exactly this. In six years it has trained more than 60 clinicians and placed their work in print more than 50 times—in *The New Yorker*, *The Atlantic*, *The New York Times*, *The Washington Post*, STAT, NPR, and many others. Some had never published outside a medical journal. The training is rare. It should not be.

I am here because of this workshop. So is the book on the way, and the manuscript out of its drawer. It gave me a way to bring 35 years of clinical work to people who will never sit in my office, in a voice I would not have

found alone. That is the gift Stephen Fried, Rita Charon, and their colleagues Joan Bregstein and Meg Gladieux give every cohort.

That is what writing has cost me. It is also what it has been worth.

Jonathan Slater, MD, writes on child mental health and public health. His *MedPage Today* op-ed "No, That AI Chatbot Is Not Your Friend" won a gold medal at the 2026 Digital Health Awards, and he was recently interviewed on NPR's *Here & Now*. He serves on the Academy Advisory Board of the Columbia Medical Journalism Workshop and welcomes inquiries from colleagues about supporting the program, who can reach him at jonathanslater.com.

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Poetry

Suicide Precautions

■ Phoebe Prioleau, MD

One blanket at night
removed during the day.
Your food arrives
lukewarm on purpose.
Someone else has cut
your French toast into strips.
All you want is a pad of paper
and your felt-tip pens.



{HOPE}

*"An Original Sonnet (a Media of Love):
With Evocative Emotion*

One Syllable Word Connected By Its Innards"

■ Richard H. Smith, MD

Love's depth of hope continuing life endures
 Foul interruptions for achieving goals.
 Each goal acquires new space to clearly see
 The next life stage to have fulfilling roles.
 One's growth ahead requires self nourishment
 Supplied by roadways with sufficient length
 For fertile gardens filled with many plants
 Of weeds, flowers, fruit or vegetables with strength.
 Some weeds are green, well worth their special touch,
 And awesome flowers are sweet, attractive treats
 Of blossom flavor for a soup with fruit
 And vegetables of protein, starch and sweets.
 All growth with plant-like self surprise, elect
 And satisfy the {HOPE} for self respect.

Author's note:

The plants are symbols of control-by-self styles:
 Weeds are intrusive, unwanted self mistake surprises.
 Flowers are attractive decorative surprises like
 San Francisco hairdos.
 Fruit and vegetables are self controlled, gratifying, productive surprises
 such as children seeking mother's attention or cooking tomatoes, beans,
 tofu, onions for a meal.
 A recognized self-surprise assures self control of change that evokes
 feeling secure. Feeling control of change is a life-ESSENTIAL belief for
 all animals.



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Wanjikū F.M. Njoroge, MD
Deputy Program Chair



Joel Stoddard, MD, MAS
Assistant Program Chair



Nicole Cotton, MD
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Jennifer E. Holton, MD
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AMERICAN ACADEMY OF
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AACAP 2026

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Join Us for AACAP's 2026 Annual Meeting

The challenges facing children, adolescents, and families have never been more complex. At the same time, the opportunities for innovation, collaboration, and meaningful impact have never been greater. That is why we are excited to welcome you to AACAP's 2026 Annual Meeting, taking place October 26-31, 2026, in Atlanta, Georgia, and online through CAP@Home.

Each year, the Annual Meeting brings together colleagues who share a deep commitment to advancing the mental health and well-being of young people. It is a place to explore new research, gain practical skills for clinical practice, and learn from the perspectives of one another.

Whether you join us in Atlanta or participate virtually, you'll find outstanding educational programming from leaders across the field, including interactive learning experiences, CME opportunities, and sessions designed to support your professional growth. This year's program offers something for every learner, from hands-on workshops and special interest study groups

to plenary sessions, institutes, new research poster presentations, and bonus on-demand content. You can begin earning CME credit as early as October 5 through on-demand content, with access to recorded sessions available through December 7, 2026.

- In Atlanta, you'll have time to learn face-to-face with colleagues from around the world, reconnect with friends, meet new collaborators, visit the poster and exhibit halls, participate in wellness activities, and enjoy one of the nation's most vibrant and culturally diverse cities.
- Through CAP@Home, you can attend live sessions and access content on demand from your home or office over nine weeks.

However you choose to participate, we welcome you as part of a community working together to advance excellence in child and adolescent mental health care.

The future of our field depends on learning from one another, embracing new discoveries, and remaining

committed to the patients and families we serve. We look forward to sharing that work with you at AACAP's 2026 Annual Meeting.

We can't wait to welcome you this October.



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Program Chair



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Assistant Program Chair



Program Highlights

Be sure to add these Plenary Sessions to your schedule, featuring a variety of hot topics in the field! All of these programs are offered both in-person in Atlanta and via AACAP's CAP@Home Virtual Experience.

Presidential Interview: John T. Walkup, MD, Interviews Awais Aftab, MD

Tuesday, October 27, 2026; 11:00 am–12:15 pm



*John T. Walkup, MD,
AACAP President,
Ann & Robert H.
Lurie Children's
Hospital*



*Awais Aftab, MD,
Case Western
Reserve University,
Southwest General
Health Center*

Psychiatry is under more public scrutiny than it has seen in a generation. Thanks to the MAHA movement, stimulants and antidepressants are on trial in the court of public opinion. Antipsychiatry arguments that once were confined to

the fringe are now widely circulating among parents and patients and clinicians are hearing pointed questions about overdiagnosis, iatrogenic harm, and when to start and stop medications. In this Presidential Interview, John Walkup, MD, and Awais Aftab, MD, meet these criticisms head-on. Which questions are worth addressing? Which problems are rooted in confusion? What does an honest, philosophically serious child psychiatrist look like on the other side? The conversation ranges from diagnostic validity, deprescribing, the cultural politics of mental health, and the future of psychiatric classification and treatment, always with an eye toward what practicing child and adolescent psychiatrists most need to be thinking about.

Awais Aftab, MD, is clinical associate professor of psychiatry at Case Western Reserve University and a psychiatrist at Southwest General Health Center. His academic and public-facing work focuses on conceptual and critical issues in the field. He led the interview series "Conversations in Critical Psychiatry" for *Psychiatric Times*, with a book adaptation published by Oxford University Press (2024). He is a senior editor for the journal *Philosophy, Psychiatry, & Psychology*. He has been recognized by *Lancet Psychiatry* as "one of the discipline's foremost public intellectuals" and is the recipient of 2026 Distinguished Service Award by the American Psychiatric Association. His bylines include *The New York Times*, and he writes on his newsletter *Psychiatry at the Margins*.

James C. Harris, MD, Developmental Neuropsychiatry Forum

Supported by James C. Harris, MD (in memoriam), and Catherine DeAngelis, MD, MPH

Tuesday, October 27, 2026; 1:30–3:30 pm



*Matthew State, MD,
PhD, The University
of California
San Francisco
Weill Institute for
Neurosciences*



*Alison T. Singer,
MBA, Autism Science
Foundation*

The 2026 Harris Forum speakers provide complementary perspectives on the translation of autism genetic discoveries into treatments. Dr. Matthew State presents the scientific framework for understanding how the identification of over 100 high-confidence autism risk genes is being leveraged toward therapeutic development, with particular focus on profound autism as a scientifically tractable entry point. Alison Singer provides the essential family perspective, addressing what families of individuals with profound

autism most need to know about genetic testing, emerging treatments, and clinical trial participation. Together, these presentations highlight both the scientific possibilities and the urgent daily realities faced by families, and the ways in which child psychiatrists can serve as partners in advancing care and quality of life for these patients.

