Presidential Address: Working Together—Innovating for Impact: A Call to Action to Address the Crisis in Children's Mental Health

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I am deeply honored to serve as your 37th President of the American Academy of Child and Adolescent Psychiatry (AACAP). Thank you for your support for our great leadership team at AACAP.

I will share a bit about who I am and how I came to a career in child and adolescent psychiatry, and—perhaps most importantly—how I came to my vision to address the ongoing mental health crisis facing children, families, and communities.

To put this moment in context, I want to first recognize the contributions of Presidents Drs. Warren Ng and Tami Benton, who have laid the foundation for our enduring innovation and growth. Through Dr. Ng's initiative **CAPture Belonging,** we have built our diverse and dynamic workforce, and through Dr. Benton's initiative **Bringing the Village to the Children,** we have established and deepened those collaborative relationships that are essential to move our field forward for children, families, and communities.

Together we have built our foundation and are ready to move into the next phase of our mission: Working Together—Innovating for Impact.

Before elaborating on my presidential theme for the coming years, I would like to tell you a bit about myself.

I was born and raised in the Twin Cities of St. Paul and Minneapolis, Minnesota. I was the fourth of 4 children, with 3 older sisters. My father was a clergyman, and my mother worked part time as an administrative assistant.

I attended public schools and went to college at the University of Minnesota during the Vietnam War era.

College during the Vietnam era bore no resemblance to college in the prior era or even now. The entire community was preoccupied with protesting the war: everyone—students and faculty alike—was literally on strike. The protest about the war in Vietnam was unfolding in the context of widespread social change—the civil rights movement, women's liberation, the sexual revolution, the free speech movement. The counterculture was surging, drug use was on the rise, there was Woodstock and the incredible music scene, bell bottom pants, tie-dyed shirts, long hair. It was truly a time of enormous cultural change that had a significant impact on me and on our country, which I believe has ongoing effects on our culture and politics today.[1]

My first exposure to medicine was during college, working the night shift at the University of Minnesota Hospital Information Desk. As you can imagine, it was pretty quiet at the Information Desk, so to pass the time I would hang out with the medical students, residents, and nursing assistants on the night shift. Just as college came to an end, so did the Vietnam War.

One night on break I saw an ad on a job board for a full time "psych tech" on the child psychiatry inpatient unit. I interviewed with Willam Easson, MD, and got the job. That was the beginning of my exposure to child psychiatry and the beginning of this journey. While working as a "psych tech," I went back to school, did the pre-med classwork, worked with some great child psychiatrists, and was accepted to the University of Minnesota Medical School. I considered a number of pediatric specialties; but, in the end, I followed my heart, and completed my general psychiatry and then child psychiatry clinical and research fellowship at Yale and the Yale Child Study Center.

My first faculty position was at Johns Hopkins, running an adolescent inpatient unit. I transitioned to the training director after a few years on faculty, got a career development grant from the National Institute of Mental Health (NIMH), participated in a number of NIMH clinical trials (which all went by their initials: TADS, CAMS, TEAMS, TASA, CBIT) as well as some industry-sponsored trials of selective serotonin reuptake inhibitors (SSRIs), all of which established the evidence base for our current treatment of depression, anxiety, bipolar disorder, suicide in teens, obsessive-compulsive disorder, and Tourette syndrome.

Concurrently, I became engaged with the team at the Johns Hopkins Center for Indigenous Health, working with the team to develop substance use and suicide prevention interventions with tribal communities in the southwestern United States.

After 20 years at Johns Hopkins, I moved to become the Division Director at Weill Cornell Medicine in Manhattan, and more recently took on the leadership role as Department Chair of Child and Adolescent Psychiatry at the Ann and Robert H. Lurie Children's Hospital of Chicago. Along the way, I served as the *JAACAP* Deputy Editor for Psychopharmacology for 10 years and was elected as Councilor at Large for 3 years.

Looking back, there are so many people to thank along the way: my early mentors in child psychiatry at the University of Minnesota; the team of faculty in general and child psychiatry at Yale; and, perhaps most importantly, those people at the Yale Child Study Center and Johns Hopkins who started me on the academic and leadership pathway.

My current team includes my colleagues at Lurie Children's Hospital—we have over 80 faculty and 250 employees in our department. You know many of our leaders led by Aron Janssen, MD, Vice Chair for Clinical Services; Andrea Spencer, MD, Vice Chair for Research; Scott Compton, PhD, Vice Chair for Psychology; and Jon Chapman, LCSW, our Executive Director.

