MENTAL HEALTH WEEKLY
Essential information for decision-makers

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SAMHSA earlier this month released new strategic guidelines for behavioral health care and treatment. SAMHSA announced new priorities this month with officials indicating they will no longer be sidetracked by "misguided policies" or investments in "unsupported clinical interventions." SAMHSA also indicated plans to move away from the support of specific populations. Leaders in the field indicate that the planned strategies represent a retreat from important and impactful innovations over the past several decades.
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SAMHSA's new strategic priorities raise concerns, mixed reaction in the field

The Substance Abuse and Mental Health Services Administration (SAMHSA) on Sept. 10 unveiled a sweeping overhaul of its strategic priorities, sparking mixed reactions across the behavioral health field (samhsa.gov/about/strategic-priorities). In its newly released executive summary, the agency pledged to "change the trajectory" of serious mental illness, addiction and loss of life by abandoning what it calls "misguided policies" and "unsupported clinical interventions."

SAMHSA emphasized a shift toward "gold-standard science and research," while distancing itself from any "unlawful focus on specific populations."

The priorities reflect a broader alignment with the Trump administration's "Make America Healthy Again" agenda and include expanded involuntary treatment, reduced support for harm reduction and Housing First models and a rejection of diversity, equity and inclusion (DEI) initiatives, SAMHSA officials stated.

Bottom Line...
Some in the field are concerned that SAMHSA's new strategic priorities may unravel decades of progress and advances made in integration and peer support, for example.

In its executive summary, SAMHSA indicated that it would leverage its data, expertise, resources, training and technical assistance to advance:

- Preventing substance misuse, abuse and addiction;

See **SAMHSA** page 2

Lagging numbers in CARE Court continue to stoke California debate

Nearly two years after the first group of California counties began implementing a legislatively approved measure to refer individuals with serious mental illness to mandated treatment, deep division remains over the appropriateness of the state's direction. Individuals' and groups' judgment concerning the CARE (Community Assistance, Recovery and Empowerment) Court initiative largely rests on their views in general about the efficacy of coerced mental health care.

Those who argue against the state's commitment to CARE Court believe some recently published numbers back their claim, as a nonprofit news organization's analysis has shown an extremely limited impact of the program in most California counties so far. At the same time, however, momentum has built toward expanding the conditions under which a judge could mandate an individual's treatment.

Disagreement likely will continue over the question of whether

Bottom Line...
California appears headed toward expanding the criteria under which individuals with serious mental illness can be referred to and retained in involuntary treatment in the CARE Court program.

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- Addressing serious mental illness;
- Expanding crisis intervention care and services;
- Improving access to evidence-based treatment for mental illness, substance use and co-occurring disorders;
- Helping individuals achieve long-term recovery and sobriety; and
- Identifying and addressing emerging behavioral health threats.

The federal agency has indicated it has already put these strategic priorities to work for the Department and Administration, such as expanding outpatient treatment and civil commitment and convening a technical expert panel on ending homelessness.

Among its priorities, SAMHSA indicated the agency will deprioritize support for "housing first" policies that fail to ensure accountability and fail to promote treatment, recovery and self-sufficiency. SAMHSA will increase competition among grantees through broadening the applicant pool and hold grantees to higher standards of effectiveness in reducing homelessness and increasing public safety.

SAMHSA stated that it will ensure that federal funds for Certified Community Behavioral Health Clinics reduce rather than promote homelessness by supporting, to the maximum extent permitted by law, comprehensive services for individuals with serious mental illness and substance use disorder, including crisis intervention services.

Concerns

The Alliance for Rights and Recovery indicated that "while there are several notable items, more details are needed to best understand their actual intent and impact. At the same time, there are a number of plainly stated priorities that represent wholesale retreats from many of the most important and impactful innovations of the past 50 years."

"SAMHSA's 'new' approach represents an outrageous and reckless repudiation and retreat from decades of progress that have been proven to draw people away from rather than engage them to the help they need and want," Harvey Rosenthal, CEO of the Alliance for Rights and Recovery, told *MHW*. "Instead, these regressive approaches have proven to be ineffective in successfully engaging and serving people who have been failed or not responded to traditional approaches by removing access to trusted lasting relationships and undermining approaches that recognize cultural and gender diversity."