Program Highlights

Research Symposium: Maternal Mental Health, Intrauterine Exposure and Child Outcomes

Tuesday, October 27, 2026; 4:45–6:45 pm



Veerle Bergink, MD, PhD, Icahn School of Medicine at Mount Sinai



Moriah E. Thomason, PhD, New York University

Intrauterine exposures including maternal stress, substance use, environmental toxins, infections, and metabolic conditions, have increasingly been recognized as key determinants of child and adolescent mental health. This Symposium aims to highlight intrauterine exposures as a critical mental health issue and to generate a preliminary set of research priorities to advance an emerging child and adolescent psychiatry research agenda in this domain. Dr. Veerle Bergink addresses how various intrauterine exposures influence fetal

brain development and contribute to later emotional, behavioral, and cognitive outcomes. Then, Dr. Moriah Thomason expands on innovative neuroscience techniques to evaluate the effects of intrauterine exposures. This preliminary research agenda spanning clinical, developmental, biological, and population-level perspectives, ultimately presents advancing efforts to prevent adverse outcomes and promote healthier developmental trajectories.

Opening Plenary: Calling In: Showcasing Your Passion with Compassion

Wednesday, October 28; 8:30–10:15 am



John T. Walkup, MD, AACAP President, Ann & Robert H. Lurie Children's Hospital



Loretta Ross

During this plenary program, AACAP recognizes major accomplishments and awardees from the past year and Loretta Ross gives the plenary address, *Calling In: Showcasing Your Passion with Compassion*.

Loretta J. Ross is a nationally renowned activist, public intellectual, and professor whose work over the past five decades has transformed how we think about human rights, equity, and social change. A sought-after speaker and strategist, she helps leaders, institutions, and communities navigate complexity with courage, clarity, and compassion. She is among the most prominent voices of "Calling In," a transformative approach that invites empathy, accountability,

and grace into difficult conversations. Her newest book, *Calling In: How to Start Making Change with Those You'd Rather Cancel* (2025), builds on her nationally acclaimed work challenging cancel culture and offering a more compassionate framework for fostering dialogue across differences. As a 2022 MacArthur "Genius" Fellow, Ms. Ross is helping redefine what it means to do justice work in our polarized times.

Program Highlights

Town Meeting: Shaping Minds, Shaping Justice: Children's Mental Health Through the Lens of Atlanta's Civil Rights Movement

Thursday, October 29, 2026; 11:00 am–12:30 pm



Moderators:
Sarah Vinson, MD,
Department Chair
Psychiatry and Behavioral
Sciences, Morehouse
School of Medicine



Mab Segrest, Author,
Administrations of
Lunacy: Racism
and the Haunting of
American Psychiatry
at the Milledgeville
Asylum



Nicole Cotton, MD,
Director of Undergraduate
Medical Education for
Psychiatry, Associate
Professor, Morehouse
School of Medicine



Darlene Lynch,
Georgia Appleseed
Center for Law and
Justice



Panelists:
Jose Ramirez Gang,
Jose Ramirez Gang,
Consulting and
Training, LLC



Danny Malec,
Executive Director,
Georgia Conflict
Center



Gail Mattox McCoy,
PhD, Professor Emeritus,
Morehouse School of
Medicine

AACAP's Town Meeting explores the enduring connections between children's mental health, resilience, community, and social justice through the lens of Atlanta's rich civil rights history. Atlanta has long stood at the forefront of movements for equity and change; this session brings together local community leaders and scholars to reflect on how generations of children, families, and communities have cultivated resilience, hope, and collective strength in the pursuit of justice and well-being. By connecting lessons from Atlanta's civil rights legacy to current challenges facing children and families, this Town Meeting highlights the vital role of community in promoting mental health and advancing justice. Attendees gain a deeper appreciation for the historical foundations of resilience and discover opportunities to strengthen partnerships that support the well-being and empowerment of all children and families.

Nosphitz Cline History Lecture: Curious Children, Wise Elders: How Intelligences Evolve

Thursday, October 29, 2026; 1:30–3:00 pm



Alison Gopnik, PhD,
University Professor
of Psychology
and Professor of
Philosophy, University
of California, Berkeley,
and Member,
Berkeley AI Research
Group

Cognitive science suggests that there are multiple forms of intelligence and that these intelligences trade off against each other and have a distinctive developmental profile and evolutionary history. Dr. Gopnik explores two very different kinds of cognition characterizing childhood and elderhood. Childhood is characterized by exploration. Children seek out

information about the world. However, forgoing reward for exploration requires support and nurturance from others—it requires care and teaching. Care and teaching are characteristics of elders, and the intelligence of care has a distinctive structure. It involves empowering others—giving them the resources they need to be effective. The combination of these different kinds of intelligence across the course of a life explains human success.

Program Highlights

Lawrence A. Stone, MD, Plenary Session: Understanding Posttraumatic Growth

Friday, October 30, 2026; 12:30–2:00 pm



Richard G. Tedeschi, PhD, Executive Director, Boulder Crest Institute for Post-traumatic Growth; Professor Emeritus, University of North Carolina at Charlotte

Dr. Tedeschi and his colleague, Lawrence Calhoun, defined the concept of post-traumatic growth (PTG) and how traumatic events can be catalysts for positive change. In this presentation, Dr. Tedeschi describes how people can respond to trauma in transformative ways. He discusses the various versions of PTG and the process by which it

occurs, and how these transformations can occur in the aftermath of all kinds of traumatic events. He also describes the ways people can act as expert companions in order to facilitate the process of post-traumatic growth.

At Riley Children's Health, NIH-funded research helps advance pediatric mental health innovation, translating discoveries into evidence-based care across a wide range of clinical settings. In addition, our clinical offerings include:

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Focus On

AACAP is at a critical junction—both evolving the old and bringing in the new. *Working Together: Innovation for Impact*, the presidential theme of AACAP President John T. Walkup, MD, and President-Elect Timothy E. Wilens, MD, is focused on creativity, novel diagnostics and therapeutics, more efficient practices, smart expansion of population health management, and the integration of new technologies. Nothing is more emblematic of new technologies than artificial intelligence (AI). AI has incredible potential for both positive and negative outcomes. Learning more about, and participating in AI is becoming a central competency in child and adolescent psychiatry.

Come join us in Atlanta to learn more about AI. At this year's meeting, there are 18 different presentations on AI, including an Institute with five hours

of pre-recorded content to watch over two months, from AI-enhanced diagnostic systems, to AI linked therapeutics. Beginner lectures on AI are plentiful. There will be discussions on the implementation and “how to’s” of AI in office practice to the ethics of AI chat boxes and implications of AI-human interactions. New “toolboxes” to further engage AI will be described. For researchers, AI use in biomarkers, electronic health informatics, prediction of mood disorders, and use with imaging will be presented. And if social media is where you land, well, even the interface and utility of AI in social media will be highlighted.

AACAP and its membership are very dedicated to providing timely and relevant information. Given the accelerated progress of large language models/AI in psychiatry, plan to attend a couple of these highly informative



Timothy E. Wilens, MD
AACAP President-Elect

and well-constructed presentations that will undoubtedly challenge you while positioning you to join the innovation movement at AACAP. For complete details, visit: <https://aacap.confex.com/aacap/2026/meetinginfo.cgi/ModuleMeetingInfo/ArtificialIntelligence>

Guide to Exhibits

Make the most of your Annual Meeting experience in the Exhibit Hall, where you can explore innovative products and services, discover career opportunities, connect with colleagues, and access valuable resources supporting child and adolescent psychiatry.