Over the years, working on the Orange *Journal* and presenting at AACAP's institutes and annual meetings has been a joy. Learning with you has shaped my practice and my leadership. I bring that experience and my love for child and adolescent psychiatry to this presidency.

SO WHAT I HAVE LEARNED IN MY CAREER, AND WHAT DO I WANT TO DO AS PRESIDENT OF AACAP?

It was the work in Indigenous communities that exposed me to the imperative to take a public health approach to mental health. Like my job as a psych tech, my ongoing involvement at the Johns Hopkins Center for Indigenous Health and now projects in Chicago were career changing for me. These experiences convinced me—and I hope to convince you—that to address our current mental health crisis, we need to "widen our lane"[2] and develop a population mental health approach to child mental health.

SO WHAT ARE WE FACING IN THIS YOUTH MENTAL HEALTH CRISIS?

We are seeing many young people with mental illness who benefit from our treatments, yet too often they lack the personal, family, or community resources to move beyond symptom relief to full recovery. We also see a growing number of young people who might otherwise be well but arrive overwhelmed by despair, disconnected from peers and school, and unprepared for a rapidly changing world. Their families and communities are under strain and need a clear roadmap to support their children, restore connection, and bring calm and predictability to daily life.

Recently (October 20, 2025), the American Academy of Pediatrics, AACAP, and the Children's Hospital Association renewed, for the fourth year running, our Declaration of a National Emergency in Child and Adolescent Mental Health,[3] which began during the COVID-19 pandemic and has continued as new and potentially ongoing disruptions and uncertainty are affecting children, their families and communities.

To address this challenge, we need to expand beyond individual or small group treatment approaches to incorporate population-based approaches—prevention, mental health promotion, and recovery strategies with a focus on community-based programming.

Promoting population mental health is not new, but our country desperately needs a cohesive, evidence-based, and policy-supported approach to anchor population health within the full continuum of mental health care. Child and adolescent psychiatrists are natural leaders in this work, but we need to develop our strategy, prepare ourselves, and get to work.

HERE IS WHAT A PUBLIC HEALTH APPROACH AND THE POTENTIAL FOR POPULATION-WIDE IMPACT LOOKS LIKE ON THE GROUND

My first experience at the Johns Hopkins Center for Indigenous Health[4] was working with the White Mountain Apache Tribe in Arizona.[5] Johns Hopkins had a long-term relationship with the White Mountain Apache and had built a trusted partnership working on a number of challenges largely focused on infectious disease prevention.

I was in my Hopkins Division Director's office when a call came in from the Johns Hopkins Center asking if anyone was willing to join a meeting the next day with the White Mountain Apache tribal leadership. The Tribe were seeking a consultation with the Hopkins Center regarding a recent spike in youth suicide. I said "yes."

The next day, over 20 inches of snow fell in Baltimore. I drove in and, even though Johns Hopkins was "closed," the team at Hopkins and tribal leadership all came together.

We began by listening to tribal leaders and learned very quickly about the many challenges facing the youth, their families, and community; yet, at the same time, how

important it would be for any solution or program to build off the community's ongoing resilience to historical and current adversities.

Given the challenging mental health treatment landscape on the reservation, we worked with tribal leaders to begin building a family-based program to interrupt the intergenerational cycle of historical trauma and adversity.

The idea of a family focused intervention was fully aligned with the Tribe's traditions and values and took advantage of the Tribe's focus on family and clan as the source of resilience in the face of ongoing adversity.

And from a public health point of view, it was also clear that strengthening families is core to the development of strong communities, and that strong communities have the capacity and are essential to meet the kind of health and mental health challenges the Tribe was experiencing. Our goal was to develop a mental health prevention and promotion partnership with the ultimate goal of focusing on strengthening young families as key to reducing youth suicide and substance abuse risk.

The result is the "Family Spirit" program,[6] which employs local Indigenous family health educators to go into the homes of pregnant teens and younger moms and work with them until their child's third birthday. Data from that intervention have documented the value for both the parent and child.[7] While initial efforts focused on a home visiting intervention for pregnant teens, the home visiting model is now used more broadly by the community to work with youth at risk for suicide, support fathers' roles in their families, address chronic health problems common in Native communities like type 2 diabetes, and maintain the reproductive capacity of the community with sexually transmitted disease prevention and treatment. The home visiting–based model of care was also critical during the darkest days of the COVID pandemic, supporting families with food and resources to stay healthy.