Rosenthal also noted that "the Administration and its allies have suggested the heinous coercive use of involuntary institutionalization or injections that trample people's rights and self-determination."

"Engagement is the key," added Rosenthal. "We've learned to start with where people are including linking people to lifesaving housing first models rather than withholding access to housing based on compliance with traditional treatment and returning us to police-based first responder approaches rather than using very successful models that rely on teams of mental health works and emergency medical technicians."

The new direction threatens to unravel decades of progress according to Ron Manderscheid, Ph.D., a longtime advocate and adjunct professor at Johns Hopkins and University of Southern California. In an article published by the Action Alliance, Manderscheid warned that SAMHSA's realignment "risks undoing the advances made since the late 1990s in recovery orientation, consumer voice, peer support, integrated care and the recognition of behavioral health as inseparable from overall health."

Manderscheid wrote in part, "SAMHSA's newly announced priorities represent more than a bureaucratic shift — they threaten to reverse 25 years of progress in behavioral health. By sidelining recovery, weakening consumer voice, marginalizing peer support, narrowing integration efforts and retreating into fragmented categorical silos, SAMHSA risks

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undoing reforms that have improved lives across the country."

He added, "Stakeholders must respond quickly to ensure that behavioral health policy continues to move forward — not backward — so that the vision of recovery, dignity and full community inclusion remains central. This will involve reaching out to work with SAMHSA to change the priorities just announced. The next 25 years of progress depend on it."

share these goals and are committed to ensuring our members can deliver benefits that are both effective and of the highest value."

She added, "Our members believe the next step is not only to expand access, but to elevate it, ensuring that access means high-quality, evidence-based care. They are eager to play a leadership role in making sure Americans with mental health and substance use disorders receive effective treatment that is also affordable and sustainable."

"SAMHSA's current priorities reflect an emphasis on measurable, evidence-based clinical interventions, broader access and more targeted use of resources to address challenges such as overdose and serious mental illness."

Debbie Witchey

ABHW seeks leadership role

"SAMHSA's current priorities reflect an emphasis on measurable, evidence-based clinical interventions, broader access and more targeted use of resources to address challenges such as overdose and serious mental illness," Debbie Witchey, CEO of the Association for Behavioral Health and Wellness, told *MHW*.

The agency's framing suggests a shift away from what it views as ineffective or outdated approaches and toward standardization and a focus on interventions with proven impact, she stated. "At ABHW, we

Witchey noted that SAMHSA's emphasis on measurable outcomes and access to evidence-based treatments such as MAT (Medication-Assisted Treatment), crisis services and care coordination addresses urgent gaps like overdose and untreated serious mental illness. "This approach can help direct resources to the highest impact services," she said. "At the same time, many with lived experience and community providers stress the importance of recovery supports, including peer services, housing, employment and long-term psychosocial care. A framework that leans too narrowly on clinical interventions risks sidelining these critical elements of recovery. Stable funding, technical assistance and workforce investments remain essential to building a system that responds to the full spectrum of needs."

Witchey also commented on the proposed consolidation of SAMSHA and the Health Resources and Services Administration (HRSA) (see "Field responds to 'dramatic restructuring' of SAMHSA into new agency," *MHW*, April 7; https://doi.org/10.1002/mhw.34401). "If the goal of consolidation is to create a health care system that delivers better outcomes in the most efficient way possible, it is a laudable effort," she said. "If, however, the primary objective is cost-cutting, the result could be even greater harm for people living with mental health and substance use disorders. Consolidating SAMHSA and HRSA into the new Administration for a Healthy America brings both opportunities and risks."