Before you arrive, preview the Exhibit Hall using AACAP's **interactive floor plan**. Planning ahead will help you identify exhibitors you want to visit and maximize your time onsite.

Be sure to download the Annual Meeting App (sponsored by American Professional Agency, Inc.) on your iPhone, iPad, or

Android device. The app and interactive floor plan include exhibitor descriptions, booth locations, and contact information, making it easy to map your route and connect with organizations of interest. Attendees will also receive an onsite Exhibits Guide featuring the floor plan and complete exhibitor listings.

While you're in the Exhibit Hall, stop by the **Headshot Booth** (sponsored by Trayt Health) for a complimentary professional headshot. A photographer will be available during Exhibit Hall hours, and attendees will receive their high-quality digital photo emailed to them the same day.

Location

- The AACAP Exhibit Hall is located in the **Grand Hall, Lower Level II, Hyatt Regency Atlanta**.

Exhibit Hall Hours

- **Wednesday, October 28:**
12:00–6:00 pm
- **Thursday, October 29:**
10:00 am–4:00 pm
- **Friday, October 30:**
10:00 am–12:30 pm

We look forward to welcoming you to the Exhibit Hall and helping you discover new ideas, resources, and connections throughout the meeting!

ON DEMAND:

Douglas B. Hansen, MD

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- Strategies to reduce stigma in clinical settings
- Techniques to enhance youth engagement and motivation
- Identify different strategies for working with unmotivated/resistant drug-using adolescents and their families.

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Funding for this initiative was made possible (in part) by grant no. 1H79TI088037 from Substance Abuse and Mental Health Services (SAMHSA).

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- **Emotional and Behavioral Dysregulation**
- **FREE Increasing Motivation and Decreasing Stigma Among Youth With Substance Use Disorders**
- **Pediatric Psychopharmacology**
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VYKAT® XR (diazoxide choline) extended-release tablets, for oral use

Brief Summary: For full Prescribing Information and Medication Guide, refer to the package insert.

INDICATIONS AND USAGE

VYKAT XR is indicated for the treatment of hyperphagia in adults and pediatric patients 4 years of age and older with Prader-Willi syndrome (PWS).

CONTRAINDICATIONS

VYKAT XR is contraindicated in patients with known hypersensitivity to diazoxide, other components of VYKAT XR, or to thiazides. Erythema multiforme has been reported with VYKAT XR.

WARNINGS AND PRECAUTIONS**Hyperglycemia**

VYKAT XR increases blood glucose, due primarily to an inhibition of insulin release from the pancreas. Hyperglycemia, including severe adverse reactions associated with diabetic ketoacidosis, occurred in VYKAT XR-treated patients during clinical trials.

Precipitating conditions for diabetic ketoacidosis may include reduction in the dosages of concomitant antihyperglycemic medications, increase in the dosages of concomitant growth hormone, intercurrent illness, surgery, volume depletion or alcohol abuse. Signs and symptoms of ketoacidosis include nausea, vomiting, abdominal pain, generalized malaise and shortness of breath.

Before initiating VYKAT XR, test fasting plasma glucose (FPG) and HbA1c; optimize blood glucose in patients who have hyperglycemia. After initiating treatment with VYKAT XR, regularly monitor fasting glucose (FPG or fasting blood glucose) and HbA1c. Monitor fasting glucose more frequently for the first few weeks of treatment with VYKAT XR in patients with risk factors for hyperglycemia, such as obesity, elevated FPG, HbA1c at the upper limit of normal or above, concomitant use of growth hormone, or concomitant use of systemic corticosteroids.

Advise patients of the signs and symptoms of hyperglycemia (e.g., excessive thirst, urinating more often than usual or higher amount of urine than usual, or increased appetite with weight loss). If a patient experiences hyperglycemia after initiating treatment with VYKAT XR, monitor fasting glucose as clinically indicated, and at least twice weekly until fasting glucose decreases to normal levels. Consider monitoring ketones in patients with worsening hyperglycemia.

If hyperglycemia is treated with anti-hyperglycemic medication during VYKAT XR treatment, continue monitoring fasting glucose at least once a week for 8 weeks, followed by once every 2 weeks and as clinically indicated. Consider consultation with a healthcare provider with expertise in the treatment of hyperglycemia and counsel patients on lifestyle changes. Based on the severity of the hyperglycemia, VYKAT XR may require dosage interruption, reduction, or discontinuation in order to avoid progression to ketoacidosis.

Risk of Fluid Overload

Edema, including general, localized, and peripheral edema, occurred in 27% of VYKAT XR-treated patients versus 12% of placebo-treated patients in the placebo-controlled trial with treatment-naïve subjects (Study 1). Severe adverse reactions associated with fluid overload, including pulmonary edema, were reported in VYKAT XR-treated patients during clinical trials.

The antidiuretic property of diazoxide may lead to significant fluid retention, which may precipitate congestive heart failure in patients with compromised cardiac reserve. VYKAT XR has not been studied in patients with compromised cardiac reserve and should be used with caution in these patients.

Monitor for signs or symptoms of edema or fluid overload and consider appropriate clinical management, which may include VYKAT XR dosage reduction or treatment interruption, if clinically significant.

ADVERSE REACTIONS

The following clinically significant adverse reactions are discussed in greater detail in other sections of the labeling:

- Hyperglycemia
- Risk of Fluid Overload

Adverse Reactions from Clinical Studies of VYKAT XR in Patients with PWS

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In the clinical study development program for treatment of hyperphagia in patients aged 4 years and older with PWS, a total of 125 patients received at least 1 dose of VYKAT XR. Patients received dosages of VYKAT XR up to 5.8 mg/kg/day (up to a maximum dosage of 525 mg/day) for up to 4.86 years (median: 3.0 years) in the following studies:

- Study 1: 13-week, randomized, double-blind, placebo-controlled, parallel-arm study in which 126 patients were randomized in a 2:1 ratio to VYKAT XR or placebo and received at least one dose of VYKAT XR.
- Study 2-OLE: A long-term, open-label, maintenance treatment period in 115 patients (mean duration 2.6 years; maximum duration 4.3 years) who had previously been enrolled in Study 1.

- Study 2-RWP: A 16-week, double-blind, placebo-controlled, randomized withdrawal treatment period, in which 77 patients who had completed Study 1 and Study 2-OLE were randomized in a 1:1 ratio to VYKAT XR or placebo.
- Study 3: A long-term, open-label, maintenance study in 77 patients who had completed Study 1 and Study 2-OLE.

Adverse reactions leading to discontinuation in VYKAT XR-treated patients included aggression, diabetes mellitus, fluid retention, hirsutism, hyperglycemia, lower respiratory tract infection, peripheral edema, pulmonary edema, and papular rash.

The primary safety analyses are based on Study 1. The most common adverse reactions (10% or more and at least 2% greater than in placebo) in Study 1 were hypertrichosis, edema, hyperglycemia, and rash.

Table 3 presents adverse reactions that occurred in at least 5% of patients in Study 1 receiving VYKAT XR and 2% more frequently in VYKAT XR-treated patients than placebo.

Table 3: Adverse Reactions Occurring in ≥5% of Patients with PWS Receiving VYKAT XR and at Least 2% Greater than Placebo in Study 1

Adverse Reaction	VYKAT XR (N=84)	Placebo (N=42)
Hypertrichosis	36%	14%
Edema*	27%	12%
Hyperglycemia**	17%	5%
Rash***	12%	2%
Pyrexia	6%	0%
Arthralgia	5%	2%
Influenza	5%	2%
Nasopharyngitis	5%	2%

*Edema includes peripheral edema, periorbital edema, swelling face, pulmonary edema, and peripheral swelling.