After about 10 years of working on the Family Spirit program, the Tribe experienced another spike in suicide. As a sovereign nation, the White Mountain Apache responded by developing a suicide surveillance system that included mandated reporting of suicidal thoughts and behavior, and related binge drinking and drug use. Building on the home visiting model of Family Spirit, the suicide surveillance and prevention initiative called Celebrating Life[8] has resulted in decreased rates of suicide within the community during a time when suicide rates were increasing in the rest of the country.[9]

The Family Spirit early childhood home-visiting intervention is now an evidence-based intervention endorsed by several federal and state review boards that make it eligible for federal funding. Nearly 200 Native communities and several non-indigenous communities in the United States have been trained to use it, and now Indigenous communities in Canada, Australia, and New Zealand are adapting the model with the Center for Indigenous Health.

Such rapid and widespread dissemination is truly possible when communities own, integrate, implement, and sustain promotion and prevention activities into their communities. Dissemination happens when other communities with similar challenges understand that they have the people, the need, and the wherewithal to take on the challenge. Perhaps most importantly, the White Mountain Apache have built capacity within their community to continue their effort to take on current challenges and those that might come along in the future.[10]

Two people I have work closely with for over 25 years are Novalene Alsenay Goklish and Francene Larzelere Sinquah. While I am privileged to have been their mentee, I am also proud to have been able to join them on their professional journey from their work on "Family Spirit" and "Celebrating Life" through getting their doctorates in psychology and joining the faculty at Johns Hopkins.

Another example is here in Chicago, where Andrea Spencer, MD, and I have been fortunate to work with Communities United,[11] a youth leadership development program that engages young people in systems change. The Communities United program "Healing Through Justice" creates a pathway for youth to learn about themselves and their communities, identify relevant issues to work on, and then move to action to effectively address long-standing health and mental health disparities in their communities.

The Communities United program is intentional in addressing the mental health needs of youth with whom they work, while at the same time working for systems change in the community. Their programming has evolved to reflect youths' observations that when they are engaged in meaningful, purpose-driven activities, they experience personal healing from the collective trauma that they, their families, and communities have experienced.

This observation—the healing power of meaningful, purpose-driven activity coupled with both personal and community-based narrative change—has transformed how I understand and think about trauma and, particularly, the collective trauma so many of our communities experience.

We are currently developing the materials and processes to broadly implement "Healing Through Justice" in Chicago, to not only demonstrate its effectiveness in systems change but also to document improvements in youth well-being. We believe that other youth-facing organizations can and will be excited to make intentional the healing power of the core principles of Healing Through Justice and work toward rapid and extensive dissemination across communities.

One more shout out. Maria DeGillo was my first contact at Communities United; she continues to keep me

on my toes. She also introduced to the United co-directors Jenny Arwade and Raul Botello, and the literally hundreds of young people who have found a way to heal themselves while working to heal their community.

WHY HAVE THESE COMMUNITY-BASED INTERVENTIONS BEEN SO SUCCESSFUL?

It is very clear to me—and I hope I have convinced you—that the leadership of the community in the design and implementation of mental health programming can have big population-wide impact.

If we want to fully address today's mental health crisis, we need to learn from these and many other community-based examples and build within child psychiatry the capacity to engage and work collaboratively with youth, families, and communities.

Today, my message to you is this: "Listen to the lived experience of families and communities; they will point us in the right direction, give us their all, and we will build on their strengths and traditions of resilience."

This is the future of an expanded vision of population mental health in child and adolescent psychiatry.

WHY NOW?

We are so ready. Our workforce has never been stronger, and it is eager to engage. Thank you, Dr. Ng. Our partnerships are deep and active, and we are engaged in children's mental health like never before. Thank you, Dr. Benton. AACAP's Central Office has the leadership, resources, and personnel to get the work done. You are here today, invested in AACAP. We are ready, and we will build our strategy with your help.

WORKING TOGETHER—INNOVATING FOR IMPACT

There are 4 major areas of focus in Working Together: Innovating for Impact

- Working Together
- Innovating for Impact—Mental Health Promotion, Prevention, and Clinical Care
- Innovating for Impact—Education and Training
- Innovating for Impact—Research and Scholarship

The goal of Working Together is to partner with members, AACAP committees and teams, and community allies to build a strategic plan that advances a public mental health mindset.

We will work to empower youth and families and will partner with pediatrics, schools, community organizations, and government to scale solutions. To meet this moment, we need focus and discipline. We will set clear priorities, sequence the work, and hold ourselves accountable for results. We will invest in what works and will track progress with measures that matter to the children, families, and communities we serve.

I am very optimistic for our future, but I do understand the world we live in offers many challenges to our beliefs and values. We can debate ideas and have difficult conversations but need to remain aligned around what brings us together—serving children, families, and communities.