She noted that if done well, it can strengthen integration between behavioral health and primary care, streamline funding and guidance, align workforce development and raise the visibility of behavioral health across federal priorities. "Yet the transition also carries risks of operational disruption and a shift in focus away from recovery and peer support. Ultimately, success will depend on capturing the benefits of efficiency and alignment while preserving the expertise and recovery frameworks essential to meaningful, long-term outcomes," Witchey stated. •

APA, LMSA partner to advance Latino mental health equity

Observing a need to address longstanding disparities in mental health care, the American Psychiatric Association (APA) and the Latino Medical Student Association (LMSA) last week announced a strategic collaboration aimed at improving behavioral health outcomes for Latino communities nationwide. The partnership will focus on expanding access to culturally responsive services, increasing the number of Latino mental health professionals and

Bottom Line...

This strategic collaboration will focus on increasing access to culturally responsive MH services and evidence-based information and expanding the pipeline of Latino MH professionals.

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dismantling systemic barriers that hinder equitable care.

Through joint initiatives such as educational campaigns, workforce development programs and research on Latino behavioral health needs, APA and LMSA aim to foster lasting change, officials stated. The collaboration also includes support for APA's Spanish-language resource hub, LaSaludMental.org, and advocacy for policies that promote linguistically appropriate care. Leaders from both organizations emphasize that this alliance is not only timely but essential to ensuring Latino communities receive the mental health support they deserve.

The partnership aligns with APA's broader diversity and health equity initiatives. "This collaboration reflects one of APA's strategic priorities to invest in health equity initiatives," Theresa Miskimen Rivera, M.D., APA, told *MHW*. "It also builds on past partnerships." APA has previously collaborated with groups such as the National Latino Behavioral Health Association and promoted initiatives like the Hispanic/Latino Behavioral Health Center of Excellence, showing a consistent commitment to Latino mental health, she said.

"The effort also strengthens APA's long-standing focus on ensuring psychiatry is inclusive and representative, consistent with initiatives like the Diversity Leadership Fellowship program," Miskimen Rivera added.

"We are highly motivated this year to engage in strategic partnerships that allow us to advance our mission of diversifying the physician workforce in the U.S. while also creating innovative benefits and opportunities for our members," Christopher Hernandez Salinas, vice president of operations for LMSA, told *MHW*. "In these trying times, forming allyship is crucially needed for LMSA and we are hopeful that by engaging in such collaboration, we can reach more people while also advancing the mission of the APA."

New initiatives

Through this partnership, APA and LMSA will work together on a range of initiatives, including:

- Developing joint educational campaigns to raise awareness about mental health in Latino communities, such as APA's Spanish-language resource website, LaSaludMental.org.;
- Promoting policies that support culturally and linguistically appropriate services;
- Conducting research and data analysis on Latino behavioral health needs and outcomes; and
- Supporting workforce development and training programs for Latino psychiatrists and mental and behavioral health professionals.

Collaboration moving forward

While addressing specific outcomes APA hopes to achieve through this collaboration in the next three years, Miskimen Rivera noted that it is essential to expand access to culturally responsive resources. "APA and LMSA will build on APA's Spanish-language platform, LaSaludMental.org, to provide more Latino families with evidence-based information tailored to their needs," she said.

Miskimen Rivera added, "We also want to increase awareness and reduce stigma. Joint educational campaigns will normalize conversations around mental health, echoing APA's broader public education efforts like Mental Health Month campaigns and Spanish-language materials."

"This partnership will help reduce stigma by promoting culturally tailored resources and education that resonate with Latino communities," said Salinas. "By increasing the visibility of Latino psychiatrists and future physicians, we hope to normalize conversations about mental health and show that seeking care is both safe and empowering."

He added, "Through joint initiatives, we can address misconceptions directly, uplift community voices and highlight mental health as an integral part of overall well-being. Together, LMSA and the APA will foster trust and create pathways for care that honor culture and identity."

Miskimen Rivera noted that APA continues to ensure mental health services are culturally and linguistically appropriate for Latino communities. "We continue to expand our resources," she stated. "Our website LaSaludMental.org is central to APA's effort to reach Spanish-speaking communities with accurate and culturally resonant information. APA also promotes training of bilingual providers and the use of interpreters, reflecting our understanding that language is often a barrier to care."

"We are continuously engaged with policy advocacy. APA continues to advocate for federal and state policies that fund and require linguistically appropriate services, building on its past statements on parity and equitable access," she said.