**Hyperglycemia includes type 2 diabetes mellitus.

***Rash includes contact dermatitis, erythema multiforme, maculo-papular rash, papular rash, and urticaria.

In Study 2-RWP, the adverse reactions that occurred most frequently (at least 5%) and to a greater extent than placebo included:

Immune System Disorders: Seasonal allergy

Investigations: Increased weight

Nervous System Disorders: Hyperphagia, anxiety, affect lability, anger, compulsive hoarding, suicidal ideation

Respiratory Disorders: Streptococcal pharyngitis, upper respiratory infection

Skin and Subcutaneous Tissue Disorders: Hirsutism

Erythema multiforme was reported in one subject in Study 1. One subject in Study 3 experienced a serious adverse reaction of diabetic ketoacidosis.

Adverse Reactions from Clinical Trials or Postmarketing Experience of Diazoxide in An Unapproved Population

The following adverse reactions associated with use of diazoxide for an unapproved population have been identified in clinical studies or post-marketing reports. Because some of these reactions were reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Immune System Disorders: Hypersensitivity

Investigations: Increased serum uric acid, transient neutropenia, thrombocytopenia, decreased hemoglobin/hematocrit, eosinophilia

Respiratory Disorders: Pulmonary hypertension

Special Senses: Cataracts

Musculoskeletal and Connective Tissue Disorders: Abnormal facial features

DRUG INTERACTIONS

Table 4 displays clinically significant drug interactions with VYKAT XR.

Table 4: Clinically Significant Drug Interactions with VYKAT XR

Drug or Drug Class	Prevention or Management	Mechanism and Clinical Effect(s)
Strong CYP1A2 Inhibitors	Reduce the dosage of VYKAT XR when concomitantly used with strong inhibitors of CYP1A2.	VYKAT XR is a CYP1A2 substrate. Concomitant use of VYKAT XR with strong CYP1A2 inhibitors increases exposure of diazoxide, which may increase the frequency and/or severity of adverse reactions from VYKAT XR.
CYP1A2 Substrates	Concomitant use of VYKAT XR with CYP1A2 substrates is not recommended.	VYKAT XR is an inhibitor of CYP1A2. Concomitant use of VYKAT XR with CYP1A2 substrates increases exposure of these substrates. This may increase the frequency and/or severity of adverse reactions from such substrates.

(continued)

Table 4: Clinically Significant Drug Interactions with VYKAT XR

Drug or Drug Class	Prevention or Management	Mechanism and Clinical Effect(s)
Strong CYP3A4 Inhibitors	Monitor the frequency and severity of adverse reactions from VYKAT XR. A dosage reduction of VYKAT XR may be needed when used concomitantly with strong CYP3A4 inhibitors.	Concomitant use of VYKAT XR with strong CYP3A4 inhibitors increases exposure of diazoxide, which may increase the frequency and/or severity of adverse reactions from VYKAT XR.
Dual Strong CYP3A4 / Moderate 1A2 Inducers	Concomitant use of VYKAT XR with dual strong CYP3A4/moderate CYP1A2 inducers is not recommended.	VYKAT XR is a substrate of CYP3A4 and CYP1A2. Concomitant use of VYKAT XR with strong CYP3A4/moderate 1A2 inducers may decrease exposure of VYKAT XR. This may decrease the efficacy of VYKAT XR.
Drugs Highly Bound to Protein	Monitor international normalized ratio (INR) in patients who use coumarin or its derivatives concomitantly with VYKAT XR. Dosage modification of coumarin or its derivatives may be needed when used concomitantly with VYKAT XR. Monitor diphenylhydantoin serum levels when VYKAT XR is used concomitantly with diphenylhydantoin. Dosage modification of diphenylhydantoin may be needed when used concomitantly with VYKAT XR.	Diazoxide is highly bound to serum proteins. Diazoxide may displace other drugs which are also highly bound to protein resulting in higher or lower blood levels of the concomitantly used drugs. The impact of protein binding displacement is expected to be clinically important for drugs with narrow therapeutic range such as coumarin or its derivatives and diphenylhydantoin. Protein binding displacement may result in an increased risk of adverse reactions due to higher blood levels of coumarin or its derivative or loss of efficacy due to lower exposures of diphenylhydantoin.
Thiazide or Other Diuretics	Monitor for signs and symptoms of hyperglycemia and hyperuricemia when VYKAT XR is used concomitantly with thiazides or other diuretics. Dosage adjustment of VYKAT XR or diuretics may be needed when VYKAT XR is concomitantly used with diuretics.	Both diazoxide and thiazides or other diuretics may produce hyperglycemia and hyperuricemia. The concomitant use of VYKAT XR with thiazides or other diuretics may potentiate the hyperglycemic and hyperuricemic effects of diazoxide.

1 See www.fda.gov/CYPandTransporterInteractingDrugs for examples of strong CYP1A2 and CYP3A4 inhibitors, sensitive CYP1A2 substrates, and dual strong CYP3A4 / moderate 1A2 inducers.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

Available data from case reports with diazoxide use during pregnancy are insufficient to identify a drug-associated risk of major birth defects, miscarriage, or other adverse maternal outcomes.

Adverse reactions, including hyperglycemia, alopecia, and hypertrichosis lanuginosa, have been reported in neonates exposed to diazoxide in utero prior to delivery.

Clinical Considerations

Fetal/Neonatal Adverse Reactions

Diazoxide crosses the placenta and has been detected in cord blood. Based on adverse reactions reported in adults, in utero exposure of the infant prior to delivery may produce fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism, and possibly other adverse reactions. Monitor infants who were exposed to diazoxide in utero for adverse reactions and treat accordingly.

Labor or Delivery

Intravenous administration of diazoxide during labor may cause cessation of uterine contractions, which may require administration of oxytocic agents to reinstate labor. However, this has not been reported with diazoxide when administered orally. Use caution in administering VYKAT XR during labor.

Lactation

Risk Summary

Diazoxide is present in human milk. There are no data on the effects of diazoxide on the breastfed infant or on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for VYKAT XR and any potential adverse effects on the breastfed child from VYKAT XR or from the underlying maternal condition.

Clinical Considerations

Because of potential adverse reactions, including hyperglycemia, monitoring the infant's blood glucose may be advisable, especially during the neonatal period.

Pediatric Use

The safety and effectiveness of VYKAT XR have been established for the treatment of hyperphagia in pediatric patients 4 years of age and older with PWS.

The safety and effectiveness of VYKAT XR have not been established for the treatment of hyperphagia in pediatric patients with PWS less than 4 years of age.

Adverse Reactions in Pediatric Patients in an Unapproved Population

The following postmarketing adverse reactions have been reported with the use of other diazoxide products for the treatment of hyperinsulinemic hypoglycemia, an unapproved population:

- Pulmonary hypertension in pediatric patients less than 6 months of age, including neonates.
- Transient cataracts in association with hyperosmolar coma in a pediatric patient that subsided with correction of the hyperosmolarity.
- Development of abnormal facial features with chronic use in pediatric patients.

VYKAT XR is not approved and is not recommended for the treatment of hyperinsulinemic hypoglycemia.

Geriatric Use

Clinical studies of VYKAT XR did not include any subjects 65 years of age and older to determine whether they respond differently from younger adult subjects.