In an effort to promote unity and empower us for the future, we held a Town Hall: Spirituality in Mental Health at AACAP's 2025 Annual Meeting on October 23, 2025. The 5 panelists—each from a different spiritual tradition—discussed their understanding of the role of spirituality in mental health, the pathway of spiritual connection with others, and, importantly, provided guidance as to how we as child psychiatrists can care for our best selves while serving children, families, and communities.

INNOVATING FOR IMPACT—MENTAL HEALTH PROMOTION, PREVENTION, AND CLINICAL CARE

I believe we have a pretty good idea of what needs to be done at all levels of mental health care. Yet our program development processes and methods of care delivery need to be updated to match the world in which children and families live.

I have been impressed, over the past couple of years, with the number of intervention innovators who have come upon the scene who are not necessarily tracking in the traditional pathway of research.

I believe we need to rethink our pathways of innovation and discovery, and embrace the energy of this generation of innovators. They have much to teach us about discovery and implementation!

As we advance a population approach, we will also strengthen day-to-day practice. AACAP will continue to press for parity, fair reimbursement, and policies that let teams deliver high quality.

At AACAP's 2025 Annual Meeting, we discussed many ways we are supporting members. You can visit AACAP's website to learn more.

INNOVATING FOR IMPACT—EDUCATION AND TRAINING

There are so many young people today who are interested in psychiatry that we need to be relentless in thinking about how best to make the pathway to child psychiatry more

direct and transparent for undergrads, pre-meds, and medical students. Like everything we have discussed today, starting really early in the recruitment process and becoming a strong public advocate for mental health will be critically important to engage the next generation of child and adolescent psychiatrists.

The nature of training will have to change, too, if we are to fully embrace a population health approach. We have historically focused on mastering clinical and professional skills. The next generation of child psychiatrists will also have to be trained in team building and leadership and in advocacy to fully realize our role as leaders in population mental health.

This shift in our role needs to start at the earliest levels of training, but we need to continue to work with established child and adolescent psychiatrists to meet current-day needs and challenges. Dr. Benton launched the Collaborative Leadership Initiative Steering Committee this year with a plan to support a competitive annual Collaborative Leadership Training Initiative, starting in 2027.

INNOVATING FOR IMPACT—RESEARCH AND SCHOLARSHIP

Roughly 20 years ago, national research funding shifted decisively toward basic science. The balance moved from about half clinical and half basic science to something closer to 80% basic.

The decade prior was a robust decade of child psychiatry clinical research that built our workforce and generated foundational trials in attention-deficit/hyperactivity disorder, anxiety, major depression, bipolar disorder, autism care, and more. As funding priorities changed, support for clinical studies and for training child and adolescent psychiatrists as clinician-scientists receded dramatically.

The world hasn't stop asking questions that we are uniquely positioned to answer—like how to improve well-being for all children, address and prevent suicide, reduce disparities, spread what works, and deliver care that is personalized, measured, and high quality. If we align funding, mentorship, and partnerships around these aims, we can convert discovery into impact for the children, families, and the communities we serve. It is my belief we have a ready workforce eager to tackle these challenges and to innovate in promotion, prevention, and clinical care.

Here is how we move forward, together:

- Launch a presidential task force on Working Together—Innovating for Impact.
- Engage our External Advisory Board to set clear targets for advocacy and action.
- Broaden member engagement through ongoing governance review and Pathways to Leadership initiative.
- Build our capacity for leadership through our *Collaborative Leadership Training Program.*
- Center youth, family, and community voice in strategic planning to learn what works and where we must improve.
- Convene regular listening sessions with members and AACAP leadership.
- Mobilize Regional Organizations of Child and Adolescent Psychiatry (ROCAPs) to translate our mission in culturally responsive ways across the diverse populations and cultures in the United States.
- Advocate for federal investments that rebuild the innovation infrastructure and bring effective models to scale.
- Align this work in a unified strategic plan with priorities, timelines, and transparent progress updates.

SUMMARY

Working with communities has taught me that our greatest assets are already here in our communities. When we develop strong partnerships and pair what we know with what communities want to do, we strengthen families and communities and create local solutions that last. We are ready to take on the challenges we face. We have a skilled and energetic workforce, strong collaborations, experienced staff, and the will to lead. Each of you in this room and watching on their screens proves every day that, by working together, we can innovate for impact. Let's seize this moment for the children, families, and the communities we serve. Together we will build a system worthy of their future.

[a]Ann and Robert H. Lurie Children's Hospital of Chicago and Northwestern University Feinberg School of Medicine, Chicago, Illinois; [b]President of the American Academy of Child and Adolescent Psychiatry, 2026-2028.

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