Workforce development

"Another vital step, one that I am focusing on in my presidential year, is supporting workforce development," Miskimen Rivera said. Consistent with APA's Minority Fellowship Program and equity-focused workforce initiatives, this partnership will emphasize training opportunities and programs that expand the pipeline of Latino psychiatrists and behavioral health professionals, she explained.

"APA supports research into workforce gaps and disparities, using data to guide interventions and ensure that services meet the cultural and linguistic needs of Latino communities," said Miskimen Rivera.

APA also wants to advance policy advocacy. "APA has consistently urged federal and state leaders to support parity, telehealth and culturally competent care," she said. "This collaboration reinforces APA's role in shaping policies that guarantee linguistically appropriate services for Latino populations."

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FROM THE FIELD

Unseen Risks: How AI chatbots threaten vulnerable youth

By by J. Ryan Fuller, Ph.D.

I am a clinical psychologist and co-founder of a SaaS [Software as a Service] company employing AI in mental health. I am horrified by young lives lost as the government does not step up to study and regulate AI chatbots.

Adam Raine, only 16 years old, committed suicide in April 2025. He had many troubling interactions with ChatGPT, which reinforced suicidal thoughts, provided guidance on methods and even offered to help draft a suicide note, according to *The Guardian*. His parents have sued OpenAI.

A similar tragedy befell Sewell Setzer III, a 14-year-old boy, in February 2024. His parents sued Character.ai after a chatbot with whom he had a disturbing relationship encouraged him to "come home," as reported in *The Washington Post*. This haunting phrase led him to take his own life.

These cases underscore an urgent call to action: AI chatbots are not hypothetical risks to mental health; they are already impacting lives in devastating ways. The potential dangers of AI replacing human connections have become painfully real.

It's easy to see how anyone experiencing internal torment, desperation and isolation could be tempted to seek solace from a chatbot. This artificial entity can quickly become your best friend, biggest fan or romantic partner.

But instead of providing appropriate human support, AI can push one deeper into isolation, pulling a vulnerable person into an illusion of intimacy and comfort.

These tragedies are a glaring reminder of the dangers AI can pose, especially to children. A 2021 SAMHSA report found that 20% of adolescents experienced a depressive episode in 2020, rates that are likely rising. Many are at risk.

AI has permeated mental health care as chatbots are marketed as tools for bridging the gap to access. The National Eating Disorders Association's now-defunct AI chatbot, "Tessa," provided life-threatening dieting advice. Anorexia nervosa, one of the deadliest mental health disorders, exemplifies how AI's guidance could be fatal. These examples illustrate the urgent need for comprehensive regulation.

As a clinical psychologist deeply invested in both the promise and the perils of AI, I recognize that chatbots could expand access to care, especially at times when live support is unavailable. But there is also capacity for harm.

The seductive convenience of an AI companion that never tires or judges can easily replace real, human connections crucial for healing, growth and genuine mental well-being.

Avoiding the risks of initiating and maintaining human relationships is the very essence of what psychologists work to eradicate in those suffering from anxiety and depression. Without the risks of judgment, criticism or rejection, humans won't learn the necessary skills to manage their emotions or navigate interpersonal conflicts.

Chatbots *feel safe*, but that faux safety can bring danger. Preventing pain and risk exacerbates anxiety and depression, erasing opportunities to learn necessary life skills, and frequently leads to isolation and despair. AI's substitute for human interaction is especially concerning for adolescents, whose developing brains may be more sensitive to social stimuli and isolation.

Research shows quality relationships are vital to mental health, life satisfaction and even longevity. Conversely, social isolation exacerbates depression, anxiety and, tragically, suicidal ideation. AI may reduce immediate feelings of loneliness, but could also worsen long-term mental health outcomes by discouraging the pursuit of real relationships.

The stakes could not be higher. The U.S. Food and Drug Administration would never consider releasing a pharmaceutical that children could access, if there was even the slightest risk of danger.

What will it take to have an effective institution created to fund the necessary research, provide rigorous testing and propose immediately needed policy?

AI chatbots are widely available and marketed to children. There are no safeguards providing significant protection. It is a "Wild West" scenario for our most vulnerable, our children.