Renal Impairment

VYKAT XR has not been studied in patients with renal impairment. VYKAT XR is not recommended in patients with renal impairment.

Hepatic Impairment

VYKAT XR has not been studied in patients with hepatic impairment. VYKAT XR is not recommended in patients with hepatic impairment.

OVERDOSAGE

An overdosage of VYKAT XR may cause marked hyperglycemia, which may be associated with ketoacidosis.

No specific antidotes for VYKAT XR are known. Monitor ketones in patients with severe hyperglycemia following overdose and consider insulin treatment if necessary. Treat severe hyperglycemia associated with ketoacidosis with prompt insulin administration and restoration of fluid and electrolyte balance. Because of VYKAT XR's long half-life (approximately 106 hours) in patients with PWS, the symptoms of overdosage (hyperglycemia, with or without ketoacidosis) require prolonged surveillance for periods up to three weeks or until blood sugar levels stabilize within the patient's normal range. Consider contacting a Poison Help line (1-800-222-1222) or a medical toxicologist for overdosage management recommendations for VYKAT XR.

To report SUSPECTED ADVERSE REACTIONS, contact Soleno Therapeutics, Inc. at 1-833-765-3661 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Manufactured for:

Soleno Therapeutics, Inc.
100 Marine Parkway, Suite 400
Redwood City, CA 94065

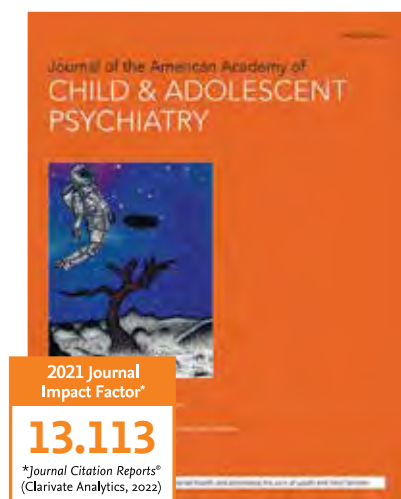
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Source PI: Revised 3/2025.

C-US-VYK-00640 08/2026

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Biopsychorelational Healing Conference: Bringing Psychiatry and Family Therapy Together



■ **Deepika Shaligram, MD, Michelle Rickerby, MD, Rajesh Mehta, MD, Noah Spector, PhD, Abigail Ross, PhD, Rishi Kapur, MD, Manijeh Daneshpour, PhD, Jaswant Guzder MD, Rama Rao Gogineni, MD**

The Bridging Minds, Systems, and Relationships: Biopsychorelational Healing Conference brought psychiatry and family therapy together to explore how relationships, families, and systems shape mental health and healing.

The *Bridging Minds, Systems, and Relationships* conference is an innovative interdisciplinary collaboration of three professional organizations for the advancement of mental health of children and their families. The leaders of the American Academy of Child and Adolescent Psychiatry's Family Committee, the Association of Family Psychiatrists and the Family Process Institute launched this conference as a platform to bridge the historically siloed disciplines of Psychiatry and Family Therapy.

On April 4, 2026, mental health professionals from across the globe convened for a landmark conference that recognized the interconnectedness of biology of the mind, interpersonal relationships, and social systems.

Conference Chair, Dr. Manijeh Daneshpour, System-wide Couples and Family Therapy Director, Alliant

University and Past-President of Family Process Institute addressed the audience comprising couple and family therapists, psychiatrists, psychologists, and social workers, along with trainees of these disciplines and systems-oriented clinicians to emphasize the importance

of understanding how relational dynamics, and broader systemic forces interact in clinical work in today's troubled world.

As current day mental health challenges are influenced by migration, social inequities, intergenerational trauma, and systemic stressors, the four conference panels explored a shared framework for understanding and treating mental health concerns within a collaborative, ethical, and culturally responsive healthcare system.

The first panel, *Systemic & Relational Perspectives in Psychiatry and Therapy*, featured **Drs. Noah Spector** and **Rishi Kapur**, co-directors of Family Therapy training at the Children's Hospital of Eastern Ontario, Ottawa. They explored the current status of Family Therapy education within a systemic context drawing on their experiences of teaching the family therapy program for the core Psychiatry residents and Child and Adolescent Psychiatric Fellows at University of Ottawa with an emphasis on cultural humility to serve diverse



populations. They compared and contrasted their own rich family therapy training with contemporary family therapy training which is influenced by ACGME requirements, technological advances (televisits) and other barriers that have sparked creative adaptation and innovation.^{1,2}

Building on this foundation, Panel II, *From Loss to Resilience: Biopsychorelational Approaches with Refugee Families*, shifted attention to global mental health realities. **Drs. Jaswant Guzder** and **Rajesh Mehta** explored the profound relational disruptions experienced by displaced and refugee families, including ways to ease cultural dislocation and intergenerational conflict.³

They drew from their own experiences with immigration with its associated risk and resilience-building opportunities to illustrate conditions for family adaptation and well-being. Their discussion emphasized resilience-building strategies rooted in family systems and cultural responsiveness, while also highlighting the implications for policy and community-level responses to the global refugee crisis.

The focus then shifted to novel approaches for dissemination and application in Panel III, *Integrated Care Models—From Theory to Practice*, where **Drs. Deepika Shaligram**, **Abigail Ross** and **Michelle Rickerby** shared models of effective collaboration between psychiatrists and therapists in the outpatient psychiatry, primary care, and partial hospital settings. Dr. Shaligram described family therapy principles incorporated as a single session intervention in the child psychiatry evaluation and psychopharmacology follow up visits in a coordinated care model. Dr. Ross described the Family Based Crisis Intervention she had developed and adapted for youth with suicidal ideation presenting to the primary care setting in an integrated care model. Dr. Rickerby discussed the Family Based Integrated Care for medically complex youth that she had pioneered in the partial hospital at Brown University.⁴

Lastly, Panel IV, *Ethical, Cultural, and Generational Challenges in Collaborative Care* featured **Drs. Daneshpour** and **Rama Rao Gogineni** who examined common challenges in family therapy. They considered the problems of loyalty conflicts, generational value differences, and ethical dilemmas that arise in systemic work, particularly within multicultural and intergenerational family systems. Their dialogue reinforced the importance of reflective practice and cultural humility in collaborative care.

The day concluded with an all-presenters panel discussion and an interactive audience Q&A, allowing attendees to raise clinical, institutional, and systemic conundrums and identify potential strategies to aid clinical

practice, training, and research. The panel discussed relational interventions as a complement to pharmacological treatments, to offer holistic healing consistent with both medical and therapeutic models.

As a virtual event, the conference's reach extended across geographic boundaries, drawing 413 registrants including 327 trainees from the US, UK, Canada, Middle East and Asia. The inaugural *Bridging Minds, Systems, and Relationships* conference marked a significant step toward a more integrated, relational, and globally responsive approach to mental health through the recognition of healing as a process embedded in relationships, systems, and shared responsibility.

BRIDGING MINDS, SYSTEMS, AND RELATIONSHIPS
A Biopsychorelational Healing Conference

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WHY THIS CONFERENCE MATTERS
First-of-its-kind event uniting Family Therapy & Psychiatry for systemic and relational care.