I do not suggest a halt to AI development, but I believe firmly that regulation, research and safeguards be established before AI's effects on mental health escalate. Policymakers must swiftly engage in this conversation to ensure AI is both effective and safe, just as drugs are regulated to protect users.

AI is not just another tool. It has the power to shape our psychology, relationships and even our sense of reality. We need a comprehensive, government-backed research initiative to monitor AI's influence on mental health, social networks and even family structures.

I can't imagine what the loved ones of Sewell Setzer III and Adam Raine are experiencing. It's

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heartbreaking that the government and private sector have done so little.

We cannot afford to be passive in the face of technology that can both save and threaten lives. Our society must prioritize safety over profit, regulation over rushed deployment and human connection over digital convenience. It's time for policymakers to step up and ensure AI serves as a tool for support, not a pathway to despair.

J. Ryan Fuller, Ph.D., is a clinical psychologist, executive director of New York Behavioral Health and co-founder of My Best Practice, an evidence-based electronic health record for mental health practitioners that integrates AI technology. With 20+ years of experience in mental health research, clinical practice and education, he also coaches start-up founders in mental health technology.

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The partnership with the APA aligns directly with LMSA's long-term goals of advancing Latino health equity, particularly in the area of mental health, said Salinas. "We are prioritizing three initiatives: launching a dedicated blog in collaboration with LaSaludMental.org to provide targeted content on Latino mental health and medical student well-being, expanding our psychiatric specialty section with the APA's support to create mentorship and pathways for students interested in the field and co-hosting sessions at our national and regional conferences to bring culturally-tailored mental health resources to our members," he stated. •

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there has been enough time to offer any definitive judgment on the merits of California's approach to addressing the needs of persons with serious mental illness, many experiencing homelessness.

"Inherent in this population, it takes time," Le Ondra Clark Harvey, Ph.D., CEO of the California Council of Community Behavioral Health Agencies, told *MHW*. "These are the sickest of the sickest people."

Analysis of numbers

Earlier this month, the news organization CalMatters published an analysis based on data from all California counties and a series of interviews; the last of the counties to launch the program came on board at the end of last year (see "Amid lingering concerns, CARE Court in California goes statewide," *MHW*, Dec. 16, 2024; https://doi.org/10.1002/mhw.34272). The CalMatters report found that through July of this year, only 2,421 petitions to the court system had been filed, even though the law allows a broad diversity of professionals and family members to file petitions.

Moreover, only 528 of the more than 2,400 petitions led to approved treatment agreements or treatment plans. These numbers are far below what Gov. Gavin Newsom and state officials had been projecting in advancing the CARE Court concept. This is happening in part because the law's narrow criteria for qualifying an individual for mandated treatment are resulting in dismissal of nearly half of the filed petitions.

"Inherent in this population, it takes time. These are the sickest of the sickest people."

Le Ondra Clark Harvey, Ph.D.

CARE Court eligibility has been limited to individuals experiencing schizophrenia and other psychotic disorders, as the program's mission has focused on assisting individuals seen as lacking the ability to pursue and maintain treatment.

Also, the vast majority of successful petitions thus far have led to voluntary treatment agreements that the court system has little capacity to enforce. Only 14 of the 528 successful petitions have resulted in court-mandated treatment plans that are designed to offer a year of services and lead to a program graduation.

Other problems uncovered in the CalMatters report include logistical difficulties for petitioners in fulfilling program requirements. A San Diego County behavioral health program leader said in the article that many overworked clinicians and first responders fail to show up as required at the first court hearing following a filed petition. In other cases, once petitioners have seen some requests being denied, they have grown reluctant to pursue further efforts.

It is looking increasingly likely that the response to some of these concerns will come in the form of expanded criteria for program eligibility. As *MHW* was going to press, it

appeared that a bill sponsored by State Sen. Thomas Umberg was headed toward final passage; the measure's main provision would expand the program's covered mental health conditions to include bipolar disorder with psychotic features. Judges also would be required to consider CARE Court as an option in misdemeanor cases in which an accused individual is deemed incompetent to stand trial.