CONFERENCE HIGHLIGHTS

- Integrated Care Models
- Global Refugee and Mental Health Strategies

Interdisciplinary Conference

WHO SHOULD ATTEND

- Family Therapists
- Psychiatrists
- Social Workers
- Medical Providers
- Researchers
- Graduate Students

REGISTER NOW:
www.familypsychiatrists.pages.dev/conference

Presented by:
Family Process Institute | Association of Family Psychiatry
Alliant University

FOR YOUR INFORMATION

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Noah Spector, PhD, Program Director, Mind Matters Team, Children's Hospital of Eastern Ontario Research Institute

Rishi Kapur, MD, Child Psychiatrist, Children's Hospital of Eastern Ontario

Jaswant Guzder, MD, Child Psychiatrist, Psychoanalyst, and Family Therapist; Co-Director, Social and Cultural Division, Department of Psychiatry, University of British Columbia

Rajesh Mehta, MD, Child Psychiatrist; Director of Psychotherapy Training, Child and Adolescent Psychiatry Fellowship Program, Children's Hospital of The King's Daughters

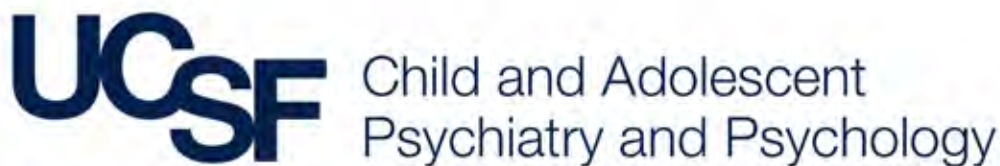
Deepika Shaligram, MD, Child Psychiatrist; Co-Director, Massachusetts Child Psychiatry Access Program, Boston Children's Hospital; Co-Chair, AACAP Diversity and Culture Committee and Task Force on Children, Families, and Immigration

Abigail Ross, PhD, Social Worker, University of Pennsylvania

Michelle Rickerby, MD, Child Psychiatrist; Co-Chair, AACAP Family Committee

Manijeh Daneshpour, PhD, System-Wide Couples and Family Therapy Director, Alliant University; Past President, Family Process Institute

Rao Gogineni, MD, Child Psychiatrist; President, Association of Family Psychiatrists



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AACAP's K12 Program Welcomes New Cohort

AACAP welcomed its sixth cohort of the AACAP Physician Scientist Program in Substance Use at this year's K12 Annual Retreat in Washington, DC, July 8–11. Supported by a National Institute of Drug Abuse (NIDA) Career Development Award (K12) first given to AACAP in 1998, the AACAP Physician Scientist Program in Substance Use funds up to five years of salary support, research support, and mentored substance use research training for a select cohort of qualified child and adolescent psychiatrists.

The Program evolved out of AACAP and NIDA's shared mission to:

- Increase the number of child and adolescent psychiatrist investigators conducting both substance use and mental health research, and
- Effectively disseminate pediatric substance use research to increase scientific knowledge and improve clinical practice

Between 1998 and 2025, 32 scholars completed the NIDA/AACAP program, making significant contributions to child and adolescent substance use research and clinical practice. Under the leadership of Program Directors, Bennett Leventhal, MD, Paula Riggs, MD, and Kevin Gray, MD, these scholars produced 1,145 peer-reviewed publications (297 first- or senior-authored), developed 1,642 scientific research presentations, and secured over 300 grant awards, including over 75 NIH R-series grants, 20+ U-series grants, 10+ P-series grants, and more than 60 foundation grants.

Alongside the current Program Director, Kevin Gray, MD, and Advisory Committee Chair, Manpreet Singh, MD, Sarah Hellwege, MEd, AACAP's Director of Research, Grants, and Workforce serves as the Program Administrator with strong support from Daphney Chancy-Green, MS, AACAP's Grants and Research Program Manager. Current K12 Advisory Committee members include Lillian Gelberg, MD, MSPH, Leslie Hulvershorn, MD, Yasmin Hurd, PhD, Frances R. Levin, MD, and Timothy E. Wilens, MD. Each



K12 Annual Retreat Participants

scholar also designates a primary home institution mentor to provide year-round research mentorship and participate as K12 program faculty during K12 annual retreats.

The K12 annual retreats are held in June just prior to the College of Problems on Drug Dependence (CPDD) Annual Meeting, and are designed to develop core competencies and skills necessary to scholars' successful academic career development. Supported by their mentors, Advisory Committee Members, Principal Investigator, NIDA representatives (Karen Seymour, PhD, and Geetha Subramaniam, MD), and AACAP staff, the new cohort receive expert feedback and guidance on their research. Over time, these retreats have become the cornerstone of the program, fostering the development of a strong, national community of scholars and mentors.

The six current NIDA/AACAP scholars, listed below, have demonstrated remarkable progress and academic achievement at this early stage of their career. We are confident they will soon join their predecessors as scientific leaders in the field.

Peter Jackson, MD

University of Vermont

Project: Foundations for Family Communication about Parental SUD: Measurement, Cohort Evidence, and Family-Informed Design

Primary Mentor: Hugh Garavan, PhD

Sivabalaji Kaliyamurthy MBBS

Children's National

Project: Developing a Brief Inpatient Intervention for Adolescents Using Cannabis

Primary Mentor: Richard Schottenfeld, MD

Amalia Londoño Tobón, MD

Georgetown University

Project: Adapting and Piloting a Multi-Component Obstetric Practice Approach to Increase Access to Perinatal Substance Use Disorder Care for Mother-Infant Dyads

Primary Mentor: Nancy Byatt, DO, MS, MBA

Elizabeth Olsen, MD

Brown University

Project: Our VOICES: Tailored Cannabis Use Intervention for Female Adolescents in Mental Health Treatment

Primary Mentor: Larry K. Brown, MD

Aaron Quiggle, MD, MS

Mass General/Harvard Medical School

Project: Controlled Trial of Delayed/Extended-Release Methylphenidate for Adolescents and Young Adults with ADHD and Cannabis Use Disorder

Primary Mentor: Timothy Wilens, MD

Tara Thompson-Felix, MD

Yale School of Medicine

Project: Cannabis Use in Pregnancy and Child Neurodevelopment: Investigating the epigenetic landscape of iPSC neuron and microglia derived extracellular vesicles

Primary Mentor: Linda Mayes, MD

We would like to congratulate the NIDA/AACAP K12 scholars. We look forward to your continued contributions to the field.

Membership **CORNER**

In Memoriam

William G. Bach, MD

Sandra Michael Elam, MD

Cleopatra Ortiz, MD

William Sack, MD

Theodore Shapiro, MD



Being an AACAP Owl

AACAP Members qualify as Life Members when their age and membership years total 103, with a minimum age of 65 and continuous membership.

Benefits: Annual AACAP Membership Dues are optional. A voluntary subscription is available for \$60. Receive the Owl Newsletter, which contains updates focused around your community!

Are you a Life Member who would like to be more involved in Life Member activities? Contact AACAP's Development Department at 202.966.7300, ext. 140.