Umberg told *MHW* that he sees the rollout of CARE Court as an "incremental process." He and his legislative staff report that some cases have been getting dismissed because individuals have shown some progress, but sometimes progress has been defined too broadly to include just one meeting with a caseworker or a short-term use of a medication.

Clark Harvey agrees that the establishment of CARE Court reflects a desire to do better for this high-need population, but also believes there needs to be better training of the personnel involved in the program and wider use of peers and culturally responsive staff. She said broadening the categories of eligible individuals "could be concerning if we haven't identified best practices."

The law was originally characterized as a vehicle for reaching untreated and unhoused individuals, with some leaders hoping it also would offer relief to family members desperate to get help for a struggling loved one.

Seven California counties began implementing the CARE Act in October 2023, with Los Angeles County joining in two months later. According to the CalMatters report, Los Angeles County still had no successful program completions as of the end of July.

Some strong opposition

Several groups remain bitterly opposed to the CARE Court concept. In a July letter to the state Assembly Appropriations Committee, Mental Health America of California termed CARE Court "an unproven statewide mental health program that has cost taxpayers millions of dollars as California faces a multi-billion-dollar deficit."

A senior attorney with the Western Center on Law and Poverty, which in 2022 filed a legal challenge in an attempt to block implementation of CARE Court, wrote in a July online article that the program remains flawed because local governments are under no obligation to provide the necessary treatment and housing support for the affected individuals.

Attorney Joy Dockter wrote that "the challenge is that besides CARE Court, there are no existing structures within counties to hold multiple systems collectively accountable to deliver housing, health and other services to people who are unhoused and struggling with debilitating mental illness. Western Center encourages the state to seek solutions that will actually increase the availability of intensive behavioral health care, and not merely force more people into a system that is not equipped to help." •

Preschoolers with ADHD often medicated against guidelines

A new Stanford Medicine–led study has found that many preschool-aged children diagnosed with attention deficit hyperactivity disorder (ADHD) are being prescribed stimulant medication within just one month of diagnosis — contrary to treatment guidelines set by the American Academy of Pediatrics (AAP). The findings, published in *JAMA Network Open*, raise concerns about the clinical decision-making process and highlight systemic gaps in access to behavioral interventions.

The study, "ADHD Diagnosis and Timing of Medication Initiation Among Children Aged 3 to 5 Years," highlights a gap in medical care for 4- and 5-year-olds with ADHD. "The purpose of the research is to determine to what extent pediatricians are adhering to guidelines for the treatment of ADHD," Yair Bannett, M.D., MS, assistant professor of Developmental-Behavioral Pediatrics at the Stanford University School of Medicine, told *MHW*.

Bannett had conducted previous studies involving ADHD treatment, most recently a medical chart review study two years ago in *JAMA Pediatrics*, "Rate of Pediatrician Recommendations for Behavioral Treatment for Preschoolers with Attention-Deficit/Hyperactivity Disorder Diagnosis or Related Symptoms."

The results of that cohort study suggest that within a large community-based health care network, most preschool-aged children with primary care provider–diagnosed ADHD or ADHD symptoms were not offered first-line, evidence-based behavioral treatment.

"What's unique about our [current] study is that we specifically looked at the timing of the ADHD medication treatment and how quickly it started," Bannett indicated.

Study method

Researchers conducted an analysis of medical records from nearly 10,000 young children with ADHD who received care in eight pediatric health networks in the United States. Participants were children aged 3 to 5 years seen between 2016 to 2023. Data were extracted from the PEDSnet database on April 18, 2025. Researchers also evaluated patient factors associated with the time from first diagnosis to prescription.

AAP guidelines

Recognizing the early onset of ADHD, the AAP subcommittee published updated evidence-based clinical practice guidelines for primary care management of ADHD in 2011 and reaffirmed in 2019, the study indicated. These guidelines include a separate set of recommendations for

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management of ADHD and ADHD symptoms in preschool-age children (aged 4–5 years).

The guidelines recommend that primary care pediatricians start with parent training in behavior management and then consider medication treatment with methylphenidate as a second-line treatment, given stronger evidence for behavioral intervention than for medications in this age group.