Welcome **New AACAP Members**

Heather Addison, DO,
Chesapeake, VA

Megan Aguilera, MD, New Haven, CT

Haralambos Andrianakos,
Centennial, CO

Isaac Asemota, Greenville, NC

Sanjana Baliga, San Jose, CA

Marvi Buridi, MD, Prospect, KY

Tarah Celestin, MD, Washington, DC

John Chang, Riverside, CA

Loren Cobb, MD, Minneapolis, MN

Ethan Coleman, Kalamazoo, MI

Joao Pedro, Costa Cruz, Boston, MA

Sahar Delavari, MD, Pittsburgh, PA

Elijah Dorroh, Maple Heights, OH

Razaq Durodoye, Cleveland, OH

Abdallahman A. Elaksher,
Las Cruces, NM

Carly Fiest, New York, NY

Elizabeth Fuentes, Buffalo, NY

Julia Gex, Houston, TX

Maria Gianelle, MD, Baltimore, MD

Michelle Guo, MD, Cambridge, MA

Jeu-Hee Hahn, MD, Broomall, PA

Jasmine Hartsook, Spokane, WA

Carmen Hollifield, MD, Las Vegas, NV

Kai Huang, San Francisco, CA

Selma Janbey, MD, Brooklyn, NY

Kassidy Kanja, MD, Santa Clara, CA

Yeonju Kim, Detroit, MI

Ramya Kommidi, DO, Franklin Park, NJ

Lina Lew, San Francisco, CA

Nevin Lewis, Houston, TX

Conor Malloy, MD, Sarasota, FL

Anna Meehan, Chapel Hill, NC

Hakim-muta Muhammad, MD,
Newark, NJ

Jessyca Naegele, MD, Durham, NC

Niesa Nelson, Elmsford, NY

Amal Jude Noureldine, DO,
Las Vegas, NV

Ijeoma Nwugwo, Buffalo, NY

Amanda Nyuma, Portland, OR

Oreoluwajoju Olojede, Chicago, IL

Andrea Omehe, MD, Atlanta, GA

Andrea Orpia, Ellicott City, MD

Samuel Palmer, Nashville, TN

Pankti Parikh, DO, Bradenton, FL

Matthew Percello, DO, Albany, NY

Vanuyen Pham, Phoenix, AZ

Dhruv Raman, Philadelphia, PA

Philip Riendeau, Farmington, MI

Abdelrahman, Seif, MD, Lubbock, TX

Kara Shannon, MD, Houston, TX

Annabelle Song, Federal Way, WA

Matthew Spretz, MD, Shrewsbury, MA

Andrew Scott Tubbs, MD, PhD,
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Vinay K. Vaz, MD, Baton Rouge, LA

David C. Wang, MD, PhD,
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Grace Williamson, Philadelphia, PA

Lena Wood, Burlington, VT

Rohma Zaidi, Kansas City, MO

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Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

W W W . A A C A P . O R G

Policy Statement on the Role of AI in the Delivery of Child and Adolescent Mental Health Care

Background

Artificial intelligence (AI), also called augmented intelligence, including machine learning and predictive analytics, offers significant opportunities to improve mental healthcare for children and adolescents, such as enhancing care quality, assisting workflows, and integrating vast data.

The application of AI in the delivery of pediatric mental health care is still in its infancy. As AI science develops, important consideration should be given to transparency related to AI in clinical decision-making, security and privacy of patient and provider data, bias in development, and equity in the application of AI-supported mental health care and data analysis across all patient populations.

To ensure effective, safe, and ethical integration of AI into child and adolescent mental health care, the American Academy of Child and Adolescent Psychiatry recommends:

- Development of AI systems that prioritizes transparency and equity and includes rigorous testing and validation, including end-user testing in diverse real-world settings representative of the diverse US population, and continuous improvement processes informed by expert clinician feedback.
- Physicians and health systems disclose the use of AI in patient care activities to patients and families
- Robust data collection and management processes that protect the security and privacy of health data of minors and vulnerable patients, including the ability for data anonymization/pseudonymization.
- Clear national policies that govern healthcare AI adoption and utilization to optimize safety and mitigate inequities. Special attention must be given to the risks of AI to children and adolescents.
- State and federal regulatory requirements regarding oversight, transparency, disclosure, and audits to ensure automated decision-making systems do not reduce needed care, systematically withhold it, or override clinical judgment.
- Federal and state funding for comprehensive education for clinicians at all levels to practice in AI-enabled systems, covering fundamentals, ethics, uses, opportunities, risks, and limitations

*AI assisted in the creation of this position statement.

The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health.

Approved by Council June 2026

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

W W W . A A C A P . O R G

Policy Statement on the Use of Service Intensity Instruments in Pediatric Mental Health Care Planning

Background

A System of Care approach serves as an organizational framework and philosophy to strengthen the structure and delivery of mental health services by organizing child-serving systems in the System of Care to be family-driven and youth-guided in order to provide more effective coordinated interventions for children and adolescents with complex needs. The impact of this philosophy is evidenced by recent health care reforms including the movements toward value-based care, home and community-based care, and integration of behavioral health and primary care.

Research has consistently demonstrated improved clinical and functional outcomes when System of Care principles are applied. However, a gap remains: there is no universally accepted framework that reliably guides decision-making regarding service intensity needs while also serving as a validated tool for monitoring treatment outcomes. There are, however, service intensity assessment instruments* in the field that support the determination of mental health service needs across the lifespan of patients.

The youth-serving tools take into consideration pediatric developmental stages, complex and/or co-morbid health conditions, family and caregiver roles, and the nature of community supports in treatment and care planning and help identify a broad services array that should be universally available in a comprehensive continuum of care in order to effectively address the identified service needs of the population served. Notably, the effective use of service intensity instruments should be supported by training to ensure that users have the necessary knowledge and skills to properly utilize the instruments. It should be noted that other assessment instruments are useful in certain contexts but are limited by their reliance on diagnostic categorization and do not cover treatment intensity. However, they can be used to complement service intensity determination in mental health care planning.

To support national utilization of validated service intensity instruments in pediatric mental health care planning, AACAP recommends:

- Providers in all youth-serving systems of care and payors utilize service intensity determination instruments to identify the mental healthcare service array and supports that best meet the needs of children, adolescents and their families.
- Youth-serving systems adopt and utilize service intensity determination instruments to identify gaps in the service array and guide the development of a full continuum of pediatric mental health care services.
- System of care administrators utilize service intensity determination instruments to measure individual and program outcomes.
- State and federal policy makers mandate the utilization of service intensity determination instruments by youth-serving systems and insurance benefit utilization managers to support the appropriate clinically indicated allocation of mental health services and supports.

***Level of Care Utilization System**, developed by American Association for Community Psychiatry Child and Adolescent Service Intensity Instrument-Child and Adolescent Level of Care Utilization System, co-developed by American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry.

Early Childhood Service Intensity Instrument, developed by the American Academy of Child and Adolescent Psychiatry.

The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health.

Approved by Council June 2026

CLASSIFIEDS

Company: Newport Healthcare
(1382826)

Posted: 07/14/2026

Closing: 09/13/2026

Title: Medical Director Psychiatrist

Job ID: 22425058

URL: <https://jobs.source.aacap.org/jobs/22425058>

Job Description:

Newport Healthcare, is seeking a Medical Director Psychiatrist for the St. Cloud & Wright Co., MN Residential Treatment Programs for Adolescents & Young Adults. This role encompasses clinical & leadership responsibilities. Under the supervision of the Executive Director, the Director of Psychiatry assists in providing oversight of the Psychiatry team as well as managing a caseload, executing initial psych. evaluations for new residents with mental or emotional problems and offering counseling & psychotherapy to clients in distress. Are you a passionate psychiatrist ready to make a difference in the lives of young people? Join our dynamic team at Newport Healthcare, where you'll play a vital role in providing exceptional psychiatric care to our residents! Key Responsibilities: Collaborate with a dedicated mental health team to oversee psychiatric care for all residents. Conduct thorough psychiatric evaluations within 48 hours of admission. Attend to residents requiring psychiatric assistance during treatment. Facilitate staff training on key psychiatric issues and standards. Liaise with the Medical Director, Clinical Director, and outreach teams to build relationships with hospitals. Manage a caseload and document patient encounters through progress notes and EMR. Provide support for patient admissions, including initial evaluations and assessments. Maintain excellent communication with families and outpatient providers. Participate in weekly treatment team meetings and assist with utilization reviews. Ensure compliance with Physician Collaborative Agreements and provide age-appropriate care.