These guidelines recommend that children under age 6 begin with six months of behavioral therapy before medication is considered, Bannett noted. Behavioral therapy for children with ADHD is focused on the parent or the caregiver; it does not involve individual therapy. It's called parent therapy or behavioral management, Bannett explained. A teacher could do it, he said.

The evidence-based behavioral treatment recommended by the AAP is called parent training in behavior management. The training helps parents build strong, positive relationships with their children; offers guidance in rewarding a child's good behaviors and ignoring negative behaviors and recommends tools that help children with ADHD, such as making visual schedules to help them stay organized.

Today, there are online options that can assist parents, including self-led training, said Bannett. Group therapy is another option where parents meet with other parents to learn strategies and talk about challenges. Adults can learn strategies around behavioral modifications, changing environment or using a positive discipline approach versus a punitive one, said Bannett.

Results

Of 712,478 children seen in primary care at ages 3 to 5 years, 9,708 (1.4%) had an ADHD diagnosis (disorder level) at ages 4 to 5 years. The rate of ADHD diagnosis was variable across institutions (0.5%–3.1%). The median age at first ADHD-related diagnosis was 5.31 (4.86–5.66) years. Of 9,708 children with ADHD, 7,414 (76.4%) were male; 1,762 (18.1%) were Hispanic; 122 (1.3%) were non-Hispanic Asian; 3,014 (31.0%) were non-Hispanic Black; 479 (4.9%) were non-Hispanic multiracial; 3,782 (39.0%) were non-Hispanic white; 148 (1.5%) were non-Hispanic other; and 401 (4.1%) were of unknown race and ethnicity; 6,624 (68.2%) were prescribed medications for ADHD, including stimulants (5,131 children [77.5% of prescribed children]), nonstimulants (1,108 children [16.7%]) and both (385 children [5.8%]). Rates of ADHD medication prescriptions varied across institutions.

The research found that Asian, Black and Hispanic children are less likely prescribed medication earlier compared to white children, said Bannett.

Overall, approximately two-thirds (68.2%) of preschool-age children with ADHD seen in primary care were prescribed ADHD medications before age 7 years, with 42.2% of children prescribed within 30 days of their initial ADHD-related diagnosis, contrary to practice guidelines that recommend first starting with evidence-based nonpharmacological intervention.

"We found evidence for disparities in care with high rates of early medication treatment among white children and those with public insurance," said Bannett. "These findings highlight the need to investigate factors influencing early medication treatment of preschoolers with ADHD, especially in specific patient subgroups."

He continued, "We're planning the next study that would involve looking into the medical charts of children diagnosed with ADHD." Behavioral treatment is the only way to capture clinical notes documented by physicians, Bannett added.

Clinicians who work with children with ADHD should always try to offer a behavioral treatment approach, if possible, he noted. Bannett cited an online program, Triple P — Positive Parenting Program, which helps parents with interventions for children with ADHD. •

Coming up...

Mental Health America is holding its annual conference, "Turn Awareness into Action," **Oct. 16–17** in **Washington, D.C.** Visit **https://mhanational.org/conference** for more information.

In case you haven't heard...

A new study from Michigan State University's Department of Kinesiology suggests that augmented and virtual reality (AR/VR) sports games may enhance psychological well-being and reduce loneliness. Led by assistant professors Sanghoon Kim and Sangchul Park, the research found that AR/VR games such as virtual table tennis or bowling foster social connection through avatars, real-time communication and nonverbal cues. Published in the *International Journal of Human-Computer Interaction*, the study surveyed 345 players and revealed that those more engaged in AR/VR sports reported higher psychological well-being. The benefits were especially pronounced among individuals experiencing loneliness, suggesting that virtual social presence can positively impact mental health. However, researchers caution that AR/VR gaming isn't a universal solution. Some users may struggle with virtual interaction, limiting its effectiveness. The authors urge practitioners and policymakers to consider both the potential and limitations of AR/VR sports games in mental health strategies. "These findings show that well-being is shaped by both enjoyment and social experience," Kim and Park noted, emphasizing the need for thoughtful integration of gaming into therapeutic contexts.