Job Requirements:

Education: Doctorate in Medicine (MD) required. Board Certification: Board Certified in Child & Adolescent and Adult Psychiatry. Licensed to practice in the State. Preferred Experience: Experience with adolescent psychiatry is required. Residential Experience: Experience in Residential and/or Inpatient settings is strongly preferred. Leadership Experience: Minimum of 5 years of Medical Director/Physician leadership experience is required.

Company: Windsor Regional Hospital
(1427162)

Posted: 07/10/2026

Closing: 09/09/2026

Title: Child & Adolescent Psychiatrists

Job ID: 22415922

URL: <https://jobs.source.aacap.org/jobs/22415922>

Job Description:

Windsor Regional Hospital (WRH) is seeking full-time and part-time hospital-based Child & Adolescent Psychiatrists to contribute to the top-tier care provided within our Mental Health Program. This is an exceptional opportunity to join an innovative, collegial, and well-established group of psychiatrists during an exciting period of restructuring. We are currently expanding our inpatient and consultation-liaison programs, seeking candidates who bring not only clinical excellence but a drive for sustainable modernization in service delivery. The inpatient unit is located at Maryvale Adolescent & Family Services, currently operating as a 6-bed acute unit with an average length of stay of one week. As a key member of our team, you will work within a mental health agency that integrates acute inpatient care with day treatment and outpatient counseling, providing a comprehensive continuum of care for young people in the Windsor-Essex and Chatham-Kent regions. Clinical Responsibilities of Active Staff: Inpatient Care: Sharing responsibility for youth inpatient services at Maryvale, managing acute cases for youth experiencing serious psychiatric problems. Consultation-Liaison:

Providing expert consultation services to admitted patients on the pediatric floor at WRH. Multidisciplinary Collaboration: Working alongside a specialized team of Social Workers, Child & Youth Workers, and Psychologists to deliver holistic care. On-Call Coverage: Participating in a shared on-call rotation with a dedicated team of Child & Adolescent Psychiatrists. Outpatient Follow-Up: Providing continuity of care through outpatient clinic follow-ups for the aforementioned patient populations. Academic Contribution: Serving as a role model and educator for undergraduate medical students and residents, with eligibility for faculty appointments with the Schulich School of Medicine & Dentistry. Why Choose Psychiatry at WRH? Innovative Culture: We are renowned for being an early adopter of new technology and a progressive program management model that supports clinical decision-making and accountability. Supportive Leadership: Work under a contemporary group of Department Chiefs and a Senior Leadership Team committed to best practices and sustainable change. Work-Life Balance: Enjoy great flexibility with full-time or part-time options and a highly attractive compensation and relocation package. Integrated Practice: Access to personal offices for private patient follow-ups or community referrals through Maryvale Adolescent & Family Services. Community: Live in a welcoming, friendly, and safe community with abundant additional practice opportunities in the surrounding area. Why Windsor Regional Hospital? Windsor Regional Hospital (WRH) offers the opportunity for a fantastic career in

an award-winning health care facility. WRH is a 600 bed multi-site health service organization providing Acute Medical and Surgical Services including Renal, Trauma, Emergency, Family Birthing Centre, Neonatal Intensive Care, Pediatrics Services, Critical Care (ICU/CCU), Regional Cancer Services (Inpatient Oncology, Windsor Regional Cancer Centre, Breast Health Centre), Neurosciences and Mental Health Services to 400,000 people in Windsor and Essex County. In recognition of the growing needs of the region, WRH plans for a major reform of the Windsor-Essex Hospitals System, which includes construction of a state-of-the-art acute care hospital. WRH is actively planning to break ground on the new acute care hospital in 2026. To learn more, go to <http://www.wrh.on.ca/windsorhospitals>

Why Windsor-Essex? The Windsor-Essex area is ecologically rich with extensive parkland along with a southwest location that extends warm weather activities such as golfing, gardening, and water sports. Windsor offers the unique opportunities of a larger metropolitan area and the benefits of a smaller community. Living directly across the border from Detroit, Michigan places you on a cosmopolitan stage where arts, culture, big league sports, and entertainment are just moments away. Best of all, you can enjoy access to all of these big-city advantages while living in the relative tranquility (and low costs) of a much smaller, friendlier community.

Job Requirements:

What you bring to Our Team: Hold or be eligible for certification by the Royal College of Physicians and Surgeons of Canada or hold US Board Certification (or equivalent) in Psychiatry. Possess

or be eligible for Ontario Licensure with the CPSO (CPSO pathway licensure is available for US Board Certified Physicians). A high level of professional competency in Child & Adolescent Psychiatry. Exceptional organizational and communication skills with a demonstrated commitment to interdisciplinary teamwork. A drive to contribute to the growth and modernization of our clinical services. Apply Today: Join us in providing essential, acute psychiatric care to youth in the Windsor-Essex region. Please submit your most recent CV and a letter outlining your interest to: Dr. Corina Velehorsch—Chief of Psychiatry C/o Chelsey Thornton—Medical Affairs careers@wrh.on.ca

Please note: Only those chosen for an interview will be contacted.

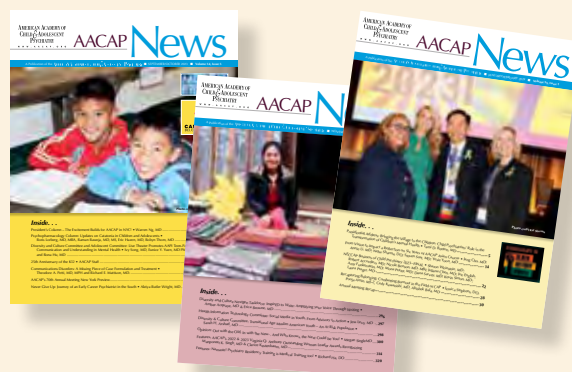
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- **Committees/Assembly.** Write on behalf of an AACAP committee or regional organization to share activity reports or updates (chair must approve before submission).
- **Opinions.** Write on a topic of particular interest to members, including a debate or "a day in the life" of a particular person.
- **Features.** Highlight member achievements. Discuss movies or literature. Submit photographs, poetry, cartoons, and other art forms.
- **Length of Articles**
 - ▶ Columns, Committees/Assembly, Opinions, Features—600-1,200 words
 - ▶ Creative Arts—up to 2 pages/issue
 - ▶ Letters to Editor—up to 250 words

Production Schedule

AACAP News is published six times a year—in January, March, May, July, September, and November. The 10th of the month (two months before the date of issue) is the deadline for articles.



Citations and References

AACAP News generally follows the American Medical Association (AMA) style for citations and references that is used in the *Journal of the American Academy of Child and Adolescent Psychiatry* (JAACAP). Drafts with references in incorrect style will be returned to the author for revision. Articles in AACAP News should have no more than six references. Authors should make sure that every citation in the text of the article has an appropriate entry in the references. Also, all references should be cited in the text. Indicate references by consecutive superscript Arabic numerals in the order in which they appear in the text. List all authors' names for each publication (up to three). Refer to *Index Medicus* for the appropriate abbreviations of journals.

For complete Policies and Procedures, please contact communications@aacap.org.

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